

Close to the edge

Discursive, embodied and gendered stress in
modern youth

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*To my family: Vera, Manne, Tord, Katja, Rita, Susanna, Ronnie, Rolle,
Christina, Birgit, Sture, Elna, Staffan & Co.*

*Mamma förstår ingenting. 'Habitos' är inte mammas språk (Vera 3 år)
Är du inte klar med den där boken snart? (Vera 10 år)*

*Manne gillar inte rosa. Bara stora pojkar gillar rosa (Manne 3 år)
Men mamma vet du, ingen läser så där långt i en tidning! (Manne 13 år)*

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Abstract

Background Adolescent subjective health and mental problems have become a public health concern not only in Sweden but worldwide. The overall aim of this thesis is to deepen and widen the understanding of young peoples' subjective health, psychosomatic and stress-related problems. A special focus is put on experienced stress among adolescent girls and young women. The study setting is one youth health centre, and three upper secondary schools in Umeå, a university town in northern Sweden. The research design combines qualitative and quantitative methods with the main focus on qualitative methods. An interdisciplinary theoretical synthesis is utilised, primarily based on bio-psycho-social, phenomenological, and social constructionist approaches.

The three qualitative papers (I-III) are based on the same sample of 40 young women who had sought help at the youth health centre because of their stress-related problems. Paper I explores the stressors experienced by the young women, whereas Paper II explores the lived experiences of stress. Paper III examines the young women's experiences of living in a violent partner relationship as young teenagers, and how this has affected their lives and health over time. Paper IV investigates perceived stress and subjective health complaints among older adolescents in upper secondary school.

Methods Data was derived from: a) a qualitative interview study with 40 adolescent girls and young women, aged between 16–25 years, who had sought help at the youth health centre for stress problems. Qualitative content analysis was used in combination with discourse-orientated analysis (Paper I); a phenomenological approach (Paper II), and narrative method (Paper III); b) a school-based survey with a sample of 16–18-year-old boys and girls (n=1027), in upper secondary school, grades 1 and 2, from different educational programs at three schools. Perceived stress, self-rated health, subjective health complaints, anxiety, and depression, were measured with a questionnaire including a set of instruments. Statistical analyses were descriptive and analytical.

Results Paper I identified multiple stressors of modernity, gender orders and youth. Contextual factors, including social constructions and practices of gender, played an important role for the stress experienced by these young women. The results revealed that multiple and intersecting stressors and demands connected to essential life spheres, contributed not only to experiences of distress but also to feelings of constraint. Moreover, the roles of excessive taking of responsibility and failing adult support were revealed.

Paper II illuminated multidimensional lived and embodied experiences of distress. 'Living close to the edge' emerged as the common theme running through all of the interviews and captured the young women's sometimes unbearable situations. The theme contains dimensions of physical, emotional, cognitive, social, and existential distress, as well as dimensions of distrust and disempowerment.

Paper III examined two Swedish adolescent girls' experiences of living in a violent relationship as teenagers, and how this has affected their lives and health over time. The analysis revealed violation, stress, trauma, coping, and agency during adolescence and the transition into adulthood.

Paper IV showed a high level of perceived stress, and subjective health and stress complaints among boys and girls. High pressure and excessive demands from school were experienced by a majority of boys and girls. Perceived stress was correlated with subjective health and stress complaints and anxiety. There was a clear gender difference: two to three times as many girls than boys reported subjective health complaints, e.g. headaches, tiredness and sleeping difficulties, musculoskeletal pain, sadness and anxiety.

Conclusion Several issues of relevance to public health were raised throughout the thesis. According to the interview results, the young women face multiple and intersecting stressors of modernity, gender orders and being young, which correspond to their multidimensional experiences of 'living close to the edge'. Their experiences of stress are multidimensional, and include physical, emotional, cognitive, social and existential dimensions. Findings from the qualitative study were also mirrored in the findings from the larger group of adolescents in the school survey, where a high proportion of older adolescents, particularly girls, reported perceptions of stress. Moreover, perceived stress correlated to a variety of subjective health complaints and anxiety. The results can be understood and explained from a variety of perspectives. The experience of 'managing alone' indicated perceptions of inadequate social support. The overall results indicated a risk of more negative health development, particularly among adolescent girls and young women. Stressors of modernity, gender orders and youth were prominent. The continuation and normalisation of oppression and violence are also discussed as a severe gendered stressor in young women's lives. This calls for a broad contextualised and gender-sensitive approach to young people's stress and health problems. In conclusion, the age and gender gap in adolescent health needs to be further explored, and processes of distress, distrust and disempowerment have to be taken more seriously.

Svensk sammanfattning

Under det senaste decenniet har medier och flertalet nationella forskningsrapporter informerat om ökande psykisk ohälsa och stress bland barn och unga i Sverige. Denna avhandlings syfte är att med hjälp av en utforskande och tvärvetenskaplig ansats fördjupa förståelsen av subjektiva ohälsoproblem och upplevd stress bland unga i Sverige, med speciellt fokus på flickors och unga kvinnors upplevda stressproblem.

Avhandlingen har en explorativ och flexibel studiedesign som kombinerar kvalitativa och kvantitativa forskningsmetoder med särskild tyngdpunkt på de kvalitativa metoderna. Datainsamling har genomförts med a) kvalitativa forskningsintervjuer med en grupp flickor och unga kvinnor (16–25 år) som sökt hjälp för stressrelaterade problem på en ungdomshälsomottagning i Umeå, och b) en skolbaserad enkätundersökning med totalt 1027 pojkar och flickor, 16–18 år, i åk 1–2 på tre kommunala gymnasieskolor i Umeå.

Forskningsintervjuerna har huvudsakligen analyserats med kvalitativ innehållsanalys. Innehållsanalysen har i de olika delarbetena sedan kombinerats med diskursorienterad analys (Artikel I), med fenomenologisk ansats (Artikel II) och med narrativ metod (Artikel III). Skolenkäten har analyserats med deskriptiva och analytiska statistiska metoder (Artikel IV).

Resultaten från den kvalitativa intervjuundersökningen med unga kvinnor belyser a) multipla stressorer som kan hänföras till flera parallella områden i livet – men även till samhällsliga diskurser: modernitetens stressorer, genusordningarnas stressorer och ungdomsårens stressorer, b) multidimensionella, levda och förkroppsligade erfarenheter av stress och ”att leva på gränsen” som innefattar fysiska, emotionella, kognitiva, sociala och existentiella dimensioner och c) erfarenheter av våld och kontroll i partnerrelationer samt deras konsekvenser.

Resultaten från enkätundersökningen med gymnasielever visar att en stor andel av ungdomarna rapporterar subjektiva hälso- och stressbesvär av olika slag inklusive oro och ångest. Jämfört med pojkarna så är det två till tre gånger fler flickor som rapporterar besvär och denna skillnad är signifikant. En majoritet av ungdomarna håller ett högt tempo och upplever sig också pressade av krav från skolan samt av egna inre krav. Upplevelserna av stress i form av högt tempo och höga krav korrelerar med de subjektiva hälso- och stressbesvären samt med ångest.

Sammanfattningsvis visar avhandlingen att ungas stressrelaterade och subjektiva hälsobesvär bör förstås i ett vidare socialt sammanhang som inkluderar ett genusperspektiv. Kontext- och genusspecifika interventionsmodeller behöver utvecklas för att möta dessa hälsoproblem, men stress bland unga behöver också diskuteras och studeras vidare i relation till hur samhällsutvecklingen och dess värdegrunder påverkar unga av idag.

Original papers

This thesis is based on the following papers:

- I Wiklund, M., Bengs, C., Malmgren-Olsson, E-B., & Öhman, A. (2010). Young women facing multiple and intersecting stressors of modernity, gender orders and youth. *Social Science and Medicine*. 71(9) 1567-1575.
- II Wiklund, M., Öhman, A., Bengs, C., & Malmgren-Olsson, E-B. Living close to the edge: Dimensions of distress, distrust and disempowerment in young women. Submitted.
- III Wiklund, M., Malmgren-Olsson, E-B., Bengs, C., & Öhman, A. (2010). “He messed me up”. Swedish adolescent girls’ experiences of gender-related partner violence and its consequences over time. *Violence Against Women*. 16(2) 207–232.
- IV Wiklund, M., Malmgren-Olsson, E-B., Öhman, A., Bergström, E., & Fjellman-Wiklund, A. Subjective health complaints are related to perceived stress in older adolescents. Submitted.

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Table 1. Overview of Papers I-IV

	Paper I	Paper II	Paper III	Paper IV
Title	Young women facing multiple and intersecting stressors of modernity, gender orders and youth	Living close to the edge: Dimensions of distress, distrust and disempowerment in young women	"He messed me up", Swedish adolescent girls' experiences of gender-related partner violence and its consequences over time	Subjective health complaints are related to perceived stress in older adolescents
Aim	To explore stressors experienced by adolescent Swedish girls and young women who had sought help at a youth health centre	To explore the lived experiences of stress among adolescent girls and young women who had sought help at a youth health center	To examine young women's experiences of living in a violent partner relationship as young teenagers, and how this has affected their lives and health over time	To investigate subjective health complaints and perceived stress among upper secondary school adolescents
Setting	Youth health centre			Upper secondary schools
Study design	Qualitative study			Quantitative study School survey
Participants	Adolescent girls/young women aged 16-25 years (n=40)			Adolescents, boys and girls (n=1027), grade 1-2, 3 schools
Data-collection	Individual research interviews			Class room questionnaire
Data-analysis	Qualitative content analysis, Discourse-oriented approach	Qualitative content analysis, Phenomenological approach	Qualitative content analysis, Narrative method	Statistical analyses: Mixed model analysis Factor analysis Correlations

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Introduction

About ten years ago, alarming reports about stress, eating disorders, self-harm, suicide, violence, and the ‘obesity epidemic’ among children and adolescents began to emerge in the Swedish news media (Figure 1), causing the Children’s Ombudsman to call for action (2003). These reports about stress amongst the young, especially girls, coincided with similarly dramatic reporting about ‘burn-out’ and ‘exhaustion disorders’ in the adult population. Sick leave rates reached unprecedented levels, prompting the new Swedish government to tighten health insurance rules (Ministry of Health and Social Affairs, 2008).

This social climate spawned many self-help books geared towards young people, particularly girls and young women (Gauntlett, 2002; McRobbie, 2009). Lay people wrote best-selling books about their own experiences and TV programmes and interventions coached parents to be better parents. The commercial market, the so-called therapy culture and self-help movement sought to combat the perceived stress and illness in society with an emphasis on ‘mindfulness’ and ‘wellbeing’. Professionals mobilised and tried to understand the situation. Cognitive behavioural therapy had its big breakthrough as an evidence-based method (Kåver, 2007; SBU, 2010). Research projects and reports on young people’s stress and health were initiated and presented (SOU, 2006).

The sketched scenario is part of a modernity characterised by individualisation and self-regulation (McRobbie, 2009; Rose, 1999; Skeggs, 2004). Interestingly, these descriptions are not unique to contemporary societies. In a historical perspective, Johannisson (2006) has described the heavy demands on the urban individual in a modern era:

The similarity between the situation at the turn of the 19th century and that of today is striking in regard to an increasing decline in mental health. Both eras define their times as being characterised by major changes, increased information flows, and heavy demands on the urban individual – and all of it happening in a whirling market economy. At both points in time, new diagnoses appear that identify and legitimise the symptoms of stress and internal discomfort in a culture strongly marked by competition, achievement, and a high tempo.

The unifying component in this case, seems to be the perception of an accelerated rate of change, an ever-growing flow of innovations which, on a subjective level, is in danger of creating spontaneous feelings of inadequacy, of not being able to keep up mentally, physically, and emotionally. This is what makes up modernity’s identity – the expectation that the individual be limitlessly adaptable, flexible, and progress-oriented. (Johannisson, 2006, p. 3-4)

Parallel to these alarming reports about stress and ill-health among contemporary Western youth, contradictory images and discourses began

to emerge. Girls and women were socially constructed as either ‘success-girls’ or ‘at-risk girls’ (Harris, 2004a). Moreover, the ‘girl-power’ movement was strong in the commercialised and individualised youth culture (Harris, 2004a). Boys and young (working class) men were occasionally presented as the ‘losers’ of the modern age (Anoop & Kehily, 2008). The picture of gender identity was, and continues to be, ‘multi-voiced’, with its multiple young femininities and masculinities comprising the complex reality of modern youth gender identity (Anoop & Kehily, 2008; Frih & Söderberg, 2010; Frosh, Phoenix & Pattman, 2002; Phoenix, 1997; Walkerdine, Lucey & Melody, 2001).

This thesis is a part of this contemporary and complex context; it is a part of the production and reproduction of discourses influenced by gendered images and perceptions, all concerning young people and their health. The risk of medicalisation and construction of young people as sickly, in decline, and in need of being ‘worked on’ and changed is apparent. At the same time, young people’s experiences and problems need to be heard, problematised, and taken seriously. To continuously view girls and young women as ‘vulnerable’ and ‘weak’, or as somehow ‘problematic’ is not constructive, and neither is it to individualise structural problems and societal developments. Nevertheless, young people’s individual experiences cannot be neglected.

Mental health problems in youth – a global health concern

Internationally, the mental health of young people has been defined as a global health concern and a global health challenge (Patel, Flisher, Hetrick & McGorry, 2007; WHO, 2003, 2005). As mentioned above, Swedish media and researchers have frequently reported increases in self-reported mental, psychosomatic and stress-related problems among children and young people, especially in adolescent girls and young women (Berntsson & Köhler, 2001; Hagquist, 2009, 2010; Stefansson, 2006; Östberg, Alfven & Hjern, 2006). However, the time trends regarding Swedish children’s mental health seem discrepant (Hagquist, 2010). A recent systematic literature review on the epidemiology of mental health of people aged 0-19 years, commissioned by the Royal Swedish Academy of Sciences, concluded that since few national epidemiological studies meet the criteria for global evidence, time trends remain difficult to evaluate and therefore it is problematic to propose public health policies based on such evidence (Petersen, Bergström, Cederblad, Ivarsson, Köhler, Rydell et al., 2010). However, several single studies have indicated that “depressive symptoms, irritability and bad

temper had increased among older adolescents in particular among girls in recent decades” (Petersen et al, 2010, p. 11-12). Regarding psychosomatic and somatic problems, time trends are contradictory, but most studies have shown a slight increase since the 1980s. Moreover, all studies which have examined differences between boys and girls have shown that self-reported psychosomatic complaints are more common among girls (p. 12).

Age and gender in subjective health

A consistent finding, both in Sweden and internationally, is that, during adolescence, an age- and gender gap in subjective health is evolving; older adolescents report more subjective health complaints than younger children and, with age, girls report more problems than boys (European Commission, 2000; Hagquist, 2009, 2010; Michel, Bisegger, Fuhr, Abel, & The Kidscreen Group, 2009; Ravens-Sieberer, Torsheim, Hetland, Vollebergh, Cavallo, Jericek et al., 2009; Sweeting & West, 2003; Torbjørn Torsheim, Ravens-Sieberer, Hetland, Välimaa, Danielson & Overpeck, 2006). Most studies are performed among younger adolescents, while less is known about the health development among older adolescents and during the transition into young adulthood.

However, although the gender differences in subjective health development during adolescence have been consistently reported for several years, there is little conclusive information about the explanations behind these differences. A variety of possible explanatory factors have been put forward, in relation not only to mental health problems in general, but also to biological, emotional, psychological and sociological differences between girls and boys. Explanatory factors on individual (micro) and group (meso) levels, as well as on societal and structural levels (macro levels) can be assumed to influence young people’s subjective health. In order to explain gender differences in health, the use of individual-centred explanation models seems common, although several public health researchers have pointed towards structural explanation models (Baum, 2008; Kolip & Schmidt, 1999; Landstedt, Asplund & Gillander Gådin, 2009; WHO, 2003, 2005). In comparisons across countries, Torsheim et al. (2006) found that gender differences in health are more prominent in countries with a low gender-development index, and therefore argue for the need to incorporate socio-contextual factors in the study of adolescents’ subjective health.

Gender and body

Young people of today are growing up in an era of great societal and individual focus on body and health. Ideals of health, fitness, and slimness interact with ideals of beauty and femininity, and this has been defined as a dilemma in relation to girls' eating-disturbances (Edlund, 1997; Petersen & Lupton, 1996; Thurfjell, Von Knorring, Eliasson, Swenne & Engström, 2006b). Physical appearance seems to be an integral contributor to young people's positive or negative development and self-image (Bengs, 2000; Wright, O'Flynn & Macdonald, 2006). Body image, or the 'body self', forms not only part of the self and self-image, but also part of the social presentation and the 'making of a self' in relation to others. So, in addition to psychosomatic problems and stress, girls' perception of their bodies seems to be more fragmented and problematic than boys' – a phenomenon that can be understood in the Western social context of gendered images and ideals of body and beauty (Bengs, 2000; Frost, 2005; Wright et al., 2006). With higher age, girls more frequently report that they want to change their weight. Thurfjell et al. (2006a; 2006b) discussed this in their studies of girls' eating disorders in relation to gendered body ideals. Also boys construct themselves in relation to discourses of health and fitness (Wright et al., 2006). It is noteworthy that Danielsson (2010) has pointed also to the problematic relationship between body and sexuality among adolescent boys suffering from depression.

Young people's own experiences and perspectives

The Child Convention sets out the principle that children and young people are entitled to enjoy their childhood or adolescence, and are entitled to be heard (United Nations, 1989). Childhood and adolescence should be regarded as more than merely transitional periods to adulthood. Children and youths have the right to be defined and treated as human *beings*, not as human 'becomings' (Petersen, 2008). Children and young people in society, who are dependent on others to articulate on their behalf, cannot do research on themselves. Children and young people constitute social categories with their own unique needs, which should be viewed with the same importance as those of other social groups (Bing, 2003). In science, children and young people are increasingly being seen as competent and involved actors, and information about young people's own experiences and reflections have become an important source of information.

Rationale

Despite the above descriptions of negative signs in girls' and boys' subjective health and stress, these signs are seldom seen in relation to the social context and gender perspectives, or explained on a theoretical level (Kolip & Schmidt, 1999). Young people's life situations may affect their health in various ways, and are thus potentially important sources of knowledge.

