Stress and coping strategies among immigrant caregivers in elderly care: A qualitative study from Western Norway

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Abstract

Background: In the wake of an increasingly ageing population, the reliance on immigrant health workers has increased. Various studies have demonstrated that caregiving is stressful and that stress-related outcomes are especially high among this group.

Aims: This study aimed to explore how immigrant health workers experience working in elderly care in western Norway.

Methods: Data from thirteen immigrant caregivers was collected between March 2020 and August 2020, using semi-structured face-to-face interviews. Thematic network analysis was used to identify key themes that captured participant experiences. Job demands-resources theory was used in this thesis to further interpret participants' experiences.

Findings: Work stress was a major problem and was conceptualized by participants as closely related to language barriers, staffing problems, a strained relationship with patients, and poor cooperation with colleagues and superiors leading to various adverse work outcomes and poor work satisfaction. Participants highlighted a range of coping strategies which include maintaining a positive perspective, positive aspects of work and quitting as an alternative in which all these leads to their increased well-being.

Conclusion: The findings extend current knowledge about immigrant caregivers' work stress by identifying the challenges within their workplace and providing a basic understanding of how they deal with their daily work constraints. The findings outline how participants understood, managed and motivated themselves to cope with their daily work challenges, stay well and improve their overall job satisfaction in their work lives.

Keywords: Job demands-resources theory, Sense of Coherence, immigrant care workers, care work, nursing homes, long term care, work stress, coping strategies

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Abbreviations and Acronyms

NAV: Norwegian Labour and Welfare Administration

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Dedication

I dedicate this study to my parents and belated grandfathers and grandmothers.

Chapter 1 Background

Introduction

In the wake of an increasingly ageing population, there is an increasing reliance on immigrant healthcare workers to adequately meet the ageing population's care needs in western societies (1-10). In Norway, the recruitment of immigrant workers into caregiving for the elderly has become imperative. Immigrant caregivers are amongst the most vulnerable members of society which is often concealed from the public eyes and public policy (11). Due to the precarious positions of immigrants, immigrant caregivers are often involuntarily engaged in 3-D jobs (dirty, dangerous, and demanding) (11). For example, lower-paid and less skilled jobs (e.g., care assistants) with unsatisfactory working conditions (12). Unsatisfactory working conditions, for example, the experience of staffing problems, a strained relationship with patients and poor cooperation with colleagues and superiors can challenge and jeopardize immigrant care workers' well-being and require them to draw upon their resources. Sometimes, they are also being degraded or demeaned due to their immigrant status (11). For example, being disrespected by their patients, colleagues, and superiors. In addition to this, working within an environment that requires them to use not their native tongue can also be very challenging. Care work is precarious and can negatively affect the well-being of both care workers and their care recipients (13). Prolonged exposure to these working environments can lead to compromised health outcomes (e.g., strains (14) such as stress, burnout and feelings of dissatisfaction (15)) and adverse organisational outcomes (e.g., increased workers turnover rate (16-18), decreased job satisfaction (19, 20), and decreased quality of care (18)) among them). Also, immigrants' precarious position can prevent them from making any changes to their working environments (21). Based on studies of immigrant health workers, this study aimed *to explore how immigrant health workers experience working in elderly care in western Norway*. Using empirical examples from my interviews, I have highlighted how immigrant caregivers experience their work-life, followed by their coping strategies to adjust to their work expectations and how these challenges have pushed them to the breaking point.

Healthcare workforce

According to the Norwegian Labour and Welfare Administration's (NAV) survey, the health and care sector needs around 12,750 people to occupy the healthcare sector positions, which are 950 more than the year before. NAV estimates that there is a lack of 4,500 nurses and 1,100 special nurses throughout the country (22). Around 1650 of those nurses are required within Central Norway. The shortage of nurses can threaten the quality and the sustainability of the health care system within Norway. To address this crisis, Norway invites nurses from other countries (23). At the beginning of 2019, the immigrant population accounted for 14.4% of the total population. The majority of immigrants (48%) originate from countries in the European Economic Area (EEA), followed by Asian (34%) and African countries (14%) (22).

The Oxford Advanced Learner´s Dictionary of Current English defines an immigrant as "A person who has come to live permanently in a country that is not their own." (24). The parallel term in Norwegian, *innvandre*r is an individual who comes from abroad to settle down for good- *"kommer fra utlandet for å slå seg ned for godt."* (25). In this study, "immigrant" is used to refer to my participants.

Immigrants are increasingly seen to constitute a vital supplement to 'native' professional care in Norway. In the past, informal care work's responsibilities were given mainly to women (26, 27). However, the current trend is that an equal number of men contribute to the labour market (28). Therefore, informal care by family members is primarily replaced by formal care services provided by the municipalities. Long-term increased life expectancy and rapid growth of Norway's ageing population coupled with declining domestic labour supplies (28) have presented serious challenges: particularly concerning the care needed for a growing number of elderly people. In this 'care deficit' situation, immigrant caregivers play an essential role in remedying the increasing demand for workers, care for the ageing population, and mitigating the problem of 'care deficit' (29, 30) for long-term care services within Norway.

Nursing homes have played a pivotal role in Norwegian elderly care for decades (31). The increased demand for adequate long-term care services has intensified the pressure on nursing homes to recruit qualified health care professionals. Due to the deficiencies of healthcare workers (26), nursing homes are seen using the Active Labour Market Programs (ALMP) to target the unemployed groups of immigrants to address the shortage of native-born caregivers

(29, 30). In Norway, this category of caregivers commonly includes '*pleieassistent'* or 'unskilled healthcare assistants'. While most hiring is done through nursing homes who are obligated to have "sufficient and professional staff," it is they who decide what is "sufficient" and "professional". There are no formal staffing requirements in place: for instance, the ratio of registered nurses to the number of residents (32). Widespread use of unqualified staff can be seen in long-term care run by the municipalities (33). The use of unskilled healthcare assistants in care work within long-term care facilities can have broad implications for their working conditions, thus, affecting the quality of care they provide to the elderly, their working environments, and their overall well-being.

Care work

Many immigrants were classified as "less skilled" in Norway despite having a college or university education level. Immigrant nurses can be seen having difficulty transferring their education to their new home country (26, 34) and, therefore have to work within lower positions indicated by their education (26, 35). Thus, leading to them involuntary work in lower-paid and less skilled jobs (e.g., care assistants) (36).

Care work refers to "occupations in which workers are supposed to provide a face-to-face service that develops the recipient's human capabilities". The term "human capabilities" refers to the "health, skills, or proclivities that are useful to oneself or others" and which involves "physical and mental health, physical skills, cognitive skills, and emotional skills" (37). A previous study of 2001 defined care work as "the work of looking after the physical, psychological, emotional, and developmental needs of one or more other people" (38).

Care work has been classified according to two groups: firstly, the care work that includes a direct conversation with the patient, which can be demonstrated as face-to-face activities referred to as "relational" care. This kind of care work typically depends upon nannies, childcare workers, nurses, doctors, teachers, caregivers in nursing homes. While, for the elderly, the caregivers provide the care work in households. The second one refers to those activities which do not involve face-to-face activities such as cleaning, cooking, laundry, and other household tasks for proper maintenance, which refers to "non-relational" care (39). In this study, care work performed by the participants [('*pleieassistent'* or 'unskilled healthcare assistants', authorised semi-skilled professional '*helsefagarbeider' or* 'healthcare workers' and

'hjemmesykepleien' or 'home-based health care')] included both- "relational" care and "non-relational" care in nursing homes and residential homes.

Work stress in care workers

Stress refers to a pattern of negative physiological states and psychological responses occurring in situations where individuals perceive threats to their well-being, which they may be unable to meet" (40). In the workplace setting, stress involves the relationships between individuals and their working environments that are considered as challenging or exceeding their (job/individual) resources and jeopardizing their well-being (41). Stressors are the environmental stimuli that impact the well-being of the individual: strains involve the individual's physiological and psychological reactions to such stressors, and adverse health outcomes are the negative health conditions of the individuals who are exposed to stressors (42). The most frequently cited occupational stressors for full-time workers (including care workers) are job demands, in which many of whom are experiencing increased levels of work-related stress, fatigue (43-46) and feelings of dissatisfaction (15).

Job demands are one of the most common sources of work-related stress. In the long-term care centres, caregivers' working environments are demanding and strenuous (15) as they provide care to patients whose demands are significantly high (47-53). This type of caregiving can cause excessive strains (14) such as stress, burnout and feelings of dissatisfaction (15) and is thus a major work stressor. Caregivers must always be on the lookout as falls are a continual risk for patients with high care demands (54) which require tremendous attention. This potential risk increases the caregivers' physical efforts (e.g., the lifting of heavy elderly) as well as contributes to poor health such as chronic low back pain (52), an increase in the rate of injuries from repetitive motion and psychological stress (55). Taking care of patients with high care demands can jeopardizing the well-being of caregivers (41). A recent study showed that one-third of the care workers reported that they are not in optimal health (52). Deteriorating health was the primary reason which leads to poor organisational outcomes such as the immigrant care workers' desire to quit their job (52). These working environments challenge and jeopardize the caregivers' physical and psychological well-being and require them to utilise personal or job resources. In the domain of occupational stress, work stressors (e.g., caring for patients with high care demands) are equated to job demands, where such working environments require sustained physical/ psychological efforts from them, finally resulting in

considerable physiological and psychological hazards and leading to adverse organisational outcomes.

The most commonly reported work stress or stressor within the caregiving workforce is 'work overload' (when work demands exceed the caregivers' ability to meet them) (56-59). For example, working environments with low "caregivers to resident ratios" and working within limited job resources (56). Besides, immigrant caregivers are expected to do more work than their native co-workers (common workplace discrimination (52)), leading to them enduring a heavier workload and working overtime (52). A cross-sectional survey on nurses using a self-administered questionnaire showed that as much as 4.4% were being exposed to an unmanageable workload (60) which can heighten occupational stress (61-63) and burnout (64). Work stressors (particularly work overload, limit participation in decision making, and client disability care) were shown to lead to burnout ($p < .001$) (64). Researchers, using between 37 and 86 different studies samples from all types of occupations (thus not limited to care work), found that prolonged workload, role conflict, and role ambiguity can increase workers' dissatisfaction, result in anxiety, and lower work commitment leading to burn out (64-68). Thus, in the domain of occupational stress, the high workload is equated with job demand, which can lead to health impairment outcomes (e.g., illness or injuries (69), poor health and well-being (70, 71)). Adverse organisational outcomes from job demands (high workload) included increased workers' turnover rate (16-18), decreased job satisfaction (19, 20), and poor quality of care (18). A literature review conducted by Hayes et al. (2012) focused on the causes and consequences of worker turnover within healthcare institutions. They found that excessive workload can cause worker turnover particularly when there exists low job control, lack of team support (18), and perceived lack of control (56, 58, 72). Commonly reported lack of control is within decision-making situations, time management, and appears to contribute to feelings of frailty and helplessness. Besides, immigrant healthcare workers could often believe that they were unable to change their working environments (72). The precarious position of immigrants can therefore impede their ability to make any changes to their working environments (21).

Emotional demands are closely akin to stress and professional burnout (73) and can be an important aspect of care work that entails significant interactions with people (e.g., patients, colleagues and superiors). Immigrant care workers' daily experiences can include stress arising from the social aspects of the working environments such as physical, mental, and sexual abuse

(74-77), bullying, harassment, and discrimination (76). Workplace harassment differs from discrimination where it involves negative actions toward a worker due to attributes (e.g., race, ethnicity or gender) that lead to a hostile work environment whereas discrimination refers to unequal treatment or limiting of opportunities due to these attributes (78). Inappropriate sexual behaviour is commonly reported by informal and formal caregivers (79, 80) and the perpetrator of workplace injustice can be an institution, an organization, a supervisor, a colleague, or a client (76). In a Norwegian representative sample (including care workers in a nursing home), as much as 1.1% of participants self-labelled as victims of sexual harassment, whereas 18.4% reported exposure to sexually harassing behaviour during the last six months (81). Nurses (including other care workers) are more likely to experience offensive behaviours than other occupational groups (82). Unskilled service providers who work alone are at a higher risk of being exposed to clients' misbehaviour (83). Furthermore, Nielsen et al., (2017) highlighted that care workers are unlikely to label inappropriate sexual behaviour from patients as harassment, especially towards demented or cognitively impaired patients. Their study included group interviews with care workers, managers, shop stewards, and safety representatives in hospitals (with most of the interviewees being trained nurses) working in nursing homes, community health centres, rehabilitation care centres, and psychiatric residential facilities (82). Meta-analytical findings provided evidence that victims of sexual harassment report higher levels of general stress, depression, anxiety, posttraumatic stress, psychosomatic complaints as well as reduced productivity and job satisfaction (84-88). Sexual harassment can be considered a major work stressor (84).

Workplace bullying is a social stressor that can impact the well-being of the victims (89). Kandelman and colleagues (2018) examined the risk factors for job burnout among nursing home caregivers in France (90). These included death announcements, pain assessments, working in a profit-making establishment, and the antecedent of bullying by a resident. Workplace bullying is one type of harassment that involves actions that harass, offend or socially exclude a worker or group of workers or that negatively impact the person or group's work tasks (91). Nybakken and colleagues (2018) likewise noted the prevalence of aggressive and bullying behaviour toward caregivers by nursing home residents with dementia. Their study was a meta-ethnography set in five countries (92). Lack of appreciation and respect is another significant social stressor commonly observed within work relationships of caregivers, upper management, nurses, patients, and their families (72, 93, 94). Furthermore, clients are more likely to engage in aggressive behaviour, especially when they are not satisfied,

intoxicated, or find themselves in a stressful situation (83). The caregivers' and care recipients' relationship, thus, can also be ambivalent and shaped by exploitation and discrimination (95-98).

Experiences of discrimination, harassment and bullying in the workplace can function as stressors provoking a psychological and/or physiological stress response (76). An unjust working environment (abuse, discrimination, harassment and bullying) can result in caregivers experiencing adverse work-related outcomes (99, 100). Health impairment outcomes included poor psychological and physical health (91), depression (101-103) and burnout (104). Adverse organisational outcomes included loss of confidence as a professional (105), diminished work motivation (106), decreased job performance (91) and job dissatisfaction (107). The behavioural (e.g., quitting the job) and psychological reactions (e.g., Dissatisfaction and frustration) of a worker can be significantly influenced by the relationships with their colleagues and their superiors (108-115). Negative feelings such as dissatisfaction and frustration can arise when their work is not valued by other people within their organisation (e.g., being treated like a slave) (93), feeling lonely and abandoned due to lack of support from their colleagues (116), and a feeling their supervisors do not acknowledge their suggestions or feedback (117), often leaving them with unresolved queries (94, 116). Unjust working environments in the domain of occupational stress are, thus, equated with job demands.

Job stress can also arise from personal aspects such as role insufficiency where a worker's education, skills, appropriateness of the worker's training and experience to job requirements cannot suffice the job demands. The impact of communicating in a second language on stress has been long recognized in psychology (118). A recent phenomenological study conducted in Japan's formal long-term care setting had highlighted the impact of language barriers as a factor contributing to workers' stress and how it deters workers from acquiring leadership positions or advancing in their profession (52). Immigrants who do not speak the host country's dominant language are more vulnerable to occupational injuries (119). Thirty per cent of those with severe occupational injuries in a Norwegian emergency ward had a non-Scandinavian language as their first language (119). Thus, role insufficiency in the occupational stress domain is equated to job demands. In the context of this study, a language barrier constitutes an instance whereby the participants cannot communicate with their patients or colleagues because of differences in languages spoken or differences in proficiencies of a common language.

Study rationale and aims

Research on caregiver' work stress and its implications are scarce, with the caregivers usually being mixed in with other health workforce groups, e.g. nurses (120). For the past 10 years, many international studies have focused on care workers' work stress and their health outcomes within the elderly care setting. These displayed no results of any studies which focused on immigrant care workers' work stress and its outcomes within elderly care settings in Norway. The most recent Scandinavian study considering care workers' well-being was conducted by Åhlin et al., (2015) in Sweden on registered nurses and nurse assistants (non-immigrant) working in public and private nursing homes in Sweden (121). Other studies were performed in Canada (122, 123), Spain (124, 125), Israel (126) and Austria (127). However, these studies do not involve caregivers who are immigrants. Thus, by far, only limited studies have been conducted on immigrant healthcare workers in Norway (26, 35, 95, 128-131). However, these studies do not consider immigrant care workers' work stress and their implications.

In Norway, the literature on elderly care workers considers immigrant care workers as a valuable resource in meeting workforce challenges (129, 132-134). Immigrant care workers' experiences of work stress, whether physical, emotional, mental, or social can negatively impact them, their employers, and their patients. Zúñiga et al., (2015) found that better quality of care was associated with less stress experienced by the workers, and suggested more support in handling work stressors was required to promote quality care in nursing homes (135). There is a need to identify better ways of supporting these workers to enable them to better manage their work stress. However, before these can be developed, there is a need for an improved understanding of their work-life and the coping strategies they employ in response to challenges in their work-life which influence their daily work stress along with its impact on their health, motivational process, and care quality.

Research questions

Based on the overall interest in immigrant caregivers' daily work experience of work stress as elderly care providers, the research aims to seek answers to the following research questions:

1. How do immigrant caregivers experience their work-life?

2. What are the coping strategies that these immigrant caregivers employ in response to challenges in their work-life?

Theoretical framework

Job demands-resources theory

Care work can jeopardize the health and well-being of care workers since their working environments are often demanding and strenuous (15). Prolonged exposure to high-stress working environments: more specifically, demanding aspect of work (e.g., work overload, time pressure, and difficult physical environments) can lead to negative work outcomes. Workers are likely to experience health impairment due to arising physiological, psychological, and/or emotional traumas experienced by the workers (136, 137) (e.g., exhaustion (138, 139), burnout (140-142), physical "overuse" injuries and stress-related illness (45, 143-150)) which can lead to negative organisational outcomes. For examples, a decreased in productivity (151), decrease in work engagement (152, 153), impaired in-role performance (151, 154), higher level of worker turnover (151), absenteeism (151, 155) and a significant drop in overall contributions to the organisation (156). Thus, increased job demands could lead to increased work-related stress and work stress-related outcomes.

In the workplace setting, work-related stress involves the interactions between individuals and their working environments which exceed the workers' resources (e.g., personal resources and/or job resources), capabilities and skills to cope: thus, jeopardising their health and well-being (41). Hence, the working environment is one of the most important resources of occupational stress (157). One of the most influential models of work stress is the 'job demands-resources model' (154, 156, 158, 159) which proposes how a worker's well-being can be shaped by two sets of working environments (job demands and job resources).

