This is the published version of a paper published in *SAGE Open*.

Citation for the original published paper (version of record):

Living close to the edge: embodied dimensions of distress during emerging adulthood.
*SAGE Open*, 2(4): 1-17
http://dx.doi.org/10.1177/2158244014537083

Access to the published version may require subscription.

N.B. When citing this work, cite the original published paper.

Permanent link to this version:
http://urn.kb.se/resolve?urn=urn:nbn:se:umu:diva-37134
Living Close to the Edge: Embodied Dimensions of Distress During Emerging Adulthood
Maria Wiklund, Ann Öhman, Carita Bengs and Eva-Britt Malmgren-Olsson
SAGE Open 2014 4:
DOI: 10.1177/2158244014537083

The online version of this article can be found at:
/content/4/2/2158244014537083

Published by:
SAGE
http://www.sagepublications.com

Additional services and information for SAGE Open can be found at:

Email Alerts: /cgi/alerts

Subscriptions: /subscriptions

Reprints: http://www.sagepub.com/journalsReprints.nav
Living Close to the Edge: Embodied Dimensions of Distress During Emerging Adulthood

Maria Wiklund¹, Ann Öhman², Carita Bengs³, and Eva-Britt Malmgren-Olsson⁴

Abstract

Although self-reported stress-related problems are common among Swedish adolescent girls and young women, few qualitative studies have been carried out of young people’s own understandings and descriptions of their lived embodied experiences of stress-related illness. The aim of the present study, therefore, was to explore and analyze the lived embodied experiences of stress among adolescent girls and young women who had sought help at a youth health center. Interviews with 40 girls and young women aged 16 to 25 were analyzed with qualitative content analysis. “Living close to the edge” was interpreted as the common theme running through all of the interviews and representing the participants’ sometimes unbearable situations. The theme contains embodied dimensions of physical, emotional, cognitive, social, and existential distress, as well as dimensions of distrust and disempowerment. The findings highlight the importance of addressing these dimensions in youth health interventions, and the importance of contextualizing young women’s distress is emphasized. These young women’s experiences of stress and illness were multifaceted, which place high demands on health facilities and intervention programs. It is important to integrate context- and gender-sensitive models and approaches in youth health as well as in primary care settings.

Keywords

stress, mental health, anxiety, youth health, gender, embodiment, adolescence, qualitative interviews, medical sociology, sociology of the body.

Introduction

In this article, we explore dimensions of lived embodied experiences of distress, with a focus on stress, in a group of Northern Swedish adolescent girls and young women who had sought help for stress-related problems at a youth health center. We view the phenomenon of young women’s experiences of stress and high demands as an empirical example of what Connell (2012) calls social and gendered embodiment. Thus, we view stress-related ill health as developing in close interaction between the individual and contextual conditions. The focus of our analysis is the young women’s own narrations of such complex reciprocal processes where external social and gendered conditions merge with internal body-anchored responses and experiences, with our main focus on the individual and internal aspects. External stressors and societal discourses have been in focus in previous publications (Wiklund, Bengs, Malmgren-Olsson, & Öhman, 2010; Wiklund, Malmgren-Olsson, Bengs, & Öhman, 2010).

Gendered Patterns of Stress and Mental Health During Youth

Mental, stress-related, and psychosomatic ill health among adolescents is a growing public health concern in Sweden and internationally, especially among adolescent girls and young women (M. Danielsson et al., 2012; Hagquist, 2009; Lager, Berlin, Heimerson, & Danielsson, 2012; Patel, Flisher, Hetrick, & McGorry, 2007; Schraml, Perski, Grossi, & Simonsson-Sarnecki, 2011; Tick, van der Ende, & Verhulst, 2008; Torsheim et al., 2006). In comparisons across Europe, adolescent girls report lower subjective health and health-related quality of life than boys of the same age (European Commission, 2000; Michel, Bisegger, Fuhr, Abel, & The Kidscreen Group, 2009). In Sweden, anxiety, worry, and anguish are most prevalent among girls and young women aged 16 to 24 years (M. Danielsson et al., 2012; Wiklund, Malmgren-Olsson, Öhman, Bergstrom, & Fjellman-Wiklund, 2012). According to a recent survey, a

¹Department of Community Medicine and Rehabilitation, Physiotherapy, Umeå, Umeå University, Sweden.
²Umeå Centre for Gender Studies, Umeå University, Umeå, Sweden.
³Department of Sociology, Umeå University, Umeå, Sweden.
⁴Department of Community Medicine and Rehabilitation, Physiotherapy, Umeå University, Umeå, Sweden.

Corresponding Author:
Maria Wiklund, Department of Community Medicine and Rehabilitation, Physiotherapy, Umeå University, S-901 87 Umeå, Sweden.
Email: maria.wiklund@physiother.umu.se
high percentage of young people (47% of young women and 29% of young men) reported feeling stressed often or very often, and perceived stress and psychosomatic health problems peaked in adolescent girls at 16 to 18 years of age (Friberg, Hagquist, & Osika, 2012). Suicidal thoughts and attempts are also more common among young Swedish women, although suicides are more prevalent among young men (Lager et al., 2012; Titelman et al., 2013). Explanatory models for the gendered patterns of mental ill health in young people remain relatively undeveloped, although diverse factors at the individual, group, and structural levels have been suggested such as educational pressure, peer hierarchies, financial stress, and high rates of youth unemployment (Hagquist, 1998; Lindström & Rosvall, 2014; Modin, Östberg, & Almqvist, 2011; Strandh, Winefield, Nilsson, & Hammarström, 2014). However, within public health sciences and health research, there is a growing body of research that also highlights social and structural processes of gender as being related to the development of health problems throughout the course of life (Landstedt, Asplund, & Gillander Gådin, 2009; Maclean, Sweeting, & Hunt, 2010; Wiklund, Bengs, et al., 2010). Gender is then defined as an important social determinant of health (A. Öhman, 2008; Sen & Östlin, 2010).

During emerging adulthood, girls and young women seem to face multiple stressors and high demands connected to parallel life spheres that may shape their health negatively; these stressors can also be related to contemporary societal discourses of modernity and hierarchies of gender (Wiklund, Bengs, et al., 2010). These external and gendered stressors include pressures on performance and educational success; the struggle for social value through physical appearance and corporeal capital; exposure to sexual harassment and violence; and difficulties accessing wider societal resources such as health services or the labor market (Frost, 2005; Harris, 2004; Salmela-Aro & Tynkkynen, 2012; Wiklund, Malmgren-Olsson, et al., 2010). High levels of social responsibility taking among adolescent girls have also been indicated in combination with low adult and societal support (Gillander Gådin & Hammarström, 2000; Landstedt, Asplund, & Gillander Gådin, 2009; Wiklund, Bengs, et al., 2010). Thus, practicing contemporary young femininity seems to be tied to stress and high demands, along with insufficient support.

Nevertheless, studies on stress and stress management models are often gender blind. In addition, Swedish public health studies on stress often use quantitative methods to map the magnitude of the problem in the adult population (M. Danielsson et al., 2012); qualitative approaches focusing on stress-related illness are less common, especially in relation to young people in different life situations and sociocultural contexts. Youth health perspectives are relatively rare in Swedish gender studies. We therefore aimed to explore dimensions of the lived embodied experiences of stress as narrated by Northern Swedish adolescent girls and young women who had sought help for stress-related problems at a youth health center. By doing this, we hoped to address a gap in Swedish public health research, as well as in gender and youth studies. We will discuss the results in the light of an interdisciplinary framework, including gender perspectives, to develop a basis for broadened understandings of stress-related problems in this group and context.

