ADOLESCENT BOYS' HEALTH

- managing emotions, masculinities and subjective social status

Eva Randell

Department of Public Health and Clinical Medicine,
Epidemiology and Global Health
Umeå University 2016

Responsible publisher under Swedish law: The Dean of the Medical Faculty
This work is protected by the Swedish Copyright Legislation (Act 1960:729)
ISBN: 978-91-7601-523-0
ISSN: 0346-6612
Cover: Blue boys, a painting by Hans Löfgren, Umeå
Elektronisk version tillgänglig på http://umu.diva-portal.org/
Printed by Print & Media, Umeå University
Umeå, Sweden 2016

I would like to dedicate this thesis to all the adolescent boys who are dealing with their health and emotions and reflecting about what it means to become a young man.

Table of Contents

Table of Contents **iii**
Abstract **v**
Sammanfattning på svenska **vii**
Abbreviations **ix**
Original papers **x**
Preface **xi**
Introduction **1**
Research position and pre-understanding **3**
My ontological and epistemological position 3
Professional position 4
From the public health point of view 5
Theoretical concepts and perspectives **6**
Health and wellbeing **7**
Measuring health *8*
Body and mind in health *10*
Emotion management *11*
Self-conscious emotions of pride and shame *12*
Social status and subjective social status *13*
Gender **15**
Gender construction *15*
Masculinities *16*
Research on health and gender **18**
Adolescent health *18*
Gender-specific health *19*
Exploring health *20*
Health and emotions *21*
Rational for the study **21**
Knowledge gap *23*
Aims **24**
Overall aim **24**
Specific aims **24**
Methods and materials **25**
Settings **25**
Study design **26**
Research setting **27**
Recruitment and participants **28**
Papers I-II 28
Papers III-IV 30
Paper IV 30
Data collection **30**

Interviews 30
Questionnaire 31
Variables included in the analyses 32
Data analyses **35**
Papers I-II 35
Paper III 35
Paper IV 36
Ethical considerations **37**
Results **39**
Health - holistic, dialectic or dualistic? **39**
Valuing health 41
Health and emotions **42**
Feeling health in interaction 42
Health, pride and shame 43
Managing health 47
Health and gender **51**
Masculinity and emotions 51
Being young in gendered space 53
Health and the impact and meaning of subjective social status **54**
Summary of the main findings **59**
Discussion **60**
Health **60**
The complexity of health as a concept and experience 60
Finding a balance 62
Valuing dimensions of health 63
Health and emotions **64**
The impact of pride and shame 65
Managing health 67
Health and subjective social status **70**
Methodological considerations **72**
Trustworthiness 72
Validity and reliability 73
The importance of context 75
Conclusions **76**
Implications for practice **78**
Future research **79**
Acknowledgements **81**
Appendices **83**
Appendix 1. Interview guide used in study I 83
References **84**

Abstract

Title: Adolescent boys' health – managing emotions, masculinities and subjective social status

The health of adolescent boys is complex and surprisingly little is known about how adolescent boys perceive, conceptualise and experience their health. Thus, the overall aim of this thesis was to explore adolescent boys' perceptions and experiences of health, emotions, masculinity and subjective social status (SSS).

This thesis consists of a qualitative, a quantitative and a mixed methods study. The qualitative study aimed to explore how adolescent boys understand the concept of health and what they find important for its achievement. Furthermore, the adolescent boys' views of masculinity, emotion management and their potential effects on wellbeing were explored. For this purpose, individual interviews were conducted with 33 adolescent boys aged 16-17 years. The quantitative study aimed to investigate the associations between pride, shame and health in adolescence. Data were collected through a cross-sectional postal survey with 705 adolescents. The purpose of the mixed methods study was to investigate associations between SSS in school, socioeconomic status (SES) and self-rated health (SRH), and to explore the concept of SSS in school. Cross-sectional data were combined with interview data in which the meaning of SSS was further explored. Individual interviews with 35 adolescents aged 17-18 years were conducted.

In the qualitative study, data were analysed using Grounded Theory. In the quantitative study, statistical analyses (e.g., chi-square test and uni- and multivariable logistic regression analyses) were performed. In the mixed method study, a combination of statistical analyses and thematic network analysis was applied.

The results showed that there was a complexity in how the adolescent boys viewed, experienced, dealt with and valued health. On a conceptual level, they perceived health as holistic but when dealing with difficult emotions, they were prone to separate the body from the mind. Thus, the adolescent boys experienced a difference between health as a concept and health as an experience (paper I). Concerning emotional orientation in masculinity, two main categories of masculine conceptions were identified: a gender-normative masculinity and a non-gender-normative masculinity (paper II). Gender-normative masculinity comprised two seemingly opposite emotional masculinity orientations, one towards toughness and the other towards

sensitivity, both of which were highly influenced by contextual and situational group norms and demands, despite that their expressions are in contrast to each other. Non-gender-normative masculinity included an orientation towards sincerity, emphasising the personal values of the boys. Emotions were expressed more independently of peer group norms. The findings suggest that different masculinities and the expression of emotions are intricately intertwined and that managing emotions is vital for wellbeing. The present findings also showed that both shame and pride were significantly associated with SRH, and furthermore, that there seems to be a protective effect of experiencing pride for health (paper III). The results also demonstrated that SSS is strongly related to SRH, and high SRH is related to high SSS, and further that the positioning was done in a gendered space (paper IV).

Results from all studies suggest that the emotional and relational aspects, as well as perceived SSS, were strongly related to SRH. Positive emotions, trustful relationships and having a sense of belonging were important factors for health and pride was an important emotion protecting health. Physical health, on the other hand, had a more subordinated value, but the body was experienced as an important tool to achieve health. Even though health was mainly perceived in a holistic manner by the boys, there were boys who were prone to dichotomise the health experience into a mind-body dualism when having to deal with difficult emotions.

In conclusion, this thesis demonstrates that young, masculine health is largely experienced through emotions and relationships between individuals and their contexts affected by gendered practices. Health is to feel and function well in mind and body and to have trusting relationships. The results support theories on health as a social construction of interconnected processes. Having confidence in self-esteem, access to trustful relationships and the courage to resist traditional masculine norms while still reinforcing and maintaining social status are all conducive to good health. Researchers as well as professionals need to consider the complexity of adolescent boys' health in which norms, values, relationships and gender form its social determinants. Those working with young boys should encourage them to integrate physical, social and emotional aspects of health into an interconnected and holistic experience.

Keywords: Adolescent boys, emotion management, gender, health, masculinity, pride, shame, self-rated health, subjective social status

Sammanfattning på svenska

Titel: Tonårspojkars hälsa – att hantera känslor, maskuliniteter och subjektiv social status

Tonårspojkars hälsa är komplex och det finns förvånansvärt lite forskning gällande hur tonårspojkar uppfattar, konceptualiserar och upplever hälsa. Därför var det övergripande syftet med denna avhandling att undersöka tonårspojkars uppfattningar och upplevelser av hälsa, emotioner, maskuliniteter och subjektiv social status.

Denna avhandling består av tre delstudier: en kvalitativ, en kvantitativ och en mixed metod studie. Den kvalitativa studien syftade till att undersöka hur tonårspojkar uppfattar begreppet hälsa och vad de tyckte var viktigt för att uppnå hälsa, samt deras syn på manlighet, känslohantering och potentiell påverkan på deras välbefinnande. För detta ändamål genomfördes individuella intervjuer med 33 unga pojkar i åldern 16-17 år. Den kvantitativa studien syftade till att undersöka sambandet mellan stolthet, skam och hälsa i tonåren, och data samlades in genom en postenkät där 705 ungdomar deltog. Syftet med mixed metod-studien var att undersöka sambanden mellan subjektiv social status (SSS) i skolan, socioekonomisk status (SES) och självskattad hälsa (SRH) samt att undersöka innebörden av begreppet subjektiv social status. Data från en enkät kombinerades med intervjudata av 35 ungdomar i åldern 17-18 år.

I den kvalitativa studien analyserades data med hjälp av Grounded Theory metoden. I den kvantitativa studien användes statistiska analyser såsom chi-två-test samt uni- och multivariabel logistisk regressionsanalys. I mixed metod-studien användes en kombination av statistiska analyser och tematisk nätverksanalys.

Resultaten visade att det fanns en komplexitet i hur unga pojkar uppfattade, upplevde, hanterade och värderade hälsa. På en teoretisk nivå uppfattade de hälsa som holistisk men när det handlade om att hantera svåra känslor, var de benägna att separera kroppen från sinnet. Således upplevde de en skillnad mellan hälsa som begrepp och hälsa som upplevelse (I). Gällande den känslomässiga maskulina orienteringen, identifierades två huvudkategorier av maskulina föreställningar: könsnormativ och icke-könsnormativ maskulinitet (II). Könsnormativ maskulinitet bestod av två till synes motsatta maskulinitetsorienteringar, en mot tuffhet och den andra mot känslighet, som båda var starkt påverkad av kontextuella och situationella gruppnormer och krav, trots att deras uttryck kontrasterade varandra. Icke-

könsnormativ maskulinitet inkluderade en inriktning mot uppriktighet som betonade de personliga värdena för pojkar; känslor kunde uttryckas mer oberoende av kamratgruppens normer. Resultaten tyder på att olika maskuliniteter och känslouttryck är starkt sammanflätade och att känslohantering är avgörande för välbefinnandet. Resultat visade också att upplevelser av skam och stolthet var signifikant associerade med självskattad hälsa, och att stolthet verkar ha en skyddande effekt för hälsa (III). Vidare visade resultaten att det finns ett starkt samband mellan subjektiv social status och självskattad hälsa och att mycket god självskattad hälsa är relaterad till hög subjektiv social status. Positioneringarna gjordes i en starkt genuskodad skolmiljö (IV).

Resultat från alla studier visar att de känslomässiga och relationella aspekterna var avgörande för hälsa, liksom den subjektivt upplevda status som var starkt relaterad till självskattad hälsa. Positiva känslor och tillitsfulla relationer, och att känna tillhörighet och stolthet var viktiga faktorer för hälsa. Fysisk hälsa å andra sidan hade ett mer underordnat värde men kroppen var ett viktigt verktyg för att uppnå hälsa. Även om hälsa uppfattades på ett holistiskt sätt av de flesta pojkarna, fanns det pojkar som var benägna att dela upp hälsoupplevelsen i kropp och sinne när det gällde att hantera svåra känslor.

Sammanfattningsvis visar denna avhandling att den unga, manliga hälsan till stor del upplevs genom känslor och relationer mellan individer och deras sammanhang som är starkt genuskodade. Resultaten stöder teorier om hälsa som en social konstruktion av sammankopplade processer. Hälsa är att må och fungera bra i kropp och sinne och ha tillgång till tillitsfulla relationer. Att ha självkänsla, tillgång till förtroendefulla relationer och att våga stå emot traditionella maskulinitetsnormer utan att tappa status bidrar positivt till hälsa. Forskare samt yrkesverksamma måste ta hänsyn till komplexiteten i unga pojkars hälsa, där normer, värderingar, relationer och genus utgör dess sociala bestämningsfaktorer. De som arbetar med unga pojkar bör uppmuntra dem att integrera fysiska, sociala och känslomässiga aspekter av hälsa till en sammanlänkad helhetsupplevelse.

Nyckelord: Genus, känslohantering, hälsa, maskulinitet, självskattad hälsa, skam, stolthet, subjektiv social status, tonårspojkar

Abbreviations

CI Confidence interval
OR Odds ratio
SRH Self-rated health
SES Socioeconomic status
SSS Subjective social status
SPSS Statistical Package for Social Sciences
VIP Very interesting person
WHO World Health Organisation

Original papers

This thesis is based on the following papers, which will be referred to throughout as Papers I-IV in the text:

I. Randell, E., Jerdén, L., Öhman, A. & Flacking, R. What is health and what is important for its achievement? A qualitative study on adolescent boys' perceptions and experiences of health. *The Open Nursing Journal*. 2016 doi: 10.2174/1874434601610010003

II. Randell, E., Jerdén, L., Starrin, B., Öhman, A. & Flacking, R. Tough, sensitive and sincere: how adolescent boys manage masculinities and emotions. *International Journal of Adolescence and Youth*. 2015 doi: 10.1080/02673843.2015.1106414

III. Randell, E., Joffer, J., Flacking, R., Starrin, B. & Jerdén, L. Pride, shame and health among adolescents – a cross-sectional survey. *Submitted*

IV. Joffer, J., Randell, E., Öhman, A., Flacking, R., Bergström, E. & Jerdén, L. Subjective social status and health in adolescence: a mixed methods study. *In manuscript*

Preface

There is so much written in the media about girls having a hard time, and I don't want to contradict that – they do. But I think that we guys have a very hard time too, and no one writes about that, which makes it hard to be an emotional guy who shows that he's sad (boy, 16 years).

My interest in adolescent health arose from years spent as a social worker and working with young people both at social services and at schools. Being a social worker was much about contributing to the wellbeing of children and adolescents - supporting a healthy lifestyle and influencing them to avoid or stop unhealthy behaviours such as drinking too much, using drugs or committing crimes. Even though I never said that I worked with "health" issues in the social work practice, much of the supportive work was related to health and wellbeing. There were some gender differences between boys and girls in health behaviours, emotional expressions and help-seeking behaviour. For a social worker, boys as a group were harder to reach at school because they were generally more reluctant to visit me as a school counsellor. However, the boys were more frequently seen at social services because they were generally more prone to be involved in problem behaviour or with juvenile delinquency.

After starting to work as a university lecturer, I tried to integrate those various field experiences with the theoretical knowledge in my academic career, which bridged the gap between theoretical- and practice-based knowledge. My work has been enriched by a search for connecting my field experiences to existing theoretical frames, and trying to understand practice through a theoretical lens. "There is nothing so practical as a good theory", as Kurt Lewin stated in 1951, referring to a good theory which may be useful and explanatory and eventually guide effective actions. Before starting the doctoral studies, my theoretical knowledge about health was limited. However, I was driven by curiosity in approaching and exploring the field of health from the social sciences point of view with an emphasis on subjective descriptions. Our ideas about gender are deeply rooted, and when we hear expressions, such as "boys, you know how they are", implying both an expectation and an inherent explanation, we should be critical and question our preconceptions. This raised the question of what contributes to the health experience and how health is understood by adolescent boys.

And, how about the current boy code? What is ideal might vary between different settings and I assumed that the influence from the Swedish

legislation, that since many years has guaranteed equal possibilities for women and men, has had an effect shaping the modern young masculinity. I was also interested in how that possible new boy code influenced the perceived health among adolescent boys. Those working with young people need knowledge about how they can promote healthy behaviours and reduce unhealthy behaviours. A starting point in the research on children and young people was the belief that, no matter what difficulties they have, they are capable of formulating their own needs and desires. Being young today is a search for a belonging and identity. Adolescent boys in a Nordic context, influenced by a strong equality discourse, may experience contradictory requirements that can be difficult to live up to. I hoped that approaching health from different perspectives and using both qualitative and quantitative designs would produce some ideas about how health can be understood and tackled. My starting point was to listen to the boys.

Introduction

Health is the central concept in this thesis. Concern for adolescent health has received and continues to receive much attention in Sweden and in other countries. As described below, although adolescents generally are physically healthy, the mental health of adolescents has been defined as a global health concern. Indeed, research shows that the subjective health complaints of adolescents increase with age and older adolescents report more problems compared with younger adolescents.

The World Health Organisation (WHO) monitors adolescent health on a regular basis for the past three decades. In addition, health behaviours in school-aged children (HBSC) aged 11-15 years are examined in large scale cross-national studies in more than 40 countries (Currie & Alemán-Díaz, 2015; Elgar et al.).

The latest HBSC study, "Growing up unequal: gender and socioeconomic differences in young people's health and wellbeing", presents findings from the survey conducted in 42 countries with 220000 participants (WHO, 2016). According to the study, self-rated health (SRH) starts low already at age 11 and decreases with age. By age of 15, 50% of girls and 27% of boys report multiple health complaints, such as stomach ache, backache or feeling low more than once a week. Further, that lower family affluence is associated with low SRH in most participating countries. The report shows that mental health problems, measured by self-reported mental and somatic complaints, have increased more in Sweden than in other countries between 2009-10 and 2013-14. From a level close to the average, Sweden is now 8 out of 42 countries in the list of highest incidence of mental ill-health. The same decrease in mental health has not been seen in the other Nordic countries, which are among the five countries with the lowest prevalence of mental ill-health. However, older adolescents are not included in the HBSC studies and fewer studies have been conducted concerning older adolescents' SRH. A systematic literature review on mental health up to 19 years concluded that although time trends are difficult to evaluate, several studies showed increased subjective health complaints among older adolescents, as well as gender differences between boys and girls (Petersen et al., 2010). For Sweden, the message of the HBSC study is an alarming signal requiring immediate attention.

Compared with girls, boys are often viewed as problematic and 'boy crises' with references to, e.g., behavioural problems, school problems, criminality and violence, are regularly reported by the media. Kimmel (2010) highlights

three dimensions of the boy crisis: attendance (fewer males in higher education), achievement (a significant gender gap in school achievement) and behaviour (boys are diagnosed with behavioural difficulties more often than girls). He claims that the ideology of masculinity is a problem for both boys and girls, and suggests that to rescue and protect boys, we have "to reveal and challenge this ideology of masculinity, to disrupt the facile boys will be boys model, and to erode boys' sense of entitlement." (p.50).

Gender and traditional masculinities have been shown to influence the life-histories of young men, affect their mental health and the different ways they talk about their distress, which are not easy recognisable (McQueen & Henwood, 2002). One longitudinal study, following the participants from 11 to 19 years, showed that childhood adversities are associated with poorer educational outcomes of young adults, but only among boys, and suggests that boys are less capable of coping with childhood adversities than girls (Veldman et al., 2015). Male rates of suicide are significantly higher than female rates (Bertolote & Fleischmann, 2015), and traditional masculinity norms are identified as a risk factor (Coleman, 2015). One study among young men with attempted suicide found that masculinity norms discourage disclosure of emotional vulnerability and the participants used alcohol and drugs to cope, which worsened and prolonged their distress (Cleary, 2012). Thus, influence from gender norms is highlighted in many studies and there seems to be gender differences within several fields. The relation between gender, emotions and health needs more attention and gender-specific understanding.

The dissertation is expected to provide new knowledge about adolescent boys' health and related factors. This dissertation focuses mainly on adolescent boys, although both boys and girls were included in two studies (papers III-IV). The narratives and responses of the boys are analysed in relation to the girls' answers in order to be able to illustrate potential gender differences.