Job demands-resources theory represents an extension of the job demands-resources model. Job demands-resources theory proposed workers' health impairment outcomes and negative organisational outcomes as a response to the imbalance between job demands and resources. Furthermore, different coping strategies (e.g., personal resources and job crafting) could influence how workers experience work stress within their working environments. As such, the job demands-resources theory appears particularly relevant for exploring subjective

perceptions and experiences of work stress for immigrant caregivers. Therefore, this theory is used as a theoretical framework to better understand immigrant caregivers' work stress, work motivation, health and well-being.

The first set concerns job demands which represent work characteristics that exceed the worker's adaptive capabilities which eventually lead to stress. More specifically, job demands refer to those physical, psychological, social, or organisational aspects of the job that requires constant physical and/or psychological efforts and are therefore associated with certain physiological and/or psychological costs (159). When stress is generated by excessive job demands and insufficient job resources, it can be termed as work-related stress. Job demands could become job stressors when demands require higher effort for which the worker does not have the resources (160). Thus, job resources can act as a form of stress-coping elements. Under stressful working environments, workers look upon job resources (both person and organisational context) as a way to cope with job demands.

The second set of working environments concerns the extent to which the job offers resources to the worker which motivates them and mitigate the repercussions of higher job demands (161). Job resources refer to those physical, psychological, social, or organisational aspects of the job that are: (a) functional in achieving work goals: (b) reduce job demands and the associated physiological and psychological costs: or (c) stimulate personal growth, learning, and development (158, 162). Job resources can appear in many different forms: organizational (e.g., salary, career opportunities), interpersonal and social support (e.g., supervisor and co-worker support), work organisation (e.g., role clarity, participation in decision making), and the task (e.g., performance feedback, skill variety). In general, workers with a wide range of job resources will have their basic psychological needs met (e.g., the needs for autonomy, relatedness, and competence) (162-164). Job resources can buffer the impact of job demands on the job strain including strains and burnout (165, 166), and are key components to increase well-being and positive organisational outcomes such as work engagement, enjoyment and motivation (158, 167). Social Exchange Theory which also proposes that relationship are a valuable resource in initiation, strengthening and maintaining interpersonal relationships (168). For example, having a good relationship and working well together is a critical aspect of individuals' coping strategies. Besides, good relationships also activate a motivational aspect within the worker. Positive outcomes, for instance, Bakker et al.'s (2004) study of human

service professionals (thus not limited to care workers) showed that good relationships lead to dedication and extra-role performance (154) for workers.

Coping strategies

Coping strategies influence the ways the participants evaluate or assess their work stress and their working environments. Stressors can negatively impact individuals, however, they mainly depend on appraisal and adaptation processes (169). A job demand may lead to positive as well as negative outcomes depending on the job demands themselves as well as on the individual's coping ability. Coping is the process of responding to stress or, more specifically, the thoughts and actions that individuals use to manage the specific demands (external and internal) of stressful situations (125) that are appraised as impacting or exceeding the resources of the worker" (169). Coping inflexibility can impair the ability to adjust to stressors (170). Positive coping outcomes included motivation, stimulation or job satisfaction while negative outcomes include increases vulnerability to depression, anxiety or burnout.

Personal resources and job crafting have been integrated into job demands- job resources theory and are important elements in understanding worker's coping strategies within their working environments. Personal resources are positive self-evaluations linked to resiliency and refer to individuals' sense of ability to control and impact their working environment (171). Workers with personal resources (e.g., optimism, self-efficacy, hope, and resilience) are less likely to experience work stress and burnout (140) and have better well-being and job performance (172). The other coping strategies proposed by the job demands-resources theory is job crafting. Job crafting refers to workers proactively optimize their working environments by adjusting their job demands and job resources (140) to make their work less stressful and more meaningful (173) which can indirectly lead to increase work engagement and job satisfaction (174). Aaron Antonovsky theory on the sense of coherence that discussed theories behind stress and coping using three elements (comprehensibility, manageability, meaningfulness) was used to describe participants' positive self-evaluations and job crafting in the utilisation of resources and transforming their job demands into dignified work which indicate their overall well-being and their motivation indirectly.

With respect to the study's research questions, two categories (job demands and job resources) of the working environments are connected to participants' well-being and work engagement.

Furthermore, the coping mechanisms that are adopted by them is another factor to consider (125). Thus, job demands-resources theory was used as a framework to better understand immigrant caregivers' health impairment and motivational processes within their workplace.

Chapter 2: Methodological approaches

Qualitative study design

A descriptive qualitative design was used in this study to explore immigrant caregivers' experiences in the Norwegian healthcare system in Western Norway. The qualitative research approach allows researchers to gather rich and complex in-depth information of a phenomenon in the real-life context as experienced by the participants (175).

An exploratory multi-case study was chosen to obtain an in-depth appreciation of these issues (176). The research was a multi-case study that involved three different municipalities in and around Bergen (Bergen, Alver and Bjørnafjorden) as well as three different types of care (nursing homes, residential care homes and private home care). The geographical coverage of this study involved multiple municipalities in improving transferability. Thirteen participants worked in the nursing homes (13 participants), 1 participant worked in the residential care home and 4 participants worked in the private home care. Bergen had 11 participants, Alver (1 participant), and Bjornafjorden (1 participant). All participants were working or have been working in the nursing homes before moving to residential care home and private home care institutions. Several participants were found working in several Norwegian healthcare institutions (nursing home and private home care) and different municipalities at the same time. Four participants work in both nursing homes and private care homes.

Data collection

Sampling strategy

Purposive sampling, in which study participants are selected strategically given their experience or knowledge of a particular phenomenon, was employed. The study participants' experience as immigrant unskilled health workers in elderly care in the Norwegian health system, qualified them for participation in the study.

Recruitment

The difficulties in gaining access to specific fieldwork settings have been well documented by ethnographers (177-180). Upon approval from the municipalities, I used multiple recruitment approaches, including contacting the nursing homes and my network for research study participation. Some nursing home did not respond to the request or turned down the request. The primary reasons cited by non-participating institutions included considering the worker's well-being, especially during the stressful period of the Corona-19 crisis that had tremendously increased their workload. Two municipalities, Voss and Alver expressed interest in the participation and took the initiative to identify and recruit participants to the research based on their professional network. Voss municipality provides 2 participants, and Alver municipality provides four potential participants respectively. I contacted six of them, and five did not respond to my invitation messages. One of the six participants were found through this process. The original recruitment strategy was to rely on the professional network of the head of the nursing home. The idea of approaching the head of municipalities was believed to lead to greater access to the immigrant healthcare assistant. This strategy, however, was met with great challenges in recruitment. The participation rate was low, with only one enrolment among 6 participants who qualified the inclusion criteria. Owing to these challenges, the idea of recruiting through nursing homes was proved to be unproductive. Thus, I opted to turn to other strategies of recruiting.

One participant was recruited through a Facebook group called “New Friends Bergen”. I made a bulletin on the forum outlining the purpose of the research. It advised those interested in participating to send a private Facebook inbox message for further explanation and agreement to comply with the study's confidentiality. I responded by sending them an invitation email with a consent form that explained the topic, methods of the research study and confidentiality issues. Two individuals contacted me, however only one met the inclusion criteria.

Winkler’s (1987) suggestion on the use of contacts and friends to overcome the challenges of gaining access to a research setting was considered (180). However, being relatively new in Bergen, my network was limited. Four participants were referred by friends. The idea to establish new contacts by attending an English session of church gathering put me in an environment of immigrants living in Bergen. This, enable me to quickly establish new contacts with the immigrant care workers within Bergen municipalities. With the seeds from the church

gathering, I started snowballing. Most of the participants (6 participants) were recruited through the snowball sampling technique. Snowball sampling was the most efficient strategy in the recruitment for my study due to the trust between the participants with their referrals. Seven participants were recruited from established new contacts by attending English session of church gathering. During the process of recruitment, voluntary participation was emphasised to ensure that only the genuine participant is recruited and was willing to share their thought freely.

Characteristics of the study participants

The sample for these in-depth semi-structured interviews was conducted with a total of 13 immigrant caregivers, nine female and four male, between 27 and 49 years and from various countries. Participants in this study arrived in Norway through different paths: 2 through marriage visa, 6 through study visa that eventually led to working visa, one as a refugee, 1 for relationship and 3 for family reunification. They ended up working in Norwegian's elderly care for different reasons. Participants' knowledge and educational qualifications also varied. All the participants held a bachelor degree from their home countries and had experiences working in the Norwegian nursing home. However, some participants had left the nursing home to work in the residential care home and private home care. Table 1 gives an overview of the participants' demographic profile.

Table 1: Characteristic of the participants who participated in this study.

Participant	Pseudonyms	Gender	Age Group	Ethnicity	Education background	Role	Years of experience
1	Christine	Female	31	Asian	Marketing manager	Nursing assistant	2
2	Edwin	Male	27	Mediterranean	Law student	Nursing assistant/ Personal assistant	4
3	Lucy	Female	49	Asian	Accountant	Nursing assistant	7
4	Diana	Female	32	European	Medical student	Nursing assistant and home care nurse	6 months
5	Audrey	Female	33	Asian	Nursing	Nursing assistant	10
6	Britney	Female	37	Asian	Nursing	Nursing assistant and home care nurse	6
7	Cheryl	Female	36	Asian	Nursing	Nursing assistant and home care nurse	7
8	Myra	Female	30	Asian	Nursing, pharmacist	Nursing assistant	4 months
9	Nicky	Male	27	Asian	Medical doctor	Nursing assistant	1
10	Richard	Male	36	Asian	Nursing	Nursing assistant and home care nurse	6
11	Daisy	Female	42	Asian	Nursing	Nursing assistant and home care nurse	6
12	Rebecca	Female	36	Asian	Nursing	Nursing assistant	4 months
13	George	Male	27	Oceana	Physiotherapy	Nursing assistant	6 months

Semi-structured interview

I used the qualitative semi-structured interview as my method in collecting data for this study. Gadamer equated "the metaphor of dialogue with the logic of question and answer" where language is only properly itself when it is dialogue, where question and answer, answer and question are exchanged with one another" (181). Knowledge is constructed in the dialogue with the study participants (182) to produce shared knowledge. Interviews consist of a series of questions and answers to explore, understand and collect experiential narrative material that may serve as a resource for developing a richer and deeper understanding of a human phenomenon, and to create a conversational relationship with the participants about the meaning of an experience (183). According to van Manen, "the art of the researcher in the hermeneutic interview is to keep the question (of the meaning of the phenomenon) open, [and] to keep himself or herself and the participant orientated to the substance of the thing being questioned" (183). This study considered in-depth individual interviews a powerful tool and optimal data collection method for gathering first-hand information of immigrant care worker working histories, perspective, and their day-to-day experiences in the Norwegian healthcare system. The interviews followed a semi-structured interview guide (Refer to appendix G) with open-ended questions. The selection of semi-structured, interviews was based on the assumption that the participants had the relevant knowledge and ability to share this knowledge and bring me into their work-life experience.

Probes were used for further thoughts and reflections. My role was to encourage, through probing questions, to generate rich in-depth and qualitative information from the immigrant care workers. Although I was required to steer the interview to meet the research objectives, the participant held the space to talk about their experiences spontaneously and invariable sequence, allowing the generation of more questions and the rise of new issues as the interview evolved. Several techniques were used to engage the participants, including funnelling from broad open questions to narrower topics, probing to elicit further details, and encouraging storytelling (184). During the interview, I used my empathy to make the participants feel comfortable in sharing "their story''.

Interviews initially planned for three months period occurred over six months due to the COVID-19 outbreak. The first interview took place in March 2020, following approval from municipalities in February 2020 and the last in August 2020. The interviews took place in

various settings, based primarily on where the participants felt comfortable or convenient. Two interviews took place in my home, one at the participant's house, one in a restaurant and the rest were over Facebook call (9 participants). A short 10–15 minute online follow-up interview was conducted with 8 participants during November and December 2020. To maintain privacy and confidentiality, all of the video calls were conducted in a private and secure room.

The type of interview initially planned for this research was face-to-face verbal interchange. However, shortly before I was scheduled to commence the interview with the first participant, the Corona pandemic broke out. Out of fear, participants requested to delay the face-to-face interview. Given the tight timeline for the research project, the supervisors had recommended an online interview instead. Nine interviews were performed using an online platform (Facebook messenger's video call) while the remaining 4 participants were interviewed face-to-face.

Interviews were conducted in Norwegian and English with an interpreter's aid when the interviews involved the Norwegian language. Ten out of the 13 participants answered in English, while the other three participants required the interpreter's services. The interview lasted between 30 and 90 minutes. To retain the collected data's accuracy and credibility, all interviews were audio-recorded, transcribed, translated (for the interview conducted in Norwegian) and uploaded to a password protected device.

Data management and analysis

Transcription and Translation

All interviews were electronically audio-recorded. Field notes were used as a way of recording reflections on interactions, perceptions on ideas and issues that arise, and the participants' general mood and tone during the interview. Besides, the level of engagement of participants throughout the interview process was also recorded. The field notes kept questions raised during the interviews and helped probe the coming interviews.

After each interview, recorded data was transcribed verbatim by me, word for word. I listened to each interview multiple times to ensure that the transcriptions precisely matched the participants' wording. I did not edit for grammatical errors: therefore, the data is in a

conversational format. Even though the quality of the recording was poor at times: nevertheless, we were able to figure out what the participant was talking about to get a meaningful transcription. Therefore, the interview interpretations did not seem to have any significant disparities that would affect the study's overall results (185). Furthermore, a short follow-up interview was conducted in November to confirm the accuracy of the data further.

This study was conducted in Norwegian and English with a sole researcher with an interpreter and translator (who are the same person) when the interviews involved the Norwegian language. I could not conduct the interviews conducted in Norwegian by myself without an interpreter: therefore, an interpreter/translator was used in this study. I performed all the transcription, translation and analysing of the data manually. Following the thematic analysis strategy, interviews conducted in Norwegian were transcribed into Norwegian and then translated into English. Transcription and translation involving Norwegian were counter checked by the translator.

Some of the study participants were not proficient in English after years of living in Norway, where English is not Norway's official language. Therefore, to address the language barrier and maintain the integrity and credibility of translated qualitative data, an interpreter/translator was used to mediate the language barrier between the participants and me. Ten interviews were performed in English, whereas three interviews were conducted in Norwegian, an interpreter was present throughout the whole process of interviewing. The interpreter provided written translation services for the interviews conducted in the Norwegian language. The interpreter, who was also the translator, performed an accuracy and validity check on the translation of the three interviews performed in the Norwegian language.

Language is a known challenge in cross-language qualitative research, which may threaten the credibility, transferability, dependability, and confirmability of the research findings. ‘Cross-language research’ describes studies in which a language barrier is present between qualitative researchers and their participants (186, 187). When the participant speaks a different language than the researcher, ‘it is more appropriate for researchers to use the informant's language to understand health experiences and perceptions of health care (185).

Interpreter/ translator

The interpreter/ translator was a 21-year-old Norwegian Filipino who moved to Norway 11 years ago. The interpreter had no prior training in interpreting. Being a Norwegian Filipino gave the advantage that she was familiar with and could understand immigrants' spoken Norwegian. The interpreter and I had several rounds of practice before the interview session with the participants to ensure an active interview model was adopted. The interpreter built a strong rapport with the participant and retrieved a more in-depth exploration of the concepts being raised (188) by adding new questions and raising more questions and follow up.

The interpreter/translator and I are both immigrants, which gave us a sense of approachability to the participants who were also immigrants, allowing a greater sense of trust, which is essential because they would feel more comfortable and express themselves more freely. It has been shown that gender, racial identity, social class, and shared experiences can affect study participants' research process and willingness to talk to the researchers (189).

The interpreter and researcher are close in age and both women. This was also seen as an advantage, as both could more closely relate to each other (190). Having a greater mutual understanding with the interpreter/translator appeared to be advantageous to the interview process. Being neighbours living on the same floor with the interpreter/translator made the interaction outside of interviews hours easier and we regularly met to discuss and reflect upon the conducted interviews. We discussed concepts and reflected upon the meaning of tones in the spoken language, gestures, and body language.

Analysis procedure

Thematic analysis

Data analysis proceed hand-in-hand with other parts of developing the qualitative study, the data collection and the write up of findings (191). The interview guides were adjusted several times to better fit the individuals' circumstances. Analysing the data was done manually using thematic network analysis. Thematic network analysis is a method that, through the systematic organisation of the data, allows the researcher to discover meanings across a dataset and to categorise these meanings according to main findings and the topic of research (192). The six

steps in the following, which forms thematic network analysis will be disclosed concerning this study.

1. Familiarising yourself with the data

I went through the transcribed interviews and field notes multiple times. Field notes were read through together with the transcribed material, and new notes were made each time to capture the interview's essence accurately. I had a small notebook in which each participant had a few pages of key points and notes from our interviews. The transcripts were also annotated to go deeper into the data.

2. Generating Initial Codes

Coding of the data started with the division into initial codes. Codes apply as the keywords or topics that categorise the data. Using Microsoft Word, sentences were commented with codes as the keywords or topics that categorise the data manually. Some codes either stood alone or gave meaning together with other codes. Code names were developed from the words or quotes the participants had said, and others were from my interpretation of the quotes or concerning the study's framework. On some occasion, portions of data were coded with several codes. Codes were sometimes renamed to capture new pieces of data. The first draft of codes resulted in 80 codes. Some of the codes that were derived at this stage were “poor communication”, “tired”, “back problems” etc.

3. Searching for themes

Step three is where the codes started to take shape concerning to- and continuous of each other. The initial codes' list was further commented to create an organised idea of the data, and initial themes also started to emerge. Codes were reduced and merged, re-grouped multiple times and choices of how best to organise codes under themes to present the essence of the data were made. The quotes' piles were extracted and categorised into a separate word file for an easier overview, and the initial grouping of codes.

4. Reviewing potential themes

The themes and quotes were read through multiple times and held up against the themes. The entire data set was going through again to secure coherence and ensure that the data's meaning was captured in the framework. As the work progressed, this study ended with a data-set of four organising themes for the global theme named unsatisfactory working conditions (language barriers, staffing problems, strained relationship with patients and poor cooperation with colleagues and superiors) and three organising themes for the second global theme named coping with daily work challenges (maintaining a positive perspective, positive aspects of work and quitting as an alternative). Table two shows the summary of the themes that emerged from the data.