There are still relatively few qualitative public health studies exploring young people's own self-narrated experiences of stress and stressors in life, analysed from sociocultural and gender-theoretical perspectives. Furthermore, there is also a need for theory integration of sociocultural and gender perspectives into public health sciences (Hammarström & Ripper, 1999; Kolip & Schmidt, 1999; Öhman, 2008). Within the medical field, gender and sex are often used as binary statistical variables, but not discussed from a sociocultural viewpoint (Risberg, Johansson, & Hamberg, 2009). Few youth health studies have been performed within Swedish feminist research (Gådin Gillander & Hammarström, 1998; Landstedt et al., 2009).

In summary, today's stress-related and psychosomatic problems among young people are presumed to be multifactorial and complex: physiological, psychological, and social factors on individual, group, and structural levels are assumed to interact, which justifies a multidisciplinary research approach integrating a focus on subjective health, a youth perspective, gender theories and qualitative methodology.

Aim

Overall aim

The overall aim of the thesis project is to deepen and widen the understanding of young peoples' subjective health, psychosomatic and stress-related problems. A special focus is put on experienced stress among adolescent girls and young women.

- To explore *stressors* experienced by adolescent Swedish girls and young women who sought help for stress-related health problems at a youth health centre (Paper I).
- To explore *the lived experiences of stress* among adolescent girls and young women who had sought help at a youth health centre (Paper II).
- To examine young women's experiences of living in a violent partner relationship as young teenagers, and how this has affected their lives and health over time (Paper III).
- To investigate subjective health complaints and perceived stress among girls and boys attending upper secondary school (Paper IV).
- To develop and utilise an interdisciplinary theoretical and conceptual framework, with a special focus on social context and gender, as a basis for a broadened understanding of young people's problems relating to subjective health and stress (Papers I-IV).

Theoretical and conceptual framework

In this thesis an interdisciplinary theoretical synthesis is utilised primarily based on bio-psycho-social, phenomenological, and social constructionist approaches. The chosen approaches originate in different epistemological and ontological paradigms and positions; these differences are mirrored in the terminology and choice of research methods, as well as in the interpretation of results. In the following section, I first present a brief overview over ontological and epistemological positions that have influenced my research process. Secondly, I present the main theoretical perspectives and concepts that frame the thesis.

Ontology and epistemology – my position and perspectives

Throughout this research project I have employed, and benefited from, many diverse research paradigms and scientific positions. I have often found my own position as rather ‘situated’, that is, dependent on context, situation and collaborations. My own position as a researcher can thus be defined as a struggle to bring about convergence of the dominant research paradigms – a position which is reflected in the attached papers (Figure 2). Furthermore, I intend to widen the understanding of young people’s stress by using biomedical knowledge, phenomenology, social sciences and gender theories, as well as by listening to young people’s own reflections and experiences. In such a process, I believe that concepts of ontology and epistemology from theory of science can be used not only to better understand the tensions between diverging scientific perspectives, but also to make visible the advantages gained by combining complementary scientific perspectives and methods (Denzin & Lincoln, 2003b).

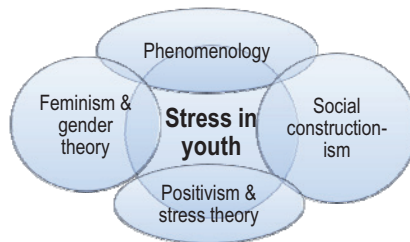


Figure 2. Research paradigms and theories synthesised in the thesis.

Positivism

Through the positivistic research approach and the attached statistical methods, the health of whole populations can be studied and be related to socio-demographic factors. Overarching patterns in health can emerge and can be compared across groups, contexts, and over time (Dawson & Trapp, 2004). However, the positivistic and biomedical paradigm has, among others, been criticised for creating reductionism and dualism such as that seen in the nature/nurture or body/mind dichotomies (Denzin & Lincoln, 2003b; Nettleton, 1995; Petersen & Lupton, 1996). Within physiotherapy, there is a post-positivistic modification – a somewhat ‘weaker’ positivism, which has been similarly criticised in theories and methods based on the bio-psycho-social model and the concept of psychosomatics, which advocate a holistic approach acknowledging individual’s experiences, embodiment, emotions and thoughts (Bunkan, 2008; Mattsson & Mattsson, 2002; Roxendal, 1985; Roxendal & Winberg, 2002; Skjaerven, Kristoffersen, & Gard, 2008).

Bio-psycho-social and psychosomatic approaches

Psychosomatic medicine is a humanist-orientated branch in the medical field that emphasises a holistic approach and studies the mutual interactions between biological, psychological, and social factors in health and in the onset and progress of disease (Mattsson & Mattsson, 2002; Theorell & Sivik, 1995). Similarly, the bio-psycho-social model describes the interplay between the individual and society in the development of illness and disease (Engel, 1977). These approaches try to explain the causes of ill-health, but are also interested in the individual’s experiences and feelings associated with disease – the so-called meaning. Sivik and Theorell (1995) formulated the basic axiom that an individual “in every moment is a thinking, feeling and acting being” (p. 15). In Sweden, there are several links between psychosomatic medicine and the multiple system approaches within modern stress research (Arnetz & Ekman, 2006). Based on similar assumptions, theoretical and methodological development has been ongoing in Scandinavian physiotherapy for several decades (Bunkan, 2008; Gunnerius & Meurle-Hallberg, 1990; Lundvik-Gyllensten, 2001; Roxendal, 1985). The Swedish physiotherapist Roxendal (1987) has defined a holistic approach, with special focus on body, and which integrates physical and physiological processes with psychological and emotional aspects:

The human being is, if healthy, whole and indivisible. The wholeness, in this perspective, embraces the body with physical parts and physiological processes, bodily actions (motor), mental life (perception and cognition), existential conditions and vitality (motivational factors). The body, according to the

physiotherapist, is the body as a whole and not only as one or more parts that work more or less well. (Roxendal, 1987, p. 23)

However, these bio-psycho-social approaches are, as often utilised, primarily holistic approaches on an individual and intra-individual micro level. The bio-psycho-social model has therefore been criticised, and modifications have been suggested which, for instance, include social constructionist perspectives in combination with materialist perspectives (Yardley, 1996). The psychosomatic perspective, and its studies, often lack in-depth integrations and analysis of the implications of social aspects for the ‘whole’; such examples include social processes and social relationships on the meso level, and societal structures and discourses on the macro level – and how these interplay in processes of health, illness and disease. Also, perspectives on gender and power are rare in the psychosomatic theories. On the other hand, these individual-centred perspectives contribute in-depth knowledge about the intrinsic interplay on physiological and intra-individual levels that contributes knowledge within, for instance, the fields of medical sociology and body-sociology.

In the present thesis I refer to basic assumptions about the close interplay between intra-individual and contextual factors which originate in the bio-psycho-social model and psychosomatic perspectives. In line with scholars such as Yardley (1996), I suggest additional perspectives to the bio-psycho-social model, including social constructionist and gender perspectives, as well as experiential and phenomenological perspectives about ‘lived embodied experiences’. Similarly, Cosgrove (2000) has suggested that a combination of social constructionist perspectives and phenomenology is a way to achieve an understanding of young women’s distress.

Social constructionism

By contrast, the social constructionist paradigm views reality as a social construction which is local and context-bound, and changing with time (Burr, 2003; Lupton, 2003; Nettleton, 1995). Social constructionism assumes that knowledge generated through research is socially constructed through interaction between certain individuals in specific situations. Accordingly, knowledge is considered as ‘created’ and ‘situated’ – this means that research is not seen as reflecting a given reality, rather several changing realities, or so-called multiple realities (Denzin & Lincoln, 2003a). Applied to this research project, it implies that the qualitative material is ‘multi-voiced’, reflecting several aspects and perspectives, sometimes contradictory, and that the researchers always make more or less considered and active choices between these perspectives. The researcher is thus seen as a subject, and an active co-

constructor of knowledge. The research methods used in social constructionism are often naturalistic, hermeneutic and interpretive (Denzin & Lincoln, 2003b; Riessman, 2008). Criticism of social constructionism highlights, for example, the relativistic position which, in 'strong' forms, hinders the transfer and application of knowledge from one context to another.

The social constructionist approach is highly applicable in research concerning health and stress, since diseases and diagnoses mirror more than physiological and biochemical processes in the body. There are often aspects of health phenomena and diagnoses which highlight the social creation, the social status, and the meaning of illness and disease in a certain context or time period (Johannisson, 2006; Lupton, 2003). New illnesses and diagnoses appear and are explained, and are placed in a context-bound meaningful pattern (Johannisson, 2006). This thesis embraces concepts of gender, youth, health and stress – concepts that can all be regarded as socially constructed and socially shaped, and dependent on time, place and context.

Feminism

Feminist research is often based on social constructionism, but also on post-structuralist theory or critical theory, and acknowledges material conditions and power relations in the social construction of knowledge (Hammarström & Ripper, 1999). Scientific knowledge is seen as mediated by power (swe. värdemedierad). Social constructionism, including gender and feminist theories, provides critical assessment of concepts and the discursive production of e.g. power and femininity (Becker, 2010; Cosgrove, 2000; Kranz & Long, 2002). In this thesis these perspectives place the experience of stress in a wider sociocultural context, and they provide tools for the problematisation and contextualisation of young people's stress and health. Common methods used within feminist research are narrative methods and discourse analysis as utilised in Paper I and II (Winther Jørgensen & Philips, 2002). For definition of discourse see *Methods*, p. 39.

Phenomenology

The phenomenological approach is grounded in philosophy, existentialism and hermeneutics (Denzin & Lincoln, 2003b; Lindseth & Norberg, 2004). In this work, I mainly refer to 'the phenomenology of the body' based on Merleau-Ponty's (1962) theorising about 'lived embodied experiences'. As used in this thesis, the phenomenological approach addresses experiences and the central in-depth meanings of individuals' experiences of distress and illness and, furthermore, it addresses aspects of agency (Cosgrove, 2000; Jingrot & Rosberg, 2008; Marshall, 1996;

Rosberg, 2000). I view the phenomenological philosophy of lived and embodied experiences as a link between the powerful paradigms described above. In research, phenomenology can also function as a link between the descriptions and analyses of intra-individual processes and individuals' social life-worlds of social constructions, conditions and structures – the micro, meso and macro perspectives of life (Figure 3). A similar synthesis has earlier been described in the field of body-sociology (Lupton, 2003; Nettleton, 1995; Nettleton & Watson, 1998). Several other scholars argue for similar theoretical and paradigmatic syntheses in health research, for example Cosgrove (2000) has suggested a combination of social constructionism and phenomenology to gain a better understanding of young women's distress; whereas Yardley (1996) has suggested a combination of social construct and material perspectives through critical theory in the understanding of health and illness. Biomedicine and health care are often criticised for measuring the physical body without taking embodiment, emotionality and existential meaning into account – aspects that the phenomenological approach can provide together with qualitative research methods. Essential meaning may emerge by focusing on individuals' subjective life-worlds and by the inclusion of existential experiences.

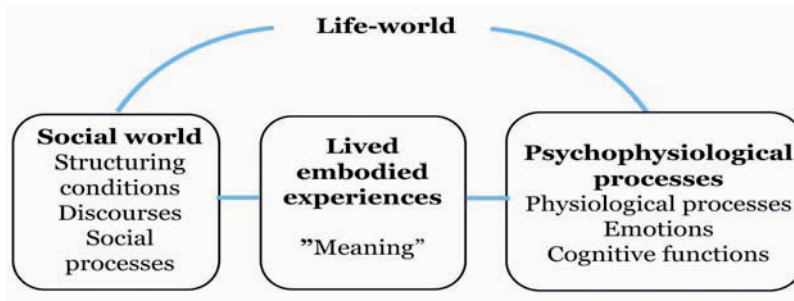


Figure 3. Tentative model for how linkages between the social world, lived embodied experiences and psycho-physiological processes form the life-world.

Bio-psycho-social aspects of health in youth

A basic assumption of this thesis is that mental health is an important part of overall health (Prince, Patel, Saxena, Maj, Maseko, Phillips et al., 2007). Another assumption is that experiential and emotional aspects, bodily experiences and bodily discomfort, as well as social and relational aspects, all need to be addressed in the studies of stress among youth. The experiential dimensions of stress as addressed in the thesis may be

captured by the English term *illness* in contrast to the term *disease*, which more distinctly refers to a biomedically defined and diagnosed condition. The Swedish terms 'må dåligt' (not feeling well), and being 'utbränd' (burned-out/stressed out), may also cover aspects in the 'grey area' between experiences of strain or 'not feeling well' and a diagnosed stress-related disease. The integration of this broad spectrum of experiences into the concepts of health and illness implies a wide definition of health, which in turn can be problematised in terms of the medicalisation and 'psychologisation' of the experiences and strain of everyday life (Furedi, 2004, 2008; Wiklund, Bengs, Malmgren-Olsson, & Öhman, 2010a). Likewise, an 'individualisation' of problems relating to stress and health can shift the focus from social determinants of health and structuring conditions in the environment (Baum, 2008; Becker, 2010).

Accordingly, the concept of health has different definitions and applications depending on the approach taken and its scientific roots (Medin & Alexandersson, 2002). In the biomedical approach, health is defined as the absence of disease, whereas holistic and socially-orientated approaches define health in a different way (Johansson, Weinehall, & Emmelin, 2009). Some of the main features of the multitude of health definitions can be described as 'health as a condition' (biomedical approach), 'health as an experience' (theological and salutogenic approach), or health as something created in the interaction between individuals and the environment formulated as 'health as a process' or 'health as a resource' (Johansson et al., 2009; World Health Organisation, 1986). Health as a resource is gained by the ability to control and master one's life situation. Moreover, health can be defined in terms of wellbeing, the ability to accomplish vital goals in life, and experiences of meaning and sense of coherence (Antonovsky, 1987). Health from a human rights perspective is another fundamental definition emphasised within public health research and policy making (Baum, 2008). As earlier mentioned, a broad and holistic definition of health is used in this thesis: health as something more than simply a lack of disease; as an experience, a resource, and a process. The human rights perspective is a key part of the body of work about gender equality in health, and in the call for freedom from oppression and violence during youth (Paper III).

Psychosomatics

The concept of 'psychosomatics' is used in this thesis (see also *Ontology and epistemology*), and is also an often-used term in national surveys of young people's subjective and self-reported health problems (Alfvén,

1993; Hjern, Alfven, & Östberg, 2008; Östberg et al., 2006). In phases of this work, the concept has been used as a working name and umbrella term for some of the bio-psycho-social interactions that are relevant to young people's health and illness related to stress of various kinds. The concept of stress is, then, included in the concept of psychosomatics, and pain or sleep problems are seen as some of the symptoms that may be psychosomatic in character. In practise, it is difficult to distinctly separate psychosomatic problems from mental problems and mental ill-health, or from stress-related problems, as there are many overlapping definitions. Some studies define psychosomatic problems as a lighter form of mental illness, whereas others describe psychosomatic forms on a sliding scale between 'simple' and 'healthy' reactions to severe problems and diseases (Lerner, 1999; Theorell & Sivik, 1995). However, the concept of 'mental distress' is sometimes used as a broader definition of mental disorders and mental ill-health (Aalto-Setälä, Poikolainen, Tuulio-Henriksson, Marttunen, & Lönnqvist, 2002), and is also used in research contexts where diagnosing is difficult. Symptoms of various degrees of severity can thus be placed along a continuum of bio-psycho-social distress. The central concept of stress is elaborated upon in the following section.

Stress and stressors

In the thesis a wide definition of stress is used including stressors and stress responses, as well as self-narrated experiences. The concept of stress is ambiguous and lacks one unifying definition. Several definitions have followed after Seyle's (1976) definition of stress as the body's 'unspecific responses' to strain and challenges, as a physiological reaction and arousal. The psychologists Lazarus and Folkman (1984) defined stress as subjective experiences arising when environmental demands exceed an individual's perceived or appraised ability to cope. In contrast to definitions with focus on either stimulus or response, they emphasise the circular relationship between the person and environment:

Psychological stress, therefore, is a relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being. (Lazarus & Folkman, 1984, p.21)

Negative stress, according to their definition, occurs as an imbalance between the demands and pressures that an individual experience and the resources or the competence she or he have to handle the situation. Moreover, Lazarus' and Folkman's definition of stress focuses on the individuals' own appraisal of a situation and on their coping strategies. In the appraisal of a situation as stressful or threatening, the human brain

and its cognitive functions are central (McEwen, 2007). In addition, Theorell (2002) has argued that people's control over their life-situation is crucial for their management of negative stress, and that stress reactions are mobilised when an individual perceives a loss of control over a situation and struggles to get it back. Accordingly, a low level of control in working life has proven to cause ill-health (Karasek & Theorell, 1990).

As indicated earlier, contemporary stress research suggests multiple system approaches acknowledging bio-psycho-social interplays on molecular, cell and individual levels as well as on group, organisation, and societal levels (Arnetz & Ekman, 2006). Nevertheless, stress research has various foci depending on discipline, and can concern: physiological responses and processes, psychological characteristics, affects and emotions, cognition, individuals' coping, contextual circumstances, work-related stress, gender aspects, or societal discourses on stress (Becker, 2010; Frankenhauser, 1993; Karasek & Theorell, 1990; McEwen, 1998, 2007; Öhman, Nordin, Bergdahl, Slunga Birgander & Stigsdotter Neely, 2007). Still, though, biomedical and behavioural-orientated stress research seems to dominate.

In addition, the concept of stress is highly bound by time and context, as the meanings and status related to stress, and stress diagnosis, vary. Thus, 'stress problems' can be regarded as a topical contemporary phenomenon – as socially constructed and socially shaped health problems, as well as subjective and 'lived' experiences. How stress is gendered among young people has been less explored, however.

Stressors

Stressors, or stress factors, can in a simplified causal model be seen as the outer conditions which lead to stress reactions or stress responses. Children and young people can react differently and perceive other stressors than adults (von Knorring & Ahmad, 2002). Children report stressors in school, with family, during leisure time and as a consequence of peer relationships (Barnombudsmannen, 2003). Adolescents highlight several stressors and demands in life such as: 'achievement-oriented society', the great freedom of choice, media and commercials, school, youth unemployment, and economical strain (SOU, 2006). In adult working life, an imbalance between high demands and low control are found to cause a strained working situation associated with ill-health, such as fatigue and exhaustion, sleeping problems, depressive mood, cognitive symptoms, cardiovascular problems, and musculoskeletal pain (Karasek & Theorell, 1990; McEwen, 2007). In school-children high

demands in school are found to be associated to subjective health complaints, particularly in girls (Eriksson & Sellström, 2010).