Research position and pre-understanding

My ontological and epistemological position

In the thesis, an interdisciplinary approach is used. It combines qualitative, quantitative and mixed methods. Studying adolescent boys' health is challenging because of its complexity. Thus, theories from both social and medical fields are used to cover the broad and multidisciplinary field that constitutes the health of adolescent boys.

It could be easy to consider medical science as an objective science but it is inevitably affected by subjective and social aspects. The basis of the thesis is that the nature of being and of knowing is affected by the researchers' assumptions: is it possible to step away from the world we study and consider it through an objective lens, or do we consider ourselves to some extent as part of the world. During the process of this thesis, philosophical questions concerning ontology, such as the nature of being and existence, combined with the epistemological question on how we know what we know, were raised. The research area was approached from different ontological and epistemological positions and I found that I could benefit from a multidisciplinary approach. On the one hand, I worked inductively from empirical research to theoretical understanding; on the other hand, concepts, possible to investigate by doing statistics, were operationalised.

The social constructionist view emphasises the social construction of reality and that knowledge and the world are socially constructed through interaction (Berger & Luckmann, 1967; Burr, 2003). Seeing the world with the eyes of the social constructionist view highlights multiple realities, knowledge bound to context and the changing nature of knowledge (Denzin & Lincoln, 2013). The roots are in symbolic interaction as developed by Mead (1934) in which the identities are created and constructed in everyday encounters in interaction. In this thesis, I am certain that I, through participation, contributed to the construction of the knowledge in the qualitative study, mainly by the shared experience with those who were interviewed. The interviews were conducted with an aim of being as objective as possible, in an awareness of being a part of the situation. Furthermore, in the quantitative studies, I contributed to create the knowledge, although I did not affect the respondents. But, by creating the research questions, operationalising the concepts, choosing the analyses and in interpreting the outcome, I became "a part" of the study object. Even if you have an aim of being objective through design and analyses, there are always subjective

features in research. Thus, I view knowledge creation in a social constructivist way, as most of the concepts, models and notions are abstractions of the "reality" and thus constructions. In this thesis, health, gender and social status can be viewed as social constructions as everyone has their own interpretations of the content, although we also have a common understanding of the meaning. However, those constructions, often contextual and situational, bound to time and place, capture aspects of the real conditions and thus represent objective phenomena possible to experience. A weak side of the social constructivist view is the context-bound nature, which may limit the transferability of the results to other contexts.

Regarding knowledge creating, I think that when quantifying knowledge, qualitative assessments and interpretations of the research questions and results are needed, and thus there is no contradiction between creating knowledge on a quantitative or qualitative basis, as both are needed. We need to quantify certain knowledge to be able to examine and evaluate different outcomes and proportions on a group level and in larger populations. While a small-scale interview study is more suitable to explore the meaning of concepts, conducting large scale surveys may give a bigger picture with regard to such things as health inequalities and gender differences. Furthermore, the positivist view is prominent when conducting statistical analyses and is required for the rigour of the analyses. Advantages can be reached through combining complementary methods and different scientific perspectives.

Professional position

Being in-between different disciplines has been a challenge but also an opportunity. Social work and public health have many similarities and both disciplines are oriented towards structural improvements and enhancing the wellbeing of people. The core definition of social work profession highlights that "the social work profession promotes social change, problem-solving in human relationships, and the empowerment and liberation of people to enhance wellbeing. Utilizing theories of human behavior and social systems, social work intervenes at the points where people interact with their environments" (Hare, 2004, p. 409). In social work promoting and preventing social problems, improving the quality of life and contributing to equal living conditions are some of the major tasks. In public health, the main concern is to focus on living conditions, environments and lifestyles that affect the health of people. What connects the two disciplines is person-in-environment, improved living conditions, enhanced wellbeing and the impact and awareness of the social determinants.

From the public health point of view

Adolescents live and develop in a social context in reciprocal interaction with others and in interaction with various factors in the environment. Thus, young people grow up surrounded by family, peers, groups, schools, community, cultural and societal influences that impact health and wellbeing (Viner et al., 2012). The biopsychosocial approach to health is rooted in the idea of considering sex and gender simultaneously and focus on how, e.g., psychosocial, behavioural and structural factors intersect with gender, shaping the health of boys and men (Griffith, 2016; Thorpe & Halkitis, 2016).

Adolescents' needs should be viewed within the social structure that shapes and supports their health, in which personal, organisational and national levels are involved. On a societal level, there is every reason to pay attention to the importance of health for children and adolescents, which is one of the most important public health goals according to the Swedish Institute of Public Health (2011). The health situation of Swedish children is in many respects among the best in the world in terms of the low infant mortality rate, high percentage of breast-fed infants and the relatively low proportion of children exposed to physical punishment (The National Board of Health and Welfare, 2009). It seems that early adolescence is a starting point for increasing subjective mental health complaints (WHO, 2016). A remaining challenge for public health in Sweden is to continue to strive for good health and improve and protect the health of young people through promotion of a healthy lifestyle. Providing support for the adolescents to achieve physically, mentally and socially good health on equal terms requires an easily accessible overall health support system that is based on the needs of the adolescents. Thus, the chances of adolescents being and feeling healthy are both an individual and societal concern and responsibility. Furthermore, promoting healthy masculinities (and femininities) is a task for the whole society.

Theoretical concepts and perspectives

In this section, a selection of concepts and theories which have been particularly important to the thesis are presented. Exploring adolescent boys' perceptions of health requires a theoretical foundation framing the research area of adolescent boys' health and gender. After presenting the most important concepts, previous research within the area of health and gender is presented.

Adolescence can be an emotionally demanding time with respect to bodily, mental and social growth and development (Rew, 2005). It is also a critical period when health behaviours for future health are established (Viner et al., 2015). It is a time of life when new skills are developed and a more complex social life, such as separation from parents and closeness to peers, take place (Coleman, 2010). It may be a period of great health but also a period of 'storm and stress' with conflicts and mood disruptions (Arnett, 1999). Definitions of adolescence and its sub-stages vary throughout the literature, but commonly used chronological parameters for adolescence consist of: "early adolescence" 11-13 years, "adolescence" 14-17 years and "young adulthood" 18-25 years (Curtis, 2015). Another way is to divide it to early adolescence (10-14 years) and late adolescence (15-19 years) (Unicef, 2011). A simple definition is the period of life when a child develops into an adult (Merriam-Webster Dictionary). WHO identifies adolescence as the period after childhood and before adulthood (ages 10 to 19).

In this thesis, the focus was on late adolescence, which usually comprises the years 15-19. In the present study, all the participants were from 16-18 years old.

Health and wellbeing

Health is a multidimensional concept, with definitions ranging from those taken from medical models based on the absence of disease and disability to more holistic models of health, such as the biopsychosocial health model, which embraces psychological and social aspects of health (Alonso, 2004; Boorse, 1977; Larson, 1999; Ott et al., 2011; White, 2009). Since ancient times, health has been regarded as a state of balance or equilibrium. Nordenfelt (1995) Nordenfelt (1995), for instance, argues for a holistic and action-oriented understanding of health in which there is a balance between what a person *wants* to do and what a person *can* do in real life. He further suggests that when persons are healthy they have the ability to realise their vital goals in different life areas, provided that these goals are realistic (Nordenfelt 2007). The emphasis is on the subjective dimension.

WHO's holistic definition of health - "a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity" - captures the subjective dimension of health (WHO, 1948). Physical health refers to physical capabilities and functional levels, mental health to emotional health and wellbeing, and social health to how well a person gets along and interacts with other people (Nutbeam, 1998; Russell, 1973; WHO, 2004). Following the idea of balance, wellbeing is suggested to be defined as "the balance point between an individual's resource pool and the challenges faced" (Dodge et al., 2012 p. 230). To conclude, the concept of health has numerous definitions and some of the characteristic features are health as a state, as a balance, as a resource and as wellbeing. Emotional processes play an important role for health and wellbeing, but emotions must be controlled and mastered if they are to contribute to an individual's health and wellbeing (Boutelle et al., 2009; Butler, 2011; Charles, 2010; Gross, 2002).

Different models, two-dimensional or on a continuum, have been displayed to illustrate the concept of health. SRH is suggested to form a continuum from poor to good health, and the concept of health can be regarded as two-dimensional with wellbeing (self-assessment) along one axis and dysfunction/ill-health (medical assessment) along the other axis (Eriksson, 1989; Jerdén, 2007; Manderbacka, Lahelma, & Martikainen, 1998).

In this thesis, both the WHO definition of holistic health and the action oriented understanding of Nordenfelt contributed to the basic foundation on how health can be understood in the context of adolescent boys. Nordenfelt presents health as the ability to achieve *vital* goals. However, he does not explicitly specify those vital goals but relates them to each community and

context but emphasises the notion of personal preferences. For Nordenfelt (1993), the influence from the environment is central: "The environment then is both a platform for action and a basis for our goalsetting" (p. 36). He claims further that health is connected to a minimal level of happiness. Nordenfelt also makes a realistic statement and does not mean "any kind of complete happiness". His understanding differs from the WHO definition, which contains the word "complete". The WHO definition of health is popular, despite criticisms of it being utopian (Larson, 1999). Nordenfelt relates health to external conditions, as well as interpersonal and internal conditions and situates the person. To be healthy is, according to Nordenfelt, "to be able to achieve what has a high priority in one's life" (p.99).

Given adolescents, I find this description of health particularly noteworthy as adolescence is a "goal oriented" period when many achievements and goals must be met. Furthermore, adolescent health cannot be separated from the health of society as we live in an interdependent existence: health is not created in vacuum and living conditions determine an individual's health (Marmot, 2004; Viner et al., 2012). Besides, those conditions can be influenced and changed.

Measuring health

Health can be approached and measured in many ways. Both the medical assessment and the individual´s self-assessment can be used to comprise the objective and subjective dimensions of health (Eriksson, 1989). A person can have a disease but experience no illness; and contrary, absence of disease does not necessarily mean that the individual is experiencing health and feeling well (Lupton, 2012). While the objective measures can be collected through clinical parameters, such as blood pressure, temperature or body mass index (BMI), the subjective measure is the individual's own perception of his/her health (Wu et al., 2013). Self-assessment and medical assessment do not always or necessarily correlate and whether SRH can reflect the objective health status is debatable. One study found that SRH reflects the objective health status well and can be used as a global measure (Wu et al., 2013).

In my understanding, being healthy is foremost a personal experience and assessment but may include objective, observable components, which, in turn, may affect the overall health experience. To worry about having a disease, as some adolescents do, may need an objective assessment to be able to be free from it and to be or to feel healthy.

A common way to measure health is The Short Form Health Survey (SF-36), which is a 36-item, patient-reported survey measuring health status, The survey has been found feasible to use (Sullivan, Karlsson, & Ware Jr, 1995). Health status is level of health of an individual person, or a group or a population, as assessed by that individual or by objective measures (Medical Dictionary, 2012). Another common instrument is the General Health Questionnaire-12 (GHQ12), which was designed to assess people's overall wellbeing (Hardy et al., 1999). Health can also be measured through a single-item question aimed to measure the overall health status of the individual, often termed as self-reported, self-perceived, self-assessed or SRH (Fayers & Sprangers, 2002; Idler & Benyamini, 1997; Jylhä, 2009; Wade & Vingilis, 1999). This single item health question comprises the individual's opinion of his/her overall health status, in which a subjective interpretation and construction of the personal meaning is enabled (Idler, Hudson, & Leventhal, 1999). With a simple question, respondents are asked to indicate how they estimate and rate their health in general. The health question may be worded a bit differently, such as "How is your health/wellbeing in general?" or "How do you consider/perceive your health/wellbeing? In youth studies, the following formulation has also been used: "A person may feel good sometimes and bad sometimes. How do you feel most of the time?" .

Self-reports are the most commonly used method when investigating and measuring health in adolescent populations. It is well documented that a single item question on SRH, regardless of the wording, is a stable predictor of mortality in an adult population (Idler & Benyamini, 1997; Jylhä, 2009; Mossey & Shapiro, 1982). Some longitudinal studies show that a SRH question is a relatively reliable measure to predict future health even among adolescents (Breidablik, Meland, & Lydersen, 2009; Haugland et al., 2001; Wade & Vingilis, 1999). Furthermore, the single health question is shown to encompass a multidimensional understanding of health in accordance with the WHO's definition in an adolescent population (Joffer et al., 2016; Vingilis, Wade, & Seeley, 2002).

In this thesis, a subjective perception and description of health was explored in the interviews. Health was also measured through SRH in the quantitative study and the adolescents answered questions regarding their overall health perception, health behaviours as well as other health-related questions. These self-reported health measurements are commonly used in surveys on adolescent health, including in HBSC studies carried out both in Sweden and in other countries (Cavallo et al., 2015; Dey, Jorm, & Mackinnon, 2015; Sonmark et al., 2016).

Body and mind in health

Concerning the relationship between body and mind there have been different views on how they are connected. The inseparability of body and mind comprises the holistic idea of health, common in holistic medicine (Rosch & Kearney, 1985).

For a long time, there was a historical assumption that body and mind were two separate entities. The concept of this dualism was developed in the 17th century by Descartes, who argued that mind and body were two distinctive, but interacting entities (Rozemond, 1998). This view suggests that there is evidence of dualistic thinking taking place already in early childhood, i.e. children are able to distinguish between the internal and external and between mental and physical phenomena (Estes, 2006). Furthermore, it has been shown that those who hold dualistic beliefs are less likely to exercise and engage in health-enhancing behaviour (Forstmann, Burgmer, & Mussweiler, 2012). Yet, most recent psychosocial theories of health reject dualism (Duncan, 2000). 'The lived body', how we experience and know the world through our bodies, represents the contrasting dialectic view of Merleau-Ponty (1962), stressing unity and emphasising the body as the embodiment of who we are (Burkitt, 1998). The lived body is human beings and consciousness interconnected, unlike Descartes mind, which is a thinking thing separate from the body (Engelsrud 2005, Rozemond 1998). The embodied perspective refers to a holistic view of health, suggesting that all parts of the body are integral and that meanings of health and illness impact on the person as a whole (Wilde, 1999).

Despite those ideas of interconnectedness of body-mind, the dualism of body and mind is still a visible mental component embedded in our western culture and many health models reflect upon this division, as well as the distinction between mental and physical illness and medical and therapeutic care (Lengen & Blasius, 2007; McWhinney & Epstein, 1997).

How young people view health and what it means for them are important and may contribute to their perceived health. Even though most of the professionals working with health recognise the interconnectedness of mind and body, at hospitals bodily health and mental health are usually cared for at separated units. This separation between mental and bodily health care may contribute to a fragmentary view of health, in which the care for the minds and bodies are viewed as different practices. For adolescents, the lack of holistic health care implies that bodies and minds are often treated by different persons. Thus, it requires ability to distinguish bodily problems

from mood and to decide whether to seek advice from a counsellor or a physician.

Emotion management

Emotions are a vital part of expressions and communication in everyday life (Goffman, 1959). The terms emotions and feelings are often used interchangeably, and the term 'feelings' implicates milder emotions (Hochschild, 1983). Hochschild (1979, 1983) offers a way of understanding emotions as social expressions of the emotional state of the individual and as part of the presentation of self. According to Hochschild (1979, 1990), individuals follow 'feeling rules', socially shared norms as to what emotions are appropriate to show, and when. Emotion management is described as the efforts individuals take to cope with feeling rules and the work required to generate emotions that are appropriate for a situation (Hochschild, 1979). Following Mead (1934) and Goffman (1959), Hochschild uses an interactionist perspective. Mead (1934) underlined the importance of social interaction for human development, i.e. internalising the generalised attitudes and perspectives of significant others and the behaviour conditioned by the social context. Goffman (1959) suggested that behaviours in public settings always include the presentation of self, a performance of a character to the audience in face-to-face interaction. Furthermore, Goffman postulated that emotions are social and that self-presentations are modified depending on the acceptance or rejection of others. Goffman's 'actors' made an effort to manage outer impressions and appearances and mainly focused on surface acting.

Hochschild (1979) further emphasises the management of inner emotions, i.e. deep acting, working on real emotion inside the individual. In surface acting, facial expressions and outer appearances are modified, whereas in deep acting the inner emotions are shaped (Hochschild, 1983). The expectations to enact situationally appropriate feeling rules result in different emotional responses among individuals, responses that involve both surface and deep acting (Hochschild, 1979, 1983). Emotions can be managed differently. One way is that thoughts change how we feel: thoughts can be changed through cognitive skills. A second way is that the body can be involved to lead emotions in a more manageable direction. A third way is through expressive gestures (e.g., smiling, grimacing, crying). Thus, both surface and deep acting are involved in emotion management in which feeling rules are also used to evaluate emotional responses Thus, both surface and deep acting are involved in emotion management in which

feeling rules are also used to evaluate emotional responses (Hochschild, 1979, 1983).

Emotional experience may be especially intense in adolescence, as studies indicate that adolescents experience more frequent and intense emotions than younger or older persons (Silk, Steinberg, & Morris, 2003). For adolescents, much behaviour, such as norm and boundary testing and risk-taking, are emotionally influenced behaviours, driven by their own curiosity or by group norms. Further, what the boys show and hide and with whom they share may depend on individual and group norms and contextual feeling rules. Those everyday social interactions may be stressful and the close connection between stress, emotions and coping strategy has been shown (Lazarus, 1999). He further suggests that certain emotions (e.g., anxiety, shame and sadness) could be called stress emotions because they usually arise from stressful and challenging situations. Even love, pride and happiness, usually treated as desirable emotions, can be stressful. With stress, Lazarus and Folkman (1984) refer to a relationship between individuals and the environment that is appraised by the individuals as exceeding their resources and thus endangering their wellbeing.

Self-conscious emotions of pride and shame

Shame and guilt are two major concepts within the framework of self-conscious emotions, but also humiliation, embarrassment and pride, the latter being the positive emotional counterpart to shame (Tracy, Robins, & Tangney, 2007). In comparison with primary emotions, self-conscious emotions develop later in childhood compared, probably because they require self-awareness (Lewis, 2003). How children come to understand self-conscious emotions arises from the quality of interaction with significant others (e.g., parents, siblings and other adult authorities) (Lagattuta & Thompson, 2007). Shame, for instance, comes about through self-reflection and requires the self to both produce and experience it (Lewis, 2003). Thus, the combination of complex cognitive capacities and social processes is involved in the development of self-conscious emotions (Tracy & Robins, 2004).