**Theoretical and Conceptual Frame**

**Social and Gendered Embodiment Expressed as Stress**

Given our special focus on exploring individual experiences of stress and expressions of social and gendered embodiment during emerging adulthood, the conceptual and theoretical frame for this study draws on an interdisciplinary synthesis of biopsychosocial, phenomenological, gender, and social constructionist perspectives as outlined by Wiklund (2010) in relation to discursive, gendered, and embodied stress in youth. The interdisciplinary synthesis addresses diverse aspects of stress, body–self, embodiment, and gender as described in the following.

**Stress approaches.** Definitions of stress vary with discipline, and in this study, we use a multiple system approach in which we integrate social aspects of gender. Contemporary stress research within medicine and public health often suggests multiple system approaches, acknowledging biopsychosocial interplays at the molecular and intra-individual levels as well as at the organizational and societal levels (Arnetz & Ekman, 2006; Gustafsson, Janlert, Theorell, & Hammarström, 2010; Karasek & Theorell, 1990). The Swedish stress researcher Levi (2002) categorizes stress reactions into physical/physiological, cognitive, psychological/emotional, and social/behavioral. In the present study, we use the term “distress” to mark the negative character of perceived stress (Ridner, 2004). Psychological distress can be referred to co-occurring symptoms of anxiety, depression, and somatic discomfort, and indicates emotional arousal. However, these stress approaches seldom acknowledge social aspects of gender.

Within psychology, stress is commonly defined as arising when external demands exceed an individual’s appraised ability to cope (Lazarus, 1999; Lazarus & Folkman, 1984); aspects of cognition and coping are then in focus. In contrast, physiological approaches mainly focus on the stress responses that occur in stressful situations (Arnetz & Ekman, 2006; McEwen, 1998, 2007). Physiological approaches seek to explain how bodily systems such as the cardiovascular, autonomic, immune, and metabolic processes strive in threatening or stressful situations to maintain balance and reach stability through change—so-called allostasis (McEwen, 2007). During acute stress, a mobilization of energy and efforts can be observed as a state of raised alertness or alarm, as in the “fight or flight” reaction or the
“startle pattern” (McEwen, 2007). From this perspective, the psychophysiological stress system is adapted to manage sudden physical threats (M. Danielsson et al., 2012). In contrast, a situation of prolonged psychosocial stress creates fatigue and feelings of being worn out, a phenomenon known as wear and tear or allostatic overload (McEwen, 2007). Lack of recovery and lack of sleep seem to increase the risk of high allostatic load and stress-related ill health (Åkerstedt, 2006; Åkerstedt, Kecklund, & Axelsson, 2007; Ekstedt, Söderström, & Åkerstedt, 2009; Fahlen et al., 2006). Prolonged psychological stress is associated with a range of symptoms such as recurrent pain, anxiety, depression, irritability, sleep disturbance, and impaired cognitive functions (Bergdahl, Larsson, Nilsson, Åhlström, & Nyberg, 2005; Malmgren-Olsson & Armelius, 2001; L. Öhman, Nordin, Bergdahl, Slunga Birgander, & Stigsdotter Neely, 2007).

We believe that a psychophysiological perspective (Arnetz & Ekman, 2006; McEwen, 1998, 2007) on young women’s experienced distress is useful in several respects. It contributes to in-depth understanding of physiological and affective sensations and reactions that otherwise might be labeled “medically undefined,” “unexplained,” or “diffuse” (Werner & Malterud, 2003). Nevertheless, an intra-individual stress approach commonly lacks contextualization and the voices of individuals. A phenomenological approach to stress, as described below, integrates the lived embodied experiences based on lay accounts.

**Phenomenological approaches.** Phenomenological and holistically and/or psychosomatically oriented psychotherapeutic approaches to stress and mental illness use concepts such as the body–self, embodiment, lived experience, and emotionality (Gyllensten Lundvik, Skär, Miller, & Gard, 2010; Jingga & Rosberg, 2008). The body–self is seen as an essential part of subjectivity, identity, and the self, and also involves more specific aspects of breathing, muscle tension, movement quality, relation to gravity and weight, as well as mental presence and relations to others (Skjaerven, Kristoffersen, & Gard, 2008). These approaches define a number of human existence levels: physical, physiological, psychological, and existential, including self-reflection/self-reflexivity and creativity (Lundvik-Gyllensten, 2001). The term “embodiment,” including notions of lived embodied experiences, describes the daily experiences of both having and being a body (Lundvik-Gyllensten, 2001; Rosberg, 2000). This basic assumption originates in Merleau-Ponty’s (1962) phenomenology of the “lived body” that is a dialectic body philosophy integrating body and mind as meaning making in time and space. More recent feminist phenomenological approaches have developed perspectives on the lived and living body that also address social structures, discourses, hierarchies of power, and gender (Young, 2002, 2005). In line with our view, Cosgrove (2000) suggests a synthesis of phenomenological and social constructivist approaches to better understand women’s emotional distress, or as she puts it, “Social constructionism may be helpful because it highlights the discursive production of power, femininity and psycho-pathology. The strength of a phenomenological approach is that it emphasizes the richness and complexity of an individual’s lived experience and privileges agency” (p. 247).

**Social constructionism, gender, and embodiment.** Within social constructionism, health, stress, body, self, and gender are understood as social constructions (Becker, 2010; Lupton, 1998, 2003, 2013; Ussher, 2010). This implies that discourses on bodies and health shift with context and time, which is seen, for instance, in the use of metaphors or in the constructions and use of diagnosis (Becker, 2010; Nettleton & Watson, 1998). Gender can also be viewed as a social and historical construction created through social interaction. As such, it is defined as a dynamic process of social relations, norms, and power structures (Connell, 2002). Gendered power and social constructions of gender, such as femininities and masculinities, seem closely interwoven with health development over the life span (Annandale, 2009; Connell, 2012; Courtenay, 2000; Hammarström & Ripper, 1999; Saltonstall, 1993; West & Zimmerman, 1987; Wiklund, Bengs, et al., 2010). Sociological stress research indicates that “differential exposure to stressful experiences is one of the central ways that gender, racial-ethnic, marital status, and social class inequalities in health are produced” (Thoits, 2010, p. 44). Gender is then related to social inequalities in physical and psychological well-being (Thoits, 2010).

According to Connell (2002, 2012), gender always involves social embodiment. In a circular process of social embodiment, bodily processes are linked with social structures and social constructions of gender. Bodies are then viewed as “arenas where something social happens” (Connell, 2002, pp. 47–48) and also as flexible and responsive. Krieger (2005) describes embodiment as a construct, a process, and a reality where humans simultaneously are “social beings and biological organisms” (p. 350). In addition, the feminist biologists Fausto-Sterling (2000) and Birke (1999, 2000) argue for dialectic views on biology/social, nature/nurture, and sex/gender. In her studies of stress in Swedish youth, Wiklund (2010) argues that “body is not only biology—but also biology” (p. 29). This understanding, when applied to young women’s stress-related problems, assumes that the human body is socially shaped as well as a biological and material entity.