Stress responses

Individuals react and respond to stress through several parallel bodily systems such as the motoric, autonome, endocrine and immune systems (Arnetz & Ekman, 2006; Bunkan, 2008). Stress reactions can, according to Levi (2002), be grouped into four categories: physiological, emotional, cognitive, and behavioural.

During acute stress, the body prepares by mobilising energy to 'fight or flight' (McEwen, 2007). The psycho-physiological processes can be described as a 'reaction triad' between the autonomic nervous system (sympathetic and parasympathetic), the hormonal system, and a behavioural component (Folkow, 2006). During fear and stress, the muscles activate reflexively. Increased tonus and pain in the muscles are common symptoms that can be related to stress and emotions, so-called muscle stress (Alfvén, 2006). Similar processes may explain the increased tonus and alertness, which has been called the 'startle pattern' of the body (Bunkan, 2008). The temporary energy mobilisation that occurs in stressful or threatening situations is appropriate and normal; but a similar mobilisation that occurs during prolonged periods of stress, and without recovery, can cause illness and disturbances in the energy regulation and can, for instance, affect the cardiovascular system (Arnetz & Ekman, 2006). Long-lasting and prolonged stress creates a state of fatigue, labeled 'wear and tear', 'allostatic load' or 'allostatic overload' (McEwen, 2007). Prolonged psychological stress is associated with a range of physical and psychological symptoms, such as: recurrent pain, anxiety, depression, irritability, sleep disturbance, and impaired cognitive functions (Arnetz & Ekman, 2006; Bergdahl, Larsson, Nilsson, Åhlström & Nyberg, 2005; Malmgren-Olsson & Armelius, 2001; Åkerstedt, 2006; Öhman et al., 2007).

Recovery and sleep

A vital protection against stress is, however, the physiological 'anti-stress system' which seems to increase the stress tolerance. Hormones in the anti-stress system are activated by soothing stimuli such as touch and social support (Uvnäs Moberg & Peterson, 2006). Recovery and sleep are other crucial health factors often affected by perceived stress, and which are associated with stress diagnosis such as burn-out and exhaustion disorder (Ekstedt, Söderström, & Åkerstedt, 2009; Fahlen, Knutsson, Åkerstedt, Nordin, Alfredsson et al., 2006; Åkerstedt, 2006; Åkerstedt, Kecklund, & Axelsson, 2007). Lack of recovery and sleep increase the risk

of high allostatic load and development of stress-related ill-health (Åkerstedt, 2006).

Coping with stress

‘Coping’ and ‘mastering’ are concepts that describe an individual’s ability to deal with situations that are difficult or stressful (Groholt, Sommerschild, & Gjaerum, 1999; Tamm, 2002). Coping strategies describe how a person masters and adapts to stressful situations (Lazarus, 1999; Lazarus & Folkman, 1984). The different coping strategies can be problem solving and ‘emotional coping’, but they can also be the search for knowledge, social support or internal, psychological defense mechanisms. It seems as if invisible and unpredictable problems, such as pain, are more difficult to handle than the visible (Tamm 1996). Differences in coping strategies among adolescent girls with and without psychosomatic pain have been observed in some studies (Fichtel, 2003). Moreover, children and young people with chronic illnesses seem to be able to improve their coping strategies to reduce stress (Tamm, 1996). However, coping and coping strategies are often studied on an individual micro level, without taking contextual factors into account.

Affects and emotions

Affects, or emotions, are additional aspects to consider in relation to psychosomatic and stress-related problems in children and youth – especially feelings of fear, which seem closely connected to stress (Alfvén, 2006). Affects, can be characterised as physiological reactions to a stimulus, and therefore they have important signal functions and are important sources of information (Bergdahl et al., 2005; Lerner, 1999). An individual’s vitality is, according to ‘affect theory’, regarded as dependent on the ability to perceive and experience the affective signals and to understand and express emotions, as well as to be able to accommodate and tolerate emotions (Monsen, 1991). Affect theories, therefore, point to the close interplays between affects, physiological and motor functions. However, emotions are more than physiological signals and psycho-physiological processes, they occur and are interpreted or constructed in a social context – in relationships between individuals (Barbalet, 2001; L Dahlgren & Starrin, 2004; Lupton, 1998). Accordingly, emotions can also be viewed as ‘gendered’ and as such are used in the social constructions of femininity and masculinity (Lupton, 1998). Emotions are furthermore embodied (Lupton, 1998).

Theorising the body

The body, and body experiences, have central roles in experiences of stress. The body, its movements and perceptions are also central in development and identity-making during childhood and youth, both as inner experiences and outer explorations and presentations. Hence, the body is also essential in the ‘doing of gender’ (Connell, 2002).

How individuals’ bodies and embodiment are defined, described, and understood, differs between scientific disciplines and professions. Several disciplines have started to view body and its movements as an expression of culture and identity (Engelsrud, 2006). All views of the body are bound by time and culture, as the norms and values that are linked to ‘the body’ are changeable. In contemporary Western society, there is an observable body-focus and, parallel to this, an increased interest in studying and theorising the body, even within scientific fields which did not have a body-focus before, e.g. social sciences, sociology and psychology. It is, therefore, important to define the meanings of the concept of ‘body’ (Engelsrud, 2006).

Body is not only biology – but also biology

An important basic assumption in this thesis is that the body and its illness are not *only* biology – but *also* biology; this statement calls for an interdisciplinary framework in the theorising of ‘the body’. Biological and physiological aspects are central to the understanding of stress responses and the experiences of sensations perceived in the ‘inner’ body in stressful situations. Biological, physiological and motor aspects are also keys to understanding the processes involved in the development of ill-health due to stress (Arnetz & Ekman, 2006; Bunkan, 2008; McEwen, 2007; Uvnäs Moberg & Peterson, 2006). Experiential aspects contribute perspectives on how individuals themselves perceive and experience their bodies or a situation. Through reflectivity and cognitive functions, individuals also interpret a situation; their experiences are shaped not only by biological and material conditions, but also by social circumstances. Social constructions of the body are essential components in the theorising and interpretation of young people’s experiences of body, stress, and health (Frost, 2005). Another assumption is that all these aspects of the body, bodily experiences, and embodiment, play an important and integrated role in children’s and young people’s development and identity making (Bunkan, 2008; Frisé, 2007).

Physical and physiological body

The physical and physiological body is well described and studied within the biomedical fields. Biomedical definitions of the body, and its

functions, continue to have a great impact on health discourses in contemporary Western societies. A simplistic description, also from a historical viewpoint, is that biomedical disciplines have defined and studied the human body as a ‘machine’ – and as being quite distinct from its social context (Johannisson, 2006). The Swedish term ‘rörelseapparaten’ (eng. movement apparatus), used within physiotherapy, exemplifies such a biomedical view of the human body and its parts. This biomedical view has been criticised for being ‘instrumental’ and ‘mechanical’, in that it lacks the experiential, emotional and social aspects of embodiment. Public health research often studies the physical body with the help of biomarkers or measurements, e.g. cortisol, cholesterol, blood pressure, or body mass index. ‘The healthy body’ and healthy lifestyles are emphasized (Petersen & Lupton, 1996), whereas less focus has been put on the population’s ‘experienced bodies’. In sociology, by contrast, theorists such as Shilling (Shilling, 2003) have called for more emphasis on the physical body, a body of ‘blood and flesh’, because of a tilt towards an academic and theoretical view of the body which is not always grounded in empirical studies, materiality and biology. Likewise, Fraser (2009) has advocated a materialist view of body and reality within feminism.

Lived body and body-self

The anthropologist Sachs (2004) has spoken about the ‘bodily self’ as our presence in the world, and as an individual and social experience. These notions are close to phenomenological body philosophy, which is based on the assumption that humans are their experiences, and that the body is part of these lived experiences. This assumption is mirrored in the expressions of ‘lived body’ and ‘lived embodied experiences’. Phenomenology defines the body – one’s own body and that of others – as both subject and object. The relation between the lived, subjective body and the physical, objective body is circular and simultaneous – a so-called dialectical understanding of the body (Merleau-Ponty, 1962; Rosberg, 2000).

The psychosomatic-influenced psychoanalyst and physician Matthis (1997) has given a similar description of the body as both subject and object, but uses the terms ‘factic/actual body’, ‘experienced body’ and ‘reflecting body’. Matthis (1997) has defined the actual body as a physical and material entity – a “physical and fleshy presence” – and the experienced perceived body as a “psychological social form of existence”; and these bodies depend on each other. Moreover, Matthis has explained how collisions and confusion may arise when health care that, by

tradition, measures and treats the physical body, whereas the individual patients may be seeking treatment of their “experienced body”.

In physiotherapy, human bodies, physicality, bodily function and movements by tradition have been central, mainly as biomechanical, motor and physiological entities. During the last few decades the ‘lived body’ as psychosocial and existential interaction, as object and subject, has become more prominent. Theories about the body-self in relation to specific body and movement therapy continue to be developed (Engelsrud, 1990; Lundvik-Gyllensten, 2001; M. Mattsson, 1998; Rosberg, 2000; Skjaerven et al., 2008). However, contextual and gender aspects have not been explored in any great depth within physiotherapy research, or specifically considered in treatment principles.

The body-self, or body-ego, concepts stress the close interconnection and unity between body and self (as opposed to dualism) and a dialectic understanding of body (Roxendal & Winberg, 2002). The body-self involves experiences, feelings, actions and reactions, and is thus expressed in a person’s gaze, facial expression, posture, muscle tone, autonomic processes, movement quality, voice and breathing (Skjaerven et al., 2008). The body-self is changeable and is influenced by, for instance, emotional state and mood, social relations, life situations and illness. Bunkan (2008) has argued that there is a relationship between body image, self-image and weight problems, Western ideals of beauty and health, and comfort eating and guilt.

Social and gendered body

Within the sociological field, the concept of ‘social body’ is commonly used when the relationships between body, individual and society are explored and discussed. Within sociology, there are specific branches of body sociology and medical sociology, where phenomena connected to body and embodiment are studied and theorised (Lupton, 2003; Nettleton, 1995; Nettleton & Watson, 1998; Shilling, 2003). The social body is a socially constructed body based on social constructionist perspectives, and social categories such as class, ethnicity and gender are considered. The social presentation of the body, body as surface and performance, as well as body in everyday life, are studied (Butler, 1999; Nettleton & Watson, 1998).

Within gender studies, the concept of ‘gendered body’ is utilised (Connell, 2002). Gender studies on body include the complex interplay between sex and gender, the biological and the social aspects (Annandale, 2009). The definitions differ regarding how body is understood; whether as genetically programmed, as a social construction, or as an interaction in which the physical body is affected by social conditions (Connell,

2002). The biologists and feminists Fausto-Sterling (2000; 2008) and Birke (1999) have argued for a dialectic view of the links between biology and the social aspects of nature and nurture. Fausto-Sterling (2005) has demonstrated how the biological body can be altered according to context-bound societal gender ideals, for example through physical training or eating habits, and vice versa. This assumption conforms to how the body and embodiment are understood in this thesis; as dialectic.

Contextualising young people's stress and health

A basic assumption throughout this thesis is that sociocultural and gender perspectives can contribute to an understanding of young people's stress and health in relation to a broader social context. Another basic assumption is that such contextualisation of young people's experiences of stress can prevent unnecessary medicalisation and individualisation of their problems.

The agency – structure relationship

In sociological theory, as well as in gender research, the concept of 'agency' is used to emphasise individuals' own reflexivity and actions. Individuals are then viewed as active agents in their own lives. Giddens (1984) has termed the interconnections between individuals' agency and societal structures 'structuration' without further discussions on gender and power (see also Gauntlett, 2002, p. 92-94). To varying degrees, youth studies have highlighted individualisation and agency versus societal context and social structures such as class and gender inequalities – barriers that might constrain individual agency (Furlong, 2009; Furlong & Cartmel, 1997). However, several youth researchers have emphasised that young people's actions and lives are circumscribed by social factors such as age, sex, class and gender, which reflect conditions and hierarchies at the structural level in society (Furlong, 2009; Harris, 2004a).

In line, with this, Gordon et al. (2008) and Evan (2007) have used the term 'bounded agency' to describe young people's restricted and limited space of action, including restricted access to societal resources. These views stand in stark contrast to the individualistic and neoliberal discourses in late modernity that promote individual freedom without acknowledging structural constraints. Several of the cited scholars in this thesis have problematised the late modern discourses and the individualisation in society from class, gender and/or youth perspectives (Harris, 2004a; McRobbie, 2009; Rose, 1999; Skeggs, 1997, 2004). The thesis results will be discussed in relation to the concept of structuration

as a way of acknowledging the relationships between structural conditions, gender and individual agency.

Gender and gender perspectives

To apply sociocultural and gender perspectives in youth health research is crucial, as young people's living conditions seem to differ and be shaped by social factors such as gender and class. Medical explanation models, combined with sociocultural perspectives have, in other contexts, proved to be useful in explaining health aspects tied to gender (Hammarström, Lehti, Danielsson, Bengs & Johansson, 2009). Meurling et al (2003) raised the relevant question: "Why girls?" in an interdisciplinary anthology about girls' ideals, self-images and eating disorders.

Gender describes how masculinity and femininity are created according to the norms and expectations in a specific social context (Connell, 2002, 2005). These processes exist constantly between individuals in all aspects of everyday life (gender relations), on organisational levels (gender regimes), as well as on societal levels (gender orders). Thus, gender is interrelated to social structures, norms, values and practices connected to femininity and masculinity in a certain context and time, and is produced or reproduced in ongoing social processes and actions of 'doing gender' (Connell, 2002; West & Zimmerman, 1987). Within traditional gender systems, there are both dichotomies and asymmetries, which imply a separation of activities and behaviours ascribed to men and women respectively; so too are there conceptions of men as dominant and superior, and women as subordinated (Connell, 2005; Hirdman, 2003). Such gender orders can be observed in all domains in life: at individual, group and societal levels. In addition, gender orders and unequal power relations influence health in interwoven processes of 'doing health' and 'doing gender' (Connell, 1987; Hammarström & Ripper, 1999). The creation of gender is ongoing throughout life. Connell (2002) has claimed that gender, even at early ages, is negotiated as a part of an individual's agency.

Femininity and masculinity

The concepts of femininity and masculinity are thus connected to the creation of gender. Doing gender, particularly femininity, is a consistent theme throughout the thesis and is related to stress during youth. An assumption is that constructions of femininity and masculinity can be linked to health and health-related practices in everyday life (Annandale & Hunt, 1990; Annandale, 2009; Courtenay, 2000; Saltonstall, 1993). The creations of femininity and masculinity are, moreover, attached to norms and perceptions about what it is to be an ideal girl or boy, or an ideal woman or man, in a certain context (Butler, 1999; Connell, 2002;

Skeggs, 1997). Accordingly, Butler (1999) has pointed to the 'heterosexual matrix' which defines 'normal' femininity and masculinity and which is strongly linked to power. Consequently, individuals who deviate from this norm risk discrimination. Similarly, Connell (2005) has defined 'hegemonic masculinity' as the most valued gender role, and has stated that it is connected to masculine superiority and dominance. 'Emphasised femininity', by contrast, implies empathy, nurturance and compliance, as well as a subordinated position in relation to men (1987, 2002). Likewise, Skeggs (1997) has defined a 'normative femininity' which is attached to 'respectability', and in accordance with which girls and women construct themselves. This feminine norm is, according to Skeggs, a white, middleclass and heterosexual woman.

In a study of Swedish adolescent girls, Ambjörnsson (2004) noted 'ideal' behaviours such as moderation, control, prudence, caring and empathy. Sveningsson Elm (2001, 2009) has highlighted the fact that girls who deviate from the feminine norm are forced to choose between adaptation or to withstand the reactions of those provoked by their 'deviance'. Moreover, they must maintain the difficult balance between the contradictory ideals of signalling both (hetero-) sexual attractiveness and (hetero-) sexual nurturance. Femininity is thus inextricably bound to paradoxes and contradictions. In addition, several researchers have pointed to the multitude of different young femininities and masculinities (Anoop & Kehily, 2008; Frosh et al., 2002; Phoenix, 1997).

Methods

The overall research setting and design

The research setting is the municipality of Umeå, a university town in northern Sweden with about 100 000 inhabitants. This thesis is a result of a research collaboration between the County Council in Västerbotten (VLL) and the unit for Epidemiology and Global Health at Umeå University concerning health promotion within the health care sector. Moreover, the thesis also form part of a larger ongoing research project “Stress and Health among Youth” (Umeå SHY). The overall aim is to increase the understanding of stress and subjective health in young people, and to develop health-promoting and gender-sensitive intervention models in youth health and school health services. Qualitative and quantitative research methods are combined in an interdisciplinary collaboration. During the years 2005-2008 the research project performed studies in three different research settings 1) a youth health centre in Umeå, 2) three public upper secondary schools in Umeå, and 3) the school health services in Umeå municipality (Table 2). The thesis is based on the qualitative interview study at the youth health centre (Papers I-III) and the school survey (Paper IV). The intervention studies are not included in the thesis.

Table 2. Overview of the overall research project during the period 2005-2008.

Research setting	Participants	Sub-studies
Youth Health Centre Umeå	40 girls/young women 16-25 years	Interview study (Paper I-III) Intervention study - questionnaires - log books - interviews - group discussions
School Health Services Upper Secondary Schools Umeå	1027 adolescents Boys and girls 16-18 years	School survey (Paper IV)
School Health Services Upper Secondary Schools Umeå	50 girls 16-18 years	Interview study Intervention study - questionnaires - log books - interviews - group discussions

As the research field is relatively unexplored an explorative and inductive research design was used. It combines qualitative and quantitative methods with the main focus on qualitative methods (Dahlgren, Emmelin, & Winkvist, 2004; Morgan, 1998). In the qualitative parts of the research project several sources of data were obtained and triangulated (Lincoln & Guba, 1985). The data sources were individual interviews, questionnaires, log books and group discussions. Of these data sources, the interview results are presented in the thesis. In the quantitative part a questionnaire was administered and analysed. Various qualitative and quantitative research methods for collecting and analyzing data are thus utilized in the thesis (Table 3).