Self-conscious emotions occur when people see themselves through the eyes of others, and the degree of personal security individuals display is largely determined by what they believe others will think about them (Scheff, 2014; Tangney, Stuewig, & Mashek, 2007).

Emotions, such as shame and pride, are present in all social interaction and shame is suggested to be the key emotion shaping social behaviour (Scheff, 2003). Scheff (2003) underscores the signal function of shame and defines shame "as the large family of emotions that includes many cognates and variants, most notably embarrassment, guilt, humiliation, and related feelings such as shyness that originate in *threats to the social bond*" (p. 255). Accordingly, pride and shame are particularly important in interaction indicating the quality of social bond, and whereas pride signals connectedness, shame signals a threatened bond and alienation (Scheff, 2003, 2014). Shame is characterised by feeling worthless or exposed and the person who is experiencing shame tries to hide it (De Rubeis & Hollenstein, 2009). Pride is a positive emotion connected to socially valued outcomes of the individuals or being valued as a person, i.e. others viewing you as successful and admirable (Muris & Meesters, 2014; Svensson & Björklund, 2010). Two kinds of pride labels have been suggested: authentic or hubristic. Findings show that genuine self-esteem along with authentic pride is positively related to successful social relationships and mental health, whereas hubristic pride, in which the person is viewed in a grandiose manner, is positively related to aggression and other antisocial behaviours (Tracy et al., 2009).

Receiving positive or negative attention is especially important in adolescence in that it contributes to the self-image and wellbeing of the adolescent. Emotions are deeply involved in all interaction and as both femininities and masculinities are created and re-created in a joint process, the emotional expressions are gendered in our society. Emotions, such as anger and sorrow, play an important role for health and wellbeing, but emotions must be regulated and dealt with to be promotive to good health (Charles, 2010; Gross, 2002; Silk et al., 2003). Adolescents are prone to emotionally influenced behaviours and often have difficulties in controlling behaviours and emotions (Dahl, 2004). Combining both shame and pride in relation to health may reveal how those two emotions are connected and how they influence each other in adolescence.

Social status and subjective social status

Social comparisons are part of everyday life and social status comprises both material and psychosocial aspects (Marmot, 2005). The social standing of the individual seems to be a significant factor for health differences, and there is strong evidence that people of low social status more often are exposed to health risks (Marmot, 2004). Social status in adults is usually based on the socioeconomic hierarchy measuring socioeconomic parameters,

including occupation, education or income (Krieger, Williams, & Moss, 1997). From a youth perceptive, this implies analysing the socioeconomic status (SES), such as educational level of the parents. The concept of subjective social status (SSS) was introduced through the "Mac Arthur Scale of Subjective Status" and is defined as a person's sense of place within a hierarchy, which may or may not reflect objective status (Adler et al., 2000). A youth version was developed to include assessments of the socioeconomic situation of the adolescents' families and their own social position within their school, termed SSS-Society and SSS-School, respectively (Goodman et al., 2001).

In a youth context, adolescents' SSS among peer groups is suggested to be as important as parental social status for health outcomes (Boyle et al., 2011; Goodman et al., 2001). SSS refers to the subjectively perceived and contextual position in which individuals are asked to locate themselves within a social hierarchy (Nobles, Weintraub, & Adler, 2013). SSS is often measured on a ladder (Euteneuer, 2014; Goodman et al., 2001; MacLean, Hunt, & Sweeting, 2013), which in a youth context can be the individual's sense of their position related to a school or a class, called SSS-school or school-based SSS. Furthermore, SSS is suggested to be more strongly related to health among adolescents than traditional objective measures of social status, which refers more explicitly to socioeconomic factors (Adler et al., 1994; Goodman et al., 2001). There is evidence that subjective evaluations of SES predict adolescents' health ratings, even when adjusting for sociodemographic factors (Goodman et al., 2015).

Even though SES is strongly related to health in adults and in children, the associations seem less consistent for adolescents (Koivusilta, Rimpela, & Kautiainen, 2006; Marmot, 2005; Nobles et al., 2013; Pensola & Valkonen, 2000). Accordingly, inconsistent findings have been seen regarding the influence of the parental socioeconomic situation on the health of adolescents. Findings from a study with adolescents showed that both objective and subjective SES had weaker associations with health than school-based SSS (Sweeting & Hunt, 2014).

Adolescents position and compare themselves with peers, which take place in different groups important for belonging. The perceived position of the adolescent and the awareness of SSS may have implications for health, and vice versa. There seems to be a strong connection between socio-economy and health. However, the relation between socio-economy and health, as well as the relation between socio-economy and SSS is far from clear in adolescence.

Gender

Gender construction

We are surrounded by gender from the time we are born. Indeed, gender is so thoroughly embedded in our society, actions and beliefs and minds that we seldom question it. For example, parents display emotions differently when addressing their daughters compared with their sons (Goldshmidt & Weller, 2000). This, in combination with how peers, teachers and others are responding, have a strong influence on how gender identity develops and is developed (West & Zimmerman, 1987; 2009).

Sex and gender are closely related, but the term "sex" is usually understood as the biological and physiological characteristics that define men and women, whereas "gender" refers to the socially constructed characteristics of women and men – such as norms, roles and relationships of and between groups of women and men (WHO, 2011). Accordingly, while "male" and "female" are sex categories, "masculine" and feminine" represent gender categories based on cultural beliefs. Fausto-Sterling (2008) claims that people's understanding of themselves is social: "labeling someone a man or a woman is a social decision. We may use scientific knowledge to help us make the decision, but only our beliefs about gender – not science – can define our sex (p.3)." For Butler, the boundary between sex and gender is erased. The author reasons, in developing the concept of performativity, that both sex and gender are socially and culturally constructed with gender being a rehearsed act that we perform (Butler, 1990).

Adolescents are actively engaged in gender construction performing masculinity (and femininity); for them, school is an important setting to form 'feeling rules' – how to behave and what to show (Connell, 1996, 2008). In school, institutional definitions of masculinities and femininities are created in gendered practices, where boys and girls use different strategies to gain power (Gillander Gådin & Hammarström, 2005) . Many boys are socialised to hide weakness and conceal expressions of emotional vulnerability (Scheff, 2003), which relate to stereotypes of being a man and a boy (Evans et al., 2011; Oransky & Marecek, 2009). Adolescents constantly evaluate behaviours and expressions in relation to normative conceptions of gender to discredit/accept masculine or female practices (Messerschmidt, 2009). Thus, gender norms are socially constructed and what we perceive as 'male' and 'female' is contextual, cultural and changeable, and further, there are many ways of being a boy and a girl (Connell & Messerschmidt, 2005; Tischler & McCaughtry, 2011).

Identity forming and doing gender in social interaction are part of growing up. What goes on between gender and health needs more attention, and is the main reason why the relation is targeted in this thesis. The gender norms in a society are contextual and changeable and transferred to girls and boys through the socialisation process. Gender norms may give rise to gender-specific experiences. For example, help-seeking is affected by gender aspects (Marcell et al., 2002) and it may be particularly challenging to identify and reach out to those adolescent boys in need. Hypothetically, being an adolescent boy who is feeling down may be even harder for the boy than for the girl because of the gender norms. Adolescent boys' higher rate of suicide compared with girls (Hamilton & Klimes-Dougan, 2015; WHO, 2014) indicates that we might underestimate ill health among boys.

Masculinities

There are numerous definitions of masculinity reflecting the diversity of what boys and men do and what they are. When searching the literature about masculinities, my journey started with William Pollack (Pollack, 1999; Pollack & Schuster, 2000) who wrote about "boy code", a kind of masculine mask that forces boys to follow a "strict code of masculinity", and some old assertions formulated by Brannon & David 1976. The following four themes were considered as the ideal American gender role: No Sissy Stuff (to distance oneself from femininity, avoid emotions) 2) Be a Big Wheel (to strive for achievement and success) 3) Be a Sturdy Oak (avoid vulnerability, stay in control, be tough) 4) Give 'em Hell! (act aggressively to become dominant) (Brannon & David, 1976). Relatively recently, Michael Kimmel (2010) made a reference to Brannon, asserting that these ideas about "boy code" and his own concept "guy code" (2009) still remain quite firm, despite substantial changes in both men and women's lives. Perceptions about masculinity are shown to create gender role strain (Pleck, 1995) and gender role conflict (O'Neil, 2013; O'Neil, Good, & Holmes, 1995), which can negatively impact male health (Courtenay, 2000).

One of the influential concepts within the field of gender is that of 'hegemonic masculinity', defined as highly valued and culturally dominant in a given setting (Connell & Messerschmidt, 2005; De Visser, Smith, & McDonnell, 2009). Hegemonic masculinity, often characterised by emotional and physical toughness and risk taking, is based on power relations in which men in more disadvantaged positions are oppressed and considered 'subordinated' or 'marginalised' (Connell & Messerschmidt, 2005; Gough, 2006). The term hegemony was used earlier by Gramsci to

describe the dominant political and ideological power through a hegemonic culture reproduced through institutions, and in which the values and beliefs of the ruling class became the values of all (Heywood, 1998). Thus, in a historical context, hegemony refers to dominant ideas of a dominant group: what is normal and legitimate and something to aspire to in a certain context. Several factors, such as feminist theories of patriarchy and the women's liberation movement, have had a profound effect on the emerging concept of hegemonic masculinity (Connell & Messerschmidt, 2005). The concept comprises power relations both within and between genders. Furthermore, the emphasis is on change because gender practices occur in different cultural contexts and are put to action by persons representing different ages, backgrounds and class (ibid. 2005). Johansson (2000) adds two new positions to Connells original model: the concepts of nostalgic and oppositional masculinity. By nostalgic position, Johansson means a longing back to the time of "original", traditional masculinity when nothing was questioned and men had a strong inner sense of masculinity. The opposite position is characterised by a close cooperation with women and a critical attitude to the dominating masculine structure in society. Thus, other masculinity notions (such as 'nostalgic', 'oppositional' and 'inclusive') are constructed in relation to the hegemonic, as well as to the idea of a 'caring father' in the Scandinavian context, contributing to a diversity of masculinities (Anderson, 2008; Connell & Messerschmidt, 2005; Demetriou, 2001; Hearn et al., 2012; Johansson, 2011).

The concept of hegemonic masculinity has not only influenced gender studies in many academic fields but has also raised some criticism. For example, Demetriou critiseses the dualism between the hegemonic and non-hegemonic masculinities and introduces the notion of hegemonic masculine block (Demetriou, 2001). He argues that masculinity is "in a constant process of negotiation, translation, hybridization" (p 355) and unites practices from diverse masculinities (Demetriou, 2001). He highlights the contribution of gay masculinities and suggests that this "hybridisation" produces something new (e.g., when a gay subculture makes the dominant form to appear softer). The new generation of masculinity theories is the 'inclusive masculinity' in which it is no longer necessary to distance oneself from homosexuality or femininity in public (Anderson, 2008). A study conducted among 16-18-year-old adolescent boys found that the boys were able to express physical tactility and emotional intimacy without being homosexualised by their behaviour (McCormack & Anderson, 2010). Thus, softening of the gender gap and a new intimacy may be emerging in the current view among many adolescent boys.

Traditional masculinity usually refers to such attributes as toughness, anti-femininity and men being less emotionally expressive (Burn & Ward, 2005). Paul Willis (1977) showed in his classical study how working class boys developed a rebellious subculture of their own by smoking, drinking and being contemptuous against middle-class kids and against the school system. However, at the same time, they repeated their father's culture, which unwittingly contributed to their own subordination. Willis mainly focused on the consequences of a lower class background for anti-school attitudes among boys. Since that, the labour market has undergone major changes and young working-class men are more likely to be 'learning to serve' than 'learning to labour' as a result of those transitions (McDowell, 2002). The school environment is considered an arena for masculinity conceptions, fostering or inhibiting boys' development of anti-school attitudes, and the gender gap in education, boys' underperformance compared with girls and less boys going on to higher education, still remains (Kimmel, 2010; Legewie & DiPrete, 2012).

In this thesis, all the above mentioned theories gave a theoretical ground and preunderstanding to investigate adolescent boys' perceptions of masculinities and the masculinity view. The masculinity view refers to the construction of masculinity norms, values, beliefs and perceptions that the participants have internalised (Connell, 2005; Pleck, Sonenstein, & Ku, 1993). However, a special attention was paid on transparency and openness in relation to the boys narratives in the interviews, not just to confirm these prior known theories.

Research on health and gender

Adolescent health

Although adolescents are in general physically healthy, there is a concern about the high rates of self-perceived mental health problems in the adolescent population in Sweden and other countries (Eckersley, 2011; Hagquist, 2010; Patel et al., 2007; The National Board of Health and Welfare, 2013; WHO, 2016). Depression among adolescent boys and girls is a significant public health problem with substantial consequences for health and wellbeing (Breland & Park, 2008). The prevalence of mental health problems is 10-20% in children and adolescents worldwide (Kieling et al., 2011). In Sweden, a substantial amount of research shows that SRH decreases with age and mental health complaints increase, particularly among adolescent girls, but this increase is also observed in boys (Hagquist,

2009, 2010; Jerdén et al., 2011; Lager et al., 2012). A large-scale study investigating trends in adolescent health during 8 years in 32 countries found that girls rate their health as poorer than boys in all countries. Furthermore, health was found to decrease with age (Cavallo et al., 2015). Research shows that the peak in adolescent depression rates occurs between 15 and 18 years, indicating a risk for increased emotional health problems (Boutelle et al., 2009; Hankin et al., 1998). It may also indicate that late adolescence - the transition from an adolescent to a young adult - is a sensitive period in the life course and should therefore be targeted to a greater extent than it is today.

Gender-specific health

Men's health in general is somehow paradoxical: men constantly report a better subjective health than women and are less likely than women to perceive themselves as being at risk for health problems, although they are much more likely to adopt unhealthy lifestyles and are at greater risk for all leading causes of death (Courtenay, 1998, 2000; Oliffe et al., 2010). This gender pattern is also evident in adolescent boys, who are more reluctant to report ill-health and more likely to deny health problems than girls and they also regularly report a better subjective health than adolescent girls (Ciarrochi et al., 2002; Johansson, Brunnberg, & Eriksson, 2007; MacLean et al., 2013). On the other hand, adolescent boys are much more likely than girls to engage in high-risk behaviour, have more neuropsychiatric disorders and behavioural diagnoses (such as attention deficit hyperactivity disorder, autism or conduct disorders) and have an increased risk of accidents and violence (Boyle et al., 2011; Maughan et al., 2004). Further, compared with girls, adolescent boys are more likely to drop out of school, be involved in accidents, are far more likely to be perpetrators and victims of violence and, although rare, have a higher rate of suicide (Gudlaugsdottir et al., 2004; Kimmel, 2010; McLoughlin, Gould, & Malone, 2015; Rice, 2015; Wasserman, Cheng, & Jiang, 2005). Suicide rates, especially adolescent boys in the age group of 15-19 years and among young adult males, are a concern both in Sweden and in other countries (Breland & Park, 2008; Kõlves & De Leo, 2016; Wasserman et al., 2005). Male rates of suicide continue to be higher than female rates and their problems to disclose distress are shown to be related to the prevailing masculinity norms in their social environment (Cleary, 2012). Suicide is one of the leading causes of death in adolescents, and depression increases the risk (Jackson & Lurie, 2006; Patton et al., 2009). Plausible explanations for these gender differences could be gender expectations for boys to be stoic and their health behaviours demonstrating masculinity (Connell, 1996; De Visser et al., 2009; Messerschmidt, 2009).

Masculinity, nested within the norms of the society, shapes the health and health behaviours of adolescent boys and thus individual and structural factors interact in a complex way (Robertson, 2007; Thorpe & Halkitis, 2016).

Research shows that boys and men are less likely than girls and women to perceive themselves as being at risk for health problems, which, in turn, contributes to the underuse of health services (Courtenay, 2000; Courtenay & Keeling, 2000). Older adolescent boys' use of health care services is particularly lower compared with older adolescent girls (Marcell et al., 2007). Chu, Porche, and Tolman (2005) examined adolescent boys' internalisation of masculine norms measuring their attitudes and beliefs about appropriate behaviour for males and masculine norms in their peer relations. The study showed that hegemonic masculinity can limit the ways adolescent boys are able to express themselves and engage in interpersonal relationships and thus hinder their mental health. Pursuing hegemonic masculinity is connected with poorer health outcomes for men and boys because they experience a greater pressure to be strong and use behaviours that include denial of weakness and vulnerability (Courtenay, 2000).

Exploring health

Studies exploring health in a youth context have shown that young people are prone to make a distinction between mental and physical aspects of health, as well as in how these aspects are experienced and dealt with (Landstedt, Asplund, & Gillander Gådin, 2009; MacLean et al., 2013). Several studies have also shown that mental health is sometimes associated with negative aspects (e.g., distress) or considered as an uncertain concept (Armstrong, Hill, & Secker, 2000; Landstedt et al., 2009). One study found that adolescents view mental health problems in adolescence as deviant, and consequently, the adolescents were hesitant to disclose emotions and behaviours that were not regarded as 'normal' (MacLean et al., 2013). Another study underscored the social aspect of health in which health was described as a shared responsibility between adolescents and adults and mental health was seen as interactional rather than as an individual condition (Ott et al., 2011). Several studies suggest that important determinants of mental health are the quality of relationships within the family and with friends and supportive adults, as well as having a positive self-concept (Armstrong et al., 2000; Johansson et al., 2007).

Health and emotions

Compared with girls, many boys are pressured to be strong and emotionally more repressed, which may have important implications for their emotional health (Courtenay, 2003; De Visser et al., 2009; Evans et al., 2011). Emotional expressions are shown to be influenced by gender aspects and being a boy or young man and 'doing gender' is often connected to stereotypes concerning what to display (De Visser et al., 2009; West & Zimmerman, 1987). In contrast to girls, many boys are socialised to suppress expressions of emotional vulnerability in order to avoid shame (Messerschmidt, 2009; Scheff, 2000). Performances and emotion practises are formed within peer groups, and it has been shown that boys avoid displays of emotional or physical pain in groups and disparage such displays in other boys (Oransky & Marecek, 2009). Further, that boys describe hurtful interactions, (e.g., taunting, mocking and shoving) as improper behaviour, but they value these interactions as a means of bolstering their masculinity (ibid.). For adolescents, the social bonds are tested and evaluated in everyday social interaction and emotions are important for correcting and maintaining social behaviour (Muris & Meesters, 2014). How adolescents perceive and manage their health during adolescent years are strongly related to their future health experience. Poor mental health in adolescence (e.g., experiences of shame, fear, guilt and low self-esteem) has been associated with depression in early adulthood (Kinnunen et al 2010). Shaming experiences, such as being ridiculed and degraded, are shown to contribute to increased depression in adolescents in addition to psychosocial risk factors and increased hostility (De Rubeis & Hollenstein, 2009; Heaven, Ciarrochi, & Leeson, 2009; Åslund et al., 2007). Persistent shaming experiences are especially shown to result in negative health outcomes (Dickerson, Gruenewald, & Kemeny, 2004).