**Materials and Method**

**Setting, Recruitment Procedure, and Participants**

The present interview study, which forms part of a larger research project about stress and health in young people (Wiklund, 2010; Wiklund, Bengs, et al., 2010; Wiklund et al., 2012), was conducted at a youth health center in a university city in Northern Sweden. This youth health center...
specializes in psychosocial ill health in young people and is run by the local county council as the first-line primary care for young people with mental health problems. The center is based on multidisciplinary teamwork and has close cooperation with the local community, employment, and health insurance offices. It offers a number of forms of counseling, which since 2005 have included stress management courses, an intervention offered as part of our research project (Strömähl, Malmgren-Olsson, & Wiklund, 2013). The stress management intervention was announced on the center’s website, in leaflets, and on posters at the youth center, the local employment office, and school and student health services. The recruitment procedure was consecutive with no referrals; potential participants contacted the center directly by email, phone, or personal visits. All potential participants had a one-to-one meeting/consultation with a member of the research team to decide whether they should participate in the study. Intervention inclusion criteria were self-defined stress-related problems and a wish to participate in the stress management intervention. Exclusion criteria were signs of severe mental illness that might hinder or make group participation irrelevant or unsuitable.

Research interviews were conducted before and after the intervention period; the current article is based on the interviews conducted before the start of the intervention. The participants comprised 40 girls and young women, aged 16 to 25 years, who had experienced stress problems between 2005 and 2007. The participants varied in terms of family background and financial situation, level of education, and work experience. Some were students at upper secondary school or university, while others were working part-time or full-time, were unemployed, or were on sick leave. Although the majority were born in Sweden, several had moved to the area from other parts of the country.

At the time of the interview, some of the participants were experiencing acute problems of stress, whereas others were slowly recovering after a breakdown. For some, their stress-related problems had resulted in interruptions to their studies or periods of sick leave, whereas others were able to cope with their situation for the moment but found it harmful to their health and unmanageable in the long term.

In this article, we focus on the individual lived and embodied experiences of stress, including physical and emotional aspects. In a previous analysis, we explored external stress factors in the same sample (Wiklund, Bengs, et al., 2010), providing an important social and gendered context to the individual and internal aspects presented in this article.

Qualitative Research Interviews

Our inductive and explorative approach was facilitated by an emergent and flexible qualitative research design (Dahlgren, Emmelin, & Winkvist, 2004; Kvale, 1996; Lincoln & Guba, 1985). Narrative research interviews were conducted by the first author, who is an experienced physiotherapist in the field of body, stress, trauma, and body awareness therapy in diverse psychiatric and primary health care settings. This specific competence held by members of the research team informed the interview methodology and analyses, and can be described as experience based and body anchored, in line with phenomenological and psychosomatically oriented approaches within physiotherapy (Lundvik-Gyllensten, 2001; Rosberg, 2000; Stelter, 2010). The interviews took place in a consultation room at the youth health center. They were digitally recorded, and lasted between 45 and 120 min, with an average of 90 min. The interviews were performed in a dialogic and supportive manner. The opening question was “Please tell me how you came to contact the youth health center.” Continuation of the dialogue was then supported by probing questions and a thematic interview guide. Areas explored included the stressors experienced by the participant, stressful situations, emotions, bodily experiences, social relations, social support, and coping.

Qualitative Content Analysis

To identify descriptions of living with stress, the analytical process was guided by qualitative content analysis following Graneheim and Lundman (2004). In this, we were inspired by a phenomenological research approach to facilitate close analysis of lived embodied experiences of health and illness (Honkasalo, 2000; Raheim & Haland, 2006; Rosberg, 2000; Starks & Brown Trinidad, 2007). The analysis began by reading the verbatim transcriptions to gain a sense of content and meaning as a whole. Following Lindseth and Norberg (2004), all authors presented and compared their initial naïve understandings and preliminary coding. The first author then continued the analysis by producing summaries of the interviews and then a detailed coding using Open Code software (Division of Epidemiology and Global Health, 2004). The interview texts were divided into meaning units. Each meaning unit was condensed and labeled with one or more codes at a slightly higher level of abstraction. In the next stage, these were clustered into five domains, which we view as diverse dimensions of experienced stress (Table 1). The categories describe the core commonality of the experiences of the studied phenomenon, mainly encompassing the manifest meaning of the text (Graneheim & Lundman, 2004). The latent meaning was formulated as a single overarching theme (Table 1). Once the analysis was complete, each author again read several interviews to confirm or modify the results. Thus, the analytical procedure was iterative and moved between parts of the text across the material to the whole texts (Denzin & Lincoln, 2003).

Ethics

The study was approved by the Regional Ethics Committee of the Faculty of Medicine, Umeå University, Umeå, Sweden (ref: 05-045 M).
Findings: Dimensions of Living Close to the Edge

As a result of our analysis, “living close to the edge” was formulated as the latent and permeating theme in the young women’s narrations of lived and embodied experiences of stress. In talking about their experiences and overall situation, these young women used a variety of descriptions and metaphors indicating that they had reached, or were close to, an unmanageable situation. They talked about excess overload, an unsustainable situation, and how they were approaching a final stage of breakdown and exhaustion. Several used the metaphor of “vicious circles.” They worked hard, kept a high tempo, and tried to accomplish as much as possible at home, at school, or at work, as well as in their social relationships. They wanted to be perfect but seldom felt pleased with their performance. Consequently, they had guilty consciences when they were not doing or achieving anything in particular. At the time of the interviews, both their situations and their stress conditions differed considerably.

The young women seldom described single or isolated stressful events and experiences; rather, they spoke of complex, multiple, recurring, and long-lasting distress over the course of childhood through early adulthood. Their experiences can therefore be viewed as multidimensional processes over time, involving physical, emotional, cognitive, social, and existential dimensions (Figure 1). As their stories—and the phenomenon of lived and embodied stress—are complex, several aspects of the identified categories are interlinked. Within each dimension, the categories are ordered as escalating in intensity and severity, and as approaching the “edge” (see also Table 1).

Physical Dimension

The physical and bodily dimension of embodied and lived distress was prominent in the young women’s narrations. This may reflect the research setting—a youth health center—as well as interview questions such as “How do you respond to stress in life?” or “Can you tell about how you experience stress in your body?” However, the young women’s descriptions of experiences of physical sensations and suffering may have been a result of their stressful lives and the multiple demands they experienced.