Table 3. Overview of utilised research methods for data collection and data analyses in the thesis (Papers I-IV)

	Paper I	Paper II	Paper III	Paper IV
Data collection	Individual research interviews			Questionnaire
Data analyses	Qualitative content analysis	Qualitative content analysis	Qualitative content analysis	Descriptive statistics Analytical statistics
	Discourse-oriented approach	Phenomenological approach	Narrative method	
				Mixed model analysis Factor analysis Correlations

The qualitative interview study (Papers I-III)

Qualitative research methodology

Qualitative research methodology is regarded as suitable to use in unexplored areas due to its inductive and explorative character (Dahlgren et al., 2004; Denzin & Lincoln, 2003a; Lincoln & Guba, 1985). The utilized research approach is explorative, emergent and flexible which provides conditions for “being at the path of discovery” and to follow and deepen emerging themes (Dahlgren et al., 2004; Lincoln & Guba, 1985). Moreover qualitative methods facilitate the in-depth illumination of individuals’ experiences and perceptions from their own viewpoint.

Research setting

The qualitative interview study was conducted at a youth health centre in Umeå (Ungdomshälsan). The youth health centre specialises in psychosocial ill-health in young people aged 16-25 years. At the time for the study the centre was run by the local county council in cooperation with the child- and youth psychiatry, the municipality, and the employment- and health insurance offices. Much of the activities are organised as multi-professional team work. Young people contact the

youth health centre directly as outpatient visitors without referral. The youth health centre offers “drop-in” contacts, single or shorter series of individual and group consultations, as well as meetings with a multidisciplinary team. All consultations are free of charge. Since 2005, the centre has also offered a form of group intervention, or so-called “stress-management courses”, developed as a part of our larger overall research project (Table 2). The content of the intervention is a combination of body based methods such as Body Awareness Therapy (BAT) and relaxation, and reflective and supportive group discussions (Lundvik-Gyllensten, 2001; Malmgren-Olsson & Brännholm, 2002). The physiotherapist at the youth health centre was the group leader of this group intervention. For a description of the intervention model see Strömbäck (2008).

Procedure and participants

During the period 2005-2007, in total 40 adolescent girls and young women aged 16-25 years participated in the study. The sampling procedure was consecutive. Participants were adolescent girls and young women who had sought help at the youth health centre for stress-related problems and thereafter had applied to one of the stress-management courses. The group intervention was announced at the youth health centre’s homepage and through the personnel, but also on posters and leaflets at the youth health centre, the student health at the university (Studenthälsan), and at the local community, employment- and health insurance offices.

The sample of participants varied regarding family circumstances and housing conditions, socioeconomic status, education level and occupation. The age of the participants ranged from 16 to 25 years with a mean age of 21.6 years (median=22). Half of them were students either at upper secondary school, university or adult education. The remaining were working, unemployed, on part- or fulltime sick-leave and/or work-training. Some had several casual jobs and some combined studies with extra income. Most of the young women had moved from their family and were living as singles. A few lived with their family or altered between divorced parents. Some lived with a partner or a friend. The majority of participants were born in Sweden, but several had moved from other parts of Sweden.

All participants filled in questionnaires and were interviewed before and after the intervention period. The interviews that were conducted before the intervention form the basis for the analyses in Papers I-III. Papers I-II are based on interviews from all the 40 participants, whereas Paper III is based on two of these. As a result of the emergent research

design, Paper III is an in-depth exploration of two of the participants' experiences of gendered partner violence (Figure 4).

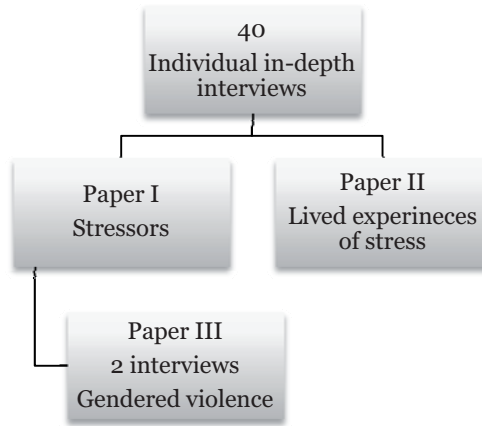


Figure 4. Overview of selected interviews in Papers I-III

Research interviews

All participants were interviewed by me personally before the start of the group intervention. In beforehand, I phoned participants and we talked about the research project and the interview situation, and we also agreed upon the time frame for the interview. The interviews took place in a consultation room at the youth health center; were digitally recorded, and lasted between 45 and 120 minutes, the average being 90 minutes. The interviews were performed in a narrative, dialogic and supportive manner. The opening phrase for the dialogue was “Please, tell me how you came to contact the youth health center.” Participants were thereafter encouraged to narrate about their own experiences and thoughts. I listened and followed up their narrations with probing and questions around emerging issues. A thematic interview guide supported the continuation of the dialogue. Areas such as their overall life-situation, experiences of stress, stressful situations, emotions, and bodily experiences connected to these situations were explored. Social relations, social support and coping were other explored areas. All the interviews were transcribed verbatim.

Analysis (Papers I-III)

Qualitative content analysis was used as the primary analysis method (Graneheim & Lundman, 2004; Hsieh & Shannon, 2005). In line with the emergent and flexible research design the content analysis was combined with other methods or approaches as described below. As the interview material is extensive the analysis was made in several steps in order to

grasp both manifest and latent meaning, parts and the whole, as well as to contextualize the content and emerging meanings. Accordingly, the analysis procedure was an oscillation between a “naive” listening to and reading of the material in order to get a sense of the whole and capture lived experiences (Lindseth & Norberg, 2004), and more structured ways to sort emerging patterns and themes. The interview texts were divided into meaning units, which were coded and condensed at a slightly higher level of abstraction (Table 4). Codes were grouped into categories or themes. Initially, a wide range of stressors/experiences were listed and briefly sorted as related to certain life-spheres and content areas. Later, summaries of single stories were made, and different ways to illustrate the content were used such as “mind-maps”. A computer software program facilitated the sorting procedure and comparisons across the whole material (“OpenCode 2.1,” 1997). Continuously, along this analytical process, triangulation and discussions in the research group facilitated the grounding of interpretations in data and theory (Lincoln & Guba, 1985).

Table 4. Examples of analytical steps from meaning units, condensed meaning units and codes to sub-themes

Meaning units	Condensed meaning units	Codes	Sub-themes
My parents are so occupied with themselves and their own lives	Parents occupied with themselves	Occupied parents	Failing adult support <ul style="list-style-type: none"> - Parents - Professionals - Society
I've been the victim of bullying... and the teachers didn't say much about it. They didn't do enough in any case.	Excluded and bullied in peer group Teachers did not act to stop the bullying	Bullied Excluded Passive teachers	
I've had a lot of contact with professionals. Whether I've actually gotten professional help, that's something else.	Lack of professional support	Many contacts with professionals Non-supportive professionals Lack of support	Social exclusion <ul style="list-style-type: none"> - Peer group
So, I want someone to care, to take a little of the responsibility. But then that's not how society works today, is it. To get help you have to ask for it, and ideally you should help yourself.	Want someone who cares and unburdens responsibility You are expected to help yourself in today's society	Want support and care Want removed burden of responsibility Pressure to manage alone Modernity norm	Responsibility-taking "Managing alone"

Discourse oriented approach (Paper I)

In paper I the later steps of the qualitative content analysis is described as “discourse-oriented”, because we used our contextual and theoretical pre-understanding in the interpretations of the emerging categories and themes. As the young women’s life-situations seemed influenced by

societal discourses, these discourses are viewed as a form of latent meaning, to be compared with the latent meaning as described in qualitative content analysis (Graneheim & Lundman, 2004). The discourse orientation is also a way of contextualizing the analysis and results (Winther Jørgensen & Philips, 2002). A combination of medical sociological, gender and feminist theories were used in the interpreting of data.

According to Lupton (2000), discourse “denote the patterns of ways of thinking, making sense of, talking or writing about, and visually portraying phenomena such as the human body, medical and nursing practices, sexuality and reproduction, illness, disease and death” (p.51). Furthermore discourses are both “delimiting, structuring what it is possible to say or do, and productive” (p. 51). In addition, discourses can be “articulated and acted upon in a range of contexts”, for example in an individual’s explanation and understanding of illness, in texts, or in mass media reports about health and disease (p.51). Thus, discourses are sited within broader sociocultural and historical contexts. Simplistic, discourse analysis strive to reveal such patterns of understanding and talking about the world, and discuss the social consequences of these different social constructions (Winther Jørgensen & Philips, 2002).

Phenomenological approach (Paper II)

The analysis in Paper II is influenced by a phenomenological research approach (Merleau-Ponty, 1962; Starks & Brown Trinidad, 2007), as the aim is to explore lived experiences of stress and stress-reactions. The “essence” of lived embodied experiences is formulated in one main theme. See also *Phenomenology*.

Narrative method (Paper III)

In paper III a combination of qualitative content analysis and a thematic narrative method was used in order to utilize the narrative character in two of the young women’s stories (Riessman, 2008). In our narrative analysis their narrations are presented as chronologically ordered sequences with related sub-themes. The analysis stays close to the narrators’ own words and the interpretations uses a “low” degree of abstraction. Results are presented with many and relatively long quotations which display thorough in-depth descriptions of individual experiences. Thematic narrative analysis primarily focuses on “what” is said in the stories and in the creation of themes. Narrative method furthermore facilitates the inclusion of temporality, sequences and consequences, contextual factors and dialogical aspects (Riessman, 2008).

The school survey (Paper IV)

During the academic year 2007-2008, a survey was conducted as a classroom survey at three of the major public upper secondary schools in Umeå. Each school offers a range of vocational and theoretical educational programs.

Participants and sampling procedure

Before the survey the principal heads of school were contacted by the research team and granted permission for the study. All primary teachers at each educational program and class were informed and invited to participate. At the time for the survey there were in total 2721 students in grades 1 and 2 at the three schools. There were 53% girls and 47% boys, 69% studied at theoretical programs and 31% at vocational programs, respectively. For practical reasons, 1545 students were not available to participate due to absence because of internship outside school. The questionnaires were administered to the 49 classes that had accepted to participate. These classes included 1176 students, 43.2% of all students in grade 1-2 at the schools. Of these 1176 invited adolescents, 1033 (87.8%) answered the questionnaire. In total 1027 answers (37.7% of the eligible and 87.3% of the invited) were finally included in the study (Figure 5).

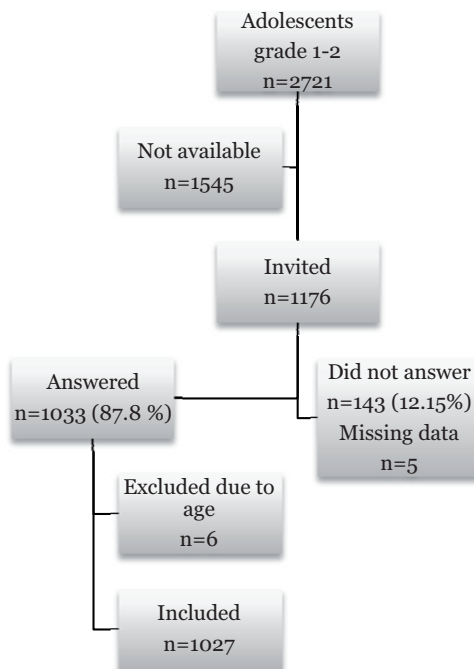


Figure 5. Overview of the sampling procedure in the school survey (Paper IV).

Nonparticipation was mainly due to absence from school on the day the questionnaire was administered. Five questionnaires were excluded due to missing data. As the selected sample was 16-18-year-olds answers from six students were excluded: 15 years (n=2), 19 years (n=2) and 20 years (n=2). Of the participating 1027 students 61% were girls and 39% were boys; 76% attended theoretical and 24% vocational study programs, respectively.

The questionnaire took 30 minutes to complete and was finished during one school hour. The survey was supervised by research assistants who also answered any questions from the students.

Measurements

Socio-demographics

Socio-demographics were assessed by the items sex, age, grade, educational program, country of birth, parental language and occupation, family situation and housing conditions.

Subjective health complaints

Subjective health complaints were measured with a 16-item symptom checklist. The used checklist consists of variables for measurements of musculoskeletal pain in different locations, complaints from the stomach and heart, tiredness, symptoms of upper respiratory infection, nausea, dizziness and sadness. Six-month symptom prevalence was estimated through the question: "In the past six months, have you had the following problem?" Response alternatives were "never", "seldom", "sometimes", "fairly often", and "very often". Response alternatives were dichotomized as "never/seldom" and "fairly often/very often", and the alternative "sometimes" was excluded. The items in the used check-list is similar to the four somatic questions used by WHO in the cross national survey Health Behaviour in School-aged Children (HBSC) (Haugland & Wold, 2001). The instrument used had additional somatic items intended to capture more symptom variation, and the response alternatives differ from those in the HBSC-instrument. A factor analysis was conducted based on the 16 variables for subjective health complaints (See *Factor analysis*, Table 5).

General self-rated health

General self-rated health was measured with one statement from the HBSC survey used in several WHO-studies with adolescents across nations (Torsheim, Vålímáa, & Danielson, 2004). The statement "I perceive my health as" have four response alternatives: "very good",

“fairly good”, “not quite good”, and “not good at all”. These alternatives were dichotomized into good (“very good/fairly good”) and bad health (“not quite good/not good”).

Medication

Medication was measured with two questions. “In the past six months, have you taken antidepressants or sedatives?” (“yes” or “no”). “How often do you self-medicate with non-prescription painkillers?” (“never”, “less than a few times each month”, “a few times each month”, “every week”, and “every day”).

Anxiety and depression

Anxiety and depression were measured with the Hospital Anxiety and Depression Scale (HADS). The HADS instrument is well established and validated (Hansson, Chotai, Nordström, & Bodlund, 2009; Lisspers, Nygren, & Söderman, 1997; Snaith, 2003; White, Leach, Sims, Atkinson & Cottrell, 1999; Zigmond & Snaith, 1983). HADS includes seven questions for anxiety and seven questions for depression. Each question scores 0-3 points. A total score of 0-7 points indicate no or normal anxiety/depression, 8-10 points indicates “possible” mild to moderate symptoms, and 11-21 points indicates a “probable” clinically significant condition of anxiety or depression.

Perceived stress

Perceived stress was measured with a stress instrument developed by Lindblad et al. (2008). The instrument has been used among adolescents but has not been evaluated in larger populations or across contexts. The instrument includes in total 16 items. Perceived stress is measured with 12 items and sleep with four items (Table 6). Recall time was the previous weeks. Response alternatives were “never”, “seldom”, “sometimes”, “often”, and “always”. For data analysis of perceived stress, response alternatives were dichotomized as “never/seldom” or “often/always”, and the alternative “sometimes” was excluded. A factor analysis was conducted based on the 16 items (see *Factor analysis*, Table 6).

Statistical analysis

Differences in proportions were calculated using Chi² tests. Independent sample t-tests were used to compare means between groups. The used mixed model analysis, factor analysis and calculations of correlations are described below.

Mixed model analysis

A hierarchical mixed model analysis was used since the data has a hierarchical structure with three levels: individual level, school class level and school level. A variance component, Intraclass Correlation Coefficient (ICC), was calculated to measure the proportion of explained variability referred to respective level. Dependent variables in the mixed models were the indices for pressure and demands, activation/activity, sleep problems, psychosomatic problems, upper respiratory problems, musculoskeletal symptoms, anxiety, and depression. One covariate, sex, was used in the models.

Factor analysis

A factor analysis using principal component analysis and varimax rotation with Kaiser normalisation was conducted for variables on a) subjective health complaints, and b) perceived stress including sleeping problems. A cut-off point for inclusion was factor loading >0.50. Cronbach's alpha was used to test reliability and values >0.6 were considered to indicate a sufficient degree of internal consistency. The factor analysis on subjective health complaints yielded three dimensions with eigenvalues larger than one: "psychosomatic symptoms" consisting of five items (eigenvalue 6.07, Cronbach's alpha 0.77); "symptoms of upper respiratory infection" consisting of four items (eigenvalue 1.33, Cronbach's alpha 0.75); "musculoskeletal symptoms" consisting of four items (eigenvalue 1.16, Cronbach's alpha 0.76) (Table 5). Selected factors with an eigenvalue greater than one explained 53.5% of the variance. Three items (dizziness, stomach pain and sleeping problems) did not reach factor loading >0.50 and were excluded. The factor analysis on perceived stress and sleep yielded three components: "pressure and demands" consisting of seven items (eigenvalue 5.97, Cronbach's alpha 0.83); "activation" consisting of five items (eigenvalue 1.41, Cronbach's alpha 0.72); "sleeping problems" consisting of four items (eigenvalue 1.04, Cronbach's alpha 0.82) (Table 6). Selected factors with an eigenvalue larger than one explain 52.7% of the variance.

Methods

Table 5. Rotated factor matrix for subjective health complaint items remaining after factor analysis

Subjective health complaint items	Factor loading		
	Component 1	Component 2	Component 3
Psychosomatic symptoms			
More tired than before	0.560		
Sadness	0.659		
Acid stomach, stomach ache	0.667		
Pain and aches in heart and chest	0.692		
Palpitations and extra heart beats	0.678		
Symptoms of upper respiratory infection			
Headache		0.526	
Cold symptoms		0.799	
Cough and hoarseness		0.793	
Nausea		0.539	
Musculoskeletal symptoms			
Neck and shoulder pain			0.616
Low back pain			0.690
Pain in extremity joints			0.774
Muscle pain			0.754

Table 6. Rotated factor matrix for stress items remaining after factor analysis

Item	Factor loading		
	Component 1	Component 2	Component 3
Pressure and demands			
I don't have time enough	0.754		
I feel under pressure from school demands	0.698		
I feel helpless	0.671		
I never feel really free	0.641		
I feel under pressure from demands at home	0.563		
I feel under pressure from my inner demands	0.536		
I don't feel rested after sleep	0.531		
Activation/high activity and tempo			
I rush even if I don't have to		0.721	
I keep a high speed all day		0.700	
I eat rapidly even if I don't have to		0.576	
I do many things at the same time		0.551	
I find it difficult to relax		0.533	
Sleeping problems			
I sleep restlessly and shallow			0.763
I have difficulty falling asleep			0.739
I wake up early in the morning			0.606
I feel restless			0.524

Correlations

Correlations between the factors for subjective health complaints and perceived stress derived from the factor analysis (see Tables 5, 6), and the standardized factors of anxiety and depression from the HADS-instrument were computed using Pearson correlation coefficients. A p -value <0.01 was considered significant.