5. Defining and naming themes

Each theme was defined in a small text sequence to test whether it served its purpose of being on the point and unique in capturing that particular part of data. The themes proved to be continuous of each other whilst still being able to stand alone. Together the themes formed an overall story of the data.

6. Producing the report

Organising themes were going through one by one. The themes at a time, meaningful quotes across the data-set were highlighted and then used to produce the report of the results while being held up against the thematic analysis to secure that quotes illustrated key conceptual findings (193, 194).

Table 2: Summary of the themes that emerged from the data.

Global theme	Organizing theme	Basic theme
Unsatisfactory working conditions	Language barriers	Compromised quality of care for the patients Compromised professional efficacy Compromised safety and well-being for the caregivers Language discrimination by the patients A hindrance to building relationships with the colleagues
	Staffing problem	Heavy workloads and prolonged work hours Exhaustion Strains, injuries, and absenteeism Emotional distress Compromised quality of care Work-home conflict Decreased organisational commitment.
	Strained relationship with patients	Discrimination, harassment, and emotional distress
	Poor cooperation with colleagues and superiors	Increased workload Exhaustion Work-home conflict Psychological distress Insufficient guidance
Coping with daily work challenges	Maintaining a positive perspective	Learning the language Empathetic thought processes Focusing on being patient Being goal-oriented Focus on job responsibilities
	Positive aspects of work	Monetary compensation Flexible day-off requests Communication with superiors Communication with colleagues Superiors' and colleagues' support Patients' respect and appreciation Stable income Meaningful work
	Quitting as an alternative	Pushed to the breaking point. Moving to the paradise of work-life

Ethics

Ethical clearance

Human subjects' protection by applying appropriate ethical principles is essential in any research study (195). This Study has applied for ethical approval from the Regionale komiteer for medisinsk og helsefaglig forskningsetikk (REK) and is registered with Data protection RETTE (System for Risiko og ETTErlevelse i forskning og utdanningsprosjekter).

Informed consent and confidentiality

All research is subject to the general thumb rule of consent and must be obtained before any data collection is done. The informed consent form (Refer to Appendix E for Norwegian informed consent form and Appendix F for English informed consent form) was preceded with detailed information about the study. This information was also used to recruit participants. Consent to participate in the study was obtained from all study participants with no exception, either verbally or written consent. A translator was present during the times when the potential participants preferred to use Norwegian. An informed consent form with information about the study was sent by email or Facebook messenger, followed by an online phone call to provide more detailed information. Participants had as much time as they needed to read, ask questions before their written consent was solicited. All identifying details have been altered To secure the participants' confidentiality. Audio files will be stored on a memory stick with a built-in security code and placed in a locked file cabinet. The participants were given a pseudonym for the transcribed interviews, and the list matching the pseudonyms and the participant's name was securely stored separately in a locked drawer. Due to the participants not anonymous to the researcher in the qualitative study, I was more obliged to protect the study data and ensure my participants' confidentiality at all time. This is in line with Munhall's view "one needs to be concerned about the usual ethical considerations of fieldwork privacy, confidentiality, achieving accurate portrayal, and inclusion and exclusion of information"(196).

I formed a relationship with the participants during the study and through the closeness established I may have somehow influenced the participants and affected their answers.

Potential harm

The study aimed to gain in-depth insight into individual work experiences, including collecting data on sensitive topics through the exploration of both positive and negative experience and was designed to be probing in nature. These characteristics of the method may provoke anxiety or distress in participants. The questions that lead to anxiety and distress depend on individual participants' biography and experience and cannot always be predicted accurately. Even when a prediction is possible, qualitative research's open-ended nature means that sensitive topics may come up. To minimise the risk of creating distress, I tried to be clear about the boundaries of my role in the study. Throughout the study, I tried to maintain a well-defined role and refrained from soliciting private information that was not relevant to the research question.

When conducting a face-to-face interview with the participants during the Corona-19 epidemic, there was a possibility of infection to myself and the participants. The health authority's corona protocol such as social distancing and handwashing/sanitising were strictly followed for the three face to face interviews. But due to social distancing regulations, the majority of the interviews (10 interviews) were conducted online.

Another research ethical issue, which is seldom mentioned in the literature, relates to the "exhaustion" of research participants. Some potential participants I contacted expressed interest in participating in the study: however, due to the time constraints between work, studies, and family, scheduled interviews were rescheduled several times. Being aware of the situation and the difficulties participants faced, I informed the participant at the very beginning of the interview that they may stop the interview anytime without giving any reason and tried to be aware of signs of emotional discomfort.

Chapter 3: Findings

Thematic network analysis revealed two global themes (unsatisfactory working conditions and coping with daily challenges), seven organising themes (language barriers, staffing problems, a strained relationship with patients, poor cooperation with colleagues and superiors, maintaining a positive perspective, positives aspects of work and quitting as an alternative) and 33 basic themes.

3.1: Unsatisfactory working conditions

The theme related to how work stress relating to the personal context, such as language barriers can pose challenges within the workplace. Participants described the effects of their language barrier experiences on their well-being and motivational process. Finally, participants described the various forms of mitigation of language barriers.

3.1.1 Language barriers

This theme illustrated language barriers as a stressor in participants' daily work life. A general description across participants showed that they experienced role insufficiency. Participants described the adverse outcomes in professional and personal well-being. Moreover, **t**he lack of language skills was described as challenging by all of the participants working within the Norwegian health care sector where Norwegian is the language used for official communication at work, "*Well, The number 1 daily stress is the language barriers* (Daisy)*.*" Each participant described language barriers as a stressful and challenging aspect of their work leading to role insufficiency.

Compromised quality of care for the patients

A finding that was commonly identified by participants was language barriers. Participants described that the challenges in understanding the different dialects and minimal language skills. Richard, who recently relocated from Eastern Norway after seven years in Western Norway, described that despite having a B1/B2 level of the Norwegian language, he still suffered from the language barrier, *"the most challenging part is when they speak to you in*

their dialect. I have learned the Norwegian language from the school, which they call Østlandet (Eastern Norway), and now I'm living in the western part, which they have their dialect too." There was an agreement from all of the participants that limited Norwegian language skills impacted their ability to communicate. Lucy described, "*I did not have so much vocabulary to interact with my colleagues or the patients. (...) sometimes, I would misunderstand what they had said and what I was supposed to do."*

Participants spoke of the inability to understand a patient's conversation which compromised the quality of care leading to dissatisfaction. Richard described, *"I had experienced before when I do not understand my patient. I cannot give them the best quality of care due to my poor communication skills."*

It is clear that across the data set, role insufficiency caused by the language barriers can lead to compromised quality of care.

Compromised professional efficacy

Participants who are working with limited Norwegian had showed compromised work participation and performance which negatively impacted their professional growth. Rebecca described, *"Language barriers indirectly compromised our work participation and performance."* Several participants described that the inability to communicate their ideas effectively can affect speaking up, causing low work participation, inhibiting professional growth and compromised quality of care. The language barrier has reduced participants' confidence and efficiency in performing their daily tasks which can compromise their work accomplishment resulting in poor quality of care for the patients. Rebecca said that the language barrier had prevented her to *"suggest on how care should be given"* without ambiguity because she *"does not have the right set of words to suggest it in Norwegian."* and *it [language barriers] also compromised the quality of care for our patients."* Rebecca was the only participant who mentioned that her professional efficacy was negatively affected connected to role insufficiency.

Compromised safety and well-being for the caregivers

It is clear that across the data set that ineffective communication can be stressful and frustrating for both participants and the patients:

> *In some instances, I can be like, "Oh my god, what do I need to do? I do not get anything on what I need to do. The word sounds so familiar, but I do not get the meaning. Of course, I will ask, "Can you repeat, or can you explain what you need me to do?" Some patients would get impatient that they have to repeat for me over and over again.* (Diana)

The participants also spoke of times where their safety and well-being was compromised because of their limited capacity to understand and fulfil the patient's needs:

> *She was sitting on the toilet, and she was telling me something while I was trying to help her with her socks. I think she wanted something, but I cannot understand what she wanted. She got so mad, maybe because I focused on her socks and then suddenly, she grabbed my hair and became aggressive (...). I do not know what to say. I was shocked. I knew she had become aggressive. I'm aware of that, but I did not expect that she would do this to me. I do not know what to say or what to do. I did not know how to respond. And shouting is not a healthy response. I was alone with my patient. I tried to be quiet and not to say anything. After that, she removed her hand from my hair. Oh my god… I was so shocked and scared. Sometimes, it is not safe to be alone with the patients. They can be aggressive.* (Cheryl)

The lack of language skills to effectively carry out their roles at work was described by several participants to have negatively affected their emotional well-being. Cheryl said that the consequences caused by her inadequate language skills had affected her emotionally. She explained that she suffered from self-blame and often felt sad, depressed and heartbroken to witness her patients giving up a conversation due to her inability to comprehend:

> *You can see that we are trying to communicate with the patient. However, we can still not understand due to the language barriers (...) and give up. It can be very heartbreaking to see that. (...) And of course, as health personnel, I can have a bad concern after that because I feel that I'm not effective enough to communicate with them, understand them and what kind of help they have asked for. I cannot get it*

immediately what they want because of the language barrier. It was challenging because, as a healthcare worker, it is not the kind of job that I wanted to give them. (…) It is a bit depressing after the job, I can say. That's a little bit sad, I can say. It is very heartbroken. (Cheryl)

Language discrimination by the patients

All of the participants spoke of having a hard time building a relationship and daily work collaboration with their patients due to the language barriers. Several participants spoke of language discriminations from patients which have resulted in emotional distress in them. Richard shared his painful experience of being bullied and shouted at work for not being fluent in the language. Richard was highly emotional when he brought up this experience which happened seven years ago and still impact him today. In an agitated tone, he described how he was bullied and harassed in the very first week at his work by his patient:

> *I was bullied! I was bullied because I cannot speak Norwegian fluently. That was the first week of my work, and I have to take care of that man. He bullied me because I cannot speak well in Norwegian. It is like the elderly client was shouting and yelling in anger for me to get out of the room.*

Diana likewise spoke of how language discrimination by her patients has an impact on her emotionally, *"I have been even cried after what I have heard from the patients. Sometimes I have heard some patients said to me, "Oh, you are an immigrant, and you do not understand Norwegian so well. Why are you here?"*

The experience that Richard went through make him felt that patients favoured Norwegian caregivers. Other forms of discrimination will be talked about in the theme named **'strained relationship with patients'**.

A hindrance to building relationships with colleagues

All of the participants spoke of having a hard time building relationship with their colleagues due to the language barriers. Language barriers are a hindrance to building workplace relationships with colleagues. Participants frequently brought up the challenges of how the

language barriers caused the loss of grip within a conversation, leading to miscommunication and also hindered relationship-building and acceptance within the workplace with colleagues. Rebecca described she *"has a problem picking up a conversation because of the lack of vocabulary."* Speaking Norwegian with limited vocabulary makes *"the conversation is minimal."* The difficulty in expressing herself and go deeper within the conversation has driven her from a deeper social interaction: "*I cannot say my deep thoughts (...) I cannot speak from my heart. I can only speak on the very surface (...)"*

Rebecca said that insufficient Norwegian proficiency skills led to failure in understanding the dialogue and affected the interaction with her colleagues:

> *My vocabulary was very lacking, and I could probably not understand, let us say, 40% of what I was hearing. I did not have so much vocabulary to interact with my colleagues or the patients, and I also felt I could not explain myself in a way that I could explain myself in English or my native language.*

Moreover, Rebecca described that it was *"quite challenging"* to relate with her colleagues due to her inability to communicate effectively, especially in a group conversation. Rebecca noted that she "*would want to participate but her mind does not think in Norwegian so she cannot right away think of something to say."* Her slipping out of a conversation was due to her mind taking time to convert her ideas and opinions to Norwegian. By the time she was ready to express herself, the conversation would have ended, Rebecca further highlighted that she "*needed to take time to translate it in my head, and by the time I am ready to speak, the conversation would be over, or the others would have changed the topic."*

Role insufficiency was also experienced by the participants who could not relate well to their patients and colleagues.

Emotional distress

Language barriers were described by several participants to have contributed to discrimination and bullying within the workplace which has resulted in emotional distress in them. Christine felt unwelcomed and excluded among her native colleagues due to her poor language skills, "*Some do not like me because I cannot speak good Norwegian."* Christine felt sad for not being

able to understand the language. When asked about Christine's relationships with her colleagues, she described being less favoured, "*The only problem is that I cannot speak very good Norwegian, so many people do not like to talk to me.*" Christine moves on to describe, *"You know, we have different colleagues at work who behaved like this. Some colleagues like me and some do not like me because I am from abroad and cannot speak good Norwegian."* Christine and other participants felt discrimination from colleagues, including impatience and avoidance. Christine continued to describe how she experienced distancing from her colleague, *"they preferred not to talk to me because they thought I did not speak good Norwegian and I did not understand what they meant, so they would not talk to me but talk to the others."* A similar incident was expressed by George:

> *Perhaps a nurse would say I cannot follow the conversation, so she would not bother speaking slowly for me, but that did not bother me. I think she was feeling like she was wasting her time trying to speak clearly for me.*

Cheryl likewise described a lack of willingness from her native colleagues to try to understand her, "*sometimes I can feel that my native colleagues noticed that I could not understand them and that I am far from understanding the conversation, I could feel that they did not want to continue the conversation to me."*

In contrast, Lucy was the only one that had established a relationship outside the workplace with her colleagues. Initially, she experienced workplace bullying and was talked behind her back. However, this got better with time due to the improvement of her Norwegian proficiency:

> *When I first started working, I felt discriminated against because of my language. I have difficulty understanding a conversation, and sometimes I would misunderstand what they had said and what I was supposed to do. They became angry and yelled at me. Later, they would cheer up. I felt like they bullied me with: "She cannot speak Norwegian" and "I do not understand what she said". They talked behind my back. That was before, but not now. During my first two years, I felt discriminated against, and that I was being bullied. But now we are good. I am comfortable when I am working with them.*

Lucy described that her ability to communicate more effectively now has resulted in easier integration and forming better relationships with her colleagues, *"It is easier to get along with them [colleagues] because I speak better Norwegian now."* Lucy has formed relationships that have extended beyond her workplace: *"Now, we often talk about going for a party. If someone here has a birthday, they will invite me to their birthday party. I fit in better now. I enjoyed working with them. We are bonding now."*

All the participants suffered from language barriers as shown in the data above to have compromised the quality of care for the patients, compromised their professional efficacy, safety and hindered relationships building within the workplace. It is clear that role insufficiency caused by the language barrier has an impact on participants' overall well-being. In some cases, role insufficiency has resulted in emotional distress in several participants. However, all the participants refer to learning the language as the most effective coping strategy to overcome challenges brought by language barriers. This will be discussed in the second global theme named **'Coping with daily work challenges'**.

3.1.2 Staffing problems

This theme involved how work environments influence participants' experiences of work stress impacted their overall well-being and motivation. This theme highlights participants' experience of job demands such as staffing problems resulting from ineffective management. Finally, participants described how they managed the challenges.

A general finding revealed that ineffective superior management resulted in staffing problems. Intense workload with limited time-frames forced them to endure longer working hours which has negatively impacted their well-being and motivation. Increased physical, mental and emotional demands were considered common causes for health impairment and negative organisational outcomes across the data set. Work-related strains, injuries and exhaustion were also considered consequences across the data set. Adverse organizational outcomes included compromised quality of care for their patients, work-home conflicts, decreased motivation, work engagement, and organizational commitments. Several participants indicated that the negative outcomes of their job even made them consider quitting.

Heavy workloads and prolonged work hours

Many participants criticised the staffing conditions and ineffective management of the nursing homes. Participants felt overwhelmed due to a worker shortage during a shift which resulted in a heavier workload, prolonged work hours and decreased work performance and quality of care for the patients. Cheryl described the need to perform double the workload when there were staffing problems:

> *For example, nine workers were on a normal day, but only five worked on the weekend. Yes. So, you need to work double. And then within the five workers, suddenly someone called in sick, so what you can expect. So, sometimes we do not have a choice. (...) we need to work double.*

As a consequence of insufficient workers within a work schedule, several participants reported that they are being assigned to work that is not aligned with their qualifications. This was a common dissatisfaction among several participants. Rebecca expressed her dissatisfaction:

> *I was not informed that there would be a time that we would be working only in the kitchen. (...) I'm educated as a nurse, and do the kitchen work is not taking my skills and knowledge to their full potential. I do not have anything against kitchen work, but I believed that for most of us who can be more productive in patient care, we should be assigned to patient care, and those who have less knowledge in patient care should be assigned to do the kitchen work. With the complexity of patient care and with the addition of things like the kitchen work, I become very unsatisfied.*

Participants were stressed and displeased with the lack of superiors' engagement over their request for additional workers. Cheryl described that her request for extra help was ignored, leaving her and her colleagues to bear the brunt of the negative consequences. Cheryl said, "*(...) they do not recruit. You need to go extra, you know! They are telling me that they are going to recruit, but nothing happened.*"

Despite the request for extra help, several participants still experience staffing shortages.