Restless and unsettled body. Experiencing a restless and unsettled body, the young women had few or no ways to unwind, rest, and relax. They described their forced tempo

<table>
<thead>
<tr>
<th>Categories and subcategories</th>
<th>Physical dimension</th>
<th>Emotional dimension</th>
<th>Cognitive dimension</th>
<th>Social dimension</th>
<th>Existential dimension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restless and unsettled body</td>
<td>Bodily discomfort</td>
<td>Frustrated self</td>
<td>Reflexive self</td>
<td>Imbalance in life</td>
<td>Questioning and doubting self</td>
</tr>
<tr>
<td>Restlessness</td>
<td>Eating problems</td>
<td>Anger and irritability</td>
<td>Self-reflexivity</td>
<td>Strong drive and engagement</td>
<td>Irresolution, uncertainty, and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Frustration</td>
<td>Problem solving</td>
<td>Difficulties prioritizing</td>
<td>doubt</td>
</tr>
<tr>
<td>Suffering body</td>
<td></td>
<td>Worrying and anxious self</td>
<td>Inattentive self</td>
<td>Chaotic life</td>
<td>Overwhelmed by life</td>
</tr>
<tr>
<td>Aches and pain</td>
<td></td>
<td>Worry, fear, and anxiety</td>
<td>Problems concentrating</td>
<td>Loss of control over life</td>
<td>Powerlessness</td>
</tr>
<tr>
<td>Problems sleeping</td>
<td></td>
<td>Panic</td>
<td>Learning problems</td>
<td>Inability to act</td>
<td></td>
</tr>
<tr>
<td>Difficulty breathing</td>
<td></td>
<td>Deflated self</td>
<td>Negative self</td>
<td>Withdrawal from social life</td>
<td></td>
</tr>
<tr>
<td>Collapsing body</td>
<td></td>
<td>Depressed mood</td>
<td>Negative, grinding</td>
<td>Social withdrawal and cutting off</td>
<td></td>
</tr>
<tr>
<td>Physical limitations</td>
<td></td>
<td>Loss of self-worth</td>
<td>thoughts</td>
<td>Social isolation</td>
<td>Giving up one’s existence</td>
</tr>
<tr>
<td>Tiredness and fatigue</td>
<td></td>
<td>Self-blame and self-harm</td>
<td>Imagining horror scenarios</td>
<td></td>
<td>Loss of meaning in life</td>
</tr>
<tr>
<td>Physical exhaustion</td>
<td>Collapse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 1. The Results Presented as Main Theme, Dimensions, Categories, and Subcategories.
and physiological arousal using expressions such as “I’m at boiling point,” “I have the creeps,” “I’m getting wound up,” or “I’m going up the wall.” They experienced a variety of physical sensations and reactions from different parts of the body, as well as more general bodily discomfort. Often a set of reactions occurred simultaneously. Physiological and autonomous arousals, such as sweating, cold sweat, dizziness, racing heart, or a high pulse, were associated with being under high pressure:

I get a purely physical irritation creeping under my skin at the back of my neck. It, like, itches. Shoulders, back, and the back of my neck, my head too; tension headache I get mostly in my forehead. Yes, and a jittery stomach or on the whole a feeling, a nervous feeling the whole time. I tremble; yes, almost everything feels wrong basically.

Other symptoms that occurred when feeling distress or anxiety were eating problems, loss of appetite, and difficulty swallowing. Upset stomach was also understood as being caused by stress. One girl said that she “vomited from stress.” Others stated that they took control of their lives and stress caused by stress. One girl said that she “vomited from stress.” Others took control of their lives and stress caused by stress. One girl said that she “vomited from stress.”

I experienced a situation of mostly physical stress that was completely unendurable. I was sleeping badly and was waking up unbelievably stressed out in the morning or in the middle of the night, or from 2 o’clock right until 6 o’clock; sometimes it was every quarter of an hour. I woke up with my pulse racing and in a cold sweat and had difficulty breathing, and was out of breath. It felt as if I’d been running; I was panting and it felt as if I couldn’t get enough air. It almost stuck like that so that it was difficult to breathe. It felt extremely uncomfortable.

Collapsing body. The negative long-term consequences of high tempo and workload during long periods were obvious among several of the young women. Limitations were expressed using phrases such as “my body sets the limits,” “it’s the body that sets the limit,” or “only my body sets the limits.” Tiredness, fatigue, and physical exhaustion were signs of such physical limits. Expressions such as “overload,” “I collapsed,” “I’m hitting a wall,” or “I fell to pieces” described total exhaustion. Some of the girls and young women had worked until they “dropped” and had been forced to interrupt their studies or work:

I fell to pieces completely. I got a terrible headache and could hardly manage to get out of bed. I went round like that in my slippers for almost two weeks and did nothing. I had such a bad headache and I was so terribly tired, it was as if I had no energy whatsoever. I was of course a little afraid of getting stuck there again. Sure I did a good job at work, but at home I could hardly manage to do anything. My days off were just spent recovering, and then work started again. I had hardly any time off, rather it was just a matter of trying to get my strength back.

Some viewed their bodies and physical reactions as limiting or too restrictive, whereas others understood them as evidence that they were exceeding the limits of their ability and capacity. Still others saw their reactions as serious “signs” or “signals” that had to be heeded to avoid collapsing or becoming ill due to stress, whereas others regretted that they had not taken those signs seriously before it was too late.
Emotional Dimension

The lived experiences of strain and distress embraced a wide range of emotions. As shown below, their narrations further illustrate the close and inseparable connections not only between emotional/affective and physical/physiological experiences but also between emotions and the social context.

Frustrated self. The emotions linked to being stressed included anger, irritation, and frustration. Anger and irritation were seen as negative if acted out toward others, for instance, friends or boyfriends, whereas anger in other situations was described as more positive and powerful than just being sad and crying. The participants also experienced instability and lability, that is, oscillations between strong emotions. One girl described how she could suddenly become sad and “in despair” and start “crying her eyes out.”

Worrying and anxious self. The young women said that they lived with constant worry, fear, or anxiety. They worried about “big things and small,” about the present and the future, about themselves, about their health, and about others. Some stated that they considered stress and worry to be “one and the same.” One girl emphasized how her world would collapse if she had to suffer any more stress in life. For some, worry and fear escalated into anxiety or panic attacks. Panic attacks or emotional breakdown generated insecurity and distrust, as they often occurred in social situations with other people and were thus difficult to handle. For some, the anxiety and panic attacks were sudden incomprehensible, which made them scared of being seriously ill or of “going mad.” One young woman broke down at work because of her intolerable work situation, which included a high tempo and hidden responsibilities such as always being the happy and “peppy” one who encouraged others. Long after these events, she understood them as recurrent panic attacks:

I was in a strange cold sweat, and began to pull at my sweater as if I couldn’t get any air. And I became nervous and my hands were wet with sweat. It felt like I would die in the room. I became very hot, in my face, like, but nevertheless cold like this, it felt strange. And my heart started pounding. And then I got one of those lumps in my throat so that I felt like I wanted to be sick even though I didn’t feel nauseous, only because I felt I was going to die. So I went out of the room and straight away it was as if I could breathe and could get some air again.

Together with fear and a sense of loss of control, the panic attacks in social situations also involved strong physical and cognitive sensations, as expressed by another participant:

I got one of those adrenaline rushes, the flight response kicks in immediately. I just wanted to get out of there, but I usually don’t do that, rather I usually grit my teeth and calm down, but then it comes, then I become very self-conscious about how I’m walking, and whether I look strange and so on. And then it gets like a vicious circle. Sometimes it feels like my brain is almost switched off, then I can suffer from memory loss basically. It’s fizzing in my head. Afterwards I don’t know what I’ve said. It’s a purely physical sense of terror, like riding a roller coaster.

As seen above, expressions of worry and anxiety corresponded to descriptions of a restless, unsettled, and collapsing body. This exemplifies the close links between the physical, emotional, and social dimensions of distress.