Rational for the study

Health is a very complex concept and studies investigating health sometimes investigate ill-health or absence of symptoms that is interpreted as health. The concept of mental health is sometimes connected to mental illness rather than mental health in adolescents' understanding (Landstedt et al., 2009; Landstedt & Gillander Gådin, 2012). How we discuss and understand the content of the health concepts may give meaning and impact what we feel.

In adolescence, many studies show gender differences in SRH, in behaviours related to health and in subjective health complaints (Jerdén et al., 2011; Wiklund et al., 2012). A consistent finding in studies of SRH is that boys report less health problems than girls. It may be that health and ill-health in general are experienced and expressed differently by girls and boys. Although girls report more health problems than boys, current research shows that adolescents of both sexes seem to be particularly vulnerable to mental health problems, including anxiety, insomnia and stress.

Boys' attitudes about masculinity are shown to impact their health and there is increased attention on how different masculinities affect young men's health behaviour and expressions, such as hindering discloser (De Visser et al., 2009; Marcell et al., 2011). Hearn et al. (2012) argue that there is little research on the effects of different masculinity beliefs on health in Sweden. Thus, existing research highlights worrying trends in health complaints in adolescents, gender differences and special health problems which may be related to masculine socialisation among adolescent boys. Previous research indicates that late adolescence may be a critical developmental period with increased health problems; combined with the low levels of help-seeking in older adolescent boys, there is particular concern for this age group. It seems that adolescent boys' health should be given special attention. More needs to be known about how adolescent boys understand the concept of health, what they experience as important for their health and how they deal with and manage emotions, as emotions need to be regulated and dealt with to be favourable to health.

The knowledge base conceptualising health from the perspective of older adolescent boys is limited and more needs to be known about factors contributing to adolescent health. Although much is known about various notions of masculinity, less is known about the relationship between masculinity and emotion management and potential effects on wellbeing in the context of adolescent boys. Furthermore, exploring emotional experiences of pride and shame and SSS in relation to SRH may increase our understanding on how emotional experiences, such as pride and shame and self-perceived social position, affect health. The associations between SSS, SES and SRH need more attention. SSS is used as a concept in quantitative studies but very little is known about what it captures with respect to adolescents. To our knowledge, there are no qualitative studies providing a deeper understanding of the concept of SSS in school.

In the thesis, a combination of qualitative and quantitative research is chosen which can provide different angels on health and gender. Qualitative

research will lead to the acquisition of knowledge on how adolescent boys view health and what *they* perceive as being important for their health. Further, it can increase our understanding about the needs of adolescent boys that, in the long term, can assist the development of interventions to improve wellbeing in this group. Aspects important for health can be systematically examined in quantitative studies. Because research shows gender differences between adolescent boys and girls, it seems reasonable to conduct gender-specific studies.

Knowledge gap

To conclude, there is a knowledge gap between how adolescent boys conceptualise and perceive health and how health is related to adolescent boys' views of emotion management and masculinity. Furthermore, the combined association between experiencing pride, shame and SRH has not been investigated in adolescence. Finally, SSS in relation to adolescents is poorly understood and needs further investigation. Further, its relation to SRH and SES is not fully understood. Adolescent boys' perceptions and experiences of health as a whole have been scarcely explored. Therefore, there is a need for studies to increase knowledge and enhance understanding of adolescent boys' health.

Aims

Overall aim

The overall aim of this thesis was to explore adolescent boys' perceptions and experiences of health, emotions, masculinity and subjective social status.

Specific aims

I: To explore how adolescent boys understand the concept of health and what they find important for its achievement.

II: To explore adolescent boys' views of masculinity and emotion management and their potential effects on emotional wellbeing.

III: To investigate the associations between pride, shame and SRH in adolescence.

IV: To investigate associations between SSS in school, SES and SRH, and to explore the concept of SSS in school.

Methods and materials

Settings

The Nordic countries consistently stand out in the annual Global Gender Gap Report, a report that measures how well countries are closing the gap between genders (Black, 2016). In Sweden, women now make up the majority of those going on to higher education and the education gender gap has been reversed. One of the global public health goals is gender equality, which emphasises same opportunities in health between genders. Gender equality underscores that women and men, regardless of age, are entitled to realise their full rights and potential to be healthy, contribute to health development and benefit from the results (WHO, 2011). Concerning gender equality, Sweden and other Nordic countries can be distinguished from other countries (Hausmann, 2013). In Sweden, the gender equality policy affects a number of areas, areas characterised by equal opportunities, rights and obligations, irrespective of gender (Gillander Gådin, Weiner, & Ahlgren, 2011; Hearn et al., 2012). School education is provided free of charge, no matter whether it is independently or municipally run. All pupils have a statutory right to school health care with the primary goal of prevention and health promotion. Furthermore, family politics is expressed in the dual-earner/dual-carer family model and the idea of a caring father was politically promoted and introduced already in the 1970s (Nyberg, 2012). Fathers use 25% of the total parental leave (Stranden, 2015). In terms of gender equality, Sweden together with other Nordic countries, is considered progressive in an international comparison (Hausmann, 2013). Sweden is socioeconomically a rather equal country, which should have a positive impact on health. Despite all these achievements, and unlike the other Nordic countries, the latest HBSC study showed that Sweden 8 of 42 countries regarding mental health problems in youth (WHO, 2016). It is a strong indicator of increased mental health problems in adolescents in Sweden.

Study design

To provide depth and breadth, this thesis includes one qualitative study (papers I and II), one quantitative study (paper III) and one mixed method study (paper IV), in which the latter was used so the studies could complement one another. A qualitative approach (Lincoln & Guba, 1985) was chosen to explore adolescent boys' understanding and experiences of health and to acquire knowledge about their emotion management and masculinity beliefs (I and II). With the aim to generate personal, rich descriptions, individual interviews were conducted using the explorative approach. A quantitative approach was used to measure the associations between SRH, pride and shame (III) and the associations between SSS, SRH and SES (IV) in a larger population and to generate data suitable for comparisons. A qualitative approach was used to explore adolescents understanding of the concept of SSS (IV). The use of the mixed method (Creswell, 2007) enabled deeper descriptions of the concept of SSS and its relationships between different aspects (IV). An overview of the four papers is presented in Table 1. The three studies are termed qualitative, quantitative and mixed methods in the method section.

Table 1. Overview of papers I-IV of this thesis

	Paper I	**Paper II**	**Paper III**	**Paper IV**
Aim	To explore how adolescent boys understand the concept of health and what they find important for its achievement.	To explore adolescent boys' views of masculinity, emotion management and their potential effects on wellbeing.	To investigate the associations between pride, shame and health in adolescent boys and girls.	To investigate associations between SSS in school, SES and SRH, and to explore the concept of SSS in school.
	Study I		**Study II**	**Study III**
Design	Grounded Theory		Descriptive, cross-sectional	Mixed methods
Year of data collection	2011-2012		2009	2009 and 2012

Data collection	In-depth interviews	VIP questionnaire	VIP questionnaire and in-depth interviews
Participants	Adolescent boys ages 16-17 years, Upper secondary schools, 10th and 11th grades N=33	Adolescents - both boys and girls, 17-18 years, Upper secondary school, 12th grade N=705	Adolescent boys and girls, 17-18 years, 12th grade N=705 and think-aloud interviews N=35
Analysis	Constant comparative analysis	Statistical analyses, chi-square, logistic regression	Statistical and thematic network analysis

Research setting

The interviews used in papers I-II and those in the qualitative part of paper IV were performed in a municipality with 56,000 inhabitants located in the middle of Sweden. The average educational level in this town corresponds to that of the average in Sweden (Statistics Sweden, 2012).

Papers III and IV used data from the last measurement of the longitudinal cohort study VIP (Very interesting person). The original cohort VIP included 1049 adolescents who completed questionnaires on four occasions from 2003 to 2009. The last measurement was conducted 2009 in the final school year (12th grade). The study was carried out in three Swedish municipalities in central and northern Sweden. Students from seven schools, which covered the highest (n=3) and lowest (n=4) educational levels of the parents in each municipality, were invited to answer a health questionnaire. Data on educational level of parents were obtained from Statistics Sweden, the official national statistical database.

Recruitment and participants

The participants in the qualitative study (papers I-II) were attending the first or second year at upper secondary school (all were 16 or 17 years old). The participants in the quantitative study (paper III) and the mixed method study (paper IV) were 17-18 years old.

Papers I-II

The participants in the qualitative interview study were selected on the basis of variances in schools and school programmes. Thus, the participants were recruited from three upper secondary schools and different programmes: one with mostly vocational programmes, one with mostly academic programmes and one large school with a combination of vocational and academic programmes. A purposive sampling procedure was adopted (Patton 2004, Polkinghorne 2005) aimed to capture a wide range of variation in perspectives and obtain maximum variation in the sample.

During the period April 2011 and May 2012, 33 adolescent boys in 10th or 11th grade participated in the study. They represented a wide range of programmes: 17 boys attended academic programmes such as Natural Science, Social Science, Arts and Technology programmes. Eleven boys attended vocational programmes such as Vehicle and Transport, Electricity and Energy, Building and Construction and Handicraft programmes. Four boys were attending the Introductory Programme and one boy attended a programme for students with learning disabilities that had a vocational focus.

The characteristics of the participants are shown in table 2. To further describe the sample, 16 of the boys lived with both their parents, 10 with one of their parents, three alternating between mother and father, one boy was in foster care and three boys lived on their own. The majority of the boys were born in Sweden but five had a migrant background: one from outside Europe and four from within Europe. Some boys lived in rural areas, some in urban areas, and they represented varying socioeconomic backgrounds. Two of the boys had dyslexia and two had diagnosed behavioural problems.

Table 2. Study I (I-II). Characteristics of the participants, n=33

Age	Living with	School/ programme	SRH	SSS
17	Alternating m/f	School 1/A	Very good	7
16	One parent	School 1/V	Neither good nor bad	6
16	Both parents	School 1/V	Very good	7
17	Both parents	School 3/A	Neither good nor bad	8
17	Both parents	School 2/V	Rather good	6
17	One parent	School 2/V	Very good	6
16	Alternating m/f	School 2/V	Very good	9
16	Foster care/m	School 2/V	Rather good	8
17	One parent	School 2/V	Rather good	7
17	Both parents	School 1/V	Very good	7
17	One parent	School 1/V	Neither good nor bad	3
17	Both parents	School 1/V	Very good	8
17	Both parents	School 1/A	Very good	7
17	One parent	School 1/V	Very good	7
17	Both parents	School 1/V	Rather good	6
17	Both parents	School 1/A	Rather good	7
17	Both parents	School 1/A	Rather bad	5
17	One parent	School 1/A	Rather good	6
16	Both parents	School 1/A	Neither good nor bad	4
16	Alone	School 3/A	Very good	9
16	Both parents	School 3/A	Rather good	9
17	One parent	School 3/A	Rather good	5
16	One parent	School 3/A	Very good	10
16	Alone	School 3/A	Very good	8
16	Both parents	School 3/A	Rather good	7
17	Both parents	School 3/A	Rather good	8
16	Alternating m/f	School 3/A	Neither good nor bad	5
16	One parent	School 3/A	Very good	6
16	Alone	School 3/A	Rather good	7
16	One parent	School 3/I	Very good	6
17	Both parents	School 3/I	Very good	7
17	Both parents	School 3/I	Very good	8
16	Both parents	School 2/I	Very good	9

School 1, academic, vocational and introductory programmes School 2, mostly vocational programmes and School 3 mostly academic programmes. A=academic; V=vocational; I=introductory

The boys rated their health (SRH) during the interview (on a 5-point scale from very good to rather bad). Their SRH was similar to those in a quantitative survey conducted in the same area in Sweden (Jerdén et al., 2011) indicating that the respondents were no more or less likely to have good SRH than Swedish boys in general. Furthermore, they also rated their SSS on a scale from 1-10 (mean SSS 6.91), which was slightly lower than the quantitative study in which the mean was 7.28 among boys. The information about SRH and SSS was used as background data to ensure that the participants were representative of this age group.

Papers III-IV

Participants in paper III and the quantitative part of paper IV comprised a sample of 318 boys and 387 girls (aged 17-18 years) in their final school year. They completed a postal questionnaire that included questions on SRH, health-related behaviours, pride and shame and SSS. Participants (n=705) were part of the VIP study and the final measurement was conducted when they were attending the 12th grade. Both boys and girls were included in papers III and IV to enable gender comparisons.

Paper IV

Participants in the qualitative part of this mixed methods study were recruited from a large school in central Sweden with academic, vocational and introductory school programmes which were all represented in the study (seven classes). The study included data from interviews conducted with 35 students in upper secondary school (17–18 years old, 12th grade), 16 girls and 19 boys. Of those 35 participants, 5 were born outside of Europe. The same data as used in paper III were used in the quantitative part of the study.

Data collection

Interviews

Data for papers I, II and the qualitative part of the paper IV were collected from interviews.

For papers I and II, 33 research interviews were conducted by me. Most of the research interviews (29 of 33) took place in conference rooms or quiet rooms at the schools. Two interviews were conducted at the home of the participants and two at the university where the first author works. The

participants received a movie ticket as reward for participating in the study. The interviews were recorded and lasted between 35 and 70 minutes (mean 49 minutes). Throughout the study, the interview guide was slightly modified in order to find new relevant categories and deepen the concepts within the categories. The interviews were kept informal and conversational, with the aim to explore and not to use direct questioning (Charmaz, 2006; Glaser, 2011). The interview guide was used as a template and comprised both open and specific questions. The guide also included probe questions to deepen the descriptions.

Health question
All 33 interviews conducted in study I contained a "health question" at the end of each interview, which was explained and asked with the following wording: "WHO claims that health consists of three parts: *mental health*, how well you feel inside of you; *physical health*, how well you feel in your body; and *social health*, how well you feel in your relations. Which of these three aspects is most important to you?"

Data for paper IV were derived from interviews conducted by Junia Joffer with 35 respondents, both boys and girls in the 12th grade. The interviews focused on the adolescents' reasoning about their SSS. The interview study used a cognitive interviewing technique ("think-aloud interviews") in which the respondents were asked to think and speak out loud (Bradburn, Sudman, & Wansink, 2004; Presser, 2004). This technique is a way to capture the thinking process and understand the strategies that respondents use to answer questions. During an interview, respondents are asked to think-aloud (e.g., verbalise inner thoughts and say everything out loud from the moment they see the question until they give an answer) (Presser, 2004). The interviewer triangulates with the respondent and follow-up questions (probing) are often used to increase more detailed inquiry (Charters, 2003). Thus, the participants were asked to speak out loud from the moment they saw the question about SSS and the interviewer asked probing questions to expand on the narratives. Respondents were instructed to report their thinking concurrently while answering the question, and retrospectively, i.e. after answering the question or finishing the questionnaire. A combination of the two methods has been suggested for producing optimal data quality (Sudman, Bradburn, & Schwarz, 1996).

Questionnaire

The data for papers III and IV were collected through a postal questionnaire (VIP study). The questionnaire was sent to the home of the participants, and

was used in the quantitative study (III) and the quantitative part of the mixed method study (IV). A questionnaire with about 60 questions was developed focusing on SRH, socio-demographic characteristics and other health-related questions. The questionnaire was constructed mainly based on the Swedish version of the WHO survey Health behaviours in school aged children and questions from other established Swedish surveys (Danielson & Marklund, 2000; Gillander Gådin & Hammarström, 2002; Granvik, 1998). The questions on shame had previously been used in adolescent studies (C. Åslund et al., 2009; C. Åslund et al., 2009) and the questions on pride had been used in a Swedish adolescent study (County Council of Västmanland, 2009).

Variables included in the analyses

Below is a summary and definition of the variables used in the study (papers III-IV).

To measure *SRH*, the following wording was used: "A person may feel good sometimes and bad sometimes. How do you feel most of the time?" Respondents were given a five-point rating scale: "very good", "rather good", "neither good, nor bad", "rather bad" and "very bad". Answers were dichotomised between very good and lower SRH. This dichotomisation was chosen in accordance with the Swedish and international public health goal of good health (Makenzius & Wamala, 2015; Sawyer et al., 2012). In the analysis, the answer "very good" was categorised as 'higher SRH' and other answers as 'lower SRH'.

Pride was measured using the following two questions: 1) "During the past 3 months, did you experience that someone has made you feel proud?" and 2) "During the past 3 months, did you experience that someone has expressed a positive opinion about you?" The response alternatives were: 1 ("no"), 2 ("yes, sometimes") and 3 ("yes, several times").

Shame was measured using four questions: 1) "During the past 3 months, did you experience that someone has insulted your dignity?", 2) "During the past 3 months, did you experience that someone has expressed derogatory comments about you?", 3) "During the past 3 months, did you experience that someone has made you an object of ridicule?" and 4) "During the past 3 months, did you experience that someone around you has ignored you?". The response alternatives were the same as those used for the pride dimension: 1 ("no"), 2 ("yes, sometimes") and 3 ("yes, several times").

Operationalisation of the pride-shame model

The *pride* index was created based on the two questions related to pride. The index, with scores from 1-3 on each of the questions, ranged between 2 and 6 and those with the scores 2-4 were considered as lower pride (LP) and those with 5-6 as higher pride (HP). The *shame* index was established based on the four questions to assess shame. The total score for the four questions ranged from 4-12: scores 4-5 referred to lower shame (LS) and scores 6-12 to higher shame (HS). The cut-off points were made close to the sample mean to form nearly equal-sized groups. Four combinations were possible: higher pride-lower shame (HP-LS), higher pride-higher shame (HP-HS), lower pride-lower shame (LP-LS) and lower pride-higher shame (LP-HS). These four combinations (groups) constituted the pride-shame model.

Country of birth was measured by the question: "In which country were you born?" The responses were dichotomised as born in or outside Sweden.