Ethics

The whole research project with included studies was approved by the Regional Ethics Committee of the Faculty of Medicine, Umeå University, Sweden (Dnr. 05-045 M).

Before the qualitative interview study (Papers I-III) potential participants received both written and oral information about the research project before they decided to participate and gave their signed informed consent. Sources of information were a written leaflet about the research project and its connections to the stress-management course, oral information from the professionals at the youth health centre and from me, the researcher. The information contained descriptions of data collection methods, analyses and publication procedure. Participants were also well informed about their confidentiality and that codes were used to ensure their confidentiality. They knew about their right to withdraw from the study at any stage without giving any particular reason. Thus, they received step-wise information and were offered the possibility to discuss and reflect upon their decisions throughout the entire process. The research project was conducted in close cooperation with the personnel at the youth health centre and participants were close to these sources of support. After the interview all participants received information about the possibility to take additional contacts with the youth health personnel if they felt a need of support around emerging issues.

Before the school survey (Paper IV) the students received information about the research project and the survey through the schools' homepages and from their teachers, the day before the survey was conducted. They were informed about their confidentiality and their right to not participate. In direct connection to the time for the survey, they received oral information from members of the research team. Their confidentiality was protected as no codes or names were collected which could trace the answers to certain individuals, and because the data was not supposed to be presented at class levels. Moreover, participants were offered the possibility to turn to school health services (school nurse or school physician) for questions or support if they felt the need. The school health personnel were well informed about the ongoing survey, its purpose and content. Research with adolescents 16 years of age and above do not need parents' permission, but parents could receive information from the schools' homepage or by contact with the research team or school health services.

Trustworthiness and validity

Trustworthiness is in qualitative studies discussed in terms of credibility, validity, reliability and transferability (Dahlgren et al., 2004; Graneheim & Lundman, 2004; Lincoln & Guba, 1985). In the qualitative studies (Papers I-III) trustworthiness was obtained by the use of several techniques. The first author's prolonged engagement with participants and research setting, recurrent interviews, the amount of interview data, thick descriptions, and the methodological and interdisciplinary triangulation aimed to increase the credibility of the study. The iterative procedure through comparisons between codes, categories, themes, and the whole empirical texts and digitally recorded interviews further aimed to increase trustworthiness (Graneheim & Lundman, 2004; Lincoln & Guba, 1985). The final results are based on continuous discussions in the research team throughout the analyses and are thus a negotiated outcome.

Reliability and validity are concepts used in quantitative research methodology. According to Dawson & Trapp (2004) validity is the property of a measurement that indicates how well it measures the characteristic and reliability is a measure of the reproducibility of a measurement. In paper IV several symptom instruments were used. Of these some were well-established and used in larger populations of adolescents and across contexts. However, the stress-instrument by Lindblad et al. (2008) is recently developed but used in at least one study with Swedish adolescents.

Results

Young women face multiple and intersecting stressors of modernity, gender orders and youth (Paper I)

The young women's stories highlight the multitude and intersections of stressors in their daily life. The stressors are connected to several vital life spheres such as school and education, the world of work including sick-leave or unemployment, as well as family, peer and partner relationships. Moreover, the stressors stretch from the past, present and into the future. Thus, the explored stressors can be described as multiple, intersecting and cumulative operating in processes over time.

The identified stressors and sub-themes are clustered into "stressors of modernity", "stressors of gender orders" and "stressors of youth". These stressors represent stressors in everyday-life, as well as stressors that can be related to more or less explicit societal discourses (Table 7).

Table 7. Young women facing multiple and intersecting stressors of modernity, gender orders and youth (Paper I)

Stressors of modernity	Stressors of gender orders	Stressors of youth
Striving for effectiveness and rationality	To please and care for others	Stressful transition into adulthood
Pressure on performance and perfection	Being responsible and taking responsibility	Struggle to enter the labour market
Struggle for social status	Unequal demands and duties	Facing negative life events
Possibilities to choose and change	Problematic female body and self	Social exclusion and rejection
	Exposure to oppression and violence	Failing adult and societal support
	Conflicting feminine positions	

Each of the above stressor and sub-theme can be further deepened and explored as the stories were rich and the interview material extensive. For a more thorough presentation of the results see Paper I (Wiklund et al., 2010a).

Vignette Nelly

The vignette below illustrates the intersections between some of the stressors of modernity, gender orders and youth presented in Table 7. Nelly is 25 years and unemployed. She has a vocational education and is looking for work without luck. She finds the situation hard to cope with. Nelly is often stressed and worried:

MW (researcher): What is stress for you?

Nelly: Tomorrow, life ahead, like, what's going to happen with it. Or what you can achieve, how things will look tomorrow, what clothes to wear, who to see. It's a lot of pressure just, what you accomplish. That's the biggest I think. And then I'd get very stressed, when it feels like you have so much to do. You're supposed to be good in every way possible, that's the hardest.

MW: Do you think that you need to be good in every way?

Nelly: Well, it's usually like this, I have to be best at everything really. I have to be best. You compare yourself with others all the time, that's just the way it is. And you want to be good... It's the same as having a job, that you want to get a job based on your qualifications and how you are. And when you don't get one I think you feel very... like you're just not good enough, that I don't have what it takes to get a job. And then you feel a lot of pressure to always be better. I feel that way a lot. Stress for me is the stress to become something, or performance. Actually, I want it to be about me, but right now, I perform for everybody else, to make everyone else happy. You want a job so that you don't have to live at home, so that mom and dad don't have to pay for you the rest of your life. You want to stand on your own two legs, have your own income and such, maybe get an apartment, hopefully. I would also like to be satisfied with how I look. Of course, everyone has something they'd like to change, but you can always like yourself more, more than you do now. Later, in the future you have to be the perfect partner, the perfect mother. Yes, I get stressed out over what I'm supposed to accomplish in general, I've realized that now during this conversation.

Nelly's narration points at intersecting stressors (Table 7). She expresses feelings of "uselessness" and stress attached to unemployment and the lack of the ability to be able to earn a living and to "stand on one's own legs". She is striving to "become something" and feels a pressure to achieve perfectly. She wants to improve her body and looks, as well as her own personality. The gendered stressors are expressed as a wish to please others. In addition, future is a stressor for her.

The stressors of modernity

The stressors of modernity are described by the subthemes “striving for effectiveness and rationality”, “pressure on performance and perfection”, “struggle for social status”, and “possibilities to choose and change”.

Sofia planned for her future life. She felt pressed for time to achieve and live now, because she knew her value was going to decrease when she became “older” and had children:

Yes, but it's a time thing, too, you know, because I've made up my mind to have children when I'm about 30. And after that it's "over" (laughs). I know life doesn't work like that ... But it's this society that makes you think that you have to have gotten a degree or qualification and travelled and all that. Yes, and manage to settle down. It's as if I have to complete all those things.

The stressors of gender orders

The stressors of gendered orders are described by the subthemes “to please and care for others”, “being responsible and taking responsibility”, “unequal demands and duties”, “problematic female body and self”, “exposure to oppression and violence” and “conflicting feminine positions”.

Eva spoke about unequal demands and duties in the family. She had noticed that her brother got more living space whereas she felt pressured by demands and restrictions:

My brother doesn't feel stress like I do. He's much less concerned. He maybe doesn't want to be a part of the family. He would rather to be by himself, do his own thing. My parents accept that he does his own thing. Our parents think that what he does is a little more ok, the limits he sets and such. They just say things like, 'he's just like that'.

The stressors of youth

The stressors of youth are described by the subthemes “stressful transition to adulthood”, “struggle to enter the labour market”, “facing negative life events”, “social exclusion and rejection”, and “failing adult and societal support”.

During youth and in school Johanna had felt deviant in her peer group:

I didn't enjoy school. I mean, it was actually a good school. But I felt like I didn't have any friends, not the friends I wanted. I mean, that's how it is in junior high school, it's always very stereotypical. If you stand out, and I stuck out pretty much so I was 'weird'. And I didn't seem any more 'normal' when I started feeling bad on top of it. So I felt very much like an outsider and very, very weird. Not that they... not that I was bullied. Ok, some of them were down right mean but I didn't feel like I fit in there.

Living close to the edge. Dimensions of distress, distrust and disempowerment (Paper II)

Paper II is illustrating physical, emotional, cognitive, social and existential dimensions of lived embodied stress and “living close to the edge” (Figure 6, Table 8). The main theme of “living close to the edge” can be seen as the phenomenological essence in the young women’s multidimensional experiences of stress in everyday life. The various dimensions of distress, distrust, and disempowerment are seen as both consequences of, and responses to, experienced stressors and constraints of modernity, gender orders and youth as described in Paper I. The sub-categories are displayed as escalating in severity and as approaching “the edge”.

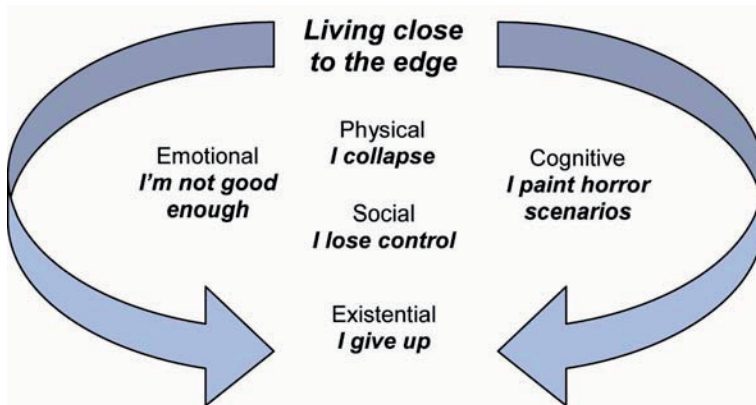


Figure 6. Dimensions of distress, distrust and disempowerment in relation to young women's embodied experiences of stress (Paper II)

The physical dimension contains experiences of restlessness, bodily discomfort and stress-responses such as eating problems, aches and pains, sleeping problems and fatigue. Bodily limitations were emphasized.

The emotional dimension display experiences of frustration and anger, worry, fear and occasionally panic, as well as depressed mood, self-blame and self-harm.

The cognitive dimension highlights reflexivity, problem solving and grinding thoughts, but also the painting of horror scenarios.

The social dimension reveals experiences of imbalance in life, loss of control, and in some cases also social withdrawal and isolation.

The existential dimension embraces experiences of irresolution, uncertainty, doubt and powerlessness, but also existential dilemmas and conflicting values. Feeling of loss of meaning with life, and occasionally suicidal thoughts, were expressed by the young women (Table 8).

Results

In several respects the girls and young women seem to embody the hectic and forced tempo of modern times, including feelings of inferiority and insufficiency connected to social categories of gender, class and youth as further elaborated on in Paper I.

Table 8. Sub-categories, categories, and dimensions of "living close to the edge" ordered as escalating in severity (the most severe at the bottom of the table) (Paper II)

LIVING CLOSE TO THE EDGE					
DIMENSIONS	PHYSICAL DIMENSION	EMOTIONAL DIMENSION	COGNITIVE DIMENSION	SOCIAL DIMENSION	EXISTENTIAL DIMENSION
Categories and sub- categories	Restless and unsettled body Bodily discomfort Restlessness Eating problems	Frustrated self Anger and irritability Frustration Lability	Reflexive self Self-reflexivity Problem- solving	Imbalance in life Strong drive and engagement Difficulties prioritizing	Questioning and doubting life Irresolution, uncertainty, and doubt Value conflicts Existential dilemmas
	Suffering body Aches and pain Problems sleeping Difficulty breathing	Worrying and anxious self Worry, fear, and anxiety Panic	Inattentive self Problems concentrating Learning problems	Chaotic life Loss of control over life Inability to act	Overwhelmed by life Powerlessness
	Collapsing body Physical limitations Tiredness and fatigue Physical exhaustion Collapse	Deflated self Depressed mood Loss of self- worth Self-blame and self- harm	Negative self Negative, grinding thoughts Imagining horror scenarios	Withdrawal from social life Social withdrawal and cutting off Social isolation	Giving up one's existence Loss of meaning in life Thoughts of suicide

Exposure to oppression and violence (Paper III)

So at first it really was a great relationship and he was so kind. But he showed later that he was really jealous after all. Because he went through my mobile phone looking for photos, and accused me of being unfaithful, which was completely absurd. And he tried to keep tabs on me by text messages, email and phone calls, almost a little threatening. I was worried that he would just turn up again, but he didn't, not yet anyway.

Exposure to oppression and violence in the forms of control and threats is in the text above expressed by Moa, 22 year old university student, who had been controlled and threatened by her boy friend. In Paper III, two other girls, Charlotte and Anna, provide a narrative about their experiences of partner violence in heterosexual relationships and its severe consequences (Wiklund, Malmgren-Olsson, Bengs, & Öhman, 2010b). The analysis highlights the young women's painful experiences, their reactions and actions, agency and coping, in chronologically ordered sequences during their transition from adolescence to young adulthood (Figure 7). Gender-related partner violence is explored and explained as a possible gendered stressor for adolescent girls and young women - a gendered stressor which may contribute to various forms of stress-related problems or ill-health, and in some cases also posttraumatic stress disorder (PTSD).

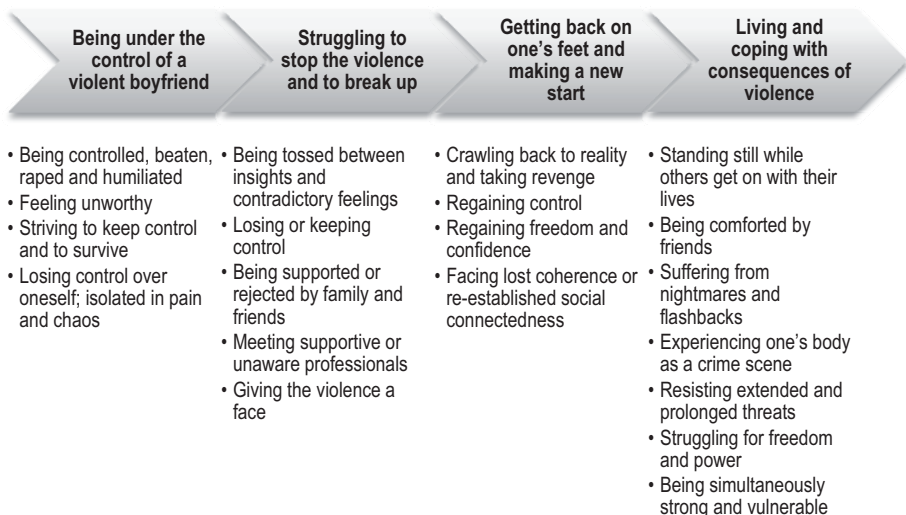


Figure 7. Temporally ordered sequences with sub-themes describing experiences and consequences of living in a violent partner relationship

Multiple young femininities (Paper I-III)

In conclusion, the young women in the interview study can be viewed as “multiple and young femininities” in relation to their experiences of stress (Figure 8). The femininities emerge from the sub-themes which were linked to the stressors of youth, modernity and gendered orders (Paper I). The multiple femininities mirror diverse feminine social positions and strategies and illustrate the multitude of ways the young women perceived, performed, handled, and understood their stressful life situations. They highlight young women’s agency. Furthermore, the femininities make clear that the young women’s lived, performed, and communicated experiences take place in a social context. Moreover, they relate to the research question about what it is like to be a young girl or women today.

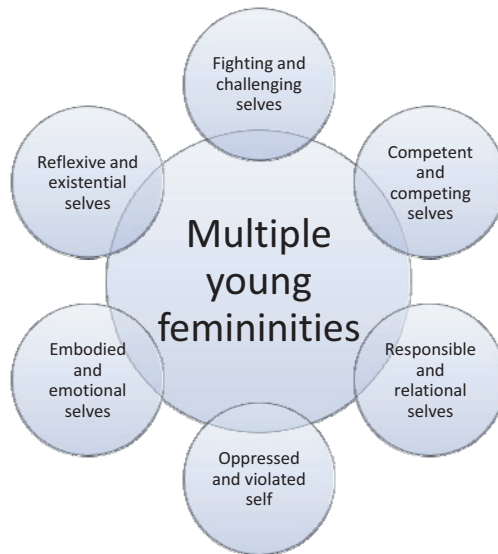


Figure 8. Multiple young femininities in relation to experiences of stress (Papers I-III)

The young femininities are viewed as dynamic and changeable social positions and strategies. Consequently, the same individual may be represented in more than one aspect of femininities. Thus, stressful conflicts, dilemmas and tensions emerged. Conflicting and contradicting experiences resulting in experiences of distress were seen as ambivalence, sometimes seen as frustration, doubt, or insecurity. Furthermore the described conflicting norms were internalised and embodied (Paper II). Norm conflicts took place within the individuals; between individuals and their immediate social surrounding; or between the individuals and the societal discourses. Several of the young women presented themselves as

“challenging and fighting selves” which furthermore promote their agency. They wanted to make a difference in the world and they challenged given norms and orders, whereas others were resigned or deflated “oppressed selves” (Paper III).

Gender differences in perceived stress and subjective health (Paper IV)

Group sociodemographics

The majority of adolescents who participated in the school-survey were 16 or 17 years old (median 16 years). Most of them lived with their family and were born in Sweden. Group socio-demographics are described in Table 9.