Deflated self. Low self-worth, self-blame, and self-punishment; impaired trust in oneself; and feeling “bad” were expressed alongside feelings of guilt and shame. Several girls had already diagnosed or labeled themselves and their problems. They used degrading and self-blaming phrases, describing themselves as “overambitious” or “a little on the edge.” The young women also described depressive mood as being associated with stress. Stress “triggered” a low mood and, in some cases, also self-disgust:

But I sink so terribly low if I make a mistake. Because then you really want to punish yourself afterwards. Yes, so I think like the world will end, you know. And then all the bad stuff comes up that you’ve stored since last time. So it works just like a trip switch for feeling down. I needed to seek help, of course, so that I have some professional to talk to. And that always brings with it a feeling of shame; you feel less capable. It’s a label. Even if other people don’t know, you still label yourself.

Self-harm or feelings of wanting to punish oneself were also described. One of the girls said she scratched herself, and another young woman said she used to bang her head against the wall. Experiences of the “deflated self” conveyed an additional dimension to the young women’s suffering, pain, and disempowerment.

Cognitive Dimension

The cognitive dimension of embodied distress represents the participants’ own appraisal of their situation as exceeding their perceived abilities to cope. However, the cognitive dimension also highlights their reflections, individual agency, and constant struggle to find solutions to their problems.

Reflexive self. The young women saw themselves as being analytical, self-analytical, and reflexive. They were often “problem solvers” in their own and others’ social lives, which manifested, for example, through their emotional work and responsibility taking. Their reflections concerned their (and others’) feelings of stress, its causes, consequences, and solutions—thoughts that occasionally turned into stressors. Experiences of lacking support made them feel alone with their problems and thoughts. Much time and effort were therefore spent on thinking and reflecting. Some even labeled themselves “over-analytical.” Several were also pressed by
their fear of making mistakes, which made them reflect even more.

**Inattentive self.** When experiencing distress, the young women found it difficult to concentrate and be mentally alert. They described how they were distant or inattentive and had difficulties taking in information, thinking clearly, and learning new things. Difficulties in showing interest in and listening to others were further aspects:

The simplest things become big and pile up [when feeling stressed] . . . I find it difficult to think clearly, it just spins in my head somehow, and I do not know where to go.

**Negative self.** Negative or repetitive thoughts were expressed and intertwined with emotions of anxiety and worry, as well as with experiences of deflation. Often, both worrying and analyzing were strongest at night when the participants were trying to sleep. They enacted horror scenarios in their imagination. One girl said she “painted situations black.” Another young woman, who anticipated events by playing out the worst possible scenario in her mind in advance, expressed this as “When you get into that negative way of thinking, then you feel sorry for yourself, blow things up out of proportion, and it becomes worse than it is.”

The cognitive dimension adds not only to aspects of being restless and unsettled but also to the mistrust and suffering in body and self. It also illustrates processes and vicious circles of disempowerment and resignation, where the participants alternated between hope and despair.

**Social Dimension**

The social dimension illuminates the young women’s experiences of imbalance and chaos in life, and their coping by withdrawal from social relationships. The young women tried to accomplish their best and live up to high standards in parallel social arenas such as school and education, family, and peer and partner relationships. However, they often felt insufficient and often lacked social support. Their constant struggle to become good and capable girls was perceived as not rewarded, and instead of recognizing that these external demands were unrealistic, many blamed themselves for falling short of society’s expectations. Furthermore, they often suffered in silence while trying to manage alone to maintain a social façade of success or normalcy.

**Imbalance in life.** Imbalance in life was expressed as a dilemma, including difficulties balancing and prioritizing between different activities and engagements, between activity and rest, or between being very social and being asocial. Often the problems of stress were associated with a strong drive, with periods of too much work or pressure, or with a desire “to be everywhere and do everything.” Many of these activities and ambitions were viewed as positive, but in the long run, too much of everything made it difficult to cope.

The participants expressed a personal responsibility for keeping “balance in life”—a notion that further mirrored their awareness of the ideal of being able to control themselves and their lives. They explained how they had to choose and prioritize, but at times, they did not want to—or were unable to:

Up to a certain limit I like having a lot to do, then it gets too much and then I can’t manage properly anymore and have difficulty winding down. I have difficulty finding a balance between being bored and having loads to do. It becomes much too much of everything, including fun things; it’s not just tiring things. It’s because I want control of things, and it may well be when I lose the control. Perhaps it’s that I’m living a little too close to that edge, then it gets too much.

**Chaotic life.** As in the quotation above, the participants described a loss of control over their lives when approaching “the edge,” and stressful situations became no longer manageable. Multiple social responsibilities and pressures, including caring for others, had become too demanding. Order and structure were transformed into a complete inability to act, and their lives descended into chaos. Behaviors such as poor eating habits and a loss of interest in hygiene were associated with a loss of control or a sense of drifting without getting anything done. Some even felt paralyzed, such as “robots” or “zombies,” during such periods of overload:

I fell into a stress trap. So it really was “overload,” as people say. It got too much and I couldn’t get any structure or order. It’s been such chaos. Now, afterwards, I have realized that no one in the world could have got structure in that situation. It is extra stressful because you find fault with yourself. Why am I unable to sort out my planning and clean properly at home?

**Withdrawal from social life.** Social withdrawal and social isolation were described as consequences of distress and overload; in other cases, conversely, loneliness led to distress. Experiences of high stress and pressure, or their physical and emotional state, led to withdrawal from social relationships, with some of the young women cutting themselves off from their social world. This was expressed as becoming “empty and indifferent,” introverted, or “disappearing from the world.”

**Existential Dimension**

The existential dimension constitutes a vital part of our in-depth explorations of the young women’s lived experiences of distress, feeling worn out, and suffering. It points to their wavering existential trust during an important transition period in life.

**Questioning and doubting self.** Irresolution, uncertainty, and doubt were experienced in a multilayered way. The young
women doubted their own body, self, personality, and health, as well as their social relationships and family life. They doubted and distrusted their capacity and capability to cope or succeed; this was often expressed as open-ended questions such as “How will I cope?” “How will I have time?” and “How should I handle this?”

Feelings of doubt, mistrust, and insecurity were also directed toward material and financial matters, which often included their future lives, their ability to earn a living, or get an education or a job. The stressful situation and lifestyle also made them question their own choices, values, and life philosophies. The participants’ own life philosophies of caring and altruism occasionally collided with the individualistic and competitive values of those around them. They questioned their social and gendered positions in life, and pointed to constraining ideals connected to femininity. One girl expressed this collision as “me against the world,” as she challenged given gender orders, “spoke out loud,” and claimed her place in different social contexts:

...like in school it’s absolutely true, too... that you shouldn’t be seen and heard as much... And then there’s this choice between being seen and heard and being a nuisance... and staying quiet.

Others had difficulties in living up to and being true to their own convictions, which were expressed as personal and existential dilemmas. Thus, they felt that their being in the world—their whole existence—was uncertain and not self-evident.

**Overwhelmed by life.** The young women expressed powerlessness when faced with pressures and life situations that were “insurmountable” and “too much.” At these times, they felt that their own abilities and resources were insufficient, and that it was impossible to influence the situation. On a more embodied level, the inability to find peace and sleep led to feelings of powerlessness in relation to body and self. The young woman below felt that she practically “broke down” due to the pressures she experienced:

I just felt powerless. It is so tiring when nothing goes with the flow and you really have to fight. Nothing is easy. It just felt like that, everything was too much. I felt completely exhausted. Both in my mind and in my body.