SES was measured by obtaining data from Statistics Sweden through data linkage at the individual level. Research has previously shown that family income, parental educational level and occupational class are factors that affect health independently and through separate pathways (Krieger et al., 1997). Thus, educational attainment was used as a single indicator (i.e. as a proxy for SES) in that it has been shown to be a valid and fairly constant measure among parents (Padilla-Moledo, Ruiz, & Castro-Piñero, 2016). When dichotomised, families in which at least one of the parents had a college or university degree were defined as 'high SES', whereas families with one or both parents with a lower or upper secondary school were defined as 'low SES'.

School experience was measured by the question: "How do you like school?" In the analysis, the alternatives "very much" and "rather much" were considered as 'positive' and "don´t like it so much" and "don´t like it at all" were considered as 'negative'.

Having enough friends was measured by the question: "Have you got as many friends as you want?" The respondents replied to this question with the alternatives: "yes, most often", "yes, sometimes" and "no, seldom". In the analysis, the answers were dichotomised with the last two labelled 'sometimes, seldom'.

Mood in family was measured by the question: "How do you consider the mood in your family?" on a five-point ordinal scale. In the analysis, the answers "very good" and "rather good" were defined as 'good' and the rest

"neither good nor bad", "rather bad" and "very bad" were defined as 'not good'.

Being *active in associations/clubs* was measured by the question: "Are you active in a spare time association (e.g. sports club, riding club, political youth organisation, scouts)?" with the response alternatives 'yes' or 'no'.

SSS in school was measured on a ladder with 10 positions from 1-10 as shown in Figure 1. The respondents rated their social position in comparison with other pupils in school on a ladder with 10 steps. The question is described in Figure 1.

Imagine that this ladder is a way of picturing your school.

At the top of the ladder are the most respected students, who everyone wants to be with and who have the highest status.

At the bottom of the ladder are the students who no one respects, who no one wants to be with and who have the lowest position.

Where would you place yourself on this ladder?

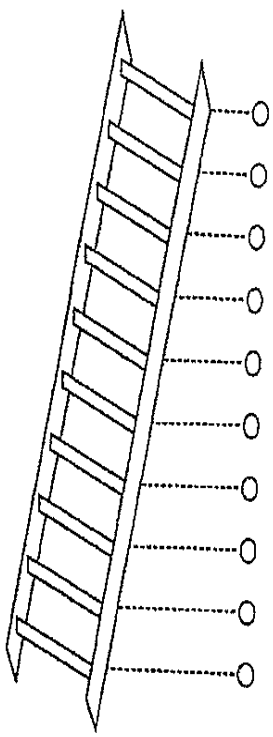

Figure 1. *The youth version of the MacArthur scale of subjective social status in school* (Goodman et al., 2001). The figure is published with permission from the author, personal communication 2016-06-17.

Data analyses

Papers I-II

The interview data were analysed with Grounded theory, gathering data and performing the analysis simultaneously: the method of constant comparison was used from initial coding to focused coding (Charmaz, 2006). Each interview was coded line-by-line while staying close to the data. In addition, to develop categories each interview was analysed with subsequent comparative analysis with other interviews. Interviews were performed until saturation was reached, and even though no new categories emerged after 20 interviews, an additional 13 interviews were conducted to ensure richness. The process included constant comparisons between identified categories and relationships between them and the final theoretical integration in which categories were integrated (Charmaz, 2006). A goal of grounded theory is to conceptualise an emergent pattern (Glaser, 2011), which in this study resulted in a model grounded in, and abstracted from, the participants' experiences. The study aimed to deepen theoretical understanding (Dahlgren et al., 2007), where participants' descriptions regarding their lived experiences were incorporated. A constructivist grounded theory approach sees both data and analysis as created through an interactive process with the data, researcher and participants, emphasising the closeness to the data and the interpretive understanding (Charmaz, 2006).

Paper III

In paper III, statistical analyses were conducted and differences in frequency distribution were analysed using Chi-square tests with $p<0.05$ as the significance level. A binary logistic regression was performed and the dependent variable, SRH, was dichotomised as higher or lower. Univariable and multivariable logistic regression models, with SRH as the dependent variable, were used to calculate odds ratios (ORs) with 95% confidence intervals (CIs) for having lower SRH compared with higher SRH.

The pride-shame model (paper III) was tested controlling for confounders. All analyses were performed separately for boys and girls so that gender differences could be tested. Data were analysed using SPSS 21.0.

Paper IV

A sequential explanatory mixed methods research design (Andrew & Halcomb, 2009) was chosen to combine qualitative interview data and quantitative cross sectional survey data from the VIP study. A questionnaire, including questions about SSS in school and SRH, was combined with the interview data in which the concept of SSS was further explored. The purpose of using a mixed methods approach was "expansion", i.e. that the quantitative and qualitative parts focused on different areas of the research question (Andrew & Halcomb, 2009). Data were integrated to expand the scope of the study. The quantitative study served as a point of departure and the qualitative part of the study was regarded as having dominant status, being the principal method (Morgan, 1998). While the quantitative part, which was analysed first, focused on relating SSS to SES and SRH, the qualitative part focused on exploring the concept of SSS in school.

In the analysis of the quantitative data, associations between SSS (10 steps) and gender were analysed using the Mann-Whitney U test. When SSS was analysed according to three groups (high, medium and low SSS), associations with SRH and SES were analysed using the Chi-square test. Categorisation was guided by empirical experiences from the interviews: steps 1-5 were defined as 'low', steps 6-8 as 'medium' and steps 9-10 as 'high'. Associations between SES and SRH were also tested using the Chi-square test. The significance level was set at $p<0.05$ for all analyses.

The interviews were transcribed verbatim and analysed using thematic network analysis, a method for conducting thematic analysis by creating global, organising and basic themes of qualitative material (Attride-Stirling, 2001). In the first stage of the analysis, all transcripts were read to acquire an overall understanding of the content. After re-reading and coding all interviews, codes were clustered into five basic themes, which, in turn, generated two organising themes. The organising themes were then clustered into one global theme representing the key point of the text. The first and second authors contributed equally to this work: both performed separate coding of all the data, discussed the findings and created the network. The findings were then discussed and negotiated within the entire research team.

Ethical considerations

Research involving humans must ensure that their human rights are protected and not violate any universally applicable ethical standards. The studies within the present thesis were conducted in accordance with the Act concerning the Ethical Review of Research involving humans (World Medical Association, 2001). Thus, ethical considerations were taken into account during the entire process of the thesis.

Study I (papers I-II) was approved in 2011 by the Research Ethics Committee at Uppsala University (Dnr 2011/106). The author of this thesis (ER) contacted the schools via the headmasters and head teachers, visited classes, and gave a short oral and written presentation. A written leaflet described the research project, the topic of the interview and that data collection involved the recording of the participants' responses during the interviews. They were also given information about their right to withdraw without explanation. They were further informed about that everything should be done to ensure their confidentiality, such as no names or recognisable personal details would be used. Both during and after the presentation of the study, the adolescent boys were given the opportunity to ask questions. All boys were given written information about the study together with a consent form and a pre-stamped envelope. Thus, they were given the possibility to reflect upon their decision to participate. Voluntary participation was stressed and they were instructed to sign the consent form and send it back to ER if they consented to being interviewed.

Children over 15 years of age are considered as autonomous decision makers in research processes according to the Swedish Act concerning the Ethical Review of Research Involving Humans (SFS 2003:460). Consequently, parental consent was not needed. Before turning on the tape recorder, all participants had an opportunity to ask questions related to the study. After each interview, the interviewer paid special attention to the participants' emotions and thoughts that had taken place during the interview and every boy was asked to express and reflect about being interviewed. The participants also received information about the possibility to take contact with the school health care personnel, who were contacted and informed about the study before the interviews were conducted. The interviewer called the boys about 1 week after the interview just to ask how they felt and whether they had any questions. This procedure was stopped because the boys did not express any needs and because they all expressed, after the interview, that being interviewed was a positive and engaging experience.

Study II (paper III) was approved 13 May 2003 by the Research Ethics Committee of the Medical Faculty, Umeå University. All participants signed an informed consent and parental consent was obtained for those under the age of 15 years who were enrolled in the study. The consent procedure followed that of 'opt out', implying that no active consent was requested. No parents refused their child to participate. Thus, all 1 046 invited adolescents were considered as the study cohort. The questionnaire was anonymous and each participant was assigned a code number. At each participating school, the school health care personnel were prepared to give additional support if it were needed. The VIP cohort was followed from 2003 to 2009 and papers III and IV used data from the last data collection.

Study III (paper IV) is a mixed methods study and combines data from two studies. Data derived from the quantitative part was the same VIP cohort as in study II. The quantitative part was approved 2003 by the Research Ethics Committee of the Medical Faculty, Umeå University and the qualitative part by the Research Ethics Committee in Uppsala (Dnr 2011-110). In the qualitative study, school nurses and class teachers were informed about the study before students were approached for recruitment. Students were provided with both oral and written information about the study during class hours. The students agreed to participation and that the results could be published by signing a consent form. The participants were informed about their right to end the interview at any time, and were free to ask questions both before and after the interview. After the interviews, the participants were asked how they felt about being interviewed and were also informed about the opportunity of visiting the school nurse/counsellor.

Results

The overall results show that health was a feeling created in interaction with others, and strongly affected by gender practices and perceived social status (Figure 2).

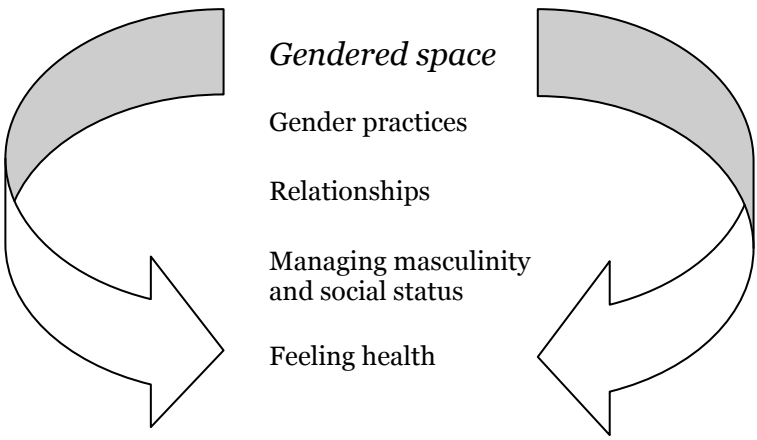

Figure 2. *Gendered experience of health*

The results illustrate how the participants mainly perceived health as an emotional and relational experience (paper I). The results show further that the experience of health was dependent on how well the body and mind were integrated within the person (paper I), how emotions and masculine norms were managed (paper II), the position and positioning of oneself in relation to others (papers II and IV), the experiences of pride and shame (papers I and III) and having access to trustful relationships (papers I-IV). The results also show that contextual factors, gender norms and gender practices played a vital role in experiences of health (papers I-IV). In the following the main results will be described.

Health - holistic, dialectic or dualistic?

The participants mainly conceived health as an emotional and a relational experience, where even the bodily state and actions were interpreted through emotions (paper I). Health was described as “feeling” health in which interacting with others, i.e. the relational health and having a body that could perform, contributed to the overall health experience. Thus, health was created in interaction with others and by doing health.

In conceptualising health, the interconnection between mind and body was evident and health was described as a holistic concept by the adolescent boys. However, when the participants referred to their own health experiences, and especially when they described dealing with difficult or overwhelming emotions, they described a more dualistic view in which the emotional and relational mind and the functional body were seen as different, yet affecting each other dialectically. Thus, several factors worked in conjunction to create a complexity in how the participants viewed, experienced, dealt with, and valued their health. How health was experienced and integrated within the person shaped their health and strategies to deal with it.

Some of the boys managed certain emotional stressors by switching between body and mind and suppressing feelings. One example is how the participants experienced and dealt with stress, which they did in two distinctive ways: the stress-resistant boys claimed they rarely experienced stress, and if they did, they could cope with it just by "switching off". The stress-sensitive boys experienced extensive stress because of schoolwork, demands regarding academic performance, reading and writing difficulties, or concentration problems. These participants seemed to have difficulties in coping with their life situations: the stress they were exposed to exceeded their capability to cope with it, which reduced their sense of good health. Another example is a boy who had deliberately harmed himself and stated: "I'd rather have pain in my body than pain in my mind". He separated mind and body because he found bodily pain easier to cope with. Other boys described the body-mind in a more complementary way. One boy explained: "If I couldn't work with my body, if I couldn't be in carpentry or exercise or play sports, I would be unhappy all the time…so I try to take care of my body." For him, body was an important tool. Although the boys described bodily processes and processes in the mind as being influenced by each other in a dialectic manner, the major finding suggests that experiencing health was mainly two-dimensional: emotional and relational health as a coherent experience and the functional body as a separate entity.

A model of adolescent boys' perceptions of health was developed in paper I. As presented in the model, emotional and social aspects of health were strongly connected and interrelated, forming the category *emotional and relational mind*. The bodily health comprised the category of *doing health as a functional condition* in which the body was described as a functional tool for health (Figure 3).

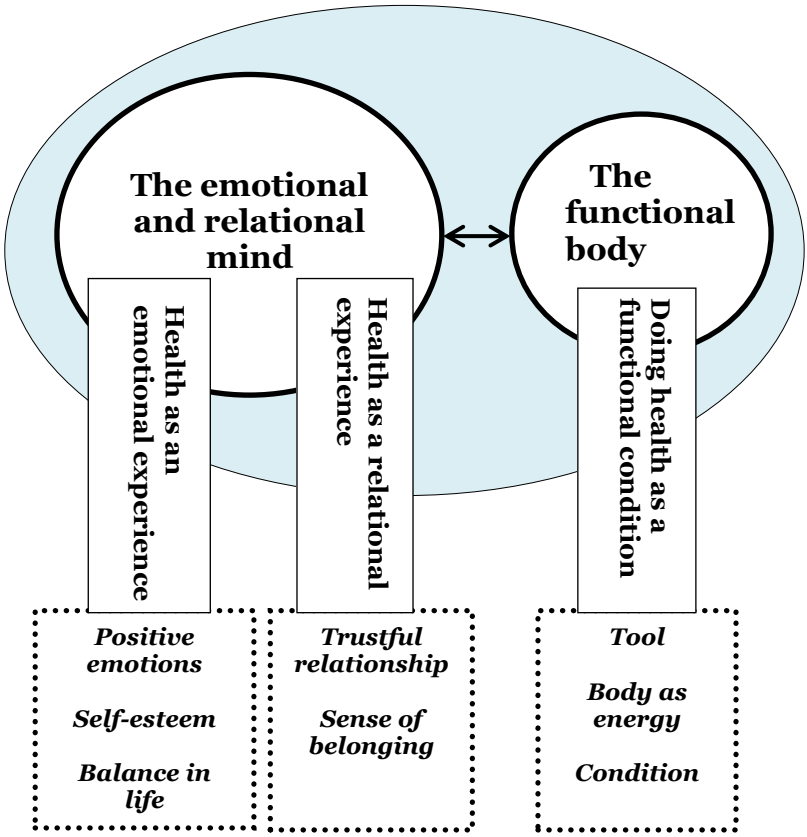

Figure 3. *Model of adolescent boys' perceptions of health.*

Valuing health

When answering the "health question", seventeen boys chose social health as the most important, of which four boys choose it in combination with mental health, indicating that they were of rather equal importance. Thirteen boys chose mental health as most important. No boy chose the option physical health alone though three boys chose it in combination with social health (one boy) and mental health (two boys). Findings based on the 33 interviews showed that social and mental health were valued as the most important aspects for the health of young adolescent boys.

Health and emotions

Feeling health in interaction

The emotional aspects of health were identified as major influences to experience health (paper I). First, p*resence of positive emotions* (e.g., happiness and freedom) and experiencing positive life events were conducive to health. Moreover, happiness was an important goal in itself. Second, the participants described that when they had confidence in their own abilities, they could accept who they were and sensed their own value: they had *self-esteem*, an attribute vitally important for health.

In the assessment of health, the subjective assessment outweighed possible objective assessments made by others. Having confidence, a sense of personal capacity and self-respect contributed to a confidence in their own ability. There was one boy with several diagnosed illnesses who claimed that he was not bothered by his health and felt well. Another boy described himself as being in great shape and that he exercised on a regular basis, but that the doctor at his school had commented several times on his weight: "If your doctor says that you are overweight and that your health is not good, it's not always the truth, because you can feel great in your mind; you can have your family". Finally, a *balance in life* was essential for emotional health. In this respect, finding a balance between emotions and demands and being able to cope with fluctuations in life were considered vital, as well as finding balance regarding stress.

Health was also experienced through interaction as relational, which comprised relationships at home, in the immediate environment, and in the community setting. The quality of relationships and being part of a group contributed to the overall health experience. Of particular importance for health was the experience of *trustful relationships* in which the boys experienced secure relationships within the family and with close friends who could provide emotional support. To be a part of a group or to be connected to others and having a *sense of belonging*, without necessarily being deeply involved in each other's lives, were also important. Belonging, having a sense of worthiness and knowing that there was a place for the boys where they were valued (papers II and IV) were central for health.

Health, pride and shame

Emotions of pride and shame were important for self-rated health (SRH), and experiencing pride was conducive to SRH (paper III). The characteristic of the study population in paper III is shown in Table 3. Compared with girls, SRH was significantly higher in boys: 45% of the boys vs. 31% of the girls rated their health as high ($p<0.01$). No differences were found between boys and girls in experiences of pride, but a significant gender difference was found in experiencing shame, with fewer boys experiencing shame (43% of the boys and 52 % of the girls) ($p<0.05$).

Table 3. Characteristics of the study population of boys (n=318) and girls (n=387)

Characteristics	**BOYS**		**GIRLS**		
	n	**%**	**n**	**%**	**χ^2**
Country of birth					
Born in Sweden	301	95	363	94	0.83
Born outside Sweden	17	5	22	6	
Mood in family					
Good	262	83	301	79	0.22
Not good	54	17	79	21	
Self-rated health					
Higher	143	45	119	31	<0.01
Lower	175	55	264	69	
Having enough friends					
Yes, most often	218	70	243	63	0.10
Sometimes, seldom	96	30	140	37	
School experience					
Positive	237	84	300	83	0.71
Negative	46	16	63	17	
Being active in associations/clubs					
Yes	154	49	194	50	0.61
No	163	51	190	50	
Parental education level					
High	177	56	202	47	0.44
Low	140	44	180	53	
Pride					
Higher	181	58	241	63	0.21
Lower	130	42	142	37	
Shame					
Higher	134	43	195	52	0.02
Lower	180	57	181	48	

Experiences of shame contributed to lower health, whereas experiencing pride seemed to be protective for health. When analysing the pride-shame model in which pride and shame (higher-lower) were combined in relation to SRH, findings showed that experiencing the combination of HS-LP was significantly associated with lower SRH and HP-LS was associated with high SRH, regardless of gender.