Table 9. Group socio-demographic variables in the school-survey

Socio-demographic variables	Total, n (%)	Girls, n (%)	Boys, n (%)
Sex	1027	(60.7)	(39.3)
Age			
16 years	567 (54.7)	(59.6)	(40.4)
17 years	425 (41.7)	(61.6)	(38.4)
18 years	39 (3.8)	(64.1)	(35.9)
Study program			
Theoretical program	774 (75.8)	478 (46.8)	296 (29.0)
Vocational program	247 (24.2)	139 (13.6)	108 (10.6)
Family situation			
Living with both parents	639 (62.2)		
Living with only one parent	142 (13.8)		
Other family combination	208 (20.2)		
Living alone	39 (3.8)		
Country of birth			
Sweden	968 (95.5)		
Other Nordic country	5 (0.5)		
Europe or North America	12 (1.2)		
Outside Europe or North America	29 (2.4)		

The hierarchal mixed model analysis

According to the hierarchal mixed model analysis factors at the individual level explained 96% to 100% of the total variability in the outcome indexes on perceived stress and reported subjective health complaints. Significant differences between boys’ and girls’ reports remained in all outcome indexes even after calculating the proportion of variability at individual, school, and school class levels.

Perceived stress

In all stress variables significantly more girls than boys reported perceived stress, both in the forms of pressure and demands and in the form of activation/activity (Table 10). A majority of adolescents reported that they felt pressure from school demands. Inner demands were common, and reported by three third of the girls and less than half of the boys. Demands from home were less pronounced.

Table 10. Prevalence (%) of often/always perceived stress expressed as pressure and demands, activation/activity and sleep problems during the previous weeks

Perceived Stress variables	Girls (%)	Boys (%)	p-value
Pressure and demands			
I don't have enough time	54.0	36.1	<0.001
I feel under pressure from school demands	86.7	59.6	<0.001
I feel helpless	19.2	5.6	<0.001
I never feel really free	73.4	49.0	<0.001
I feel under pressure from demands at home	20.6	13.8	0.01
I feel under pressure from my inner demands	75.4	41.9	<0.001
I don't feel rested after sleep	70.5	51.9	<0.001
Activation/activity			
I rush even if I don't have to	47.2	14.6	<0.001
I keep a high speed all the day	40.5	18.2	<0.001
I eat rapidly even if I don't have to	55.2	42.6	0.001
I do many things at the same time	80.2	52.7	<0.001
I find it difficult to relax	54.9	19.8	<0.001
Sleep problems			
I sleep restlessly and shallowly	19.6	6.9	<0.001
I have difficulty falling asleep	41.1	29.6	0.001
I wake up early in the morning	13.6	7.7	0.006
I feel restless	42.7	30.5	0.005

Subjective health complaints

Being tired was the most common complaint among both boys and girls, followed by being sad for girls and cold symptoms for boys. Headache, neck- and shoulder pain and low back pain were the most common ache- and pain problems (Table 11). In general, the symptom reporting was significantly higher among girls, two to three times more girls than boys.

Anxiety and depression

Overall, the adolescents scored higher on the HADS-anxiety scale than on the HADS-depression scale (Table 12). Girls scored significantly higher on the anxiety scale than boys, whereas differences in depression were non-significant. Over fifty percent of the girls scored as “possible” or “probable” anxiety in comparison to thirty percent of the boys. On the depression scale, one fourth of the adolescents scored within possible or probable depression.

Results

Table 11. Prevalence (%) of “fairly often/very often” subjective health complaints (%) in the last 6 months in adolescents

Subjective health complaint variables	Girls (%)	Boys (%)	p-value
Psychosomatic symptoms			
More tired than before	60.8	29.8	<0.001
Sadness	54.8	10.8	<0.001
Acid stomach, stomach ache	19.7	3.3	<0.001
Pain and aches in heart and chest	12.1	6.9	0.01
Palpitations and extra heart beats	7.4	4.1	0.04
Symptoms of upper respiratory infection			
Headache	49.3	15.4	<0.001
Cold symptoms	39.7	18.5	<0.001
Cough and hoarseness	15.8	7.3	<0.001
Nausea	21.1	3.0	<0.001
Musculoskeletal symptoms			
Neck and shoulder pain	46.3	14.0	<0.001
Low back pain	31.6	18.0	<0.001
Pain in extremity joints	16.4	12.2	0.1
Muscle pain	13.4	10.6	0.2
General health*			
Overall good health	79.5	87.8	0.001
Medication*			
Antidepressants or sedatives (yes)	4.7	3.5	0.3
Non-prescription painkillers, every week	17.9	7.2	0.001

*Not included in the factor analysis

Table 12. Prevalence (%) of self-reported problems with anxiety and depression according to the Hospital Anxiety and Depression Scale (mean, SD) in adolescents

HADS	Girls (%)	Boys (%)	p-value
HADS-anxiety			0.001
Total score (mean, SD)	8.5±3.8	5.8±3.3	
<i>Severity (score range)</i>			
No/normal (1-7 points) (%)	41.5	70.1	
Possible (8-10 points) (%)	31.5	21.1	
Probable (11-21 points) (%)	27.0	8.7	
HADS-depression			0.19
Total score (mean, SD)	4.1±3.0	3.5±2.7	
<i>Severity (score range)</i>			
No/normal (1-7 points) (%)	85.9	89.6	
Possible (8-10 points) (%)	10.0	7.9	
Probable (11-21 points) (%)	4.1	2.5	

Perceived stress correlates with subjective health complaints and anxiety

Perceived stress correlated significantly with subjective health complaints and anxiety (Table 13). The strongest correlations were found between perceived stress in the form of “pressure and demands” and anxiety ($r=0.71$) and between the so-called psychosomatic complaints and anxiety ($r=0.71$). Moreover, pressure and demands were significantly correlated with activation/activity ($r=0.68$), sleep problems ($r=0.48$) and musculoskeletal problems ($r=0.44$). All correlations were significant at $p \leq 0.001$.

Table 13. Correlations between factors of pressures and demands, activation/activity, sleep, subjective health complaints, anxiety and depression

Factors	Pressure and demands	Activation/activity	Sleep	Psychosomatic	Upper respiratory infections	Musculoskeletal	HADS-anxiety	HADS-depression
Pressure and demands	1	0.68	0.48	0.63	0.48	0.44	0.71	0.52
Activation/activity	0.68	1	0.50	0.55	0.44	0.39	0.66	0.39
Sleep problems	0.48	0.50	1	0.56	0.41	0.44	0.53	0.39
Psychosomatic	0.63	0.55	0.56	1	0.58	0.55	0.71	0.49
Upper respiratory infections	0.48	0.44	0.41	0.58	1	0.51	0.52	0.35
Musculoskeletal symptoms	0.44	0.39	0.44	0.55	0.51	1	0.45	0.30
HADS-anxiety	0.71	0.66	0.53	0.71	0.52	0.45	1	0.56
HADS-depression	0.52	0.39	0.39	0.49	0.35	0.30	0.56	1

All correlations were significant at $p \leq 0.001$

Discussion

According to the results of the interviews, young women are facing multiple and intersecting stressors of modernity, gender orders and being young, which correspond to their multidimensional experiences of 'living close to the edge' (Papers I-III). Certain crucial aspects of findings from the qualitative study are also mirrored in the findings from the larger group of adolescents in the school survey (Paper IV), where a high proportion of older adolescents, particularly girls, reported perceptions of stress. Moreover, perceived stress in the form of pressure, excessive demands and a high activity correlated to a variety of subjective health complaints and anxiety. The presented results can be understood and explained from a variety of perspectives. In the following section, the interdisciplinary synthesis of perspectives sketched in the theoretical framework will be used to discuss some aspects of the results. Further elaboration on the more specific results can be found in the respective papers (I-IV).

As mentioned earlier, I found the agency-structure relationship to be a useful starting point for the problematisation of the results in the thesis. A conceptual framework has been developed (Figure 9), which is a schematic illustration of the dialectic agency-structure relationship between discursive, gendered and embodied stress in modern youth. As used in the model (Figure 9), the structure-agency relationship addresses the individual micro-level of individual embodied experiences, reflexivity and actions, the societal macro-level of discourses and structures, and the meso-level of social processes at group and institutional levels. Individuals' agency can be viewed as a mediator between these levels and is, in the model, illustrated by the processes of doing both gender and stress.

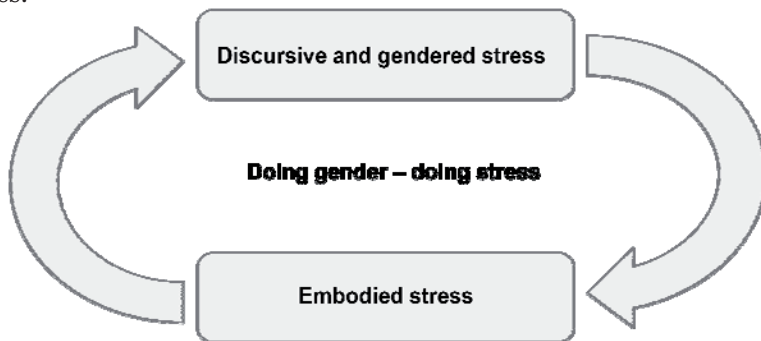


Figure 9. A conceptual framework of the structure-agency relationship between discursive, gendered and embodied stress.

Doing gender – doing stress

Results from the qualitative interview study suggested that the creation and practices of gender in several essential domains of life are interconnected with experiences of stress and distress. The concept of ‘doing gender’ can, together with the concept of ‘doing health’ (or, as in the conceptual model, ‘doing stress’), explain such reciprocal processes in which gender and health are intrinsically linked (Saltonstall, 1993; West & Zimmerman, 1987). Stress and health are here viewed as interactive processes, rather than as fixed states connected to gender. Consequently, the processes of doing health and stress are viewed as closely interlinked with social constructions of gender and power (Annandale, 2009; Courtenay, 2000). Therefore, the ‘doing of gender’ as several and diverse femininities is crucial to consider in the problematisation of ‘the doing’ of subjective (ill-) health and stress, as well as in discussions of empowering processes. By the use of these terms throughout the discussion, an emphasis will be put on the complex and dialectic processes in opposition to fixed states. The concept of femininity will serve as the focus of this section, as the bulk of this thesis concerns the experiences of young women. The processes appear to occur both as intra-individual and psycho-physiological processes, as inter-individual relationships between individuals, and as processes between the individual and societal structures and discourses. Thus, the inevitable relationships between individual agency and societal structures will also be discussed.

In addition to solely biomedical views on stress and health, young women’s and adolescents’ stress can be understood as a social phenomenon, as a context-bound process and social construction of contemporary society (Johannisson, 2006). As highlighted in Paper I, late modern discourses of individualism and ‘healthism’, including the great focus on body and self, may serve as examples of such social processes and constructions in contemporary Western society. From a phenomenological viewpoint, as presented in Paper II, these social constructions can be understood as ‘lived embodied experiences’ of discourses and conditions in present-day society. In addition, this section will consider gender and health as social processes, which emphasise individual reflexivity and agency.

In the results from the interview study, multiple young femininities emerged (see p. 53). These can be seen as a multitude of social and feminine positions, taken in relation to their experiences of stress and stressful life-situations. The multitude of young femininities also corresponds to societal discourses of modernity, gender orders and youth.

For instance, the individualistic discourse is reflected in the ‘competent and competing self’; the hierarchical gender orders in ‘the oppressed and violated self’; and the gendered healthism discourse is reflected in the ‘problematic female body and self’.

The school survey results pointed to similar processes of doing gender, where girls perceived high pressure in school, which correlated with stress symptoms and health complaints. Boys reported less perceived pressures and symptoms, which may indicate the creation of a form of masculinity, either because boys are expected to construct and perceive themselves as strong, and less emotional and vulnerable, or because boys actually perceive and/or have less pressure and demands on them. This can be contrasted to the prominent theme of girls who are constructed as ‘responsible selves’ and who are subject to ‘unequal demands and duties’ (see Paper I). In a youth context, Maclean, Sweeting and Hunt (2010) have highlighted stereotypical views of femininity and masculinity in connection to young people’s self-reports of subjective health in health surveys. They explored “whether symptom reporting is influenced by perceived societal gender- and age-related expectations and the social context of symptom experiences” (p. 1), which are aspects vital to consider in relation to the results. In the school survey, social constructions of femininity and masculinity may require addressing the problematisation of chosen measures, and for the interpretation of the results. According to Maclean et al. (2010), boys may report health problems in accordance with expectations and constructions of masculinity. They have argued that this implies that boys may underestimate psychological problems, whereas girls’ symptom-reporting is more complex. Maclean et al. (2010) have emphasised that they do not believe that young women overestimate their problems, which is a conclusion often drawn from the reasoning about differences in symptom reporting.

The impression from the current interview study was rather that the young women’s problems were signs of severe stress-related ill-health, and that these have to be taken seriously both now and in the long term. An additional viewpoint that can be linked to the results was raised by Hagquist (2010), who pointed to the fact that several surveys of adolescent health primarily focused on internalising problems which are more common among girls, whereas externalising problems are more common among boys, and not commonly measured in health surveys. Likewise, Johansson, Brunnberg & Eriksson (2007) analysed Swedish adolescents’ perceptions of mental health and observed that girls were viewed as more talkative and emotional, whereas boys were viewed as

more introverted, silent and tough. On the other hand, a study of young British masculinities observed that boys reflected about their experiences when they were given the opportunities (Frosh et al., 2002). Hence the questions of gender- and context-sensitive measurements and interpretations of results are important to consider.

Embodied stress and subjective health

However, stress and health should not only be understood as social constructions and phenomena, but also as biological, psycho-physiological and material entities (see *Theorising the body*). Materiality and ‘the physical body’, therefore, need to be addressed in the context of youth health, in parallel to the social aspects. The main theme ‘close to the edge’ that runs through this thesis asserts that there are physical and physiological limits and limitations. The young women in Paper II expressed that they were living close to their limits of their capacity, and the adolescents in Paper IV reported being highly symptomatic. The physical body was, in the interviews, expressed as *one* factor that sets limits, reflected in the sub-category ‘collapsing body’. These physical and physiological limitations among young women can be understood not only in the light of the physical body’s adaptability in stressful situations, but also of processes of allostatic overload and development of stress-related diseases (Arnetz & Ekman, 2006; McEwen, 1998, 2007). See also Papers II and IV for an elaborated discussion about negative stress development.

Stress and pain: the suffering body-self

The results from the school survey (Paper IV) showed that a high proportion of adolescents (mostly girls) reported frequent aches and pains. Aches and pains occurred most commonly in form of headaches (49 per cent of girls, 15 per cent of boys), lower back pain (31.6 of girls, 18 per cent of boys) and neck and/or shoulder pain (46 per cent of girls, 14 per cent of boys). This can be compared to another Swedish study of 13 to 18-year-olds, where the most common weekly pain was headache in girls (42 percent), muscle pain in boys (32 per cent), and thereafter back pain in both girls (24 per cent) and boys (20 per cent) (Fichtel & Larsson, 2002). Recurrent, long-lasting aches and pains are common, self-reported subjective health complaints among children and adolescents both in Sweden and internationally, and have been occasionally defined as being psychosomatic in character (Alfvén, 1993; Alfven, Östberg, & Hjern, 2008; Hjern et al., 2008). Such aches and pains are often recurrent and multiple, which implies several pain locations (Perquin, Hazebroek-Kampschreur, Hunfeld, Bohnen, van Suijlekom-Smit,

Passchier et al., 2000; Petersen, Brulin & Bergström, 2006). Thus, recurrent pain in children and youth may be viewed as a part of a 'pain syndrome' rather than as a single symptom (Petersen et al., 2006). This is also in line with our results, which indicated that ache and pain among adolescents may be viewed as part of a condition characterised by perceived pressure, high activity and physiological arousal and/or exhaustion, rather than single pain symptoms. Moreover, the results from the interview study revealed aches and pains as a part of the young women's experience of stress and distress. Aches and pains were, in Paper II, interpreted as one aspect of young women's 'suffering body' linked to the main theme of 'living close to the edge'.

Stress and anxiety: the worrying and anxious body-self

Results showed that anxiety was prominent in young women's stories about experiences of stress, in Paper II referred to as the 'worrying and anxious self'. Moreover, anxiety was reported by a high proportion of adolescents in the school survey, particularly girls. Approximately one-third of the adolescents in the school survey scored as having 'possible' or 'probable' anxiety, according to the HADS (Hospital Anxiety and Depression Scale). Furthermore, anxiety correlated with perceived stress in the forms of pressures and demands and high activity and tempo, as well as with other common health complaints (Paper IV). Similarly, the Swedish Public Health Report (National Board of Health and Welfare, 2009) has revealed increasing rates of anxiety, worry and anguish in adolescent girls aged 16-19 years. In 2007, 11.9 per cent of boys and 31.1 per cent of girls (aged 16-24 years) reported anxiety symptoms (Statistics Sweden, 2007). Another population-based Swedish study found a higher prevalence of anxiety and depression among 18 to 24-year-olds than in older people, and almost 50 per cent of young women reported that they were moderately or extremely anxious or depressed (Molarius, Berglund, Eriksson, Eriksson, Linden-Bostrom, Nordstrom et al., 2009). This can be compared to nearly 60 per cent of the girls in Paper IV, who reported anxiety.

Pressure and demands in school and education

Results from the school survey (Paper IV) showed that a majority of the adolescents perceived stress in the form of pressure and excessive demands at school, and these were associated with various subjective health complaints and anxiety. Also, results from other studies have indicated that high demands in school are associated with subjective health complaints, particularly in girls (Eriksson & Sellström, 2010; Gillander Gådin, 2000). Moreover, the interview study (Paper I) suggested that high demands were connected to pressures to achieve

perfection at school, as well as to stressors connected to social exclusion among peers. Such stressful experiences occasionally converged with experiences of failing social support from adults in school or at home, and with feelings of ‘managing alone’ or recollections of ‘crying on the toilet’ (Paper I). Thus, both the social environment in school and pressure and demands related to school work, must be regarded as important for young people’s positive or negative health development (Alfven et al., 2008; Gillander Gådin, 2000; Gillander Gådin & Hammarstrom, 2003; Hjern et al., 2008; Modin, Östberg, Toivanen, & Sundell, 2010; Östberg, 2003; Östberg & Modin, 2008). A recent study indicated that a high degree of control, but also social support, may buffer and protect against high demands in school (Modin et al., 2010). Gillander, Gådin & Hammarström (2000) have suggested that increased support to girls from teachers may be beneficial for their health and unburden those girls with too much responsibility. They have furthermore argued that school health promotion needs to address asymmetric power relations between pupils, gender inequality, and also challenge existing gender regimes at an institutional level in schools. In addition, a strong ‘sense of coherence’ has been found to promote school children’s wellbeing (Modin et al., 2010). It is noteworthy that, among the young women in the interview study, there were university students and students in adult education, who also spoke about high demands being accompanied by their own, self-inflicted pressure to perform well.