**Giving up one’s existence.** Loss of meaning and lust for life were formulated in questions such as “Is this my life?” or statements such as “If this is what life will be like, then I don’t want to live.” Suicidal thoughts were signs of being close to “giving up.” For example, one young woman who had long been a source of strength for others in the family, worked hard, and struggled with her own eating disorders described how she often thought of death. However, she felt she could not treat her parents so badly as to take her own life—so even in her thoughts of suicide, she was highly responsible and caring. Similarly, another young woman was mentally and physically exhausted after tragic deaths in her family and peer group, in addition to a great deal of daily responsibility for domestic work and relations in her family. All this together led her to consider suicide as a way out of her stressful situation:

Yes, it was like that, like, two or three months ago when it was dark and it was autumn. A friend of mine had killed herself, because she was depressed and that. So that affected me a great deal. I felt restless at that time too, and was a little down, when I heard about the girl. Then I had very strange feelings all of a sudden. “But, God, is it possible, that you’re so down that you’ll take your own life, without even thinking?” It was then that I started thinking about my own stress and depression. It’s true, I thought, “I’ll go down to the bridge and throw myself off, I can’t take it anymore. That’s the best solution.”

In sum, questioning and doubt were highlighted through the cognitive and existential dimensions, and not only reflected additional aspects of deflation, suffering, and pain but also reflected the young women’s drive and agency. Thus, the participants’ doubts embraced not only themselves, their capabilities, and their future but also their total embodied existence. A crucial aspect was their questioning and challenging of societal orders and lifestyles. This also included their own value conflicts and moral and existential dilemmas, which were often addressed as open-ended questions about their future and the development of the world as a whole. This relates to their doubt and distrust on a discursive and existential level, which corresponds to the structural dimensions of the young women’s life worlds.

**Discussion**

The theme “Living close to the edge” illustrates the girls’ and young women’s embodied and multidimensional experiences of distress. The results reveal experiences of anxiety, frustration, and collapse, as well as feelings of depression, suffering, and deflation. They also highlight existential dimensions of the young women’s doubting and questioning of personal and societal values and of their existence in the world. The participants tried to balance their lives and avoid descending into serious illness or breakdown. The use of metaphors such as “the edge” and “hitting a wall” further underlined both aspects of embodiment and the strong connections between body experiences, emotions, and reflexivity (Lupton, 2003; Nettleton & Watson, 1998). Emotions in relation to processes of doing gender were also highlighted (Shields, 2002). The results show how the young women were, on one hand, in the midst of overwhelming experiences, sometimes out of their control, and how, on the other hand, they were able to reflect on body and self in a distanced way. This illustrates both a presence in body and mind, and a
distance—a state in between—that can be related to Merleau-Ponty’s (1962) phenomenological notions of both being and having a body. In line with our observations, McLaughlin (2005) points to the body as a focus of distress, as both the expression and the object of distress. McLaughlin (2005) states that girls’ and young women’s bodies are often seen as “a site of distress and the internalizing of distress” (p. 55). It was also clear that the girls and young women in our study put stressful events into a social context.

In the following, we will discuss the results in the light of our interdisciplinary framework, including gender perspectives. By this, we outline an explanatory model where the concept of social and gendered embodiment is central for understanding the dynamic between the young women’s lived experience and agency, gendered structuring conditions, and psychophysiological stress processes.

**Embodied Loss of Basic Existential Trust and Human Value**

A phenomenological approach provides a vital basis for our in-depth understanding of the existential meanings of the young women’s experiences (Cosgrove, 2000; Merleau-Ponty, 1962). Their stories highlighted aspects of uncertainty, alienation, and weakened trust in body, self, and the world as a whole. In other words, essential aspects of the body—self were impaired, embracing several existence levels including basic existential trust. In other studies, being at home in one’s body is identified as an important dimension of health but one that is often disrupted in experiences of illness and stress-related exhaustion (Jingrot & Rosberg, 2008).

We suggest that the young women’s experiences of both acute and long-term distress can be understood in a similar manner. A painful, suffering, restless, and unsettled body (as expressed in the metaphor of “going up the wall”) together with emotions of anxiety, fear, and panic may substantiate aspects of not being home in one’s body. Difficulties to relax illuminate a disrupted harmony and vitality in basic body—self functions and rhythms (Skjaerven et al., 2008). The social and existential distrust indicates more generalized experiences of not feeling at home in the world and frictions around one’s own and others’ life goals and values.

In phenomenology, **suffering** is defined as an existential entity often connected to experiences of illness or of physical, mental, or existential pain (Ekstedt & Fagerberg, 2005). Our participants expressed their deflation through processes of impaired belief in themselves, lack of confidence, lack of self-worth, and social withdrawal. Similar notions of deflation, formulated as “being less than I could be,” are illuminated in a study of the meanings of stress for children (Kostenius & Öhrling, 2008). Our results also reveal self-blame, self-harm, and a wish to punish oneself as ways of handling failure or distress. Moreover, powerlessness and suicidal thoughts illustrate the closeness to the edge and surrendering one’s being-in-the-world. Hence, on a comprehensive level, experiences of personal suffering, deflation, and withdrawal can be understood as feelings of human dignity and value—the right and will to exist. Similar existential breakdown and **identity disruption** have been identified in adult women suffering from stress and pain (Ekstedt & Fagerberg, 2005; Raheim & Haland, 2006). In addition, Charmaz (1983, 1999) identifies a **loss of self**, related to experiences such as leading restricted lives and experiencing social isolation, as a fundamental form of suffering in chronically ill individuals—sources that all lead to a diminished self-concept, and losses of control and action. Although participants in this study cannot be defined as chronically ill, they suffered from long-term psychological distress and physical discomfort that may be similar to the more general nature of illness experiences as described by Charmaz (1983, 1999). In our view, the results of experienced suffering, identity disruption, loss of trust, and human value cannot be fully understood from a narrow and solely medicalized view, rather as losses and disruptions of a more existential character. The results may also reflect incorporated (gendered) hierarchic positions of feeling “worth less” or worthless (Charmaz, 1999, p.369).

From a feminist phenomenologist perspective, our results of the young women’s suffering and distress—including self-violence—can be interpreted as a restriction of their embodied vitality and agency, and can be compared with Young’s (2005) theorizing of girls’ and women’s inhibited movements and transcendence in a patriarchal society. At the same time, the young women were analytical and problem solving, and can be understood as reflexive and independent thinkers displaying individual reflexivity, responsibility, and agency—characteristics not only of late modernity but also of young femininity (Arnett, 1999; Giddens, 1991; Harris, 2004; Wiklund, Bengs, et al., 2010). In this individualized way, they tried to handle both the existential elements of insecurity and doubt, and the generalized feelings of powerlessness and worthlessness that had turned into hopelessness, despair, and loss of life’s meaning.