The distribution of SRH reported by boys and girls within each group of the pride-shame model in which four combinations were possible is shown in Table 4.

Table 4. Self-rated health (SRH) in boys and girls in the four groups of the pride-shame model

	BOYS		**GIRLS**	
	Lower SRH	Higher SRH	Lower SRH	Higher SRH
	n (%)	n (%)	n (%)	n (%)
HP-LS	39 (40)	59 (60)	63 (54)	53 (46)
HP-HS	44 (53)	39 (47)	83 (72)	33 (28)
LP-LS	48 (59)	33 (41)	45 (71)	18 (29)
LP-HS	39 (80)	10 (20)	62 (84)	12 (16)

HP = Higher pride; LP = Lower pride; LS = Lower shame; HS = Higher shame

A logistic regression analysis of the pride-shame model indicated that the odds of having lower SRH was highest among the boys with LP-HS (OR 5.90, 95%CI 2.64-13.18) and among the girls with LP-HS (OR 4.35, 95%CI 2.12-8.91).

Table 5. Odds ratio (OR) with 95% confidence interval (95%CI) for lower SRH in boys (n=311) in univariable and multivariable logistic regression analysis

BOYS				
Factors	*Univariable*		*Multivariable**	
	OR	95% CI	OR	95% CI
Pride-shame				
HP-LS	1.00	Ref	1.00	Ref
HP-HS	1.71	0.94-3.08	1.18	0.60-2.30
LP-LS	2.20	1.21-4.01	1.79	0.92-3.47
LP-HS	5.90	2.64-13.18	3.51	1.40-8.81
Country of birth				
Sweden	1.00	Ref	1.00	Ref
Not Sweden	0.92	0.34-2.44	1.10	0.34-3.58
Parental educational level				
High	1.00	Ref	1.00	Ref
Low	0.98	0.63-1.54	1.00	0.59-1.70
Mood in family				
Good	1.00	Ref	1.00	Ref
Not good	6.11	2.78-13.45	4.98	2.04-12.13
Having enough friends				
Yes, most often	1.00	Ref	1.00	Ref
Sometimes, seldom	2.66	1.59-4.45	2.28	1.27-4.12
School experience				
Positive	1.00	Ref	1.00	Ref
Negative	2.69	1.35-5.37	2.29	1.06-4.90
Being active in associations/ clubs				
Yes	1.00	Ref	1.00	Ref
No	1.40	0.90-2.18	1.13	0.67-1.92

Table 5 continues on next page.

Odds ratio (OR) with 95% confidence interval (95% CI) for lower SRH in girls (n=373) in univariable and multivariable logistic regression analysis

	GIRLS			
Factors	*Univariable*		*Multivariable**	
	OR	95% CI	OR	95% CI
Pride-shame				
HP-LS	1.00	Ref	1.00	Ref
HP-HS	2.12	1.23-3.65	1.57	0.85-2.90
LP-LS	2.10	1.09-4.06	2.16	1.02-4.56
LP-HS	4.35	2.12-8.91	2.70	1.22-5.96
Country of birth				
Sweden	1.00	Ref	1.00	Ref
Not Sweden	2.98	0.87-10.29	3.60	0.96-13.49
Parental educational level				
High	1.00	Ref	1.00	Ref
Low	1.13	0.73-1.75	1.17	0.71-1.94
Mood in family				
Good	1.00	Ref	1.00	Ref
Not good	2.50	1.34-4.67	1.82	0.92-3.61
Having enough friends				
Yes, most often	1.00	Ref	1.00	Ref
Sometimes, seldom	4.17	2.43-7.15	3.86	2.14-6.97
School experience				
Positive	1.00	Ref	1.00	Ref
Negative	2.19	1.12-4.29	1.41	0.67-2.95
Being active in associations/ clubs				
Yes	1.00	Ref	1.00	Ref
No	1.08	0.70-1.67	1.07	0.64-1.79

HP = Higher pride; LP = Lower pride; LS = Lower shame; HS = Higher shame. * In the multivariable analyses, all independent variables were included.

In a multivariable logistic regression analysis of the pride-shame model shown in Table 5, the odds of having lower SRH remained significantly associated among boys and girls with LP-HS, and furthermore among the girls with LP-LS, even after adjusting for potential confounders (country of birth, parental educational level, school experience, having enough friends, mood in family and being active in associations). The protective effect of experiencing pride could be found among both genders.

Managing health

Doing health

Findings from paper I demonstrated that health as a functional condition was perceived as 'doing health' in which the boys performed activities using their bodies to feel good, to achieve something or to gain a better body image. What the boy could do with his body and his ability to perform using his body were regarded as important. The body's impact on health was described in relation to three aspects. First, the body as a *tool* was an expression of the body being an instrument to achieve what was desired to enhance health. The boys also described the body as a source of *energy*, i.e. the body was viewed as a carrier of health providing embodied energy. By performing strenuous physical activities and exercising, their energy increased, which, in turn, enhanced their mental wellbeing. Finally, the body as a *condition* involved a well-functioning body as an organism, as having a healthy heart, a good immune system and sleeping and eating well: put differently, a body as a state of health and fitness worth taking care of.

With regard to emotion management, difficult or strong emotions could be released through the body. In this respect, the body was described as a valuable tool to manage emotions and achieve tranquillity (paper I). As a boy explained, "I have a very bad temper but I've solved the problem thanks to sports, so I feel good all the time when I work-out regularly." Thus, to stay emotionally healthy was partly managed by exercising. However, some boys described that emotions could be dealt with by participating in challenging or risky activities or even through self-harm. Performing challenging sports or activities was frequently used by the participants to help them to 'forget everything'. For some boys, strong emotions could also be expressed through harming property or through self-harm (paper II). For example, self-harm by burning or use of drugs was used to manage painful emotions. As one boy explained, 'I have engaged in some self-destructive and abusive behaviour

when I've felt bad … I've burned myself with a cigarette.' Some boys participated in risky activities when they have no one to turn to. Thus, the body was considered an instrument to achieve and deal with health.

Sharing

Findings from interviews (study I) showed that the boys expressed different levels of openness with respect to sharing. Partly sharing comprised *joking* away and *reformulating* things in which jokes could be liberating when a sensitive matter was joked away but could also be a way for the boy to hide behind the jokes, i.e. to use something as a means of preventing others from discovering information about them. To joke about worries or reformulate them was a safe way to approach worries without disclosing the real matter or without the risk of being judged as weak. Joking away was used as a strategy to be able to *talk and hide* at the same time. *Reformulating and rewording* was a strategy to reveal something that was experienced as emotionally shameful by focusing on some other, more accepted problem. Sharing comprised *sort of telling*, which was close to the participant's real feelings and in which some parts of the emotional worries could be exposed to others. There were also boys who honestly expressed their emotions and showed how they felt (*really telling*). They did it mostly in a face-to-face private context with their parents or close friends (both girls and boys) with whom they could speak openly about how they felt. There were also boys who did not share: "I go to myself", as one boy explained.

One major aspect promoting openness of emotions was the participants' sense of security in relationships. They described how difficult it was to turn to someone who did not know them. "A counsellor … it feels that you have to tell your whole life story in order to get help, but your close friends know most of the things and the friends can help." Feeling safe and having a friend who would not reveal your real identity to somebody else was a prerequisite. "I think that many guys are kind of afraid how people will perceive them and they think that it may seem unmanly to sit and talk about feelings. But I think that as long as I feel safe with those I am with, then it's no problem".

An important aspect facilitating openness towards sensitive emotions was communication through social media, i.e. being able to share behind the screen while maintaining anonymity. It offered a possibility for the participants, including those who were less verbally skilled, to express emotions through websites and social media or within a known network community. "That tough guy has existed much longer than the sensitive guy….and I think that Facebook has contributed to the new image. Boys are writing about love and wisdom, which they may not have done in real life."

Getting support

Many boys emphasised that they experienced a fear to be seen and judged by others. Thus, help-seeking and possibly visiting a counsellor were connected to shame emotions and even experiencing ill-health was partly seen as shameful. Some boys who had serious difficulties did turn to professional help when no other alternatives were available, but their help-seeking process and the appointment itself were preceded by much anguish and soul-searching. It was also a matter of personal courage to admit the need for support. Many of the boys seem to be affected and partly dependent on the prevailing opinions in the peer group and will not be "seen" as if they need to seek help and support. Some boys suggested that the health care personnel at schools could facilitate and reduce the help-seeking barrier. Thus, what could be done to reach out to the boys at school was explored. Making the support visible was important, as well as following characteristics of the person responding: patience and presence, being a good listener, showing understanding and having a positive attitude towards boys.

It was important to *make the support common but also anonymous*. For example, one boy emphasised that "every pupil should be given an opportunity to talk anonymously with the counsellor." Another boy emphasised anonymity: "You should have a confessional where you could go anonymously." Thus, stressing the common nature and including all pupils should give a possibility for everyone to meet the school counsellor. It seemed to be important to ensure that the pupils are well aware of the school's support system. An example of the need to open up and make the support more visible and accessible was exemplified by another boy's comment: "Raise the awareness and put up posters in the school with the text – we'll be here if you need to talk– as a reminder."

Several boys mentioned episodes when they were taken from the classroom to school meetings or to the school counsellor and this was considered a very shameful experience. These two citations underscore the importance of approaching the boys with sensitivity: "Ask when the boy is alone, never together with friends", or "Meet the boy alone before meeting the parents". In other words, approach *the boy with sensitivity and respect*.

The boys talked about the difficulty in expressing certain things and wished that the counsellor should be patient by using the following strategy: "I'll be here if you want to talk", "but they should never nag or put pressure [on one]". Thus, the voluntary aspect was crucial, as well as having enough time: "It will take some time to feel confidence, show patience". Consequently, showing *patience and presence is* critical. As one boy said, "If someone

should die, I should never go to a school social worker." This quote suggests the need for interpersonal trust (actual trust) between the boy and the professional helper before personal matters could be revealed.

The boys had concerns about not being understood and they talked about how crucial it was to be 'really' understood. The prerequisite was to listen very carefully, as one boy put it: "If the boy talks, it's very important to listen, listen so carefully that he'll be understood." Another boy who was not feeling so well also emphasised the importance of truly understanding and said: "If you knew that they (counsellors) should really understand, then some of the bad emotions would disappear." It requires not only *a good listener and an understanding person* but also trust.

Concerning the school's response to the boy pupils, several boys talked about how important it was that the school staff responded to and treated them with a *positive attitude*. The boys had experienced that boys in general were seen with more negative eyes as bullies or thugs that affected them as boys. One boy said, "That someone cares how you feel - a teacher for example." Another boy pointed out, "To hear an expression of approval and that you are good enough gives hope."

Health and gender

Masculinity and emotions

Findings from paper II showed two main categories of masculine conceptions in adolescent boys: gender-normative masculinity with an emphasis on group-based values and non-gender normative masculinity based on personal values (Figure 4).

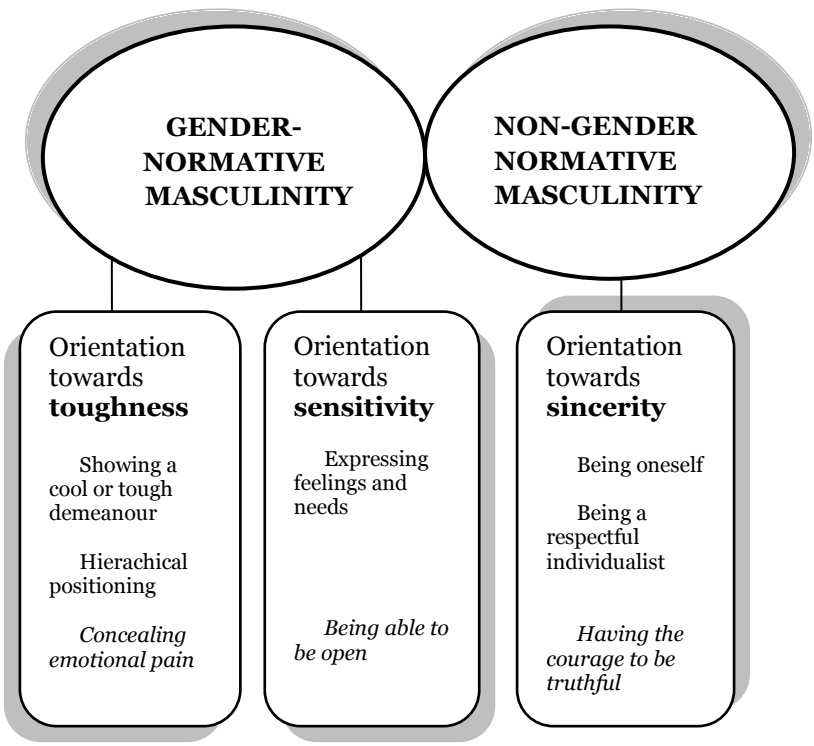

Figure 4. *Three types of emotional orientation in relation to masculinity*

Gender-normative masculinity comprised two seemingly opposite emotional masculinity orientations: one towards *toughness* and the other towards *sensitivity*, both of which were highly influenced by contextual and situational group norms and demands, despite their expressions in contrast to each other. Boys who adopted gender-normative masculinity tended to conform to the social norms of the group and followed the rules that governed behaviour and expressions about what was considered appropriately masculine (or feminine). Social norms referred to rules and

expectations for behaviour, i.e. the situational 'feeling rules'. Values refer to abstract conceptions of what is important and right or wrong according to the adolescent boy. For example, courage is a value while the expectation that a boys should not chicken out is a norm.

Common for orientations towards toughness and sensitivity was a need to act and behave in a socially accepted manner and that the peer group was a forming arena. Different social contexts contributed to various requirements regarding what emotions to display. When balancing the roles of how to be a young man, local gender practices and the collective value base, especially within a school or community setting, affected the boys' expressive behaviours.

Boys who were oriented towards toughness and those oriented towards sensitivity were influenced by the social norms within peer groups, school programmes and the local community, which contributed to shape a normative gender practice regarding what emotions to display, and how. Both these groups were hindered by the same peer group norm, albeit in different ways. And while the boys who oriented towards toughness wanted to conceal certain emotions, the sensitive boys expressed a willing to share their emotions.

Orientation towards **toughness** was indicated through having a masculine attitude by *showing a cool or tough demeanour* and *positioning oneself hierarchically*. With reference to emotional management, two markers of this orientation were noted: *concealing emotional pain* and keeping sensitive emotions inside. Toughness could be communicated through bodily expressions (e.g., saying no to an anaesthetic when visiting the dentist) or signalled through acts of bravery (e.g., playing the role of hero). It was also important to avoid shame and suppress those characteristics that are suggestive of weakness and female-like attributes and appearances. Even though toughness provided a surface of protection against being shamed, the consequences of the demands of acting tough and the lack of sharing sensitive emotions could impact wellbeing negatively.

In contrast to the orientation towards toughness, in the orientation towards **sensitivity** indicators of traditional femininity (expressions of feelings and needs) were played up. The participants' emotion management had an emphasis on *being able to be open* provided that the relationship was a secure one.

Non-gender-normative masculinity included an orientation towards ***sincerity*** that emphasised the personal norms and own values of the

participants: emotions were expressed more independently of collective peer group norms. Boys who adopted non-normative masculinity tended to emphasise distancing themselves from traditional or peer group norms by focusing on individual masculinity and their own value base. It involved a conscious distancing from prevailing gender norms, which resisted group norms. The emotional orientation towards sincerity refers to a masculine attitude of being yourself and a respectful individualist. Included in this preference was a willingness to stand up for their ideas and being the person who they really were without infringing upon others. Central to identity and wellbeing was a sense of having the courage to be truthful with their emotions and a preferred strategy was to express their feelings and really telling honestly how they feel.

Being young in gendered space

Some of the boys who were oriented towards toughness (paper II) emphasised that it was important to suppress everything that might indicate mental weakness and female-like attributes and appearances. They also showed a more traditional and restrictive sexual view, as exemplified by the following participant's comment: "A guy should not be gay or girly". Those oriented towards toughness followed the social norms of the group in order to fit in with peers. They were occupied with the role of defending traditional masculinity norms and values, such as showing strength, acting tough and avoiding all signs of weakness. In certain groups the boys conformed to peer-endorsed masculine behaviours in which signs of weakness and fear were repressed and a masculine role play was required. Even if there were openness towards homosexuality, some participants were against boys showing their homosexuality or were fearful of being labelled gay. One boy stated, "You have to be tough and cool, almost like a cover, and don't show emotions because then you run the risk of being called homo". On the other hand, boys with the emotional orientation towards sincerity showed a more individualistic and tolerant view, where respect for all individuals was important.

Findings from interviews with both boys and girls (paper IV) showed that gendered values influenced the informant's social status and the positioning of oneself was done in a gendered space. While the norms for boys' behaviours were wider and they could benefit and raise their status (e.g., from having sex with several girls), girls appeared to be more targeted to the judgment of others, especially concerning sexuality. Girls having sex with several boys would most definitely risk losing their good reputation, which

could contribute to a lowering of their social status. Such traditional ideas were expressed and recognised by both boys and girls.

Although a large number of boys had opinions about the norms and rules surrounding sexuality (paper IV), only a few discussed their sexual health or their own sexuality in relation to health (papers I-II). The focus in interviews was on common values, norms and behaviours around sexuality or the sexual behaviour of others (papers I, II and IV).

Health and the impact and meaning of subjective social status

Being affiliated to a group and being positioned in a hierarchy were important factors influencing health (paper II). The findings from paper II showed further that an expression of hierarchical positioning was the participants' subjectively perceived social status. Having a relatively high status was related to gaining greater respect from others in a given social context (paper II). Findings from paper IV showed that choice of academic orientation and different school group affiliations was very important for the individual contributing to SSS.

Results from paper IV showed that SSS in school was strongly associated with SRH in boys (p-value<0.001) and girls (p-value<0.001). High SSS was associated with high SRH and low SSS with low SRH in both boys and girls. There was no statistical significant association between SSS and SES, or between SES and SRH. Thus, SES, as measured by the educational level of the parents, was not significant for either SRH or SSS in adolescent boys and girls.