Converging and correlated stress

The overall results from the qualitative interviews and the school survey illustrated how a wide range of the experienced discomforts and reported symptoms were interconnected and often occurred simultaneously. Perceived stress was significantly correlated with various subjective health and stress symptoms; and these symptoms also correlated with each other (Paper IV). A similar picture occurred in analysis of the interviews, where stressful situations and embodied experiences of stress were connected in the stories of the young women (Paper I-III).

The overall results in this thesis indicated that several of these symptoms converged and co-occurred as part of a condition related to perceived stress and strain, and thus need to be studied as complex interplays in relation to contextual stress factors and social support. Moreover, the converging experiences of distress, as illuminated in the interview study, were described and interpreted as contributing to ‘vicious circles’ of symptoms and dimensions of distress, distrust and disempowerment. For instance, aches and pains were described as both consequences and causes of stress. Hence, the overall results support ideas about the dialectic circular interrelations between stress responses

and stressors, reactions and actions or coping, as defined by Lazarus and Folkman (1984). The study results further point to the importance of also contextualising single symptoms, and of studying these in relation to other physical bio-psycho-social health symptoms as a 'condition' of, for example, stress, pressures and demands. However, many health surveys measure symptoms such as aches and pains, sleeping disturbances, eating difficulties, anxiety or depression as single symptoms or single health problems, instead of measuring these interwoven patterns. In addition, individuals' resources and appraised ability to cope have also to be taken into consideration.

Throughout this thesis, several terms and concepts are used which more or less can be linked to young people's perceived problems along 'a continuum of bio-psycho-social distress'. By the use of a sliding scale, and a wide definition of young people's stress and health problems, the full spectrum of self-narrated descriptions and self-reports can be included; from ordinary and temporary sensations and reactions to more complex, complicated and longstanding problems. In this way, expressions of health, illness and disease are all included. Nevertheless, the diversity in the use of terminology also mirrors the wide research field with its often discrepant definitions, as well as its wide definitions of stress and health, including the broad inclusion criteria of the studies in this thesis.

In the research literature, several overlapping terms are used to describe children's and young people's perceived health, of which several concern the borderlines between *somatic*, *psychosomatic*, *mental* and *social* health, illness and disease. Likewise, the strong correlations between physical and psychological health complaints found in Paper IV were congruent with the multidimensional experiences illuminated in Paper II. These findings furthermore supported the idea about the value of an interdisciplinary framework in the analyses of these problems along a continuum of bio-psycho-social distress.

The existential dimension of stress; the existential self

An additional perspective on stress in youth, which emerged through the phenomenological approach in the analysis of lived and embodied experiences of distress, was the existential dimension, which included aspects of reflexivity around life-meaning and overwhelming experiences of powerlessness (see Paper III). Such existential dimensions have seldom been explored in health surveys or addressed in stress research. The existential aspects of loss of control and life-meaning related to high strain and overwhelming distress are also crucial to consider in relation to suicidal thoughts among young people.

Discursive and gendered stress

Young people seem to be growing up in a complex time of competing pressures and demands (Furlong, 2009; Harris, 2004a; Sanders & Munford, 2008; Walkerdine et al., 2001). These observations are supported by the results in this thesis, particularly as interpreted in Paper I. Youth and young adulthood are, in contemporary Western societies, described and constructed in various ways: as periods of 'stress and storm', uncertainty and risk, or of individual choices, development and possibilities (Arnett, 1999; Furlong & Cartmel, 1997; Giddens, 1991; Harris, 2004a). According to Harris (2004a), young people are expected to create their own chances and make the best of their own lives in a contemporary context of economic rationalism and competitive individualism. Moreover, young women are either constructed as successful 'can-do' girls or 'at-risk' girls on the decline (Harris, 2004a). Thus, individual freedom and autonomy are emphasised (Giddens, 1990, 1991), as well as individual responsibilities (Harris, 2004a). However, the most dominant descriptions of late or high modernity made by, for instance, Giddens (1990, 1991) and by Beck (1992) have also been the subjects of criticism and debate. Several researchers have pointed to the need for problematisation and integration of perspectives on gender and power within these dominating social theories (Harris, 2004b; McRobbie, 2009; Mulinari & Sandell, 2009; Petersen & Lupton, 1996; Rose, 1999; Skeggs, 2004). Aspects of gender and power will therefore be addressed in the following interpretation and discussion of the results. Furthermore, the results of this study point to the discursive and gendered aspects of stress in youth, which seem to contribute to pressure and demands, as well as scarce recognition of effort made. The most prominent contemporary discourses reflected in the results are individualism, healthism and neo-liberalism, discourses that are discussed in the following section as being strongly gendered.

Gendered modernity – gendered individualism

Results in Paper I revealed several discourses of modernity, where the individualistic discourse was prominent beside the healthism discourse. Both these discourses were, as interpreted in Paper I, gendered and accompanied by the social constructions of gender and gender orders.

The young women in this study emphasised that it was important to achieve and to develop. They struggled for social acceptance and a sense of personal value. The creation and making of the self was done in relation to body, appearance, style, social relationships and achievements. This need for individuals to be self-inventing, 'to make a self' and create a

‘subject of value’ has been defined as a modern Western characteristic and as a marker for individualism (Skeggs, 2004). Moreover, Skeggs has emphasised the body and looks as part of the making of a ‘respectable self’ and a normative femininity. Young women’s work on their body and self can also be seen as ‘unfinished projects’, a phenomenon often associated with modernity and gender (Shilling, 1993), and which seems to cause distress, as well as gendered ill-health. Similarly, Frost (2001) has highlighted young women’s bodily disgust and body hatred as a part of the struggle to achieve social acceptance through ‘corporeal capital’. For the young women in this study, the making of a perfect self and a perfect body implied great self-control through the control of weight and food-intake, as well as physical exercise. ‘Bad’ habits followed by feelings of guilt and a sense of being a ‘bad person’ being ‘fat and ugly’. Their self-blame can be viewed as forms of self-regulation and self-control.

New-old gender orders within modernity

Tensions and contradictions around girls and women’s empowerment and/or subordination were articulated in the young women’s stories and reflections (Paper I). Several of them were aware of, and articulated, the Swedish feminist discourse of equal opportunities between the sexes, but also the corresponding resistance they felt towards young women’s progress in their daily lives. Harris (2004a) and McRobbie (2009) have problematised such subordinating gender orders which correspond to ideas and discourses within post-feminism and neoliberalism in the context of modern Western societies and youth culture. McRobbie has pointed to the feminine individualisation, or feminised individualism in the aftermath of feminism. McRobbie (2009) has also argued that new constellations and constraining forms of gender power – a re-shaping of gender inequities – have emerged within female individualism. Accordingly, young women’s subordination remains ‘equivocal and substantial’, and new ‘sexual contracts’ are produced.

Moreover, McRobbie (2009) has identified the contemporary socio-political ‘violence of regulatory norms’ of young women’s production of self, mediated through images of femininity; ‘what it is to be a woman’ in the media and popular culture – an ideal which includes body and appearance, but also high achievements. This ideal, in turn, contributes to the social production of sexual difference and the belief that young women’s bodies are somehow lacking and insufficient in certain respects, thereby promoting anxiety and low self-esteem. Young women’s compliance to such regulatory norms of femininity can turn into ‘self-violence’ and normalisation of ‘female pathologies’ such as bodily discontent, distress, self-starvation and self-harm. McRobbie (2009) has made a persuasive argument that there seems to be a context-bound

‘feminine pathology’, or a set of ‘post-feminist disorders’, which can be labelled as ‘healthy signs of unhealthy femininity’, which risk becoming normalised in a socio-political context of competitive individualism and feminine individualisation. Alternative forms for doing gender must be encouraged or, as one of the interviewed women said, “girls lack healthy role-models”.

Competing versus caring selves

The interview results point at several competing discourses, which were lived, embodied and performed in various ways. The adolescent girls and young women embodied the inner and outer tensions and conflicts that were present in their immediate surroundings, as well as in contemporary Western society as a whole. The tensions between value-ground and practices of ‘competing and caring’ are one such example. The young women wanted, or felt pressured, to both care about others and to compete with others in parallel arenas in life. They took up and performed both the traditional masculine norms of competition in public life and the traditionally feminine norms of caring in domestic settings (Connell, 1987, 2002, 2005). Their struggle to both care and compete contributed to a heavy burden of contradictory demands, and was an internalisation and embodiment of classed and gendered value conflicts in contemporary society (Skeggs, 1997, 2004). The uneven distribution of gendered power is reflected, for example, in salaries and low status of the caring and nurturing versus competing sectors in Swedish society (Isaksen Widing, 1992; World Economic Forum, 2009). In line with these facts, their stories displayed the young women’s awareness of the low status of caring duties in work life, parallel to their own personal ideologies of solidarity and caring for others. Simultaneously, several emphasised the wish to be ‘at the top’ in their private, educational and working lives.

Subjective social status and the creation of a ‘subject of value’

In the analysis connected to the stressors of modernity, the interviews revealed that the respondents believed it was important to create a ‘successful self’. The young women’s strong focus on perfect performances in all arenas in life can be interpreted as the modern individual’s ‘making of a self’. However, the creation of a strong and successful self does not occur within a social vacuum. From a social constructionist perspective, this creation of a self is an ongoing and context-bound process, also attached to the doing of gender and class (Connell, 2002; Skeggs, 1997, 2004). The young women’s struggle for social acceptance and status, as well as their efforts to maintain or change their social class, can be seen in the light of such social processes. The making of a modern self is thus

accompanied by restrictions and barriers to success; for the individual girl who interprets a failure to advance as a purely personal failing, it can cause stress, distress, as well as feelings of distrust and disempowerment. In addition, Harris (2004a) has stressed the fact that success is only available for a minority of girls, although the societal discourses of 'girl-power' and 'success-girls' convey the opposite. From a similar standpoint, McRobbie (2009) has suggested the need for more social studies on how girls and young women actually progress in life. This also corresponds to other studies which indicate 'bounded agency' among youth (Evans, 2007; Furlong, 2009; Furlong & Cartmel, 1997; Gordon et al., 2008; Gordon & Lahelma, 2002).

In the stories of the young women, *perception of low social status* was a prominent theme. The sub-theme of *the struggle for social status* was related to their experiences of stress, distress and imperfection, and illustrated the young women's hard work to improve and to create a higher social value. The young women's perceptions of low social status can be problematised in relation to social categories such as age, gender and class, as well as to contemporary individualistic discourses such as neoliberalism, post-feminism and healthism (see also Paper I). Consequently, they were striving for social status and acceptance in several parallel arenas in life. They worked hard to 'become someone' or 'something', and were well aware of the presence of social ranking in different social contexts: in the peer group, in partner relationships, in school or in the labour market. They were also well aware of their social status as female 'bodies'. If they did not succeed or perform well, eat in a controlled way or control their weight, they perceived it as a personal failure. In addition, they described feelings of low self-worth. In line with the present results, several studies have shown associations between subjective social status and health (Demakakos, Nazroo, Breeze, & Marmot, 2008). Moreover, perceptions of social inferiority and emotions of social shame are related, and also classed (Dahlgren & Starrin, 2004).

Dahlgren and Starrin (2004) have argued with the findings of Sennett (1980), and have stated that subordinated individuals can be disciplined and 'shamed' in more subtle ways by those who are viewed as superior in a society. Hence, the creation of social inferiority and shaming of fellow humans are powerful 'social weapons' of the modern age, which have replaced other, more explicit forms of social punishments (Neckel, 1996). Feelings of social inferiority and shame are, in such a social climate of individualism, perceived as signs of one's own failure. From this perspective, those who are superior also 'have class' (Dahlgren & Starrin, 2004), and others, such as those seen in the results of this thesis, struggle

to either ‘maintain class’ or to leave one’s (working) class origin, and thus struggle to enter a new class and achieve a higher social value (Paper I).

Based on the results of this study, the social categories of age and gender seem likely to reinforce such perceptions of social inferiority and distress among young women in today’s society. Traditional gender hierarchies and orders place girls and women in subordinate positions. According to McRobbie (2009), amongst others, these ‘old’ gender orders seem to be reproduced within post-feministic Western society, alongside ‘old-new’ forms of gender relations. Masculine domination and superiority, and feminine subordination, are expressed in more subtle forms. Young women, therefore, must control themselves on their way to success.

Stress in socio-political landscapes

Discourses of gendered individualism, individualised femininity, and healthism can all be referred to and discussed in relation to the overarching societal and political processes of ‘neoliberalisation’. For an extended description of neoliberalisation see for example Brenner & Theodore (2005). Scholars within such fields as economics, sociology, gender and cultural studies consider political discourses as important for contemporary developments, individuals’ health, lifestyles and identity-making (Baum, 2008; McRobbie, 2009; Petersen & Lupton, 1996; Rose, 1999; Skeggs, 2004). Also the results in Paper I can be understood as mirroring a development of ‘gendered neoliberalisation’, a reproduction within modern discourses, or a reshaping of gender orders reflecting contemporary socio-political landscapes. This implies that young women’s negative experiences of excessive demands and pressure, including the resulting negative health consequences, must be discussed on a socio-political level. If neoliberalisation is also regarded as ‘gendered’, this must lead to debates about how gender equality is established in new political systems, and in times of political transition. In times of political transformation, ‘new’ gender equality questions have to be identified and raised. Accordingly, the higher degree of self-rated illness or sickness among adolescent girls and young women must be discussed in relation to the context of ‘gendered neoliberalisation’ in Swedish society. In Britain and Australia, the influence of political ideologies, and more specifically neoliberalism, are discussed in relation to the field of public health (Baum, 2008; Petersen & Lupton, 1996).

Public health relevance

In sum the results of this thesis have raised several issues, which are of relevance to public health:

- The multiple and intersecting stressors which young and healthy people seem to face in their everyday lives (Papers I, IV).
- The high proportion of older adolescents who report stress-related symptoms, subjective- and mental health complaints such as aches, pains, or anxiety (Paper IV).
- The individual suffering and complexity of experiences of stress and subjective- and mental health problems in youth, including processes of distress, distrust and disempowerment illuminated among young women suffering from distress (Papers II, IV).
- The age- and gender-related gap in subjective health and perceived stress among adolescents and young adults (Papers I-IV).
- The severe consequences of gender-related subordination, oppression and violence for adolescent girls in partner relationships (Paper III).
- The specific health discourses and ‘ideal’ images produced within public health which may contribute to negative relations to body, self and food intake, particularly among girls and young women (Paper I).

The following section will examine aspects of the individualised and gendered healthism discourses which may be of relevance to the problematisation of public health, the continuum of subordination and violence, and processes of (dis-)empowerment among young people. These are further examined in Papers I-IV. The use of theory integration in public health sciences will also be briefly looked at.

Gendered healthism

Healthism is identified as an individual-centered health discourse which emphasise individuals’ responsibility for health (Crawford, 1980; Petersen & Lupton, 1996). Healthism is also present in the lives of young people and for instance seen in their strive for fitness and healthy looks (Wright et al., 2006). Moreover, healthism is viewed as contributing to the medicalisation of everyday life (Crawford, 1980). Paper I discussed young women’s taking-up of such individualised societal discourses on

body and health linked to healthism. Also within public health policies and strategies, Petersen and Lupton (1996) identified social constructions of ideal women as 'healthy citizens' who are responsible and caring, but also physically attractive, sound and slim. The concept of a youthful and attractive body is, accordingly, a gendered health ideal within public health discourses.

The 'problematic' young women

The problematic feminine body and self were a prominent theme in the results from the interviews with young women (Paper I). It is, therefore, essential to address social constructions of gender in the problematisation of stress and health, and of health discourses in society. Ambjörnsson (2004) has described the prevailing perception of girls and women's physicality as 'problematic' and as a part of the socialisation of girls – an idea that also Annandale (2009) has expressed. The consequent social construction of girls and women as 'weak' and problematic throughout Western history has been problematised by Annandale (2009), but also by Frih (2007) in a Swedish context. These social constructions can be viewed as expressions of symbolic power in society which is holding down young women. Similarly, the individualistic healthism discourse, as well as the commercial parts of the self-help movement, reflect social constructions of young women as 'problematic' who are in constant need of improvement. Within these discourses social constructions of young women as problematic may be produced and reproduced. The body can, in these processes, be seen as the bearer of cultural and sexual symbols of societal norms and values, which also implies the embodiment and 'taking up' of contextual influences. On the other hand, according to Connell (2005), individuals do not just passively absorb outer stimuli, but are also active agents in relation to the context in which they exist (Figure 9). Similarly, Annandale (2009) has argued that human bodies should not be seen merely as 'coat racks' for social and gendered processes, which is a standpoint that stresses individual agency.

So, parallel to the important efforts to acknowledge the health problems and health consequences of social constructions of gender, a dilemma is raised concerning the construction of girls and women as weak, fragile, more sickly and problematic than boys and men. This thesis attempts to find a balance between the need to acknowledge and widen the understanding of adolescent girls' (and young women's) stress-related problems, and the ambition to not medicalise them, their situation and their problems – a struggle which necessitates the application of sociocultural and gender theoretical perspectives within public health

sciences and policies, both in the understandings *of* and in the solutions *to* the problem.

Individualised and feminised discourses of stress

In addition, feminist researchers have noticed the usage of the concept of *stress* in the production of individualised, feminised and medicalised discourses related to stress, which neglect material, contextual and structural conditions (Becker, 2010; Kranz & Long, 2002). By emphasising women's own management of stress, these experiences of stress are seen as the unavoidable burden of responsibility, which is placed on women's shoulders. Becker (2010), and also Kranz & Long (2002), have argued that an individualised and narrow view of young women's stress risk to support the status quo of current social and gendered structures. Also Ussher (2010) has highlighted the disadvantages of medicalising 'women's misery' without taking material conditions into account. Thus, stress problems as explored in this thesis can be seen as a topical contemporary phenomenon – as discursive, socially constructed and socially shaped health problems particularly tied to women.