Exhaustion

Many participants described that their overall well-being was negatively affected due to overall working conditions. Cheryl mentioned that due to the lack of workers, she often has to work "*three consecutive days"* that involved long hours where the shift is hectic, she can become utterly overwhelmed physically. Cheryl described,

> *After the job, I can feel that my body is aching, and I am exhausted. I do not have time for my family, and I felt sad because of that. I cannot stretch the time to spend on both my job and my family. So, sometimes, it is so very depressing. And also, in term of my health, it is not healthy. Especially if I have to work three days in the weekend on the same shift, which can be very busy, I can feel that my body is giving up.*

Strains, injuries, and absenteeism

May participants reported work-related strains and injuries at work, especially as a result of staffing problems. The absence of help to perform demanding tasks was described by the participants to put them at risk for substantial work-related injuries. Nicky expressed that he endured a heavy workload, as he had to look after over 20 patients alone. Moreover, he worked in complete isolation which he described as exceeding his ability to cope and has resulted in suffering repetitive strain injuries. Nicky felt overwhelmed due to inadequate staffing and too many care cases for him. Nicky mentioned:

> *Yes, they do have the instrument to help with this [lifting] but being only one nursing assistant that located over 20 to 30 patients, even if you tend to use the instruments or machines to lift the patient from the ground, it is very difficult for a person alone to operate the machine and to lift them back to the bed. So, you have to bend quite a few times to put the belt below them and then lift them with the machine. So that is why I encountered lower back pain quite frequently. (...) Usually, it is very hectic, and there tends to be only one nursing assistant for over 20-30 patients for the whole night. (...) I believe that having one nursing assistant on duty for over 20 to30 patients for a whole night has pressured me a lot to work continuously throughout the night alone even in tough circumstances, which I believe is not good for my physical and mental health.*

Likewise, Audrey described that a heavier workload has negatively affected her physical health:

> *The most challenging part for me and what affects me the most is the physical part of the job which has caused back pain in me. I have this pain in my back that makes my work more challenging. I get very tired. Sometimes my body feels that it wants to give up. (...) Things become worst when there are insufficient workers. The heavier workload can result in more severe back pain. I just cannot go to work the next day because I have not recovered from the pain. I have to take some rest for a few days.*

Several participants spoke that they are not willing to work in the nursing home for a long time. Nicky described that he felt overwhelmed and would quit when he has found other opportunities, *"I'm getting more control of the situation now. However, I do not see pursuing this for a very long time. (...) I would say I am not willing to continue working in this tough situation on a very long-term basis, so I am also looking for other job opportunities."*

A consequence that resulted from the staffing shortages was an increase in strains, injuries and absenteeism. As a result, participants highlighted that a decline in overall health was amongst the reasons that they considered quitting their job.

Emotional distress

The lack of workers during a shift can also affect the participants' well-being, where they can be found guilty for not performing their best to fulfil patients' needs. Cheryl described that it was *"very sad because you can feel that all those old people wanted to speak. Sometimes, I think that the sad thing when working in a nursing home is that there is a lack of workers, we are not talking with them [the patients]. Those old people want to express their feelings. So, at the end of the job, I always have bad concerns about why I did not do that [talk with the patients]. It is because I cannot stretch my time."*

Many participants spoke that they are not able to create meaningful conversations and connections with their patients which created distress.

Compromised quality of care

Lack of workers during a shift not only increased participants' workload but also overwhelmed them. Participants were pressured to accomplish more tasks within the same period. For example, Cheryl said, "*We need to take care of all their needs and also to finish all the other assigned tasks on time (...).*" Having the need to juggle several tasks within a limited timeframe was described by several participants to have compromised the quality of care for their patients. Cheryl described that the time pressure:

> *There was no time for one-to-one communication with them [the patients] because we are always busy and we need to finish the same routine on time. Sometimes I was not able to do the procedures on time and the patient wanted his medicine to be on time, but I was 10 minutes late. I explained to him that I could not [give the medicine on time]. I have [other] patients that I need to help before I go there [to him]. The patient was very angry.*

Participants also stated that the nursing home lack Norwegian workers,

> *What I have witnessed is that we are always lacking native workers within a shift. For example, four out of five were not native (...). It can be hard for us as well as the local when there were patients who preferred the native over immigrants' caregivers.* (Cheryl)

Richard further illustrated the situation as:

> *My colleague (the native) also has her tasks to complete. This has caused her to be unable to attend to the patient immediately. The patient can get very impatient. The patient has no choice but to wait since she is the only native during the shift. I would say, effective staff allocations is very important to ensure the quality of care.*

Several participants reported working prolonged hours. Cheryl explained that she often working two consecutive shifts back to back, *"(...) the challenges before and now is there are always lack people in the job, and we do not have a choice but to agree on working double time or two shifts (...). (...) It is like forcing us to do."*

Prolonged working hours was seen as a stressor and has resulted in participants experiencing work-home conflicts, deteriorating health and resulted in their intention to quit.

Work-home conflicts

The requirement to take on a high proportion of double shifts particularly on the hectic weekend has created challenges for some participants. Cheryl has experienced immense conflict and desperation concerning her health and family. Cheryl's explained that her energy level has depleted and lacks energy when she gets home from work, often feeling too frazzled to participate in family activities:

> *It [double shifts] affects me, especially when I have to work the next day. I cannot get enough rest because I have a family. I did not have time for my son. It is exhausting, and I have to work the next day. I can feel the exhaustion, and it is always happening (...) I have no problem when you talk about my schedule before because I do not have a kid, I do not have a family (...). It was okay, and I'm more flexible before. But now, it is a little bit harder because I have a child and I have to go to school for Norwegian courses. (...) It [weekend shift] happens to me often. And it affects not only my lifestyle but also my health.*

Many participants described an imbalance between their work and home due to staffing problems.

Decreased organisational commitment

Deterioration in health and work-home conflicts were some of the reasons participants were considering changing working environments. Some had chosen to move on to residential care home instead of nursing homes where they experienced better overall well-being and working conditions. Cheryl described:

> *I think I am going to quit my job. I am so tired. I do not have time for my son. And also, it is not good for my health. (...) The work [at the nursing home] has exhausted me physically, and the extra working hours took away my time from my family.*

Staffing problems as described in the data, a common source of participants' dissatisfaction which led to decreased organizational commitment. However, participants described several positives aspects of work that compensated for the staffing problems. This will be discussed in the second global theme named **'Coping with daily work challenges'.**

3.1.3 Strained relationship with patients

This theme covered how work stress relating to the aspect of work environments, such as dealing with challenging patients, has impacted their overall well-being and motivation. This theme highlights participants' experiences of job demands such as the experience of a strained relationship with patients. Finally, participants described how they managed to overcome the challenges and stay engaged.

Discrimination, harassment, and emotional distress

For some participants, workplace relationships preceded a rise to workplace discrimination and harassment which is considered an emotional demand. Participants' emotional demands were described in the form of discrimination, harassment and emotional distress. Diana described that:

> *There was also a problem with the elderly. There were elderly who can become very rude and disrespectful. Sometimes, of course, it is pretty hard when some patients come with such pressure. I would say that there were days when it goes really hard. Some patients can be very rude whereby they verbally discriminate or harass me with soul-crushing words. The worst thing I have experienced was an occasion whereby there was inappropriate touching from a patient.*

Diana then explained that these events had an impact on her emotional well-being:

> *I have been even cried after what I have heard from the patients. Sometimes I have heard some patient said to me, "Oh, you are an immigrant, and you do not understand Norwegian so well. (...) And some of them do not respect the immigrant workers. Sometimes, they asked, "Why have you come here? Why is it you? It is like I*

have to listen to the same questions "Why have you come here? Why is it you?" and comments like "Oh! You did not do this right. You did not do that right. I think you do not understand Norwegian at all. (...) Or comments like, you haven't worked here before, are you new? You do not even know what you need to do. (...) Honestly, it is difficult and disgusting to work with these people because I am doing my best, but I still need to listen to these bad comments that are not very nice. (...) You know that makes my mood go down, (...) it is the worst thing ever.

Diana described that sometimes she was so emotionally overwhelmed that she could feel herself shaking:

> *It hurts so much! It is so hard to work in this situation. It is kind of hard emotionally because I am so drained. Whenever I am going to work, I was shaking because I know I have to go through this situation again. I have to listen to them saying how bad I am. And I was very afraid of that patient who verbally harasses me.*

Several participants felt that not having a shared cultural outlook with the patients could potentially hinder the development of a strong caring relationship. They recounted occasions where patients openly favour Norwegian caregivers, dismissing the assistance of the participants. Many of the participants shared that the degree of their work demands depends upon patient's requests, preferences and perceptions. An example of this was when Nicky described that "*they could be quite choosy or picky on who they wanted to take care of them*".

Myra identified instances when she experienced ageism:

> *The patient told me to go away from her and do not touch her. She told me that she sees me as being just a girl, a young woman of 16 or 19 years old. I politely told her that I am here to help her and that I am a competent caregiver. But she said that she does not feel safe with me. She wanted the Norwegian to take care of her.*

Cheryl likewise stated some patients favoured Norwegian caregivers:

> *Some of [the patients] do not like workers coming from another land. They wanted only Norwegian. I have that kind of patients. (...) Some patients said that they*

only wanted care from the locals, and only the locals are allowed into their room. It is hard for me emotionally because I felt rejected and discriminated against.

Skin colour was identified by one participant as introducing an additional layer of prejudice in their interactions with the patients. Several participants highlighted the difficulties surrounding race, with respect to acceptance of the caregiver's support by the patients. Nicky was one of the participants who experienced discrimination and harassment from his patients due to his race. Nicky described:

> *I felt rejected because some patients restrained themselves from me or they are trying to restrict the offering of the help that I have to provide them. Some of them do not want to talk to me and some do not even want to listen to me. (...) If they get frustrated, then they even tend to abuse me sometimes. (...) He [the patient] mistreated me by using bad words because of my skin colour. I helped him to get up to his bed, and the moment he sat on his bed, he started to abuse me and started resisting the help that I was offering to him, and he used some offensive words towards my skin colour. Yes. I was being set aside, abused and mistreated by them because of my skin colour, which I find quite strange.*

Several participants identified moments where their care was unappreciated by their patients. Lucy said, *"We are doing the same job, but the patient did not praise me, but she praises my colleagues instead. I mean those Norwegian colleagues."* These instances were compounded by the aforementioned experiences with discrimination. Lucy, Nicky, Cheryl and Myra each related that "*I felt discriminated against"*.

Discrimination and harassment within the workplace as shown in the data, a common source of emotional distress. However, participants described several such as maintaining a positive perspective and looking upon positive aspects of work to overcome these challenges, stay well and engaged in their work. Participants' coping strategies will be discussed in the second global theme named **'Coping with daily work challenges'**.

3.1.4 Poor cooperation with colleagues and superiors

This theme involved how work stress relating to the aspect of work environments, such as poor cooperation with colleagues and superiors, can influence participants' experience of work stress and adversely impacted their well-being, motivation and organisational engagement. Finally, participants described how they managed the challenges.

This theme identified unprofessional conduct as a stressor on the participants' daily work life. The descriptions of the participants' working experiences revealed that one of the job demands included poor cooperation with colleagues which arose from "*working with colleagues who were lack of work ethics"* (Richard), "*has draining personalities"* (Daisy) and *"a micromanaged superiors"* (Britney). Participants spoke of how these relationships impacted their ability to complete tasks at work and increased stress felt by the participant. In some cases, this leads to adverse work outcomes, as detailed below.

Increased workload

The most commonly related negative outcome from colleagues' unprofessional conduct was increased workload**.** Several participants spoke of times they were required to complete unfinished tasks for co-workers who left them unfinished at the end of their shift. Diana described:

> *"(...) See! How these people work. I am pissed off to see that they care about nothing. They do not care about the nursing home and the patients. They come to work and make a mess. They make the nursing home a disgusting place to work. It is disgusting to work in such a situation. I have to clean up their mess and complete the task that they left behind. (...) I have the feeling that some of my colleagues are like, if there is an opportunity, I will go away, and they won't stay. And of course, for some of them, they are really into their job. You can see that for some of them they are like, 'Omg, this is the best job in the world.' "*

Edwin similarly described that "*some colleagues who are working in the nursing home do not like to work here. They did not like their job. They come here to work for the money."* Myra further described that the worst scenario is that*, "somebody even asked you to do their tasks by saying that they are too busy, but they are not!"* Lucy expressed sincere dissatisfaction towards colleagues who didn't do their tasks properly, *"there are those who are always on their phone*

or do nothing. When you asked them if they have clean the kitchen, they will tell you that they have cleaned it but they actually do not do it. So, in the end, I have to do it because no one can do it!" Several participants were extremely unhappy when colleagues expressed unprofessional attitudes. Lucy, Myra and Christine each related that *"they just wanted to have a good time at work."*

As a consequence of unprofessional colleagues, many participants reported being tasked with completing work they were unfamiliar with, or untrained to complete. One participant spoke of excessive administration and unfair work assignments from colleagues which lead to an increase in both workload and stress. Myra described that she can *"feel that superiority from their [colleagues] bossy attitude."* amongst her colleagues who have worked there for an extended period of time. Myra described:

> *You can sense that bossy feeling from those who have been working there for a long time and that they are showing you that they are better at things and that they are the one who is in charge of things. So sometimes, I get assigned with complicated and difficult tasks. For example, I get a very difficult patient, a patient who suffered from a very high degree of dementia, and at the same time, I was assigned to the kitchen work. This makes my work difficult. That makes me so feel so stress. This is very unfair.*

Poor cooperation with colleagues appeared to have affected participants' commitment to the organization and is detailed below in **"Quitting as an alternative"**.

Exhaustion

Several participants explained that an increased workload developed as a sense of exhaustion in them. Myra continued by underlining how an increased workload has affected her, *"When you are working more than the others, you get tired faster, and the shift is so long to finish, and you still need to do your tasks. While my colleagues have already finished their work and enjoying a good time, I'm still doing my job or my tasks."*

Christine echoed that, *"Some of my colleagues despite seeing me being overload with my tasks still request me to do their work saying that they have more important tasks to attend. This makes me feels even more tired."*

These feelings are repeated across the data set, in that participants who spoke of the increased workload resulting from unprofessional colleagues also identified feelings of exhaustion.

Work-home conflict

One participant detailed how an increase in their workload had caused a work-home conflict in their lives. Myra related, *"When I need to stay at work for a bit longer because I cannot finish my job or my tasks, I get stressed because I will miss the bus schedule, and I have to wait for another hour for the bus and sometimes I have an appointment, then I could not meet my next appointment."*

This sort of challenges to the out-of-work lives of immigrant workers brought on by the unprofessional conduct of their colleagues also relates to the adverse effect of exhaustion.

Emotional distress

Several participants spoke of the impacts that unprofessional conduct had on their emotional well-being. They felt that they had to tolerate being undermined by colleagues who always correct them in front of their patients. Diana recalled a situation where she felt offended and stressed because her colleague repeatedly displayed a lack of respect:

> *I stress from my colleagues' attitudes. One guy in my workplace, my colleague, and was kind of defensive to me. There was one situation where a patient and I are having a discussion. It was a year ago were at that time, my Norwegian was evil. In the middle of our conversation, he suddenly started to correct me right in front of the client, the patient. He told me that I am wrong and how I am supposed to say it in Norwegian. I feel offended. So I talked to him that it is not right and cannot correct me in front of the patient. I feel very uncomfortable, and this is not professional. It is my mistake, but you cannot correct me in front of the client. And then he was like, "Oh yes? I'm just teaching you the right Norwegian." And he seems to like this is not a kind of a huge problem. I feel that it is because I am a woman, so he talked to me in that way. That is what I felt towards his intention. I am very surprised. He makes me feel very uncomfortable and very ashamed.*

Lucy likewise mentioned that *"there are several colleagues in my work who is very unprofessional. They always correct me and making fun of me in front of my patients. I feel very stressed and embarrassed working with them. "*

This repeated correction and disregard for the professionalism of immigrant caregivers in front of patients with who they need to build relationships with is, as shown in the data, a common source of emotional distress.

Insufficient guidance

Insufficient guidance is a common difficulty described by the participants. Many participants mentioned that there are times where their colleagues did not provide them with professional and complete guidance, in the fear that they might perform better than them. Christine described:

> *I did not have a lot of experience with patients with eating problems. I asked my colleague how can I do it, and she is very stubborn. She very firmly pointed to her head and said to me that I have to think. I would not have asked her if I knew how to do this task. (...) she wanted to show that she is better.*

Britney expressed a belief that she has never received guidance from her colleagues, "*I asked my colleagues [for help]. I asked everyone I knew in the area, but yeah, they did not explain. They just said, "Do not do this and do not do that. I have the instinct that they are afraid that I will be better than them."*

The impacts of insufficient work guidance on the participants are further described in **"Quitting as an alternative"**, but as seen above have a clear impact on the ability of the worker to correctly and completely execute the tasks provided to them.

3.2 Coping with daily work challenges

Participants referred to maintaining a positive perspective, positive aspects of work and quitting as an alternative as their coping strategies in relation to work stress. They achieved this positive outlook by learning the language, engaging in empathetic thought processes, focusing on being

patient, being goal-oriented, and focus on job responsibilities in dealing with workplace stressors. Positives aspects of work were elaborated upon in the interviews as monetary compensation, flexible day-off requests, communication with superiors, communication with colleagues, superiors' and colleagues' support, patients respect and appreciation, stable income, and meaningful work. Two participants referred to quitting as an alternative for better overall well-being.

3.2.1 Maintaining a positive perspective

One way that participants coped with their stress arising from role insufficiency caused by language barriers was through comprehend their stressors.

Learning the language

Participants' self-evaluations have led them to identify language barriers as the main challenge leading to their stress and understand the need to improve their language skills. Cheryl comprehended that the language barrier was a challenge through self-evaluation:

> *You need to be well-versed in their language when it comes to daily work cooperation with patients and managing violence within the workplace. When you work with elderly patients with dementia, they can have mood swings due to their disease. You need to be proficient in the language to calm them down.*

In addition, all the other participants also reflected and comprehended this challenge as their *"number one daily work stress"*.

A coping strategy that all the participants refer to was learning the language, "*I have a kid plus I have to go to school, I am doing a Norwegian course. (...) I need to have Norwegian proficiency of B2 (...) (Cheryl). "* In addition, Christine noted that *"I must learn the language to get a full-time job in the nursing home and to go to the University to study nursing in the future."*

To create a more inclusive working environment for themselves, participants described the need to learn the language. The act of being able to speak Norwegian also improved cooperation with the patients and managed violence from them:

> *I have aggressive patients in my job now, but I handle it better. I can see that it's because of my language. For me, communication is really important in my job, especially when you have aggressive patients. Yes, it (language) helps me.* (Cheryl)

In addition, Richard likewise has a similar experience: *"You can see that the patient's trust was getting lower when you do not speak fluent Norwegian. This is heart-breaking. So I must improve my language to gain my patient's trust back (Richard)."*

Through self-evaluation, participants understood that inadequate proficiency in Norwegian impaired the development of good interpersonal relationships, especially with the Norwegian. Richard gave his perspective, saying that you have to speak Norwegian in social and professional situations within the workplace *"Norwegians are very nationalistic and preferred to speak in Norwegian than any other languages especially in English."* Likewise, Lucy described, *"It is a struggle, but we have to learn the language to interact with native colleagues."* Lucy coped with the language barriers by improving her language skills. Richard believes by improving his language skills lad to better support from his colleagues, *"I have seen some colleagues of mine who are getting along well with the natives. It could be because they speak Norwegian very well. (...) and they are also more willing to offer help if you spoke in Norwegian with them.*

This reflection of all participants showed how learning the host language can allow an immigrant care worker to better cope with challenges caused by the language barriers leading to better care quality, workplace relationships as well as in overcoming the additional challenges brought on by their immigrant status which leads to better well-being.