The distribution of each SSS step among boys and girls is shown in Figure 5. A significant difference was found with the boys rating their SSS higher than the girls (p-value=0.02). When SSS was divided into three categories (high, medium, low), the difference remained, i.e. the boys rated their SSS significantly higher compared with the girls (Table 5). With each higher step on the SSS ladder, the proportion of adolescents with high SRH increased (Figure 6).

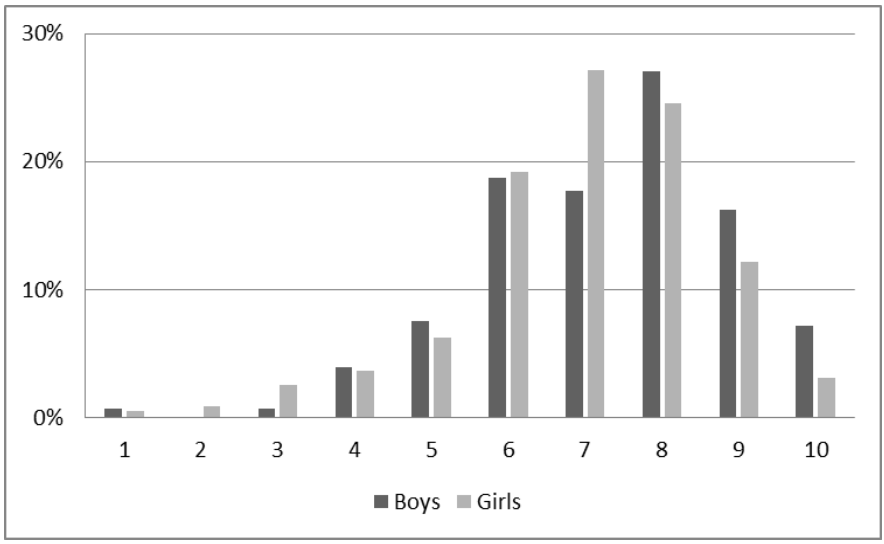

Figure 5. *Distribution of subjective social status (SSS) in school among boys (n=277) and girls (n=354)*

Table 5. Subjective social status in school among boys (n=277) and girls (n=354)

	Boys	**Girls**	**χ^2**
	n (%)	*n (%)*	*p*
Subjective social status			
High	65 (23)	54 (15)	
Medium	176 (64)	251 (71)	0.032
Low	36 (13)	49 (14)	

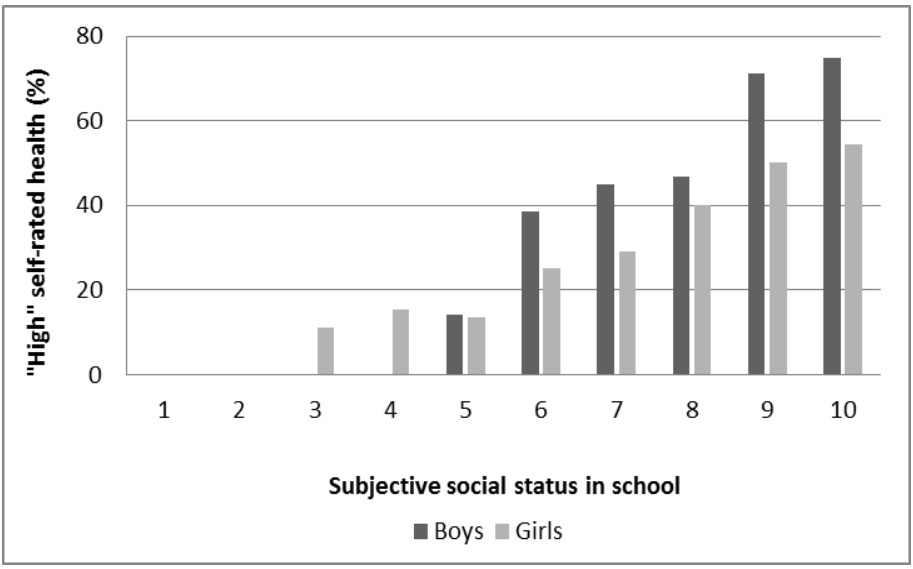

Figure 6. *Subjective social status in school among participants with 'high' self-rated health*

In paper IV, the meaning of SSS in school was further explored in interviews. Based on these interviews, a thematic network based was developed (Figure 7). Five basic themes were identified, which, in turn, generated two organising themes and one global theme. Two basic themes were developed connected at the group level (*in the group within the groups)*: making social hierarchies and displaying cultural belongings. Furthermore, three basic themes were constructed that were connected at the individual level (*individual values and behaviours)*: marketing oneself, living with the gendered norms and forcing or earning respect.

Positioning of oneself in a gendered space was the global theme connecting all the aspects on both the individual and group level. Gendered values and behaviours in school clearly influenced the informants' position on the ladder.

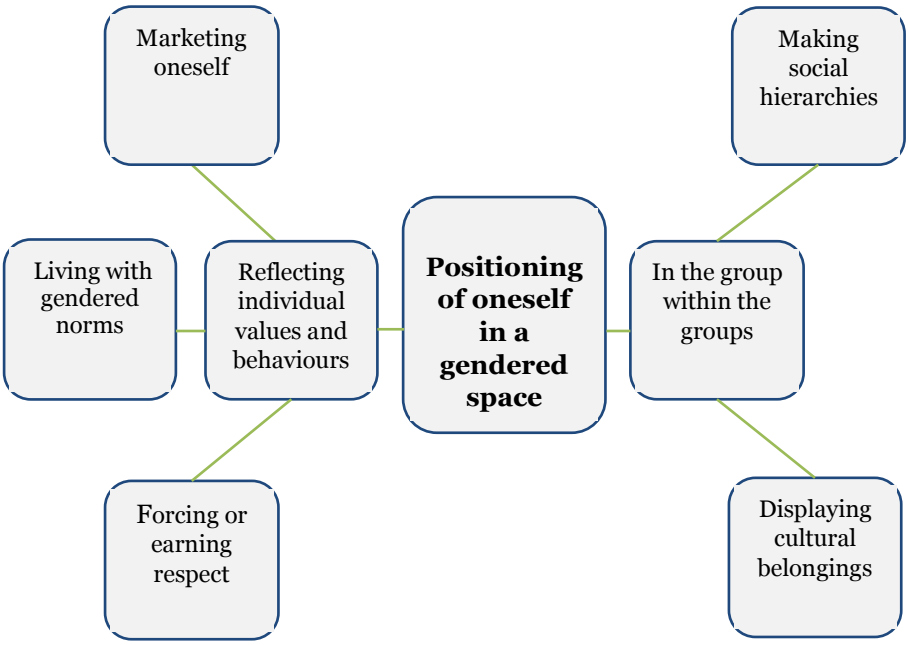

Figure 7. *Network of global, organising and basic themes describing subjective social status in school.*

The non-significant association between SSS in school and SES (measured by parental educational level) in the quantitative part of the study was in a sense supported by the few statements about family affluence in the interviews, i.e. parental socioeconomic status seemed to have a limited impact on adolescents' positioning on the ladder.

Reflecting individual values and behaviours was part of the process of positioning oneself on the ladder, which adhered to the act of striving for a higher position and a struggle for keeping the position in a gendered interaction between boys and girls. The informants' values and behaviours were expressed through aspects, such as marketing themselves at school, their way of living with gendered norms and their behaviours towards each other (by forcing or earning respect). The process of positioning also involved a negotiation of individual behaviours and values, such as how to show and gain respect.

Marketing oneself was part of the socialising process and the informants stated that it was easy to see whether students was in a high or low position by the way they looked and acted. External attributes influenced this positioning in that they were expected to look and behave in a certain way according to their gender (e.g., blond hair and a feminine look for girls and being tall and muscular for boys).

In *living with gendered norms,* the sexuality was highly gendered. Girls could lower their reputation by having several sexual partners, whereas boys could raise their status by having many partners. Participants of both genders expressed a rather similar view on how boys and girls were expected to behave, and there were obvious gender differences in what behaviours were considered acceptable.

Respect was understood in various ways and was regarded in both positive and negative terms, i.e. *forcing and earning respect*. The most highly ranked students seemed to have the possibility to influence norms, but there was a fine line between influencing norms and the risk of losing a highly ranked position. Respect was understood in both positive terms (e.g., being a good person or having respect for others) or in negative terms (e.g., when highly ranked students forced others to show them respect). This latter type of respect was not truly earned and was described by the participants as 'fake-respect'.

When positioning oneself on the ladder, the individual position was related to different hierarchies at school and the adolescents displayed different cultural belongings through different markers. The individual position was related to the status of the informants' group belonging, which, in turn, was related to other groups (*in the group within the groups*). Social hierarchy in school was largely based on academic orientation but hierarchies were created within all groups. An individual could be well respected and have many friends within the immediate social grouping (e.g., in the school class), but from a broader school perspective, the class might be in a relatively very low position, which would result in an overall low position.

Social hierarchies were made between groups (e.g., school classes, school programs, gender or cultural belonging). The informants found their closest group belonging as more important to them than their overall position in school. Academic school programmes were seen as superior to vocational school programmes and vocational programmes were in turn seen as superior to introductory school programmes. Informants represented various groups and cultures such as 'the emos', 'the media students', 'sport students' or 'the new Swedes'. Further, different ethnic belongings

contributed to the various *cultural belongings* that were *displayed*. Representing cultural minorities and having a look that differed implied a greater risk for exclusion. On the other hand, in certain groups the informants have a strong feeling of being allied and could gain power by resisting the norms together as a group. Differences could create a sense of solidarity for those who shared a group belonging.

Summary of the main findings

The main findings from the four papers are summarised below. First, there was a complexity in how the participants viewed, experienced, dealt with and valued health. The adolescent boys experienced a difference between health as a concept (more holistic) and health as an experience (more dualistic). Relational and emotional health seemed to be valued higher than physical health, although the body was an important tool in doing health (paper I).

Second, two main categories of masculine conceptions were identified: gender-normative masculinity and non-gender-normative masculinity. In addition, three emotional masculinity orientations were identified: towards toughness, sensitivity and sincerity (paper II).

Third, both shame and pride were significantly associated with SRH. Higher shame was associated with lower SRH, whereas experiencing higher pride seemed to be a protective strategy for health (paper III).

Fourth, SSS in school was strongly related to SRH and the positioning of oneself was done in a gendered space governed by traditional gender norms (paper IV).

The overall findings showed that experiencing positive emotions, having confidence in one's own ability and position, having access to trustful relationships and daring to resist traditional masculine norms while at the same time not losing social status were some of the recurrent themes contributing to good health. The adolescent boy experienced good health when he felt good in mind and body, felt himself to be someone of value and high status, had self-esteem and felt connected.

Discussion

The aim of the study has been to explore adolescent boys' perceptions of health in relation to emotion management, masculinity and SSS. The main results of this thesis are interpreted as a whole and discussed under the following sub-headings: health; health and emotions; health, gender and masculinities; and health and subjective status.

Health

The complexity of health as a concept and experience

Overall, the findings show a complexity in how the participants viewed, experienced, dealt with and valued health. Experiencing health could be interpreted as holistic, dialectic or dualistic perceptions depending on the person and social situation (papers I-II).

When the boys described strategies to deal with health, both a dualistic (Rozemond, 1999) and a dialectic view (Merleau-Ponty, 1962) emerged. Referring to their health experiences, and particularly when dealing with difficult emotional matters, the adolescents were prone to separate the mind from the body. Several boys gave examples of this dualistic view and how they used challenging sports to act out worries through the body. Some of the boys who had experienced mental ill-health expressed a strong desire to replace an internal (unspecific) pain with a visible bodily pain, which was easier to delimit and cope with. Intentional self-harm was found in some boys and it appears that deliberate self-harm was employed to manage difficult emotions that they felt could not be shared. This finding illustrates that the body is an essential part of dealing with emotions. Research indicates that emotion work can also be corporeal work and that intentional self-harm or self-injury is an embodied method of managing emotions, generally more frequently seen in adolescent girls than in adolescent boys (Chandler, 2012; Laye-Gindhu & Schonert-Reichl, 2005). Thus, harming their bodies was a way to cope with emotional health concerns. It is also suggested that beliefs in mind-body dualism can serve as a cognitive tool for coping with life's struggles (Forstmann et al., 2012). Dissociation involves a separation from self (Price, 2007). A different interpretation could be that the mind is "abandoned" in favour of the body to avoid emotional pain. Thus, the mind and body may be perceived both as an integral unit and as separable in demanding social situations.

There may be several reasons contributing to the distinction between body and mind. The current health discourse emphasises different health dimensions, above all physical and mental, which might contribute to the consolidation of the dualistic view. It is also possible that the separation between mind and body in certain social situations is related to the expression of masculine socialisation and self-control as a means to manage emotions (Courtenay, 2003; MacLean, Sweeting, & Hunt, 2010; Messerschmidt, 2009). Hypothetically, the distinction of mind and body can lead to subordination of the body, i.e. the participants placed greater value on emotional and relational aspects of health than they did on physical health.

In the boys' narratives, dualistic beliefs appeared prominent also with regard to stress: the stress-resistant boys seemed to keep the mind and body apart by 'switching off' stress or bodily discomfort. Moreover, in certain pressing conditions, the boys expressed a sense of being either in the body or in the mind. Alternating between being and having a body indicates a complex relationship between the self and body, one in which the body is perceived both as an object and as a subject. Some of the boys managed certain emotional stressors by switching between body and mind and in this way suppressing their feelings. Studies concerning perceived stress among older adolescents found that more girls report higher levels of stress symptoms than boys (Landstedt & Gillander Gådin, 2012; Strömbäck et al., 2014; Wiklund et al., 2010). It seems that some boys used a strategy involving switching between body and mind or by 'switching off' their feelings, which might explain why boys are more likely to deny health problems than girls (Ciarrochi et al., 2002).

Although a distinction between mind and body was made in several responses in relation to dealing with health, mind and body were more often not inseparable in the context of broader perceptions of health. The lived body, contrasting to the dualistic body, refers to the person through a dialectical mode following Merleau-Ponty's understanding on the 'body-subject', i.e. the body precedes the dichotomy of self and other, carries the 'self' into the world and that we are intertwined with the world as embodied beings (Engelsrud, 2005; Merleau-Ponty, 1962). In conceptualising health, the boys described an interconnection between mind and body. They showed awareness about that minds and bodies depended on each other and minds were embodied. Thus, on a theoretical level, they bridged the gap between mind and body. The relation between body and mind was important to health. It seems that many health models still reflect the dualistic idea with roots in Cartesian philosophy that body and mind are representations of different functions. The WHO health definition claims to be holistic but

defines the three dimensions mentioned above and in doing so defines boundaries and divides health into different components. The health model developed in this thesis follows that tradition of different components that together may contribute to a 'holistic' health experience (paper I).

Finding a balance

It seemed that health experiences were understood and acquired depth through awareness of the opposite of good health, i.e. experiences of ill-health. Feelings of health and ill-health were integrated in a dialectical movement (complementary) or in a dualistic movement (separated). Finding a balance and coping with fluctuations in life were also an expression of movement that included a sense that life could be both stressful and easygoing. Thus, finding a balance between emotions and demands was critical maintaining good health (paper I). Nordenfelt (1995) notes that how persons perceive their ill-health and how it limits their ability to reach important goals are more important than the ill-health itself. Similarly, the results from the thesis show that the perception and subjective experience determine health. Nordenfelt further emphasises the person's ability to achieve goals given that they are realistic under the circumstances. In the present study, the boys showed a realistic understanding that health was an overall experience; rather than feeling/being on the top all the time, they emphasised the ability to cope with fluctuations in life and find a balance (paper I). No participant mentioned 'complete' health as a goal, although all three dimensions in the WHO health definition (physical, mental and social wellbeing) proved to be important.

The demands that the participants often experienced in different social situations and contexts required careful balancing of competing views (paper II). The adolescents could be considered weak, especially in group situations, if they were emotional. Yet, in close or intimate relationships, they were expected to show feelings and be emotional. Thus, what, when and how the adolescent boys displayed these conflated emotions were dependent on context and companionship with the participants that oscillated between different social situations and contexts and expressions. Characteristics for the process of dealing with emotions include balancing between private and public, balancing between external requirements (e.g., peer pressure) and internal values and balancing between concealing and revealing emotions. This balancing act encompassed a certain amount of pressure that required both toughness and softness, which might be a dilemma for most modern teenage boys.

Valuing dimensions of health

The health dimensions (emotional, relational, physical) were valued differently; above all, the relational and emotional factors mattered most for the boys while physical health played a subordinate role. Although health was primarily described in emotional terms as 'feeling' health, the body was also important: many of the boy participants emphasised the body's ability to 'do health' and how the body was used as a tool to achieve and deal with health. Health was to feel good and function well in mind and body and to have trusting relationships.

Important for health was the presence of positive emotions (e.g., happiness and pride), experiencing self-esteem, having balance in life, having access to trustful relationships, having a sense of belonging and a sense of high subjective status (papers I-IV). Based on our findings, health could be depicted as primarily a relational and emotional experience, where the impact of physical health seemed to be of lesser importance, at least for the adolescent boys. The physical body was interpreted through social processes, judged by the ability to perform and do things and seen as a tool or a carrier of health. Accordingly, in 'doing health' the participants' ability to realise certain goals was in focus, closely connected to the action-oriented view of Nordenfelt (1995). Keeping the mind healthy was valued high and 'bodily pain was preferred over 'mental pain'.

There may be several factors affecting the superior position of social and emotional health, but the present findings suggest that the impact of close social networks and relations shapes the health experience. Maintaining social bonds is a fundamental motive for all actions involving both mental and emotional connectedness between individuals (Scheff, 2000). It is also possible that physical health is seen as a given and essential part of health among youth in welfare states, so it does not need as much attention as relationships that require daily attention and action. The boys experienced health in relationships with their families, friends and peers, in which significant trustful relationships and a sense of belonging were important for health. Mental health issues have received much attention among adolescents, but some studies have also demonstrated the relevance of relational aspects, i.e. social health. Eckersley (2011, 2006) underline the importance of cultural, existential and relational factors for adolescent health and identity and another study highlight the relational approach to health and wellbeing (Wrench, Garrett, & King, 2012). Ott et al. (2011) found that adolescents described mental health as an interaction between themselves and the environment rather than as an individual condition. Still,

it is important to argue that social health, i.e. the relational aspects of health need further study. Based on the present findings, the subjective perceptions, relational aspects and contextual factors all helped to form a basis for adolescent health. Adolescent boys belong to groups within other groups in societies, and the mutual interaction between external settings and internal responses shapes their lives and health. Adolescent boys interact in various micro systems (e.g., schools, homes and sports clubs). Those micro systems are in mutual interaction with others at the meso level (Bronfenbrenner & Morris, 2007).