The continuum and normalization of subordination and violence

Another issue of relevance to public health, intimate partner violence, emerged in the results of the qualitative interview study (Paper III). Men's violence against women is a global health concern (Ellsberg, 2006a; Ellsberg, 2006b; Heise, Ellsberg, & Gottmoeller, 2002; Scheffer Lindgren & Renck, 2008; Wood, Maforah & Jewkes, 1998) and, in the analysis of the interviews with girls and young women, it became apparent that several of the participants had experienced some form of gender-related subordination, oppression or violence in family, peer group or partner relationships. Gender-related partner violence is a clear example of the intersection between power relations on a structural and macro level (so-called gender orders in society) and gender relations on individual micro-levels. Gender-related violence or, more distinctly, boys' and men's violence against girls and women, is an extreme example of the interlinkage between the 'doing of gender orders' and the 'doing of ill-health and stress' among affected girls and women.

Moreover, gender-related partner violence is but one aspect of a gendered phenomenon that can be labelled as 'the continuum and normalisation of subordination and violence'. Processes related to the continuum and normalisation of subordination and violence are closely interconnected with the definition of 'women's dwindling living spaces', which occurs as a consequence of exposure to men's control and violence

in partner relationships (Lundgren, 2004; Mellberg, 2002). Even if the experiences of gender-related violence do not account for the majority of stress problems among young people, they still represent a severe human, social and public health problem that needs urgently to be highlighted in the context of Swedish youth health and gender (in-)equality in young ages. Also, it is important to include the more subtle and symbolic forms of subordination or marginalisation in future research and policy making.

Processes of (dis)empowerment

Empowerment is a central concept within public health and health promotion, but also within gender studies and youth health studies (Baum, 2008; Janlert, 2000; Jerdén, Burell, Stenlund, Weinehall & Bergström; Medin & Alexandersson, 2002). The concept of empowerment is often used to describe living power/everyday power (swe. vardagsmakt) and power mobilisation (Janlert, 2000). Empowerment implies that a given life situation can be controlled and mastered. Janlert (2000) has described empowerment as an effort to increase opportunities of vulnerable groups to act and to take control over their lives and health — acts that can challenge established power relations. Empowerment is discussed in relation to health, as means to achieve health and empowerment (process) or as an end in itself (outcome) (Janlert, 2000). Empowerment can, from these viewpoints, operate at micro, meso, and macro levels (Figure 10), and is interlinked with individuals' agency and power to act.

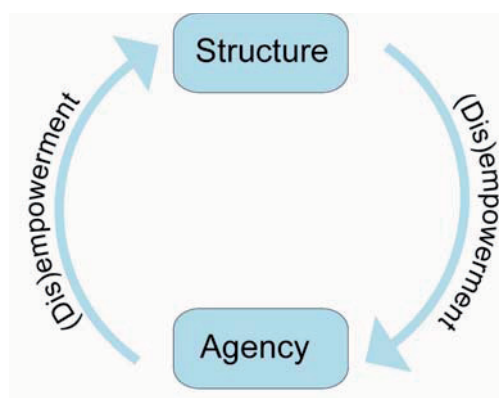


Figure 10. Tentative model of the agency-structure relationship with regard to processes of (dis)empowerment at micro and macro levels.

However, the results in this thesis rather indicated processes of disempowerment among the young women who had sought help at a youth health centre due to stress (Papers I-III). The results highlighted

processes of lost control, powerlessness, social drawback, and emergent meaninglessness in relation to lived and embodied experiences of stress (Paper II). Paper I addressed the constraints and bounded agency that can be observed in the transition into young adulthood, and within a frame of gendered ordered individualism. Paper III problematised the consequences of severe gender-related violence in partner relationships as causing a process of ‘dwindling living space’. All these aspects contribute to processes of disempowerment, which perhaps accounts for the fact that 20 percent of the girls in the school survey reported that they often felt helpless.

The high proportion of adolescents, both girls and boys, that felt pressured by demands, both in school and self-imposed, may indicate a loss of ‘everyday power’ according to Theorell’s definition of stress as occurring when an individual loses control or struggles to maintain, which can be seen as a state of powerlessness. Also according to Lazarus and Folkman’s (1984) definition of stress as an individual’s appraisal of a situation which exceeds his or her ability to cope, this state of felt pressure can be interpreted as a negative process. These indications are particularly noteworthy considering the strong correlations between perceived stress and anxiety, psychosomatic symptoms, sleeping problems and other physical and psychological complaints found in the school survey, and the multidimensional experiences of ‘living close to the edge’ that were detailed in the interviews. Feelings of decreasing personal value and loss of human dignity ought to be of interest in a public health context, as they may be consequences of the exercise of symbolic power and violence at different levels in society (Adkins & Skeggs, 2004; McRobbie, 2009). Accordingly, processes of disempowerment and empowerment need to be further problematised and investigated in studies of stress in youth.

Theory integration as a basis for action and intervention

In addition, the theory integration throughout the thesis attests that theory integration is not only of importance in health and public health sciences, but also in the more pragmatic fields of health promotion. Peterson & Lupton (1996) have argued that little attention has been paid to the analysis of discourses and practices of public health from an epistemological position or as a sociocultural practice. They have suggested that there is room for theoretically informed perspectives within contemporary public health — a suggestion that supports the idea running throughout this thesis, namely that basic assumptions and permeating discourses are important to disclose and problematise. According to McQueen & Kickbusch (2007), theory is “a source for

understanding the nature of things” (p.1). Theory is thus a systematic way of organising knowledge. This is also congruent with the aim and possible outcome of this thesis, which is to develop theoretical understanding of the phenomenon of stress among youth. In-depth understandings of subjective health problems, and stress as a phenomenon, can serve as a solid basis for interventions and policy making.

By revealing the basic assumptions in the understandings of and processes surrounding a phenomenon such as *stress*, it is also more likely that the actions taken can be problematised, scrutinised, modified and developed. Health-promoting interventions can thus be influenced by theoretical ideas and can, to some extent, be theory driven. Gender theories and gender analyses, as applied in this thesis, are such examples that may inform practice in the field of youth health. Perspectives on gender and power, including attention to discursive processes, may contribute to ‘complex’ and more ‘complicated’ understandings and explanations of young people’s subjective and mental health. This in turn highlights the need for more debate and studies about young people’s health – but also concerning issues of the formation of societal value-grounds and young people’s sense of life-meaning within times of rapid social change.

Methodological considerations

The choice of a combined qualitative and quantitative research design adds knowledge on youth and stress, from experienced, in-depth narrations to prevalence figures on group level.

The consecutive and large sample, relatively to qualitative studies, employed in the qualitative interview study (Papers I-III) provided depth, variations and complexity in the studied phenomenon of experienced stress. Furthermore, the first author's prolonged engagement was important for the trustworthiness in order to validate and confirm emerging results. Thus, the results are well grounded and anchored in data as well as in the context. Moreover, the interdisciplinary research team contributed to triangulation in the interpretations through the combination of different disciplines and theoretical perspectives. The emphasis on theoretical linkages therefore facilitates theoretical and analytical transferability although the context is local (Lincoln & Guba, 1985). Nevertheless, from a social constructionism perspective, self-narrations and interpretations of data are seen as co-constructions between researcher, participants and the context (Riessman, 2008).

The extensive data material was however also a huge challenge during the analytical phase. Codes and categories were difficult to overview in the first steps of analysis. This challenge was met through the sorting and display of data by several parallel techniques: the reading and summaries of single interviews, the repeated listening to interviews and the support by computer software. The research team continuously met and discussed emerging results. In addition, I state that since a holistic approach is applied it can be difficult, or impossible, to separate experiences in fixed and set categories.

Paper III is an example of the advantages of an emergent and explorative research design as the paper is an in-depth description and analysis of "intimate partner violence" in one of the emerging themes which was revealed during the analysis of the whole interview material. In a similar manner other sub-themes in the material could be further analysed and deepened in future analysis.

As the sample for the interview study (Papers I-III) is chosen from self-referrals to a specific stress management programme it might imply that this was a specific group of young women who differ from other young women with stress-related problems, e.g. more motivated and informed than others. I judge that their stories may well represent other young women in similar situations as several narrated about periods when they were less motivated, or socially introvert and isolated. Thus they may not differ substantially from other young women in similar contexts

experiencing the same kind of problems. The school survey of northern Swedish upper secondary school students show similar symptom reporting of subjective health- and stress problems among the girls.

The school survey had several limitations (Paper IV). The convenient character of the sampling procedure and the chosen class room distribution implied that only those adolescents who were present the actual day, and those who had teachers that had accepted to participate in the study, were able to answer the questionnaire. We did not offer absent students to fill in the questionnaire, and this had been difficult to administer as we did not have any codes due to the anonymity. It is also known that absent pupils can differ from other adolescents with respect to health and their psychosocial situation. We do not know why teachers did not answer our call for participation and whether these teachers and classes were somewhat different than those that participated. On the other hand, the response rate was high among those who were given the opportunity to participate, and still the survey covered a great variation of classes and programs. Still, we do not know if these differed to those who did not participate. In this respect a web-based or posted questionnaire might have been an alternative, although these methods also have problems with non-participation. The uneven distribution of girls/boys and theoretical/vocational programs were an additional weakness, although this distribution corresponded fairly well to that of the actual schools.

Regarding the included symptom instruments there were both strengths and weaknesses. The great variation in covered symptoms through the 16-items checklist and the stress-instrument was an advantage, as well as the inclusion of a well-established instrument for anxiety and depression. This choice was based in our clinical experiences of work with psychosomatics, stress and pain. The used stress instrument is less evaluated. On the other hand, this instrument covered several crucial aspects of perceived stress, particularly when considering the results of the qualitative study. In future research, a stress-instrument can be further modified and developed with the help of further explorative qualitative studies in additional contexts in order to cover important perceptions and aspects of stress and health.

A disadvantage, but also a challenge for future research studies, was the fact that the questionnaire in the school survey was not evaluated from the viewpoint of context and gender sensitivity. Hence, a future challenge for surveys like this is the development and evaluation of context- and gender sensitive instruments for measuring youth health. In this area various combinations of small-scale qualitative and large-scale quantitative studies have great potentials.

Conclusion

Stress-related and psychosomatic problems were between two and three times more common among girls than among boys in the school survey. Over two-thirds of the adolescents reported high pressures and demands from school (87 per cent of girls and 60 per cent of boys). Moreover, pressures and demands were associated with psychosomatic symptoms and anxiety, but also with stress-related activation and sleep problems. Stress-related ill-health is also common among adult women and may well start in adolescence, which is in accordance with our results; it often results in personal suffering and a decreased quality of life, long-term sick leave, the need for rehabilitation and losses to society (Paper IV).

Young women's self-narrated experiences of stress and illness were multifaceted, and can be placed along a continuum of psychosocial distress. Several signs of negative health development were explored, as well as signs of severe suffering and deflation. Physical, emotional, cognitive, social and existential dimensions of distress, distrust, and disempowerment exemplify the complexity of the problem. Body, embodiment and emotionality are important aspects in the understanding of young women's self-narrated experiences of stress (Papers I-III).

Multiple and intersecting stressors were prominent in young women's self-narrated experiences of stress, in addition to the pressure to 'manage alone'. Young women seem to face multiple pressures and demands linked to societal discourses of modernity, gender orders and youth. These stressors contribute not only to experiences of distress, but also to feelings of constraint. Gendered individualism and 'healthism' proved to be essential in understanding the young women's experiences of stress. Gendered demands and responsibility-taking were also illuminated. Exposure to oppression and violence was an additional gendered stressor. Perceptions of stress were also common among adolescents in the three upper secondary schools in northern Sweden that were covered in the study, particularly among girls (Papers I-IV).

Contextual factors, including social constructions and practices of gender, appeared to play an important role in creating the experienced stress. Contextualisation of young people's subjective health and stress-related problems is therefore crucial. The linkages between young people's stress and health need to be debated in relation to societal discourses and political ideologies, particularly in times of social change (Paper I).

The interdisciplinary synthesis of theoretical perspectives has contributed to the reconciliation of biopsychosocial perspectives with phenomenological and social constructivist approaches, and this has in turn shed light on young women's narrated experiences of distress. The results call for a broad contextualised and gender-sensitive approach to young people's stress and health problems (Papers I-IV).

The results accentuated the importance of acknowledging gendered living conditions. This refers back to the definitions of health as having material, physical, psychological, social and existential dimensions both as conditions, processes and resources. Experiences of stress and health are situated and created in time and place, and are dependent on available sources of support and recognition. Thus, actions for health promotion and ill-health prevention have to take this complexity into consideration. Actions must also stretch outside the field of health as the results showed the discursive, gendered and embodied aspects of stress.

Future research and implications for action

The age and gender gaps in the subjective health and stress of adolescents and young adults, need to be further explored, particularly from sociocultural and gender perspectives, as well as young people's own perspectives; qualitative studies are suitable for this purpose.

Explanation models based on young people's own experiences of their lives and health can be further developed through future explorative studies. Girls' and young women's (as well as boys' and young men's) experiences of stress and strain in life can be further studied in other contexts and sub-groups. In addition, young people's own solutions and suggestions are important to investigate.

Theoretical understanding and models based on intersections of social categories such as gender, ethnicity, sexuality and class can further be utilised. Based on such models, theory-driven interventions can be developed.

A future challenge is the development of *context- and gender-sensitive* measurements, treatment, prevention models and health promotion. It is essential that health providers and school health services integrate a context- and gender-sensitive youth approach to meet the needs of young people seeking support for stress-related ill-health.

Within physiotherapy there are well-developed models for the management of stress and pain that could be further developed to better suit young people, as well as applying sociocultural and gender perspectives.

Psychosocial working conditions in schools, including gender (in)equality, are essential aspects for future studies and interventions. Schools have long been regarded as important arenas for health promotion. Still, few school health studies have examined demand-control-support balance, or applied gender perspectives. School health services are also central.

Old and new forms of gender orders and gender inequalities are important in highlighting the context of stress and young people's health. The potential risks of viewing girls and young women as problematic (including the individualisation and medicalisation of their gendered and socially-shaped problems) have to be taken into account in understanding

their situation, as well as in future interventions and public health policies.

The continuum and normalisation of subordination and violence, including gender-related intimate partner violence, have to be addressed in future research, as well as in consultations with young people.

The societal discourses of *gendered individualism* and *gendered healthism*, which emerged in the results, are important aspects to consider in future public health research, and in intervention studies. Social constructions of gender, gendered body-ideals, and young people's taking-up of health messages all have to be taken into account in the communication of public health research and policy making – these aspects should also be studied in greater depth.

Thus, the results of this study have shown the need for greater discussions and studies about how to understand young people's experiences of distress in life and, ultimately, how to act and intervene. In public health there are always choices between individual-centered interventions, or interventions on organisational or structural levels. The current results point to stressors on micro-, meso- and macro levels, which may imply the need for more complex interventions. Stress in youth should be placed within a broader sociocultural and political context.

Locating myself

I sometimes define myself as a multi-professional – a ‘free-mover’ in the grey area between disciplines and methods. I cannot follow a set recipe. My areas of knowledge are rather to be found in the meetings, or the clashes, between pre-defined territories. As a professional, I am interested in the convergence and combination of ideas and perspectives in order to better understand and act. I have commonly been involved in collaborative work, and in processes stretching over extended periods of time. In such processes, I find the groundwork to be crucial and, in this sense, I am a very down to earth person. But, without an intellectual vision, and some kind of shared and explicit purpose, a work situation is not meaningful for me. Throughout my PhD studies, I have tried to create spaces for collaboration and creativity, for the grounding and sharing of ideas, but I see several conflicting interests and hierarchies within academia which, in my opinion, do not lead to broad and sustainable knowledge generation that can stretch outside the scientific fields; for this reason I occasionally take a critical position.

Before my physiotherapy education, I worked as an assistant nurse and physiotherapist assistant within elderly care, primary health care and in home-based care with a child in my hometown, Luleå. In my spare time, I led dance groups and was an amateur dancer. I also worked with handicraft. Since the late 1980s, I have worked as a physiotherapist within psychiatry and primary health care in Umeå, and thereafter as a teacher of the physiotherapy education at Umeå University. My special interests and competences within physiotherapy are: psychosomatics, recurrent pain, and stress and trauma treatment, with an emphasis not only on body awareness therapy [BAT], but also on communication and counseling). This work I have occasionally combined with my personal interests in expressive art, dance and movement pedagogies. In such work I have experienced salutogenic and empowering moments. Similarly, I have enjoyed the contact with students in creative reflections and ‘body-work’.

During the 1990s, I was a physiotherapist within a primary health care project, aiming for early and synchronised rehabilitation and prevention of long-term sick leave in the adult working population. The project was a collaboration between the county council and the local health insurance office, which had the aim of promoting multi-disciplinary team work and functioning rehabilitation. Together with a social worker, I initiated group counseling for women with chronic pain based on a ‘salutogenic gender perspective’, which aimed at self-efficacy and empowerment. I then led groups with women patients that combined Body Awareness

Therapy (BAT) and relaxation with reflective and supportive discussions – a similar combination to that used in the intervention part of the research in this thesis.

During the 1990s, the ‘stress boom’ in Swedish working life emerged, and adult patients with stress-related problems appeared to become more frequent visitors to the primary health care centre and physiotherapy reception. During this period I also met young people suffering from tension headaches or negative body image and I occasionally worked with the school health services. I came to understand that early and supportive consultations could reverse negative processes and prevent unnecessary ill-health. Together with physiotherapy colleagues, I initiated a forum for dialogues and development among my colleagues which we named the ‘psychosomatics group’.

Alongside my work within primary health care, I also learned that physiotherapists cannot only pick up on early signs of mental ill-health and strained life-situations, but also contribute to recovery and change – especially if this is done within a functioning interdisciplinary team and with trust in the individuals with whom the work is primarily concerned. In the meetings with patients I always emphasised the need to: “be aware of and acknowledge the burdensome (=empathy) and strengthen the vitality (=empowerment)” (swe. beakta det svåra och stärka det friska). Without initial empathy and the acceptance of difficulties, problems and conflicts, recovery cannot begin – that is my own clinical experience. My research project originates from similar beliefs and values of participation and trust in young people’s experiences and their own definitions of their situation. Nevertheless, a PhD and research training is inevitably accompanied by some compromises and, along the way, the gap between good intentions and actual actions widens. I recall one of my strongest initial ambitions and challenges was to narrow the gap between theory and practice – now I am there myself, in academia, never leaving my office chair and computer.

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