Empathetic thought processes

While experiencing discrimination and harassment from patients, all of the participants described engaging in empathetic thought processes when encountering challenging patients.

Myra said, *"I understand what they are going through, they have dementia which resulting in their unstable moods".* Likewise, Audrey described that:

> *It is because I know the reason behind their behaviour, and the real hidden cause is not because they do not like me. They have many experiences in the body, and the disease is affecting their emotions, feelings, and personality. I understand that it is not their intention to hurt me. It is because they have an underlying disease, dementia.*

Nicky maintained his positive thinking towards the elderly who have been mistreating him, by using empathy to understand the reason behind the actions of his patient, *"I think it can be because the old man was very stubborn or frustrated with his life. And it could be possible that he may have had some bad experiences with foreigners he had met in his earlier life."* This reflection of Nicky's helps show how empathy can allow an immigrant caregiver to maintain a positive approach to their patients despite challenging patient behaviours.

Focusing on being patient

Several participants spoke that it is essential to exhibit other forms of communication skills, such as being patient in dealing with challenging patients. Richard said *"You need to be very patient. I would say having lots and lots of patience is a requirement when working with the elderly."* Having worked extensively in the nursing home, Audrey described that being patient with the patients could, in turn, give her satisfaction and better motivate her to continue to engage with her patients:

> *Being patient with the patients helps me in managing difficult patients. I learned to approach patients with patience, for example, how to talk patiently to the patients. Talking with patience can calm them down or make them restful. Being patience can indeed overturn a stressful moment with the patients, and there are many times that we end up having a good time together, and we end up laughing. It is very satisfying and that is what motives me to come to work."*

This reflection of Richard and Audrey help show how focusing on being patient can allow an immigrant care worker to maintain a positive approach to their patients despite challenging patient behaviours.

Being goal-oriented

One participant explained that being goal-oriented was one of the factors that had motivated her. Diana said:

> *I have talked about why I wanted to work in administration. My goal is to make this place a better place to work. I want to work in the administration department, giving tips on how they [the caregivers] should react when they encountered unpleasant incidents from the patients. (...) I know there are many people who have experienced much worse than I have experienced. For example, the emotional distress caused by patients' verbal and touching abuse. And I think that it would be nice if the people [superiors] can hold some meeting to talk about caregivers encounter, their feeling and the support they need. I have not seen such a thing happening in this workplace. I hope I can make a change and make this place a better place to work where I can provide necessary support through working in the administration department.*

Participants who maintained a positive perspective were more effectively able to deal with both the daily challenges within their work environments, as well as the additional challenges brought on by their immigrant status.

Focus on job responsibilities

Several participants referred to shifting their focus away from unprofessional colleagues and focus on their patients helped them deal with work stress. Christine described:

> *I focus on the patients. I do not think much about them [Christine's colleague]. I feel that they [colleagues] are very selfish that they only think for themselves. They would like to have a good time at work and do not think for the patients. So, I just walked away from them and focus on my patients.*

Likewise, Richard described, *"For me, I rather focused on my patients than negative colleagues."*

Many participants spoke of focusing on their patients as a way to deal with unprofessional colleagues and to avoid the emotional difficulties that entail.

3.2.2 Positives aspects of work

Despite being overwhelmed and overworked, participants described positive aspects of work (job resources) that compensated for their challenges within their workplace. Some of the positives aspects included monetary compensation, flexible day-off requests, communication with superiors, communication with colleagues, superiors and colleagues' support, patients' respect and appreciation, stable income, and meaningful work.

Monetary compensation

The motivation behind participants' engagement despite staffing problems was monetary compensation. Nicky mentioned, *"I mean being a student, this work tends to help me financially, that's why I choose to do this job. Their pay is decent."* Several participants considered overtime compensation to be positive, Audrey said *"We often have to work longer hours because there is no one who can work but they pay a good salary for overtime."*

Overtime compensation was a way participants compensate for staffing problems which lead to work engagement.

Flexible day-off requests

Several participants mentioned their superiors' flexibility in approving the request for day-off, Cheryl said, *"My bosses are flexible in holiday's approval. When I need to request holidays, my bosses always approve my holiday leave."* Nicky described, *"My superior was very flexible in requesting my day off. She told me during the interview that I can request day-offs without giving any reasons."* Audrey likewise stated that *"My superiors were very flexible in approving day-off request. Sometimes, my body pain gets so bad that I could not go to work. My superiors were very understanding. I never have a problem requesting for the day off or last-minute day off."*

Flexible day-off was seen as a positive aspect of work to compensate for staffing problems which lead to better well-being.

Communication with superiors

Participants coping strategies included speaking up whereby they discuss their current workload and set realistic goals. Although requested, this was not always approved. Several participants described a lack of superiors' engagement in their needs where their request made to superiors was ignored. In Cheryl's case, her superiors' request for extra help was ignored, leaving her and her colleagues to bear the brunt of the negative consequences of the lack of workers, "*they do not recruit. They only use the same people in the job. You need to go extra, you know! They are telling me that they are going to recruit, but nothing happened.*"

Several participants were seen pleading over the needs for "extra help" to their superiors to support them in executing their duties. In contrast, some superiors did sign an extra position to share the workload. Some participants said that after raising the issue with their superiors it was never adequately resolved. Nicky's superiors were reluctant to provide the necessary manpower and support he requested:

> *That is not quite frequent that we tend to get extra help (...) I have seen those who tend to work continuously or in a permanent position or during the night shift have requested to our employer quite a few times that they need extra help during the nights. It was then the employer tends to sign an extra position for the night.*

Participants took account of positive aspects of work (e.g., monetary compensation, flexible day off requests and communication with superiors) as ways to compensate for staffing problems which lead to better well-being and stay engaged to their work.

Communication with colleagues

Two participants spoke of communicating their concern and dissatisfaction with an incident to the colleague in question as a great experience and an effective way of dealing with their work stress arising from the incident. Both of them stated that *"you have to stand up for yourself"* when you are being bullied within the workplace. Richard said, *"I confronted her that I'm not*

a robot to learn everything in just one snap. After that, our interaction went well: it helps." When discussing dealing with difficult colleagues in the workplace, Diana mentioned, *"You have to stand up for yourself. (...) I feel offended towards the guy I told you who correct me in front of the client. I talked to him. And after that, he never did that again."*

This reflection of Richard and Diana help show how communicating their concern and dissatisfaction can overturn a stressful moment with unprofessional colleagues.

Some participants described several positive aspects of work that arose from their working environments in dealing with challenging patients. These included superiors' and colleagues' support, patients' respect and appreciation, the stable income provided by the employer and meaningful work.

Superiors' and colleagues' support

Participants spoke of the times where colleagues assisted in executing challenging tasks or simply provided support during the workday. Rebecca described, "*I would not take care of the patient alone. So what I would do is I would bring someone to go with me to challenging patients."* Nicky, who worked alone in the department, described that he often had to run to get help from his Norwegian colleagues in the other department to assist with challenging patients, *"(...) I have to go to the other department to get the help of a native colleague."*

Some participants recounted the times where they received mentoring from their colleagues. Rebecca described,

> *I do not have much time during the shift to spoke of how care can be improved. Some senior colleagues offered some advice after working hours, for example, spoke about it when the shift ends or a conversation over the group chat. (...) we always managed to find out the solutions on how to better deal with things.*

The majority of the participants identified that having the support of superiors and colleagues in the event of a challenging patient helped to reduce their experiences of stress post-incident. Cheryl described:

It is important that my colleagues and my superiors are going to work together and my bosses step in to handle difficult patients. (...) Sometimes, it is hard with challenging patients, but of course, with the help of my colleagues and my bosses, helps me to get through the difficulties. It also reduces my stress level.

Likewise, Christine perceived superiors' support and effective management as being useful in handling challenging patients:

She thought that it was very important that I told her [about the patient who sexually harassed her]. And this shouldn't have happened at work. And she agreed with me on how I can deal with it. She avoids giving me this task [taking care of the male patient who has verbally harassed her]. (...) I am very lucky in my job. I have a good boss.

Participants who experienced superiors' and colleagues' support during difficult moments with challenging patients showed better emotional well-being.

Patients' respect and appreciation

Despite the experiences of challenging patients, the participants spoke of rewarding, uplifting and joyous times in their jobs. Participants described the positive feelings of receiving respect and appreciation from some of their patients for the work they had done for them. Diana said:

Some [of the elderly patients] said we are so happy that you came. She always says to me, Diana, that it is a good day for me when I know you are coming. When I think of that, I started crying out of joy (Diana trying to retain her tears). Somebody is happy to see me. It makes the moments you work with elderly people so much better than the times you hear negativity from the other patients, and this was what I like and motivate me to go to work.

All of the participants spoke of how patients' respect and appreciation contributed to their increased emotional well-being. Cheryl said:

The patients said that I am good and I am hardworking (Cheryl laughed with joy.). It's nice to hear that they said that you are good or nice. My time is just going to pass fast, and there is no being tired of me. Feeling tired of me is no longer a thing. I can feel those positive words! It is a motivation for me.

Audrey further illustrated, "*you will see that they are satisfied with the work that you are doing, and they are very thankful for it. They will praise you: to be particular, they will say, "You are so good, you are doing amazing, or you are an angel. Haha. (...) They are like a pain killer to the pain from this workplace."*

Several participants described patients' appreciation as a work motivation. Nicky described:

She always replied to me with a smile after every task I tend to perform to help her. I also enjoyed helping her out as she tend to transmit very positive vibes by smiling and thanking the help I have offered. I think it is mostly the joyful nature of that old lady that has created this positive situation.

As evidenced in the quotes and abstracts from participant interviews above, many participants found that receiving respect and appreciation from patients made dealing with the challenging behaviours of individual patients, or the difficulties of the workplace as a whole, more bearable.

Stable income

One participant also identified that one of the rewarding aspects of their work was having a stable salary while not having permanent residency in Norway. Diana described that, as an immigrant newly moved to this country, it is not easy for her to get a job, leading to fears of unemployment. As such, she felt that attendance at work was mandatory, even though she was very afraid of that patient who constantly harasses her:

To be honest, I was afraid during that time, I was very afraid of that patient, I did not have a family. I was here alone, and I am afraid to lose the job (...). When I experienced something bad in the workplace, I will say that it is shitty, but I continue to work there. When something like an unacceptable incident happened to me, I often am like, yes, this kind of thing has happened. And then I say to myself, okay, I should

continue working. In another moment, I will be like, no, I am not going to this patient. And then the next moment, I go to the patient and do it. Because I need the job, I need the money.

As shown in the above abstract from Diana's interview, thoughts of income stability and job security were a motivating factor for her to continue working with challenging patients.

Meaningful work

For many participants, being a caregiver was not only a source of stable income but also meant doing something worthwhile. Participants spoke of care work as meaningful work, which led to increased work motivation, engagement and self-fulfilment. Christine described meaningful interaction was what motivated her:

It is a place where a human being can care for another human being. It is an interaction where there are trust and attention. I like this kind of interaction. (...) I love my job. I cannot wait to work there. I feel like I am working as a volunteer, and I am helping other people.

Audrey likewise felt her work was meaningful and rewarding, "*You know I think I found my purpose in my job. The purpose of my job is to help people to alleviate their anxiety, not by just the medical way but for me, the care is also important. Helping them through my own personal way is a motivation to go to work.*"

Rebecca often felt that her work was meaningful and rewarding, providing a way that she can give back to the elderly for their contributions to society:

My job is very fulfilling when it comes to being able to help the elderly in the last few years of their life and giving them a quality of life that is good, happy, and that they have their needs met. Also, I always see the elderly as people who have given so much to the community. I'm grateful to them for everything going around because they kept with the way things are or have made the way things are now. So, although I am being paid and I see it as a way of giving back to them for what we have today. That is toward the elderly and me.

Participants viewed maintaining a positive perspective (e.g., learning the language, empathetic thought processes, focusing on being patient, being goal-oriented, and focus on job responsibilities) and the positive aspects of work (e.g. monetary compensation, communication with superiors, communication with colleagues, superiors' and colleagues' support, patients' respect and appreciation, stable income, and meaningful work) as ways to deal with work stressors. These all then contribute to their better overall well-being, increased work motivation, work engagement and organisational commitment.

3.2.3 Quitting as an alternative

Two participants who felt that they are unable to control and change their working environments have decided that the best decision for them is to quit and move on. They chose to leave the nursing home environment as they viewed this to be the only option for them to have better overall physical and emotional well-being.

Behavioural reactions such as the intention to quit their job were found across the narratives of several participants who displayed frustration and dissatisfaction towards their workplace. Several participants (Edwin, Cheryl, Diana, Daisy, Britney and Richard) viewed residential care home and home-based care as a gateway to better overall well-being and future within the caregiving industry. Edwin, who works both in the nursing home and home-based care, had chosen to work more hours in home-based care due to higher pay and lower job demands. He identified that *"the salary at the home-based care is higher and there is a lot less work. There is less physical work for me."* Cheryl intends to leave her position in the nursing home due to the excessive workloads, work-home conflict and her deteriorating health caused by the excessive job demands and prolonged working hours. Diana and Daisy had chosen to leave nursing homes to work in residential care homes and home-based care respectively. They made this decision after just a few months of working in the nursing home due to the high workload and excessive emotional and physical strain. Britney and Richard left nursing home care and continue their caregiving journey in the home-based environment due to the lack of control they had, and negligible support that they received within the nursing homes that they work at. Britney and Richard's painful journey from the nursing home to home-based care are discussed below.

Pushed to breaking point

"Just quit if you can not cope. There is nothing wrong with it." (Britney)

This theme illustrates the story of two of the participants (Britney and Richard) who chose to quit as they perceived this to be their only option for better overall well-being. The following paragraphs take Britney and Richard's case as an example to illustrate how a lack of control that an employee feels they have, and a lack of perceived support from colleagues and superiors (such as having no control over their work, poor interpersonal relationships with colleagues and superiors and a lack of career advancement), has caused an unpleasant working environment which has affected their overall well-being and professional growth.

"I feel like I was so small (...)."(Britney)

Several participants were dissatisfied with the poor interpersonal relationships with their colleagues and superiors, as Britney and Richard were. Britney described her relationship with the elderly as an enjoyable experience, "*Working with the elderly in the nursing home is not a problem. I enjoyed it. It is a physically heavy job, but I enjoy my job. It does not matter how heavy they are if you love your job. However, working with my colleagues is very challenging."* Britney also described:

> *Working with colleagues is quite difficult. You cannot please everyone. Even though you are doing the right thing, someone [colleagues and superior] will not be happy. They just do not like you. If you are working in a place where there is no harmony, you won't feel happy anymore. It is not like I do not enjoy working in a nursing home. It is because I do not like my colleagues. First, I felt discriminated against because I'm not good enough in Norwegian and second, there is something like superiority. I feel like I was so small and that everything I did was wrong because everything that I did, they are commenting a lot.*

Britney explained that there was no harmony in her workplace. Her superiors and her colleagues did not practice professional coaching methods to help her learn at the workplace. They were only concerned with giving commands and penalizing her rather than coaching her. Upset, Britney walked away from her colleagues:

I followed what they [colleagues and superior] have said, but it was still wrong. They just kept on commenting. I'm already trying my best to follow what they have asked me to do. I am doing all my best, but my best is just not good enough. So yea, I have to look for another workplace, but I am still working with the elderly. So, I had chosen to walk away from my colleagues and superior. I have to look for another workplace, but I am still working with the elderly.

Britney felt that whatever she did was never good enough for her colleagues and superiors. Britney felt that she was negatively branded in the workplace, which caused Britney to express many negative thoughts about herself and her abilities as a worker:

I think it's just that they looked at me like I am very dumb. They looked at me as if I do not know anything [about my job]. I felt like this is because everything that I do, they kept commenting with, "Do not do like this, but do like this." (...) The way they have treated me makes me feels like I am very dumb all of the time.

Britney felt she was being micromanaged. She described that she had no freedom within her workplace. She was extremely frustrated that she was being commented on at all the time without receiving any constructive explanation for why her actions were not permitted:

For example, if I wanted to do this to an elderly patient, they will say, "Do not do that." I know it is good for my patient, but they say, "No! Do not do that!" There is no explanation but, "Do not do that!" (...) They wanted me not to love what I am doing. You know, I have this feeling that everything I did was wrong. I did ask for help from my colleagues on what I should do, and I did my best. I felt that everything I did was just not enough!

At this point in the interview, Britney paused, looked away, trying to restrain her tears and cover her pain. She sighed loudly out of desperation, *"Aiya! They do not like me. I have a human instinct. It's just that they do not like me, and they want me to give up "Maybe".*

Richard was another participant who expressed frustration and dissatisfaction with the lack of guidance within their workplace:

She did not guide me in learning the routine, but instead, she assumed that I know everything about the routine. It is my first week, and I'm very new to the workplace, and it is her responsibility to guide me, but she did not guide me very well. When she was guiding me, she expected me to learn everything in just a snap. I say to her that "I am not a robot. Can you please slow down?" She became impatient. To her, since I'm a nurse, I should know everything. I should be able to do the task independently and correctly. It is different when she guided the others. Towards others, she is very kind and patient. So for me, it is like discrimination. She is very unprofessional. First, she did not guide me and second, she is reluctant to guide me. When she guides me, she did not guide me well. Third, she makes a big fuss and shouted at me in front of all my patients when she was not satisfied with my work. Later, I found out her intentions behind her action: she wanted me to leave, and she wanted to prove to the patients and superior that she is more of an expert and more competent than me. She wanted the patients to be angry with me. She often complains to the patients about how incompetent I am, and I have witnessed this several times. She called our superiors to complain about how bad I am. It is obvious that she wants me to leave!

This reflection during the interview led to another marked reaction from the participant. Richard paused, pulled in a long deep breath and sighed. He appeared agitated. He continued, his body language displaying both agitation and anxiety:

I'm very open to being corrected. I am very open to everyone to correct me, but I think it is very rude that you have to tell me or to correct me right in front of the patients in a very loud voice. This is disrespectful! And rude toward me and also that is not professional of her. Argh! She always corrected me in front of the patients! You know. She wanted to make the patients angry with me. I can see that the trust of the patients is getting lower and lower every time. She has caused mistrust in my patients. Patients had mistrust towards me because she always corrected me in front of the patients, which I find rude. She wanted to make the patients lose confidence in me. And she likes to do everything by herself. So, in my opinion, I have never learned anything from her.