**Contextualizing and Gendering Young Women’s Embodied Distress**

In this context, it is essential to highlight the social and gendered dimension of our results. From a social constructionist perspective, the narrations correspond to the discourses and ideal images of high tempo, effectiveness, rationality, perfection, and competition, which are present in contemporary society (Harris, 2004; Widerberg, 2006; Wiklund, Bengs, et al., 2010). Also, the observed use of vocabulary in relation to the young women’s collapsing bodies indicates that they had adopted the language often used by the media, psychological and medical science, or self-help literature in connection to exhaustion disorders or burnout (Berg, 2012). It is clear that the young women withdrew from their social lives and networks as a consequence of their stressful lives, overload, and
prolonged experiences of distress and depressed mood. Social networks and social relations are viewed as crucial determinants of health (Stephens, 2008). However, social relationships are not automatically supportive for young women (Hinton & Earnest, 2010; Wiklund, Bengs, et al., 2010). The girls and women in our study were in a transitional stage in their journey toward adult and autonomous lives. In such a process, strained social relationships or the absence of social networks and support might be detrimental to their health. In a long-term perspective, there is an obvious risk that such social withdrawal and potential isolation will also lead to a process of disempowerment. From a social constructionist and gender perspective, the young women’s social withdrawal can not only be interpreted as a failure to follow the normative trajectories set up for young women’s successful lives (Harris, 2004), but it could also be interpreted as a resistance—as a way of claiming own space and solitude (Björck, 2011). Their struggle corresponds to what Harris (2004) calls social constructions of “success girls” or “never-good-enough girls.” According to Harris, the potential for failure is central to the social construction and regulation of girls. These notions may also serve to explain the self-disgust and wish to punish oneself, which were found in this study.

We further want to acknowledge the importance of contextualizing and gendering young women’s distress, particularly in the context of youth health and primary care. This is congruent with recent health studies emphasizing the links between performances and constructions of gender, mental health, and distress (Bengs, Johansson, Danielsson, Lehti, & Hammarström, 2008; U. Danielsson, Bengs, Samuelsson, & Johansson, 2011; Emslie, Ridge, Ziebland, & Hunt, 2006; Ridge, Emslie, & White, 2011). The gendered aspect is, for example, seen in the girls’ and young women’s emotional work and caring for others, or in their attempts to control their bodies, their body size, and their food intake, emphasizing the pressure they felt to achieve and maintain the idealized notion of a thin female body (Frost, 2005; Lupton, 2013). In our previous analysis of these young women’s narrated external stress factors and demands, we suggested that the stressors experienced by the young women were multiple and connected to essential life spheres such as school and education, working life, family situation, peers, and partner relationships. Moreover, they were related to societal macro-level discourses, the demands and constraints of modernity, gender orders, and youth (Wiklund, Bengs, et al., 2010). The main theme of this study—"living close to the edge"—and the various lived and embodied dimensions of distress, distrust, and disempowerment can be interpreted as both consequences of and responses to these multiple gendered stressors and constraints. In several respects, our participants seemed to embody and negotiate a gendered modernity and individualization. Likewise, Widerberg (2006) talks of tiredness as a way of embodying modern times and argues that tiredness, restlessness, and irritability are “new” emotions linked to modernity and its accelerated life and pressure to achieve “more in less time.” This is in line with our results, which indicate that girls’ and young women’s life worlds embrace complex societal discourses, and that these seem to be embodied and materialized.

Drawing on Connell’s (2002) concepts of social and gendered embodiment, we therefore suggest that the young women’s embodiment and emotionality occurred within a complex social and gendered context. Connell suggests that gender can be “worked into the body,” and that bodies are both objects and agents in loops that link bodily processes with social structures and power relations. As Connell (2012) puts it, “Gender practice is a reflexive process of social embodiment” (p. 1677). Consequently, bodies and health are arenas for social processes. According to Connell, gender and its frictions are actively negotiated or resisted, seldom simply passively absorbed.

From a feminist perspective, Bordo states that “the continuum between female disorders and ‘normal’ feminine practice is sharply revealed through a close reading of those disorders to which women have been particularly vulnerable” (2004[1993], p. 168). Media researcher McRobbie (2009) also addresses the contemporary field of “female complaints” and “post-feminist disorders” in her examination of the contemporary sociocultural landscape of young women’s lives. We find that these notions are highly applicable to our results; the psychophysiological responses, embodied stress, and health consequences were tangible, as was the young women’s frustration and agency seen in their reflexivity and questioning of their situation. The dimensions of distress, as seen in the results, may exemplify and represent such “gendered frictions” that girls experience and negotiate. Complexities in contemporary young women’s identity constructions are also seen in other sociocultural contexts (Aapola, Gonick, & Harris, 2005; Harris, 2004; Jacques & Radvilas, 2012; McRobbie, 2009; Woods-Giscombe, 2010). Hence, the results of this study point to the importance of further examining the health consequences of young women’s troubled social and gendered positions.

**Psychophysiological and Emotional Processes Along the Continuum of Distress**

In a more in-depth sense, the psychophysiological stress reactions and stress responses described in this study may serve as examples of how social context and gender can be worked more concretely into the body in a reciprocal loop where internal processes merge with external conditions. This is an extension of Connell’s (2012) theorizing in line with Krieger’s (2005) definition of embodiment as a multi-level phenomenon integrating the interplays between “bodies, components of bodies, and the world(s) in which bodies live” (p. 351). This dynamic process points to bodies as “active and engaged entities” (Krieger, 2005, p. 351), which is in congruence with our view on psychophysiological stress.
mechanisms as responsive to situation and social context. We believe that a psychophysiological perspective can help to explain some of the mechanisms involved in the underlying processes of social and gendered embodiment, including the potential links to ill health. Taken together, the physical dimension of distress—expressed as a restless, unsettled, suffering, and collapsing body—illuminates how participants showed signs of acute stress and psychophysiological arousal, whereas others were worn out and showed signs of more long-lasting stress (Arnetz & Ekman, 2006; McEwen, 1998). Our participants’ situation, including their own appraisal of their incapability to cope, expressed an imbalance between demands and control, which in a long-term perspective is defined as strenuous and negative for health (Karasek & Theorell, 1990; Modin, Östberg, Toivanen, & Sundell, 2011). Experiences of restlessness, muscular tension, or irritation indicate activation of the physiological stress management system as a response to an appraised threat. The signs of tiredness and depressive mood, as part of the participants’ experienced resignation and disempowerment, indicate prolonged stress (Arnetz & Ekman, 2006; M. Danielsson et al., 2012). Consequently, the problems ranged in severity and revealed several processes of negative development toward ill health along a continuum of distress, representing different stages of increased psychophysiological stress responses.

The concept of allostatic overload serves as a tool to describe and explain such negative stress development over time and is therefore applicable to the results in this study (McEwen, 2007). Constant worries and difficulties sleeping, resting, and relaxing further reinforced our participants’ allostatic load (Åkerstedt, 2006; Åkerstedt et al., 2007). Moreover, the demonstrated combinations of multiple physical, emotional, and cognitive reactions and symptoms indicate prolonged stress (Arnetz & Ekman, 2006; L. Öhman et al., 2007), which point to the importance to study patterns of multiple cumulative or co-occurring stress symptoms (Alfvén, 1993; Thoits, 2010; Wiklund et al., 2012). The results show similarities with stress-related ill health such as exhaustion syndrome, burnout, and chronic stress as studied in adult populations (M. Danielsson et al., 2012; Ekstedt & Fagerberg, 2005; Eriksson, Starrin, & Janson, 2008; L. Öhman et al., 2007).