Britney experienced similar issues but with slight differences, in that she did not receive any guidance at all within her workplace despite desperately seeking help. She perceived that no

one at her job taught her anything. She felt unwanted and interpreted this treatment as a sign that several colleagues and one of her superiors did not want her at this job:

> *I asked my colleagues [for help]. I asked everyone I knew in the area, but yea, they did not explain. They just said, "Do not do this and do not do that!" So I think I was fed up, and I wanted to quit! I think it's that they did not want me, you know what I mean? They did not even want me there! There was a superiority feeling. Although I'm just a beginner, they did not give me enough time to adjust or learn more. It's been just like that from the start. They just said, "Do not do this: do not do that."*

Christine, who has not made the decision to cease her employment at a nursing home yet, recounted a similar experience, where she received no guidance even though she sought it out:

> *I did not have a lot of experience with patients who have eating problems. I asked my colleague how can I do it, and she is very stubborn. She very firmly pointed to her head and said to me that I have to think. I would not have asked her if I knew how to do that task.*

Britney felt uneasy when working with the superiors and colleagues that she identified as watchful. Getting things done under tight supervision caused significant emotional stress. Britney was unsatisfied with what she identified as consistent abusive treatment and unprofessional guidance. Britney described that she felt micro-manged and that somebody was always keeping an eye specifically on her, rather than other colleagues, displaying unprofessional behaviours. Britney decided she had reached her threshold and was unable to tolerate this hostile working environment anymore. Because of this feeling of being overwhelmed, Britney chose to quit working in this nursing home:

> *I felt that every time wherever I was, or whenever I am doing something, they [superiors and colleagues] will look at me. (...) My superior is just looking at everything that I am doing. Everywhere I go, she is there all the time! She is just there whenever I am. It is just felt like it was towards me! She always looked at me! She always looked at me, and then she talked to me, "Do not do this and that the next time." Everything is "just do not". She did not explain why I have to do this. She just says*

"do not", so what should I do? I was fed up, so I just quit! I think if you are not happy enough, then you should just quit!

Moving on to the paradise of work-life

Britney and Richard who experienced a lack of team support and perceived a lack of control over their working environments quit their job in the nursing home and continued their caregiving journey in home-based care. Richard and Britney related that they were markedly happier than they were before. Britney described:

> *Right now, I am so good! We [superiors and colleagues] are all good. There is no such thing as discrimination or racism. My superiors and colleagues now treat me equally. Although I am working with Norwegian and with other foreigners, we are all equal. Now we are all the same. There is no heavy work for me, and no light work for me. In the previous job, they took patients that were easy to take care of. Now, we are all the same. We do the same routine. We do the same rotation on the patients. There is no problem [with my colleagues and superiors]. Sometimes, they even asked me if I have any problem (...) If I asked for help, they would help me because they know that it is hard. Before, no. When I asked for help, they [my colleagues and superior] did not come. They said, "I will be there in a minute." But 10 minutes passed, 15 minutes passed, they did not come. That was a very long time for me with the patient. Now, we do correct each other if we did something wrong. They will nicely correct me with, "Maybe we, we can do this." It is not that you have to do this. They are not telling me what to do, but they say we what we have to do. That's the most important thing. We learn together. It is not that you have to learn that, but we have to learn that we have to learn together. Here, we grew professionally together. If there is something we disagree with, we say it in a good way. We joke about it, and we learned from it. It's sometimes we say that it is not good, but no one gets offended. (...) At my previous job, you cannot joke with anyone. If you crack a joke, they will just laugh in a criticized way and then they will give me a look which tells me how weird I am. Yes, I had no freedom [at my previous job].*

Britney described that she experiences more equitable treatment in her current job and that she gets the supports she needs. She does not have any intention to leave her current job because

of the treatment of her colleagues and superiors. Instead, she is looking forward in her career in caregiving, to other roles where she can better applying her nursing ability and skills. Richard expresses similar positive thoughts about his new employment:

> *I love my job now. I am responsible for only one patient. There is less physical and mental stress for me. But one thing is that I noticed that I am not improving like I used to work in the hospital. So I am considering working in the hospital but another country. And I hope I wish, and I hope I can back to my profession as a nurse. I have a dream to pursue being a nurse. I do not see myself achieving the dream of being a nurse without going through the hassle of doing the nursing degree a new.*

Richard identified an intention to leave Norway to work as a nurse using his existing credentials rather than retraining in the Norwegian system:

> *I have some friends who have already moved out of Norway because of many factors. One of the factors is to improve their skill in their profession. Here they do not have a short course for health care workers like us. During the seven years of being a health care worker here, I have only participated in three training courses. Can you imagine? Three training courses in the entire time of seven years. Sigh… I do not know what the reason behind this is.*

This sense that they did not find the complete fulfilment for their potential as a nurse when they are taking care of the mentally disabled elderly was common across several participants. Some stated an intention to quit to pursue better career opportunities in nursing elsewhere, not exclusively due to a colleague and superior actions like Richard and Britney.

Chapter 4: Discussion

Chapter 4: Discussion of findings

The flexibility of the job demands and resources theory has allowed it to be used in the immigrant caregivers working within the Norwegian nursing home. Job demands-resources theory provides a framework that can better understand immigrant caregivers' work situation and sought answers to the following research questions. The first research question is how do

immigrant caregivers experience their work-life? And the second research question is what are the coping strategies that these immigrant caregivers employ in response to challenges in their work-life?

The participants described four negative aspects of their work that resulted in their work stress such as language barriers, staffing problems, a strained relationship with patients, and poor cooperation with colleagues and superiors. Participants' experiences of job demands and job resources led to two mechanisms, in which, role insufficiency caused by language barriers and the experience of stressful working environments has caused work-related stress (e.g., exhaustion, psychosomatic health complaints, and repetitive strain injury (197, 198)) in them which negatively affected their work lives. Prolonged job demands have led participants to experience poor health, a decrease in their work performance, dissatisfaction, and a lack of work motivation. Such situations have resulted in adverse organisational outcomes (e.g., turnover intention, work engagement and organisational commitment): while resources such as maintaining a positive perspective and positive aspects of work and have the potential to lessen the negative aspects of care work and may help to limit their experience of work stress. Furthermore, positive aspects of work enhanced their work satisfaction, and motivation, which increased their overall well-being, work performance, engagement and organisational commitments (159, 167, 199-202).

This study was aimed to understand immigrant caregivers' working experience within the Norwegian nursing homes in relation to the job demands-resources theory. However, some aspects of the job demands-resources theory were unable to adequately illustrate the coping strategies utilised by the participants. It is found that Aaron Antonovsky (1979) theory on the sense of coherence that focuses on how individuals can comprehend, manage, and find meaning in stressful and highly demanding care work environments, establishes their sense of coherence. His theory provides a finer-grained account of participants' coping strategies which will be discussed in section 4.2.

4.1 Immigrant caregivers' experience of work-life

4.1.1 Language barriers

Norway has a wide variety of dialects which caused difficulty in communicating across the country. All the participants spoke of experiencing stress due to language barriers. Being unable to communicate efficiently within the workplace was problematic for the participants where Norwegian is not their first language. The analysis highlighted language barriers played an important role in work stress and acted as a significant stressor for immigrant care workers (52, 120). For many immigrant workers (including the participants), insufficient language proficiency has led to difficulties with communication (203). Communication issues, both knowledge of the language and speaking ability or understanding the dialect, are at the root causes of miscommunication (5). The finding showed that work stress arises from role insufficiency where participants' lack of language proficiency cannot fulfil job requirements and lead to work stress arising from language and miscommunication. The lack of proficiency in a language is a barrier to fully understand, implement, and complete assigned work tasks, leading to role-related stress (e.g., role insufficiency).

Job demands that participants experienced included language barriers that hindered their work performance and participation which, in turn, compromised quality of care for the patients (204), professional efficiency (203) and participants' safety and well-being (119). Role insufficiency has led to compromised quality of care for the patients and reduced professional efficacy, which in turn, has resulted in participants' reduced work accomplishment and lowered their career trajectory. Similarly, research by Asis (2020) and Storm (2019) had shown that language discrimination reduced participant career trajectory and prevented their professional growth (52, 205).

Participants' limited capacity to comprehend patients' created a stressful situation for the patients, where dissatisfied and frustrated patients caused physical violence towards the participants which compromised their safety and well-being. Research by Yagil (2008) has shown that patients are more likely to exhibit aggressive behaviour, especially when they are dissatisfied, intoxicated, or in a stressful situation (83).

Language, dialects, choice of words, and accents affect how people are classified and treated (206). In terms of social integration, language and communication issues have been commonly found to hinder the ability of immigrants to establish relationships outside their own ethnic and cultural communities. (207, 208). Similar findings were evident in this study and the study by Walsh (2009) indicating that language could act as a barrier to workplace and wider social

integration (8). For instance, the study findings demonstrated that language barriers impacted participants' daily work cooperation and social connection with their colleagues and patients. In particular, language and communication difficulties hindered relationship building between colleagues and patients, leading to negative relationships. For example, discrimination and harassment have contributed to participants' poor emotional well-being at work.

4.1.2 Staffing problems

The analysis highlighted the experience of staffing problems as a significant stressor for immigrant care workers, which resulted in unmanageable workloads and prolonged working hours (60). Research has shown that increased workload can lead to an increase in work stress (61-63). Participants reported working within an environment with low "caregivers to residents ratios" and limited job resources (56) due to inefficient management in their daily work life, for example, ignoring their suggestions or feedback (117) or leaving them with unresolved queries (94, 116)) led to them enduring a heavier workload and working overtime (52).

Working under resource-constrained conditions, especially in a physically and emotionally demanding workplace, can negatively affect workers. Indeed the participants of the study reported that heavy workloads had negatively impacted their overall well-being (70, 71). Other negative work outcomes included decreased job satisfaction (19, 20), absenteeism (209) and turnover intention (16, 17, 209). Common problems for care workers (including the participants) are exhaustion and an increase in the rate of injuries from repetitive motion (210-212). Job demands-resources theory which suggested challenges can lead an individual to experiences of chronic exhaustion (138, 139) and become cynical about their work's contribution and question the meaning of their work. Eventually, they become disengaged and inclined to withdraw psychologically from their work (213) something the participants of this study also indicated. Research shows that stressors (particularly workload) result in the psychological detachment, which in turn, can result in high strain levels and poor well-being (e.g., burnout (159) and lower life satisfaction (214)). Similarly, the study by Czuba (2019) has shown that support workers well-being and work performance (120) can be challenged by increasingly high workloads and poor working conditions. Other studies have shown that burnout, in turn, reduces job satisfaction in nursing staff and results in adverse outcomes of rationing care (e.g., activities of daily living, caring, rehabilitation, monitoring, documentation, social care and constant) (215) which decreased the quality of care (209, 216). The findings illustrated that participants who

experienced ineffective management showed poor well-being and negative organisational outcomes (e.g., low job satisfaction and turnover intention.). Findings illustrated that prolonged experience of high job demands including ineffective management by superiors could result in high-stress working environments: more specifically, work overload and time pressure would lead to adverse work outcomes (197) such as stress and strains (197, 198) in participants which required them to draw upon job resources (160).

4.1.3 Strained relationship with patients

Strained relationship with patients was also identified as a common work stressor. Challenging patient' behaviour can be seen through the patients' request for native caregivers, sexual harassment (82, 217), verbal abuse, discrimination, ageism, bullying and mistreatments which have compromised participants' well-being. The finding gains support in a Scandinavian study that demonstrated that immigrant health care workers (non-Western) were more likely to experience bullying from clients/residents (patients in this study) as compared to the natives **(**89**).** Participants spoke of aggression and unwanted sexual behaviours from patients as a stressor (218-220). However, other studies have shown that client behaviour alone is not a significant factor attributable to worker's stress and burnout (221, 222): instead, a primary factor may be how the client behaviour is perceived by the worker (223). Discrimination towards immigrant workers was shown by de Castro and colleagues (2006) whereby certain ethnic groups (Norwegian caregivers in this study) were favoured over immigrant workers (224). Ageism has been shown to affect younger workers in their twenties and older workers above fifty (225).

Abuse, harassment, discrimination and bullying can result in caregivers experiencing adverse work-related outcomes (99, 100). Similarly, a study by Okechukwu (2014) showed that workplace injustices (discrimination, harassment, and bullying) contribute to disparities in occupational health outcomes that can range from work-related injuries to lung disease to mental health (76). Health impairment outcomes included poor psychological and physical health (91). A meta-analysis of the antecedents and consequences of sexual harassment showed sexual harassment can result in poor mental health (107). Evidence from cross-sectional studies suggests that workers who experience racial or ethnic discrimination within the workplace can suffer from a range of negative psychological health outcomes. Negative psychological health outcomes included poor mental health (226, 227), psychological distress (228, 229), anxiety

and depression (230, 231), negative emotions (232), and emotional trauma (233). The study's findings revealed that participants who experienced abuse, harassment, discrimination and bullying in their workplace suffered from poor emotional well-being.

4.1.4 Poor cooperation with colleagues and superiors

Common significant stressors among nurses included stress related to problems caused by colleagues (234). Similarly, the literature showed that working with colleagues where a worker does not like and do not 'get on with' was a stressor (235). According to Giga & Hoel (2003), negative feelings a worker experience from working with these colleagues can lead to poor health (236). Existing literature confirms that colleagues who did not do their job well can result in caregivers' stress (237, 238), leading to burnout (emotional exhaustion, depersonalization, personal accomplishment) (239). The findings of the study highlighted the most common adverse outcomes resulted from poor cooperation with colleagues and superiors (e.g., colleagues who did not do their tasks properly or complete their task, excessive administration by colleagues and superiors, bossy colleagues, and lazy colleagues) was increased workload which leads to a sense of exhaustion, dissatisfaction, and work-home conflict. The impact of poor cooperation with colleagues and superiors caused unbearable emotional distress leading to participants experiencing poor well-being, frustration, dissatisfaction and increase their intention to quit their job (108-115). Participants who felt that they were unable to control and change their working environments choose to quit their job in order to have better overall well-being. Hayes and colleagues (2012) who focused on the causes and consequences of worker turnover within healthcare institutions found that excessive workload can cause worker turnover particularly when there exists a lack of team support (18) and perceived lack of job control (56, 58, 72). A Scandinavian study demonstrated that immigrant healthcare workers (non-Western) were more likely to have a negative experience from colleagues and superiors as compared to the natives (89). This present study's findings underscore previous research.

4.2 Immigrant caregivers coping strategies in response to challenges in their work-life

4.2.1 Sense of coherence

This study showed that participants with a high sense of coherence can be a protection from caregiving stress and demands, leading to better overall well-being, job satisfaction, work engagement and organisational commitment amongst immigrant caregivers working in the Norwegian's nursing homes. Research has shown that the strength of the sense of coherence included personal resource in stress management and achieving overall work satisfaction (240-242). Similarly, Masanottii (2020) found that a sense of coherence was a protective factor for the depressive state, burnout, job dissatisfaction amongst female nurses (243). Schafer and colleagues (2018) likewise indicated that having a stable sense of coherence is important for improving healthcare workers' mental health (Intensive Care Unit staff and anaesthesiology) (244). To my best knowledge, no study has been conducted and published on immigrant caregivers' stress and coping strategies using Aaron Antonovsky (1979) theory on the sense of coherence in the Norwegian nursing home. Aaron Antonovsky (1979) theory on the sense of coherence that focuses on how individuals can comprehend, manage, and find meaning in stressful and highly demanding care work environments, establishes their sense of coherence. Three components within the sense of coherence are comprehensibility, manageability, and meaningfulness. These will be discussed below in relation to participants' coping strategies.

Comprehensibility

Comprehensibility refers to the extent to which events are perceived as making logical sense, that they are ordered, consistent, and structured (245-247). Participants' adaptation process of coherence where the sense that one can usually predict one's future through the ability to derive the meaning from identifying sources of stress (e.g., lack of Norwegian proficiency) and figure out the importance to learn the language and applying it to their patients and colleagues which leads to a better work-life and well-being. This can further be explained from the norms of reciprocity where participants who have high motivation in learning the language eventually spoke better Norwegian. This offers them increased opportunities for interaction and relationship building with their native colleagues. Further, this facilitates cooperation with their patients which in turn, lead to better well-being, increased work satisfaction, work motivation and engagement.

The study by Rastogi (2017) showed positive thinking helps in stress management, increases an individual's problem-solving capacity and work performance (248). Participants' positive self-evaluation enabled them to identify work stressors whereby they can be seen adopting and

initiating changes in response to their job demands to adapt to work expectations (249). Through maintaining a positive perspective, participants have contributed to a better understanding of their work stressors and their situation in general. Participants' increased problem-solving capacity can be seen in them utilise resources such as job crafting in creating a more sustainable and inclusive working environment for themselves. Similarly, Eriksson (2017) identified that individuals with the ability to use resources that are available to them have better well-being (250). Participants' positive transformation can be seen when they started to positively self-evaluate the situation which leads them to identify and comprehend their workplace stressors. This, in turn, motivated them to use their personal resources such as maintaining a positive perspective and considering the positive aspects of work to stay well and motivated in dealing with their daily constraints. Such initiatives have enabled participants to transform job demands into dignified and satisfying work. As a result, participants who pose strong comprehensibility were more capable to select, alter and implement other resources to address stressful demands within their workplace (251).

Manageability

Learning the language

Aaron Antonovsky defines manageability as the extent to which an individual feels they can cope based on their resources such as past experiences, social support, and psychological strength (245-247). Participants coping strategies on job demands involved personal context which does not consider the social or organisational context (252). A resource that participants utilised included learning the language at a certified language school. Speaking and understanding Norwegian increases one's ability to manage stressful situations involving patients and colleagues which lead to positive outcomes (e.g., better work cooperation with patients and better relationships with colleagues to manage negative demands of care work). Learning the language becomes a form of coping in dealing with language barriers. Participants' language improvement has led to a decrease in work demands which, in turn, leads to reduced stress and resulting in them having better well-being. Khan and colleague (2021) likewise emphasized that language acquisition can contribute to immigrants' mental and physical well-being (253). Learning the language thus reduces the stresses brought by language barriers and allow immigrants to better integrate into the foreign environment (254).

Social resources

Participants' sense of manageability can be seen where they search and utilise resources under stressful working environments to cope with job demands. Another resource that participants' actively utilised was organisational resources (e.g., colleagues' and superior' support). Social aspects such as support from workplaces were perceived as a form of stress-coping, literature has also established that the support from superiors and colleagues act as a stress-deterrent (240-242).

The participants in this study often had to seek support within their workplace to manage stress. Participants' sense of manageability can be seen whereby participants getting necessary resources by asking for colleagues' help. The participants reported that acquiring help when working with difficult patients or a difficult task, and time to debrief concerns relieved a stressful situation. Social resources were experienced by participants as a job resource that emerged from the social environment in the form of superior's support (e.g., supervisory coaching (201)) and colleagues' supports (e.g., in the provision of information and resources, support, empathy, mentoring and other forms that can assist with their daily work (255)). The participants agreed on support from their colleagues and superiors helped them to cope when they felt stressed. This finding corresponds with current literature, which recognises that support from colleagues and social networks is valuable in managing stress and increasing well-being (64, 221, 223, 256).

Participants' positive self-evaluations have led them to comprehend that Norwegian is the language that connects people by default within the workplace and plays a pivotal role in relationship building and socialising within their workplace. A good relationship between participants with their superiors and colleagues can be better illustrated using Social Exchange Theory. Findings showed that superiors and colleagues favour participants who shown high motivation to learn the language, which created opportunities for their native colleagues to reciprocate, leading to better relationships between them and their colleagues. Participants expressed that when they spoke better Norwegian, their Norwegian colleagues were more likely to support them. In return, this also motivates participants to improve their language skills. Such positive work behaviour has led to fostering supportive social networks and gaining respect within their working environments which has positive impacts on participants' well-being. A better relationship with colleagues thus, creating more access to job resources, which

in turn reduce the job demands and leads to better work-life (decreased strains and improved well-being) The act of being able to speak within a language also improved cooperation with the patients. As a result, participants enjoy a more respectful and supportive working environment giving them a sense of belongingness, less workplace harassment, violence and overall well-being. Based on my observation, I speculate that learning the language can foster better daily cooperation with their patients, better support and collaboration between participants and their colleagues within their workplace which reduce the job demands and leads to better work-life.

Positive work outcomes, work engagement and organizational commitment

Social resources fostered participants to be more dedicated towards their work accomplishments. Findings showed that good workplace relationships mitigate the impact of various job demands. Participants with social resources (e.g., colleagues and superiors' support) described an increase in their work commitment and have shown increased engagement within their workplace. Participants who enjoy good relationships within the workplace deal with stress more effectively (168), mitigating stress and improving their coping ability (257). Thus, supportive work environments allow participants to be more committed to their work and organization, where they experience positive feelings of support and stimulation (258).

Colleagues' support has driven participants to execute more dedication to extra-role performance (154, 158, 167), leading to positive outcomes (158, 167) such as an increased overall satisfaction amongst colleagues and superiors. Such a positive environment has further strengthened participants' work engagement (111, 201) and organisational commitment. Social resources energize participants and foster engagement, which, in turn, resulting in positive outcomes such as high levels of performance (259). Therefore, job demands-job resources theory explains participants' work engagement because, where participants experiencing high levels of job resources, they are more likely to be engaged within their work and better-managed demands. Several meta-analyses have confirmed that job resources such as task variety, task significance, autonomy, feedback, social support from colleagues (111, 201), a high-quality relationship with the supervisor, and transformational leadership are the most important predictors of workers' work engagement (260). Social supports mitigate the demanding aspect of work on the strain, including burnout and help participants achieve work

goals or assist with their personal or professional growth (64, 165, 166, 200). Furthermore, Wong, Hui, and Law (1998) reported that several organizational resources (e.g., autonomy, skill variety, and feedback) can increase a worker's job satisfaction (261). Therefore, job resources act within a motivational role, helping fulfil participants' needs for autonomy and competence. Moreover, job resources, in particular, social support (260) echo Halbesleben (2010), who also found that job resources were positively related to work engagement (262). Other conceptually similar findings were the study among Finnish teachers working in elementary, secondary, and vocational schools. Researchers found that job resources acted as buffers and diminished the negative relationship between pupil misbehaviour and work engagement. Besides, they found that job resources influenced work engagement, especially when teachers were confronted with high pupil misconduct levels (10).

Simultaneously, socially supportive workplace communication enhanced work-life quality and helped participants deal with stress more effectively (263). As a result, participants who experienced lower exhaustion levels (165), are more stress-resistant and have better mental and physical health outcomes (264-267). Thus, the finding of the study is in coherence with the job demands-resources theory's which postulates that job resources can mitigate the impact of job demands on the strain, including burnout (165, 166) and participants who received a high degree of job resources within their workplace deals with daily job demands better and also experiences fewer job demands and strain (268). Participants can be seen enjoy working within positive working environments which enables them to work more efficiently, delivering optimal care to patients, thus improving the quality of care. In other words, participants' resources has resulted in higher manageability which in turn create a more inclusive working environment for themselves and lead to better work outcomes.

On the other hand, work engagement may also facilitate the mobilization of job resources. This is consistent with the notion that participants are motivated to find resources (269). Engaged participants, who are motivated to fulfil their work objectives, will actively find job resources (e.g., ask colleagues for help) to achieve these objectives. Furthermore, vigorous, dedicated, and absorbed workers are more likely to fulfil their work goals (270). Consequently, this will generate positive feedback, more rewards, and a more positive work climate regarding supervisors and colleagues' relations. For instance, as a positive motivational effective state, work engagement broadens by creating the urge to expand the participants through learning the language leading towards goal fulfilment.

Social Exchange Theory postulate that participants' work engagement can be reflected within the norm of reciprocity where participants perceived that they are being treated well and valued by their superiors or colleagues. The common motivational factors indicated by the participants were social supports from colleagues and superiors. Participants gladly expressed that they do have nice superiors that support them in times of difficulties which is a kind of motivation to get through daily work constraints and stay engaged. This is an agreement shared by several participants that the help from colleagues or superiors was perceived as being useful in stressful and challenging situations (64, 221, 223, 256). Participants can be seen to be more likely to respond by exerting effort with superiors or colleagues in the form of raised levels of work engagement (271). Social support obtained from colleagues and supervisors thus enhances participants' engagement (111, 201). On the other hand, it reinforces positive work behaviour and attitudes, such as organisational commitment and job satisfaction (272). Therefore, this study is also in line with Social Exchange Theory, hypothesising that the exchange of valuable resources (both participants and colleagues having a good relationship and working well together) assists initiation or introduction, strengthening and maintaining interpersonal relationships (168).

Existing literature pointed out that the negative consequences of caregiving activities on caregivers' health and quality of life are due to the experienced stress and how this stress is perceived and managed by them (273-275). Participants' personal resources such as their ability to control and impact their working environments (171), their ability to proactively optimize their working environments (140), their ability to understand, utilise resources and find meaning (245) to manage stressors and overcome their challenges contributed to their overall work satisfaction and well-being. Similarly, Sutter and colleagues highlighted that the ability to evaluate stressful events as being manageable can be a major factor in controlling stressors (276), thus allowing workers to enjoy better mental health (277, 278) and quality of life (279).

Meaningfulness

According to Aaron Antonovsky, meaningfulness refers to how much one feels that a stressful situation makes sense, and challenges considered worthy of commitment (245-247). This finding can be further mirrored within Antonovsky's theory, where the participants' sense of coherence can be seen through their ability to derive meaning from essential aspects of their

life. Gallagher and colleagues found a high sense of coherence can help an individual to adapt to caregiving's stress through reflection on their caregiving duties and provide meaning for their caregiving experience (280). Participants' sense of meaningfulness has led them to see the need to overcome language barriers for the benefits (e.g., personal, and professional gain) of acquiring better language skills. This in turn will lead to being able to make socially valued decision-making which Antonosky described as being central to meaningfulness. Participants with social supports feel their effort in their work leads to meaningful events (e.g., creating a more inclusive work environment, for example, gaining patients and colleagues' respect) and challenges within the workplace is worthy of commitment. Such meaningful events also lead to increased self-fulfilment and thus increase their motivation. Participants who found self-fulfilment within their workplace could be seen to have more motivation towards their job. Important aspects of their life can be achieved through the language, such as having a better relationship with colleagues, more positive interactions with patients, and better support from superiors within their workplace increases their motivation to overcome the challenges they faced. Thus, the concept of sense of coherence (Antonovsky, 1979) appears to adequately explain participants' well-being, job satisfaction, work engagement and organisational commitment.

Discussion of the method

This section will begin with a brief introduction to my role as a researcher throughout this study and a discussion of the method.

Reflexivity

Reflexivity refers to the phase before conducting research, where the qualitative researcher reflects upon their own role within the study and how their own background and experiences can influence the interpretations of data and the data collecting (281). As a researcher, my thoughts were to stay objective before this study and not let my background and experiences interfere with the findings. However, I am aware that my own pre-assumptions are always subconsciously present. Therefore, during the interviews, I tried to avoid leading questions and focused on the transparent methodological approach during data collection and data analysis.

Presentation of the researcher

I am a Malaysian woman who used to live and work within Malaysia and Singapore as a clinical research coordinator before migrating to Norway to further my education in global health. I enrolled in the Master of Philosophy in Global Health program at the University of Bergen in August 2018. I gave up a well-paying job because I was motivated to live, study, and work in a culturally and socially unfamiliar environment such as Norway, and to further enrich my life experience. I have found it to be a great experience. Thus far, I have not only benefited from education but also I have benefited from work experience.

Professional and personal background

I have always been interested in psychology and toxicology. During my toxicology studies, I developed an interest in adverse drug reaction that resulted in me applying to work as a clinical research coordinator, specialising in the cancer trial. Working in a high-paying yet high turnover rate has resulted in me developing another interest in employee work engagement and organisational commitment.

As a clinical research coordinator, I have worked with various patient groups, primarily with cancer patients. I have dealt with a lot of sensitive situations involving patients and their relatives. Within the workplace, I worked with various colleagues worldwide, especially from South East Asia, where my experiences have been shaped. I brought over with me into the interview sessions to indulge in immigrants' working life from a similar background. This has given me the courage to choose workplace adaptation, workplace engagement and organisational commitment for immigrants within a workplace environment. Having experienced such a background, I became aware of my pre-assumptions: however, I tried not to let these influence my participants' viewpoints. During the interview session, I mentioned that I was a clinical research coordinator working in a profession with a high turnover rate in a foreign country. It helps make participants more open up about the challenges they faced within their working environment, allowing them to share more on their coping strategies. This research topic excited both the participants and me, allowing them to see me as one of their own. All participants seemed to feel more comfortable around me, making them feel more at ease and willing to share. Being an immigrant researcher was a strengthening factor for gaining

the trust of the participants. Besides that, mentioning that I am interested in becoming a caregiver in Norway did seem to help gain trust from the participants.

Description of the methodological process

Recruitment for the interviews

During this study, I encountered several challenges from the beginning of the research in gaining approval from the municipalities during the Corona pandemic. Many municipalities turned down the application given their workers' well-being, especially during the stressful period of the Corona-19 crisis that has tremendously increased their workload. The participants' recruitment was initially planned by using the head of municipalities. However, I was still met with significant challenges. Given the difficulties in recruiting for this study, the study expanded to include caregivers who have previously worked in nursing homes but within the same field.

Settings for the interviews

Interviews were conducted online, in the homes of participants, in my home and in a restaurant. The participants selected all these places and means of interview. Therefore, the environments in which interviews were conducted proved to make the participants feel more comfortable and at ease. However, interviewing, for example, in a restaurant might have affected the participant to how much she would reveal since it is a public place even though there was no one around during that time. Conducting Facebook call interviews creates an apparent distance compared to real-life interviews. However, it did seem to help the participants feel more relaxed both in terms of being open and allocate sufficient time for the interview without feeling a need to rush somewhere else. Several participants prefer having interviews conducted at my home due to their convenience in travelling to work after the interview. Participants allocated sufficient time for the interview without feeling a need to rush to their workplace.

Obligation to participate

Before conducting the interviews, participants were informed of their full voluntary participation and freedom to withdraw from the study at all times, with no repercussions. None

of the participants expressed any other concerns about their participation or the wish to withdraw. Overall, the participants seemed very pleased with the study with a positive drive.

Limitations of the study

This master´s thesis is limited in several aspects. Applying different methods would have strengthened the results through triangulation since this study relies on a single data collection method. Furthermore, this study was conducted by a singular researcher that excluded the possibility of peer debriefing and for an external auditor to review the study, which would have strengthened the overall validity. Not to forget, this study was performed under time constraints and the limited access into the immigrant caregivers' society within Norway. The participants for this study were a convenience sample (282). Many of them were recruited through snowball sampling. Therefore, these informants' narratives are likely not a representative voice for the experiences of other immigrant caregivers living in Norway. Having interviewed only thirteen individuals, it is impossible to make any wide-reaching conclusions or generalizations. Thus, to make such generalizations, a quantitative study would be necessary: however, this research can help understand how a particular group of individuals see their experience and create meaning in their lives (283). Another limitation would be the length and depth. It is found to be impossible to cover immigrant caregivers' work challenges, well-being and work engagement working within Norway in full depth as adaptation and integration is a highly complicated and involved process that manifests in many domains of life (284). Thus, this thesis primarily focuses on adaptation and integration within the realm of work inclusion and its impacts on individuals.

Chapter 5: Conclusion and recommendations

Conclusion

This study offers insights into immigrant caregivers' experiences working in the healthcare sector. The study provides a basic understanding of how immigrant healthcare givers deal with their daily work constraints. Furthermore, the impact that these constraints can have on their health, overall job satisfaction, work engagement and their daily work lives. This study enhances understanding of immigrant caregivers' experience of work stress in Norwegian nursing homes by highlighting the challenges relating to language barriers, staffing problems,

a strained relationship with patients and poor cooperation with colleagues and superiors. These findings indicate that role insufficiency and work characteristics affecting care aides reflect factors that precipitate work stress in care work professions, with implications for quality of care for the patients, their overall well-being, work engagement and organisational commitment. This indicates that work stress in immigrant caregivers working in nursing homes warrants further attention in research and practice. As this study was carried out during the COVID-19 epidemic, participants were exposed to a higher level of stress within their workplace. Nevertheless, I believe that these findings represent the group of people who had been interviewed in this study and at the same time this study has been explained in detail which can help others to make connections. The findings of this study could be used to guide the development of interventions aimed at providing a better understanding of how immigrant caregivers' deal with their daily work constraints and to improve both their working environments (job demands and job resources) and the caregivers' ability to cope with stress.

This study outlined positive aspects of work as one of the effective stress coping strategies and motivational factors for immigrant caregivers to cope with their daily work challenges, stay well and improve their overall job satisfaction in their work lives. The findings can be presented in nursing homes to inform them of the developmental standards to support immigrant caregivers working within the nursing homes. Further, the results can be used to assist in preparing interventions and training materials for immigrant caregivers' developments. Such initiatives include the aim to foster a healthier working environment and improve workplace communication. This will in turn leads to a decrease in work stress, improvement in overall well-being for the immigrant caregivers and enhancing relationship building within the workplace, therefore, increasing their work satisfaction. Work satisfaction can, in turn, increased their work engagement and commitment to their organisation. Although this study is based on a limited sample of immigrant caregivers working in the Norwegian healthcare sector these findings may also be considered in designing stress management interventions for other occupational groups or industries.

Recommendations

While a number of recommendations can be drawn from the study itself, many of the participants also put forth some suggestions based on their experiences. Together, the following recommendations can be made:

1) A better pre-recruitment information and materials informing them about their role, the differences of cultural and local dialects and which types of challenges they may encounter.

2) A better matching for their individual needs, their professional qualifications and personal expectations through monitoring.

3) Changing the workload or in cases where changing the workload is impossible, ensuring sufficient social supports could be an effective way to reduce worker's stress.

4) Initiating, induction and adaptation courses, where possible, providing essential information and supports (supervisors/colleagues) for new immigrant caregivers. These courses should aim to provide them with a greater understanding and acceptance of professional and cultural difference (both professional and social) to adapt better and integrate into the Norwegian working environment.

5) Increasing professional satisfaction and career prospects for immigrant caregivers in a way that allow them to develop career pathways and benefit them from experience educational opportunities.

6) Setting up avenues such as an ombudsman at the workplace where workers can speak about their challenges such as sexual exploitation, discrimination, abuse and unprofessional conduct from challenging patients, colleagues or superiors.

7) Developing social supports and promoting good workplace relationships is an essential factor that can lead to reduce work stress and increase individuals' overall well-being.

8) Regularly monitoring and addressing the well-being of individuals as a priority.

9) Interventions should improve work practices as well as promoting personal interventions. This can start by monitoring the stressors in the individual and addressing those stressors.

Future research

In order to derive a better understanding of how immigrant caregivers experience their work life and the coping strategies they employ in response to challenges in their work life, future research need to be conducted in another part of Norway (e.g., Oslo) with a higher density of such demographic characteristics of samples; a quantitative study would be necessary to make any wide-reaching conclusions or generalizations. The findings of this study showed the importance of the sense of coherence in immigrant caregivers working in Norwegian nursing homes concerning their experience of work stress, well-being and motivation. Job demands and resources theory appears to not fully capture the participants' working experiences within the Norwegian healthcare sector where it does not illustrate the process in how participants understand workplace stressors, proactively find and utilise resources to optimise their working environments and how they find meaning to manage workplace stressors and motivated to overcome the challenges. These aspects that were seen in participants coping strategies were better illustrated using Antonovsky theory on the sense of coherence. Future research should look more into Antonovsky theory on the sense of coherence in the attempt to understand the negative impacts of caregiving and how it can be related to individuals' ability to comprehend, manage and provide meaning with their caregiving roles in the long-term care setting.

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Appendices

Appendix A: Norwegian Regional Ethical Committee

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK nord	Lill Martinsen		05.11.2019	32618
			Deres referanse:	

Karen Marie Moland

32618 Helsearbeidere med innvandrerbakgrunn i det norske helsevesenet

Forskningsansvarlig: Universitetet i Bergen

Søker: Karen Marie Moland

Søkers beskrivelse av formål:

The influx of immigrant workers to the Norwegian Health Care system has increased in recent years, particularly in the elderly care sector. Research on health care providers has primarily focused on skilled health care workers, and there has been a lack of emphasis on the needs and rights of the 'unskilled' immigrant health care workers, commonly working as assistants in elderly care. The structural invisibility of this occupational group could have direct effects on their working conditions and may indirectly affect the quality of services provided. In order to address this challenge, we need to better understand the role of foreign health workers and their working conditions in the Norwegian health care system. Using a qualitative research approach, this study will look into immigrant care worker experiences and how they perceive their own role and function at their workplace. The study will take place in elderly nursing homes in Bergen municipality, Norway.