Our findings of emotional distress are also supported by studies in which adolescents themselves define emotions as important for their mental health (Johansson, Brunnberg, & Eriksson, 2007). Close links between emotions, physiological processes, and stress are well established (Lazarus, 1999), as are links between emotions and psychosomatic ill health (Meurle-Hallberg & Armelius, 2006). Emotions seem to play an important role in initiating and sustaining psychosomatic complaints (Bergdahl et al., 2005). However, emotions should be defined not only as psychophysiological processes but also as social and gendered phenomena (Barbalet, 2001; Hochschild, 1979; Lamb, 2001; Lupton, 1998; Shields, 2002). In the present study, for instance, this was made clear in the participants’ descriptions of their emotional work, awareness of gendered rules about feelings, and panic attacks in strained social situations. This also exemplifies the notions of what Lupton (1998) calls the “unruliness of fluid emotion” (pp. 84-85). The autonomic nervous system then appears to be a mediator between body, affects, and emotions on one hand, and the social and gendered world on the other.

In line with contemporary notions of femininity, the young women tried to control, internalize, and regulate emotions that they felt should not be displayed. Consequently, management of emotions and stress was strived for (Berg, 2012; Lupton, 1998), whereas loss of control was seen as a failure and a social stigma. In this context, self-punishment (as seen in the results) can be interpreted as a form of exercised self-control and self-directed violence, which occurs when one feels that one is not good enough or is not performing well enough in line with one’s own or others’ expectations. Our results illustrate the complex reciprocal processes where external social and gendered conditions merge with internal body-anchored responses and experiences.

Methodological Considerations

In accordance with social constructionism, we regard the interpretations and results of this study as co-created meaning and co-produced knowledge (Denzin & Lincoln, 2003). This also applies to the issues that this study explores, and which we and/or the participants interpreted and defined as gendered, and as such tied to norms and ideals of young femininity. In our analysis and discussions, we have oscillated between remaining close to the participants’ lived experiences, as in phenomenology, and being more distanced and interpretative, as in social constructionism (Dahlgren et al., 2004). Using a qualitative and phenomenological approach, we have explored a number of central dimensions of the phenomenon of lived stress. Qualitative content analysis proved to be a suitable method of exploring the wide range of lived embodied experiences, as the method keeps to a descriptive level close to the participants’ own words and metaphors and also allows the display of diversity in categories (Graneheim & Lundman, 2004). Trustworthiness was obtained through prolonged engagement with the participants, thick descriptions, and the interdisciplinary triangulation between investigators with different professional and theoretical backgrounds (public health, physiotherapy, sociology, and gender studies). The interdisciplinary research team facilitated not only the triangulation during the analysis (Lincoln & Guba, 1985) but also the development of a theoretical framework that narrowed the gap between the disciplines of health sciences, social sciences, and gender studies. This supports the view that biosocial approaches have the potential to address complex intersections between social, gendered, and biological processes over the life span (Springer, Hankivsky, & Bates, 2012). Still, the theoretical framework can be further
developed and modified in relation to other empirical materials and contexts.

The study also has its limitations. The representation of different ethnic groups was limited, as the majority of the participants were born in Sweden. In addition, the study did not include boys/men. The dimensions of distress that we have illuminated here may be universal and also true for boys/men in certain contexts. However, we have made theoretical and analytical generalizations in relation to the research literature on aspects such as young femininity, in line with established procedures in qualitative methodology (Lincoln & Guba, 1985). Yet, the sample was not representative from a statistical point of view. It was a consecutive sample, and the participants had themselves contacted the youth health center and applied to the research project, which could imply that they were motivated and strong enough to seek support. However, several participants described periods when they had not been able to seek professional help, or did not have access to support, and these narrations were also included in the results. Nevertheless, we believe that the results of the study reflect crucial dimensions of experienced stress and distress, which can be further deepened and discussed in future studies.

Conclusions and Implications

In this study, we have explored the lived embodied multidimensional experiences of stress, and of “living close to the edge,” as narrated by Northern Swedish adolescent girls and young women. These physical, emotional, cognitive, social, and existential dimensions are viewed as empirical examples of gendered and social embodiment, and illustrate the complex gendered biopsychosocial processes where external structuring conditions merge with internal body-anchored responses and experiences. Through this, essential aspects of the young women’s body–self were impaired, embracing several vital existence levels including basic existential trust. The distress, as seen in the results, may represent “gendered frictions” that girls experience and negotiate, which exemplify how gender and stress are not only “worked into the body” but also “acted out”. Accordingly, multiple dimensions of embodiment are central to integrate into our understandings of the dynamic co-constructions of stress, mental ill health, and gender along the life span. The phenomenon of stressful young femininity would also be important to study in other social contexts and in global perspectives. Our results also reveal that the young women’s experiences of distress and illness were multifaceted, which place high demands on health facilities and intervention programs. It is essential that health providers integrate a gender perspective that can meet the needs of young women seeking support for stress-related ill health (see, for instance, Strömbäck et al., 2013). Their gendered social life circumstances need to be brought up and scrutinized in relation to external/internal pressures and demands, as well as related to sources of social and societal support, and to potential social inequalities in health and well-being. In parallel, prolonged and multidimensional symptoms of stress and ill health must be addressed and taken seriously. Based on findings in this study, we suggest intervention models with a holistic, context-sensitive, and gender-sensitive approach that can address multidimensional aspects of overload and distress, including existential aspects and young women’s own reflectivity and agency.

By drawing on an interdisciplinary synthesis of theoretical perspectives, we hope to have contributed to bridging biopsychosocial perspectives with phenomenology and social constructivist and gender approaches to shed light on young women’s narrated experiences of stress.

Acknowledgment

We thank all the participants in the study.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research and/or authorship of this article: This work was supported by Västerbotten County Council, the Swedish Research Institute (Grant 521-2005-4848 and Grant 344-2011-5478); Umeå Center for Global Health Research at Umeå University (grant from the Swedish Council of Working Life and Social Research, No. 2006-1512); and the Umeå Center for Gender Studies (UCGS), Umeå University, Sweden.

References


Author Biographies

Maria Wiklund, PhD in Public Health, is a senior lecturer in Physiotherapy, Department of Community Medicine and Rehabilitation, Umeå University, Sweden. She is also a qualified physiotherapist specializing in psychosomatics and basic body awareness therapy (BBAT). Her research focus is on psychosomatics, stress, embodiment, medical sociology, and the development of health-promoting gender-sensitive interventions among young people.

Ann Öhman, PhD, is a professor at the Umeå Centre for Gender Studies, and also affiliated to the Epidemiology and Global Health Unit, Department of Public Health and Clinical Medicine, Umeå University, Umeå, Sweden. She specializes in public health, gender studies, medical sociology and qualitative methodology.

Carita Bengs, PhD, is an associate professor in sociology, and head of Department of Sociology, Umeå University, Umeå Sweden. Her main areas of research lies within the fields of medical sociology, sociology of the body, gender, youth, media, emotions and disability. She has focused on gendered and cultural expressions of health and illness, e.g. the influence of mass media and gendered constructions of depression in newspapers.

Eva-Britt Malmgren-Olsson, PhD, is a senior lecturer in Physiotherapy, Department of Community Medicine and Rehabilitation, Umeå University, Sweden. She is a senior researcher specializing in musculoskeletal pain and interventions, with special reference to basic body awareness treatment (BBAT) and stress management.