REKs vurdering

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK nord) i møtet 24.10.19. Vurderingen er gjort med hjemmel i helseforskningsloven § 10.

Formål
Det framgår av søknaden at formålet med prosjektet er å utforske og samle inn beretninger fra og om ufaglærte utenlandske arbeideres daglige aktiviteter og opplevelser i eldreomsorgsboliger.

Alle skriftlige henvendelser om saken må sendes via REK-portalen
Du finner informasjon om REK på våre hjemmesider rekportalen.no

Om prosjektet
De prosjektene som skal framlegges for REK er prosjekt som dreier seg om *«medisinsk og helsefaglig forskning på mennesker, humant biologisk materiale eller helseopplysninger»*, jf. helseforskningsloven § 2. *«Medisinsk og helsefaglig forskning»* er i § 4 a), definert som *«virksomhet som utføres med vitenskapelig metodikk for å skaffe til veie ny kunnskap om helse og sykdom»*. Det er altså formålet med studien som avgjør om et prosjekt skal anses som framleggelsespliktig for REK eller ikke.

I dette prosjektet er formålet: "*to better understand the role of foreign health workers and their working conditions in the Norwegian health care system" (vår understrekning).*
Videre: "*this study will look into immigrant care worker experiences and how they perceive their own role and function at their workplace."*

Prosjektet skal således ikke vurderes etter helseforskningsloven.

Vedtak

Avvist (utenfor mandat)

Etter søknaden fremstår prosjektet ikke som et medisinsk og helsefaglig forskningsprosjekt som faller innenfor helseforskningsloven.

Prosjektet er ikke framleggingspliktig, jf. helseforskningsloven § 2.

Vi gjør oppmerksom på at etter personopplysningsloven må det foreligge et behandlingsgrunnlag etter personvernforordningen. Dette må forankres i egen institusjon.

Med vennlig hilsen

May Britt Rossvoll
sekretariatsleder

Appendix B: Approval letter from Alver municipality

Alver kommune
Helse Omsorg
Sjukeheimstenesta

Heng Wei Khor
Senter for internasjonal helse
Institutt for global helse og samfunnsmedisin
Universitetet i Bergen

Knarvik, 02.04.202020

Helsearbeidarar med innvandrarbakgrunn i norske sjukeheimar

Vi viser til førespurnad om å delta i ovennevnte forskingsprosjekt. Det femgår av søknaden at formået med prosjektet er å få auka kunnskap om rolla til ufaglærte helsearbeidarar med innvandrarbakgrunn og deira arbeidsvilkår i norske sjukeheimar. Studien baserer seg på intervju med desse arbeidstakarane.

Alver kommune ønskjer å delta i studien.

Med vennleg helsing
Alver kommune

Simon Grandahl

Simon Grandahl
Tenesteleiar sjukeheimstenesta

Alver kommune
Postboks 4, 5906 Frekhaug
Innbyggjarservice: +47 56 37 50 00
post@alver.kommune.no
www.alver.kommune.no
Kontonummer: 3207 29 30559
Organisasjonsnummer: 920 290 922

Appendix C: Approval letter from Bjørnafjorden municipality

Bjørnafjorden kommune
Sjukeheim Os

Heng Wei Khor
Alrek Studenboliger
5009 BERGEN

Referansenr.	Saksnr.	Saksh.	Dykkar ref.	Brevdato
20/22187	20/5212	Hilde Storum - 56 57 50 00 post@bjornafjorden.kommune.no		07.05.2020

Svar på førespurnad om masterstudie om innvandrarar som pleiemedarbeidarar i sjukeheim

Hei
Beklager sterkt at du har måtta vente så lenge på tilbakemelding på om du kan bruke informantar frå Luranetunet i ditt masterstudie. Som eg forstår på deg har du allereie rekruttert to deltakere herfra og at du berre treng godkjenning til dette får leiinga. Eg synest tema for studiet ditt er både spennande og viktig. Du har lagt ved dokumentasjon på etiske og helsejuridiske overveiingar, samt korleis du har tenkt å ivareta personvernet til infomantane dine.
Eg vil difor gi godkjenning til dette, men må samtidig gjera deg oppmerksom på at vi ikkje har kapasitet i desse tider til å bidra med noko anna ut over dette.

Lykke til med studiet !

Med vennleg helsing

Hilde Storum
Assisterande einingsleiar Luranetunet bu- og behandlingssenter

Brevet er godkjent elektronisk og har derfor inga underskrift.

Side 1 av 1

Bjørnafjorden kommune
Postadresse:
Postboks 24
5649 Eikelandsosen

Besøksadresse:
Bjørnafjorden rådhus,
Torggata 7, 5200

Sentralbord +47 56 57 50 00
post@bjornafjorden.kommune.no
bjornafjordenkommune.no

Bankgiro: 3201.48.86388
Org.nr.: 844 458 312

Appendix D: Approval letter from Voss municipality

Master student Heng Wei Khor

Senter for internasjonal helse

Institutt for global helse og samfunnsmedisin,

Universitetet i Bergen

Helse og omsorg

Voss Kommune

«Helsearbeidere med innvandrerbakgrunn i det norske helsevesenet»

Vi viser til søknad om godkjenning av ovennevnte forskningsprosjekt.
Det framgår av søknaden at formålet med prosjektet er å øke vår kunnskap om rollen til ufaglærte helsearbeideres med innvandrerbakgrunn og deres arbeidsvilkår i norske sykehjem. Studien vil utforske og samle inn beretninger gjennom intervju med disse arbeidstakerne om deres daglige aktiviteter og opplevelser i eldreomsorgen.

Voss kommune godkjenner søknaden og ønsker å være involvert i planleggingen. Det er et krav at intervjuene ikke foregår innenfor arbeidstid.

Voss 20.01.2020

signatur

Gunborg O. Rekve

områdeleiar

Appendix E: Letter of consent (Norwegian)

Skriftlig samtykkeskjema

UNIVERSITY OF BERGEN

INVITASJON TIL Å DELTA I ET FORSKNINGSPROSJEKT

En studie av helsearbeidere (pleiemedhjelpere) med innvandrerbakgrunn og deres erfaringer med å jobbe på norske sykehjem.

Student: Khor Heng Wei
Main supervisors: David Lackland Sam, Faculty of Psychology, Department of Psychosocial Science, University of Bergen
Medveileder: Karen Marie Moland, Center of International Health, Department of Global Public Health and Primary Care, University of Bergen

Du blir invitert til å delta i et forskningsprosjekt med tittelen 'En studie av helsearbeidere (pleiemedhjelpere) med innvandrerbakgrunn og deres erfaringer med å jobbe på norske sykehjem'. Du er blitt identifisert som en potensiell deltaker basert på studiets forhåndsbestemte kriterier. Din deltakelse i denne studien er frivillig. Personopplysninger og dine svar vil bli anonymisert og vil ikkje ha noen betydning for din jobbsituasjon.

HVA ER PROSJEKTET OM?

Antall innvandrere i det norske helsevesenet har økt de siste årene, særlig innen eldreomsorgen, men vi har liten kunnskap om deres arbeidsforhold og erfaringer som arbeidstakere. Med en kvalitativ forskningstilnærming vil denne studien undersøke hvordan arbeidstakere i denne gruppen oppfatter sin egen rolle og funksjon på arbeidsplassen og hvordan de opplever samarbeid med pasienter, pårørende og kolleger. Studien bare finne sted på sykehjem i ulike kommuner i Vestland fylke.

Forskeren, som er masterstudent i Global Helse, vil gjennomføre et individuelt online-intervju med deltakerne i studien. Intervjuet vil foregå på norsk eller engelsk ut frå deltakers preferanse. Dersom norsk foretrekkes, vil en oversetter vil være tilstede under intervjuet. Dette vil avtales på forhånd. Intervjuet vil vare fra 1 til 1.30 timer og vil gjennomføres på et tidspunkt som passer deltakeren. Intervjuet vil tas opp på digital lydopptaker dersom deltaker tillater dette. Lydfilene blir lagret sikkert på en minnepinne med en innebygd sikkerhetskode og plassert i et

låst filskap. Personopplysninger blir anonymisert. For å sikre deltakernes konfidensialitet etter at intervjuene er gjennomført, vil dataene bli kryptert og lagret i et passordbeskyttet enhet. Prosjektet forventes å være avsluttet i desember 2020.

FORDELER OG RISIKO VED Å DELTA

Som deltaker er det ingen direkte fordel du kan få fra studien. Intervjuet kan oppleves som en mulighet til å diskutere personlige spørsmål som kanskje ikke lett blir reist andre steder med en nøytral person. Potensielle risikoer og ulemper ved å delta er relatert til de psykologiske forholdene. Tidligere traumatiske opplevelser kan dukke opp igjen under intervjuet. Om dette skulle hende vil du koples til Ressurssenter for traumatisk stress (RVTS).

FRIVILLIG DELTAKELSE OG MULIGHETEN TIL Å TREKKE SEG UT AV STUDIEN

Deltakelse i prosjektet er frivillig. Hvis du ønsker å delta, må du signere samtykkeerklæringen på siste side. Du kan når som helst og uten grunn trekke tilbake ditt samtykke. Dette vil ikke ha noen konsekvenser for deg. Hvis du bestemmer deg for å trekke deltakelse i prosjektet, kan du kreve at personopplysningene dine blir slettet. Hvis du på et senere tidspunkt ønsker å trekke tilbake samtykke eller har spørsmål angående prosjektet, kan du ringe forskeren Khor Heng Wei på +47 93 99 69 87 eller sende en e-post til forskeren på Heng.Khor@student.uib.no . Hvis forskeren ikke kan kontaktes, kan du kontakte hennes hovedveileder prof David Lackland Sam på 55 58 32 15 og medveileder prof Karen Marie Moland på 55 58 99 62. Du kan også kontakte dem via e-post til David. Sam@uib.no og Karen.moland@uib.no.

HVA SKJER DERE PERSONLIGE DATA?

All informasjon vil bli behandlet og brukt uten ditt navn eller personnummer eller annen informasjon som kan identifisere deg. En kode kobler deg og dine personlige data via en identifikasjonsliste. Bare hovedforskeren Khor Heng Wei, veilederne: David Lackland Sam og Karen Marie Moland vil ha tilgang til denne listen. Informasjon om deg blir anonymisert og vil bli slettet fem år etter at prosjektet er avsluttet.

KOMPENSASJON

Det er ingen kompensasjon for å delta i studien.

GODKJENNING

Dette prosjektet er godkjent av deltakende kommuner (Se godkjenningsbrev).

KONTAKTINFORMASJON

Har du spørsmål angående forskningsprosjektet, kan du ta kontakt med forsker Khor Heng Wei på +47 93 99 69 87 eller sende en e-post til forskeren på Heng.Khor@student.uib.no. Hvis hovedforskeren ikke er kontaktbar, kan du kontakte en av mine to veiledere: Prof David Lackland Sam på +47 55 58 32 15 og medveileder prof Karen Marie Moland på 55 58 99 62. Du kan også nå dem ved å e-post til henholdsvis David.Sam@uib.no og Karen.moland@uib.no. Du kan også komme i kontakt med institusjonens databeskyttelsesansvarlig hvis du har spørsmål relatert til bruken av dine personlige helseopplysninger om helse i forskningsprosjektet: nesstar@nsd.no

JEG SAMTYKKER I Å DELTA I FORSKNINGSPROSJEKTET, OG AT MINE OPPLYSNINGER KAN BRUKES SOM BESKREVET OVER

By og dato | Deltakernes underskrift

Deltakerens navn (i BLOCK LETTERS)

Jeg bekrefter at jeg har gitt informasjon om forskningsprosjektet

By og dato | Signatur

Rolle i forskningsprosjektet

By og dato | Signatur

Rolle i forskningsprosjektet

Appendix F: Letter of consent (English)

Written Consent Form

UNIVERSITY OF BERGEN

INVITATION TO PARTICIPATE IN A RESEARCH PROJECT

The roles and experiences of immigrant healthcare workers in the Norwegian health care system
Principle investigator: Khor Heng Wei
Main supervisors: David Lackland Sam, Faculty of Psychology, Department of Psychosocial Science, University of Bergen
Co-supervisor: Karen Marie Moland, Center of International Health, Department of Global Public Health and Primary Care, University of Bergen

You are invited to participate in a research project entitled 'The roles and experiences of immigrant healthcare workers in the Norwegian health care system'. You have been identified as a potential participant based on the study's predetermined criteria. Your participant in this study is voluntary. Personal data gathered on your experiences will be anonymized and will not affect your work.

WHAT IS THE PROJECT ABOUT?

The influx of immigrant workers to the Norwegian health care system has increased in recent years, particularly in the elderly care sector. Research on health care providers has focused primarily on skilled health care workers, and there has been a lack of emphasis on the needs and rights of the 'unskilled' immigrant health care workers, commonly working as assistants in elderly care. The structural invisibility of this occupational group could have direct effects on their working conditions and may indirectly affect the quality of services provided. In order to address this challenge, we need more knowledge about the experiences of low-skilled foreign health workers in Norway. Using a qualitative research approach, this study will look into immigrant health-care workers' experiences and how they perceive their own role and function in their workplace. This study is hoped to contribute towards improving immigrant care worker's working conditions, their quality of life and the quality of services they provide to the elderly. The study takes place at nursing homes in various municipalities in Norway.

The researcher, who is a master's student in Global Health, will conduct an individual online telephone or video interview with the study participants. The interview will take place in Norwegian or English based on the participant's preference. If Norwegian is preferred, a translator will be present during the interview. This will be agreed in advance. The interview will last from 1 to 1.5 hours and will be conducted at a time that suits the participant. The interview will be recorded on digital audio recorder, if allowed by the participant. The audio files are stored securely on a memory stick with a built-in security code and placed in a locked file cabinet. Personal information is anonymized. To ensure the participants' confidentiality after the interviews have been completed, the data will be encrypted and stored in a password protected device. The project is expected to be completed in December 2020.

FORESEEABLE BENEFITS AND PREDICTABLE RISKS AND BURDENS OF TAKING PART

As a participant, there is no direct benefit you can get from the study. The interview can be seen as an opportunity to discuss personal issues that may not be easily raised elsewhere with a neutral person. Potential risks and disadvantages of participating are related to psychological conditions. Previous traumatic experiences may reappear during the interview. If this is the case, you will be connected to the Resource Center for Traumatic Stress (RVTS).

VOLUNTARY PARTICIPATION AND THE POSSIBILITY OF WITHDRAW CONSENT

Participation in the project is voluntary. If you wish to participate, you must sign the consent form on the last page. You can withdraw your consent at any time and for no reason. This will have no consequences for you. If you decide to participate in the project, you may require that your personal information be deleted. If you later wish to withdraw consent or have questions regarding the project, you can call the researcher Khor Heng Wei on +47 93 99 69 87 or send an e-mail to the researcher at Heng.Khor@student.uib.no. If the researcher cannot be contacted, you can contact her main supervisor Prof David Lackland Sam on 55 58 32 15 and co-supervisor Prof Karen Marie Moland on 55 58 99 62. You can also contact them by e-mail to David. Sam@uib.no and Karen.moland@uib.no.

WHAT WILL HAPPEN TO YOUR PERSONAL DATA?

All information will be processed and used without your name or social security number or other information that can identify you. A code connects you and your personal data through an identification list. Only principal researcher Khor Heng Wei will have access to this list. Information about you will be anonymized and will be deleted five years after the project is completed.

COMPENSATION

There is no compensation for participating in the study.

APPROVAL

This project is approved by participating municipalities (See approval letter).

CONTACT INFORMATION

You may also contact the institution's data protection officer if you have questions related to the use of your personal health information about health in the research project: nesstar@nsd.no

I CONSENT TO PARTICIPATING IN THE RESEARCH PROJECT AND THAT MY PERSONAL DATA CONCERING HEALTH CAN BE USED AS DESCRIBED ABOVE

City/Town and date	Participant's Signature
	Participant's Name (in BLOCK LETTERS)

I confirm that I have given information about the research project.

City/Town and date	Signature
	Role in the research project

Place and date	Signature
	Role in the research project

Appendix G: Interview guide

Background exploration:

- o Would you mind sharing some details on your background?
  - o (Probe: How old are you? Where do you come from? How long have you stayed here? How do you end up here? Do you have a family here? What is your educational background? How long have you been working in this nursing home?)

Working in Norway:

  - o How did you come to work in elderly care?
  - o How long have you been working in the field of elderly care?
  - o When you accepted to work with the elderly, what were your expectations in terms of the type of work you will be doing?

At work:

- o How did you experience working in the nursing home?
- o Can you please describe a typical working day?
  - o (Probe: What do you usually do when you first arrived at the nursing home? What time do you usually have a break? How long is your break and who do you spend your break with? What do you usually do after your break? How is your day usually end with? How and when does the handover usually take places?)
- o How do you feel about your job?
  - o (Probe: What is unique about the type of work you do? Can you give an example of an interesting part of your work where you enjoy it a lot? Can you give an example when you feel overwhelmed? What barriers or challenges did you face? How did you overcome these?)
- o How do you feel your competence matches your job?

Working relations with the elderly:

- o How would you describe your relationship with the elderly in this nursing home?

- Can you describe a particular situation in your working life where you think you had a very positive feeling about your work with an elderly person? What do you think created this positive situation?
- Explore the opposite of the above. Ask how they manage this situation.
- What do you think is the general attitude of your elderly clients towards you?
- Can you recall any incident where you experienced elderly clients complain about you as a person and your ability to care for them?
    - Explore issues related to language, ethnic background and cultural differences and discrimination.

Working relations with superiors:

- How will you describe the relationship between you and your superiors?
- Can you describe a particular situation in your working life where you think you had a very good/positive feeling about your work with your superiors? What do you think created this interaction?
- Explore the opposite of the above. Ask how you manage this situation.

Working relations with colleagues:

- How will you describe the relationship between you and your colleagues?
- Can you describe a particular situation in your working life where you think you had a very good/positive feeling about your work with your colleague? What do you think created this interaction?
- Explore the opposite of the above. Ask how you manage this situation.
- How do you perceive and experience the division of labour?
- How do you perceive and experience work collaboration with their colleagues?

Future:

- How do you see your future as a foreigner working in elderly care in Norway in 5-10 years?
  - If participant considers changing in his/her field of work, probe why and if they still want to remain, find out why.