Health and emotions

The boys' approaches to masculine expressions and emotion management were linked to their value base, their capacity to resist norms and their sense of relational security (paper II). Emotions were closely connected to both health and performing masculine behaviours. Those performances were embedded in both situational and contextual surroundings, as well as linked to the adolescents' values and sense of relational security, which, taken together, affected emotional expressions. Although displays of masculine actions and behaviours differed depending on the context, social situation and person, the adolescent boys favoured certain emotional orientations. Three emotional orientations were identified: towards toughness, towards sensitivity and towards sincerity. Of those three orientations, toughness and sensitivity represented gender-normative masculinity and sincerity non-gender-normative masculinity.

The feeling rules in different social contexts affected their expressions. Whereas toughness and expressing a cool demeanour were more desirable in the presence of certain peer groups, showing emotions and empathy for others were sought for in close or intimate relationships. Connell (2005) contends that most men simultaneously embody hegemonic and subordinated masculinities. The present findings support the possibility of having different masculinity positions depending on the context.

Comparing the three orientations, some common and distinctive characteristics were observed (paper II). There was a tension between peer group-based and individually based masculinity orientations. Boys processed their emotions in relation to their own value base or to peer group norms. Hypothetically, certain qualities in emotion management can be distinguished for each emotional orientation: the boys who were oriented towards toughness were more prone to use bodily strategies of emotion

regulation; the boys oriented towards sensitivity emphasised expressive strategies through sharing; and those who were oriented towards sincerity had a preference for cognitive strategies. Hochschild (1983) describes cognitive, bodily and expressive strategies as well as emotion work on specific emotions. One recent study shows that adolescents' use of strategy type is related to their wellbeing: a conscious cognitive change (reappraising) results in better health outcomes, e.g. greater life satisfaction and more positive emotions, whereas suppressive strategies imply greater loneliness and negative emotions (Verzeletti et al., 2016). Thus, a greater reliance on conscious cognitive change as a way to modify the impact of emotional experience was positively associated with better wellbeing outcomes (ibid.). In line with those findings, findings from study I showed that there were boys who used intensive thinking and reflecting as a cognitive way to process and overcome difficult emotions. Verzeletti et al. also found that adolescents are likely to suppress the display of their emotions, not letting others know what they feel. Similarly, there were boys who could not openly express their emotions (papers I and II). Many of the participants often dealt with their emotions in solitude affected by the feeling rule of 'manage on your own'. In that hidden and private region, 'deep acting' (Hochschild, 1979) and 'back stage' (Goffman, 1959) the participants could feel free to express feelings and emotions that may be unacceptable to their peers. The boys were sometimes forced to conform and play a role when interacting with their peers to fit in with peer expectations. The role play was for the benefit of the audience on the 'front stage' (Goffman, 1959).

The impact of pride and shame

Findings from papers I-II show that help-seeking behaviour was hindered in the group of adolescent boys who were fearful of being seen and judged by others. This finding is consistent with other studies (MacLean et al., 2010; Marcell et al., 2002). Some boys expressed a desire for help seeking on equal terms between genders (e.g., adolescent boys should be able to seek help just as girls can) (papers I-II). Turning to professionals for support may be considered a 'last option' and was associated not only with shame and failure, but also with a lack of trust. Ciarrochi et al. (2002) have shown that adolescents who are poor at managing emotions are the least likely to seek help. There may be gender differences and one study show that although being bullied may be shameful for both boys and girls, the threshold for admitting to being bullied is arguably higher for boys (Eriksen & Lyng, 2016). Shame is the master emotion that is present in everyday situations regulating the expressions and occurring when bonds are threatened (Scheff, 2003). Therefore, for some of the boys, being in need of support may signal

weakness in the eyes of the teenager himself and the significant others and some of the boys did all they could to avoid being stigmatised. In our contemporary society, it seems that help-seeking is still associated with stigma and shame is silencing some boys. Health dialogues are held by the school nurses in Sweden on a regular basis. The visits could be offered by the school counsellor to equate the contacts with school health care.

Understanding of the role that emotions play for adolescent social development and health is critical and it seemed that most adolescent boys struggled between expressing and suppressing emotions. Findings from paper III show that pride is a powerful emotion that can contradict experiences of shame. An environment characterised by a lack of positive comments (papers I and III) and where the individual is subjected to shame were found unfavourable for health. However, experiences of pride may counteract and mitigate experiences of shame. Findings from paper III show that there were no differences between boys and girls in experiences of pride. These findings contradict those in a recent study, in which pride expressions were examined among younger and older adolescents (Webb et al., 2016). Webb et al. found that girls reported more experiences of intense pride and had a higher likelihood of expressing pride than boys. Further, older adolescents were more likely to suppress or express modesty in pride-eliciting situations (ibid.). Martens, Tracy, and Shariff (2012) suggest that both pride and shame expressions function as social signals that benefit both observers and expressers. The authors further showed a relation between pride and social status. More specifically, displays of pride may increase social status when the pride is deserved but also may decrease social inclusion when pride is undeserved.

Findings from paper III show that a significant gender difference was found in experiencing shame, where fewer boys than girls experienced shame. Women are stereotypically described as more likely than men to experience emotions (e.g., guilt and shame), but are less likely than men to experience pride (Plant et al., 2000). However, a review on gender and emotion expressions in childhood and adolescence found few gender differences, with girls showing more positive emotions and internalising emotions (e.g., sadness, anxiety, sympathy) than boys and boys showing more externalising emotions (e.g., anger). The review also reported that emotional expressions were context dependent (Chaplin & Aldao, 2013). Another review found that guilt and shame displays showed small gender differences, whereas embarrassment, authentic pride and hubristic pride showed gender similarities (Else-Quest et al., 2012). The results of the thesis imply, in line with Chaplin and Aldao, that boys are as emotional as girls but we should consider the role and impact of social context in emotional expressions.

Managing health

The feeling rule of 'showing strength' affected the wellbeing of some boys; boys who experienced difficulty sharing their problems were more prone to risk their wellbeing and manage their emotions in a challenging or destructive manner.

Findings from study I show that social media offered an arena for interaction for the boys and sensitive emotions could be expressed behind the screen. It is suggested that social media shapes the emotional expressions and can have a positive impact on loneliness and intimacy, and further, that the effects may lead to more positive outcomes for boys than for girls (Wood, Bukowski, & Lis, 2016). Another study highlight the positive role of internet use for young people in need of additional support (Bannon et al., 2015) In accordance with those findings, the use of internet seemed to contribute to connectedness and better expressive competence in adolescent boys.

The thesis shows that person, social interaction and context are three aspects of health and should be considered as an interdependent whole. Trustful relationships were an indispensable part of health and the boys were constantly struggling with the question of whom to trust. Sharing and possible help seeking were a matter of trust. The importance of trust was shown to be important for adolescent health, and higher trust in authorities, institutions and community is related to healthier behaviours (Mmari et al., 2016). A barrier between adolescent boys and the healthcare system has been demonstrated in several studies resulting in lower help seeking for boys and men. One study found that beliefs in mind and body dualism can hinder help seeking especially in males (Caldwell, 2016). Findings from papers I-II suggested that perceiving of the mind as distinct from the body, may be such barrier to help seeking. The importance of welcoming the boys by showing that health seeking is congruent with being a healthy and responsible person is suggested (Conway et al., 2016). In agreement with Conway, the process of reaching out to boys begins with building trust.

Health, gender and masculinities

The present findings show that boys and girls differed in their SRH: the boys rated their health significantly better than the girls (papers III-IV), which is in agreement with previous research (Cosma, 2016; Ravens-Sieberer et al., 2009; Wiklund et al., 2012). There are several possible explanations to the gender difference, including that boys experience fewer health problems or underreport health complaints, which may be related to a strategy of preventing shame (Courtenay, 2003). Both boys and girls experienced pride to a similar extent but a larger proportion of girls experienced higher shame. There was also a significant difference between boys and girls in SSS.

Findings from paper IV showed that the social position was highly dependent on the gendered norms that framed the sexual and moral behaviours and regulation of both boys and girls. Each group within the school has to respond and relate to these norms, and in the descriptions of the participants, surprisingly many boys and girls expressed traditional gender norms. The reproduction of a gender order, in which boys are considered the norm, has been described in other studies (Gillander Gådin & Hammarström, 2000; Martinsson & Reimers, 2008). Both complementary and dominant gender ideologies have been described. One Swedish study showed that school is an important arena for sexualised behaviours in which boys strive for power and dominance over girls (Gillander Gådin & Hammarström, 2005). The results in paper IV are consistent with those findings, and having many sexual partners increased the status for the boys but the same behaviour lowered the status for the girls. Thus, the sexualisation of the school space was largely a reproduction of a gendered order in which women's sexuality is restricted and put under moral judgement and scrutiny. Tolman, Davis, and Bowman (2016) claim that institutionalised heterosexuality is reproduced through the functioning of the hierarchical complementary of feminine and masculine ideologies. Even though girls seemed to have more norms to follow and appeared to be more targeted to the judgment of others, especially concerning sexuality, those gender practices seem to hinder and affect (although in different ways) the life of both boys and girls in preserving gender inequality (paper IV).

Traditional gender norms and expressions of traditional masculinity were also found in the interviews (papers I-II). Boys with an orientation towards toughness held to the more traditional masculinity ideology (Burn & Ward, 2005), which was dominated by being tough, exhibiting self-restraint and holding back emotions. This position, which is closer to the concept of hegemonic masculinity (Connell & Messerschmidt, 2005), was associated

with a fear of being labelled 'gay' or 'girly' and therefore led to concealing expressions of weakness, especially in a group context.

Although Sweden is one of the most gender-equal countries in the world with a strong gender equality discourse (Gillander Gådin et al., 2011; Hearn et al., 2012), a gender stereotypical masculine culture was found with consciously performed behaviours that restricted the possibility for some adolescents to express their need for emotional support. However, those findings were contradicted by the boys who were oriented towards sincerity who emphasised being the persons they were and thus resisting the prevailing norms (paper II). Findings from papers II and IV imply that understanding adolescent boys' health should be seen within the wider frame of gendered social relations, the social game between boys and girls. It seems that that both boys and girls have norms to follow, but while the norms for the girls concern restricted sexuality the norms for the boys pertain to restricted emotionality.

Performing masculinities involved a tension between the new versus the more traditional way of being an adolescent boy (paper II). Boys with an emotional masculinity orientation towards toughness held to the more traditional view of masculinity. Manifestations of gender-normative behaviour in adolescent boys comprised behaviours and actions to preserve masculinity. Some boys in the study described attributes (e.g., toughness and strength) in relation to masculinity and an unspoken but present gender role of being tough influenced their behaviours. One study found three main behaviours that serve to prevent or punish insufficiently perceived masculine behaviour and to apply pressure to other boys: masculine norm enforcement, status elevation and preservation, and friendship enhancement (Reigeluth & Addis, 2016). For boys and young men, physical risk is promoted and their bodies are agents of gendered social practice through demonstrations of for example strength and risk taking (Evans et al., 2011). Because of strong group pressure, some boys in study I had been involved in fights as a way to demonstrate masculinity and power. Boys and men are affected by gender role expectations set by society, and failure to live up to these gender role expectations may cause psychological distress in some males. Such distress may increase the risk to engage in violent behaviours as a means of demonstrating masculinity (Molcho et al., 2015; Reidy et al., 2015).

Orientations towards sensitivity and sincerity represent an approach related to both 'oppositional' and 'inclusive' masculinity (Anderson, 2008; Johansson & Ottemo, 2015). Those boys appreciated openness in expressing emotions; however, there was a difference in how dependent they were on

relational and contextual factors. Boys who adhered to the orientation of sensitivity emphasised being emotional, but to be able to be open and share emotions depended on having trusting and secure relationships. Boys who were oriented towards sincerity preferred honesty in emotions and were more self-reliant in relationships. One possible explanation for this position of strength may be their capacity to resist norms of masculinity. Resistance, or non-conformity, to norms of masculinity emphasises the agency of the individual and is associated with higher self-esteem and wellbeing (Way et al., 2014). The boys oriented towards sincerity were less dependent on contextual factors and stressed the importance of independency and individuality, and were thus more prone to resist peer group norms. From a historical perspective, much has been changed concerning masculinity (Thompson Jr & Bennett, 2015). Based on the findings in the thesis, a range of masculinities exist and the boys' constructions of masculine identities were local and individualistic, parallel to the traditional view. In addition, the participants performed different aspects of their masculinity within group and individual contexts.

Health and subjective social status

There was a strong association between SRH and SSS in school but no association between SSS and SES was found in the quantitative part of paper IV. One explanation for these findings could be that the aim was to explore SSS in school and not SSS 'in general' and thus financial assets and influences from home may contribute less to status. Another explanation could be the relative equality in health (West, 1997) during adolescence and the relative equality in economy in Sweden (Stenmark et al., 2015). As there were strong associations between SRH and SSS, high SSS is beneficial for health; or contrary, that high SRH implies a sense of high status. However, the cross-sectional design does not allow the possibility to indicate the direction of these two possibilities.

Findings from paper IV indicate that belonging to a high status group, in combination with attractive personal qualities, entailed a top position in social status. Descriptions of status were linked to both individual and group characteristics (e.g., personal qualities and behaviours), as well as to school programmes and group belongings. Furthermore, the concept of SSS seemed to be more connected to social processes than to material wealth in a youth context. Financial assets were subordinate to personal qualities, abilities and having access to high status groups. The status varied also depending on the adolescents' group belongings and the relation within a group and between

groups contributed to the complexity regarding positions. There were participants who attended high-status academic programmes but who had a lower self-perceived position, whereas there were participants who attended low-status vocational programmes but who had a high SSS. The findings indicate that SSS was something more than just personal qualities.

Hierarchies were largely, but not only, based on different school programmes, where the programme itself sorted the students into higher or lower status in school. The making of social status seemed to be embedded in the structure of the school system, mostly in the division between academic, vocational and introductory programmes, which contributed to differences. Also rejection and acceptance were embedded within groups in school hierarchy. In addition, the possible lasting consequences in future educational attainment and labour market outcomes should be considered, as the academic orientation provides a basis for future SES. Thus, implicit in a choice of the school programme lays the future socioeconomy of the adolescent, not yet fully realised or recognised. Although the different programmes placed adolescents within the school hierarchy, our findings suggest that having access to a group in a close surrounding contributed the most to the feeling of being connected and valued. Previous research has shown that the importance of peer relations increases through childhood and adolescence in which peer acceptance and peer rejection are important determinants irrespective of gender (Flacking et al., 2014; Sentse, Kretschmer, & Salmivalli, 2015). Findings from paper IV show that school class was the primary arena for the socialization process. The importance of the relational aspects emerged even here, suggesting that 'correct' friends, relationships and group belonging may be the most influential aspects of social status. Discrimination and low participation in the class are associated with increased risk for psychosomatic problems (Carlerby et al., 2012). Another study found that low social status in groups can produce a sense of threatened social worth (Davis & Reyna, 2015). Similarly, the social exclusion of students from cultural minorities emerged in paper IV. One Australian study, conducted among refugee youths (11-19 years), found that SSS was an important indicator for belonging and that feeling socially included in the society was important for wellbeing (Correa-Velez, Gifford, & Barnett, 2010). Accordingly, the importance of having access to a close group should not be underestimated.

Methodological considerations

In this thesis, three methods were used: qualitative (I-II), quantitative (III) and mixed methods (IV). The different designs meant different methodological considerations when conducting the studies and in interpreting the findings. The quantitative and qualitative designs often use different frameworks for ensuring rigour. The term trustworthiness is often used in qualitative studies instead of validity and reliability, but there is no consensus (Rolfe, 2006; Sandelowski, 1993). Methodological considerations are discussed below.

Trustworthiness

Four criteria are suggested for a trustworthy study: credibility, transferability, dependability and confirmability (Lincoln & Guba, 1985). In the qualitative study (papers I-II) and in the qualitative part of the mixed method study (paper IV), the study population included participants from different schools and school programmes and from varying socioeconomic backgrounds. There is always a risk of elite bias in qualitative studies when only the most articulated or high-status members of a group volunteer to participate (Morrow, 2005). In study I, variation was achieved in that boys of few words and well-articulated boys were represented. The boys rated their SRH and SSS during the interview, and their SRH was similar to those in a quantitative survey conducted in the same area in Sweden (Jerdén et al., 2011). We believe that this, in combination with the sample size (33 boys) increases the trustworthiness of the study (Graneheim & Lundman, 2004). Charmaz (2006) argues that theoretical codes serve as interpretive frames offering an abstract understanding of relationships. Although no new categories emerged after twenty interviews, an additional 13 interviews were conducted to ensure richness and reach saturation in theoretical coding. Furthermore, the interview questions were posed as openly as possible to obtain rich descriptions. In study I, the large amount of interview data, the use of the iterative process with constant comparisons and the analyst triangulation helped to strengthen credibility and dependability.

We regard the credibility of the qualitative part of the mixed method study (paper IV) as high because of the relatively large sample (n=35) that included both genders from different socioeconomic backgrounds and from several educational programmes (academic, vocational and introductory). Another strength of the interviews was that both concurrent and retrospective think-aloud techniques with probes were used, which gives

those participants that were not so verbally skilled a possibility to develop their descriptions. The think-aloud technique with probes resulted in rich descriptions and allowed us to explore the SSS question in depth. The participants understood SSS as a multidimensional concept and they could easily describe the different aspects of it, implying that SSS in school is a feasible measure of social status in adolescence. Finally, separate coding of all interview transcripts was performed by the first and second authors, and the codes and themes were developed, negotiated and analysed together with the whole research group. The interdisciplinary contribution from all co-authors further increased the credibility of the study.

The research team and co-authors comprised a female social worker, a female paediatric nurse, a male general practitioner, a female public health worker, a female physiotherapist and a male sociologist, all of which contributed to multiple perspectives and interdisciplinary approach. Reflexivity throughout the research process, the analyst triangulation and theory integration, with all authors contributing to the analytical process, helped to establish credibility and confirmability of the results (Dahlgren et al., 2007; Lincoln & Guba, 1985; Malterud, 2001).

Being a middle-aged, well-educated woman who could have been the mother of the participants probably influenced the interaction with the participants in the interviews and raised some concerns important to consider. Awareness of one's own subjectivity, power and position is crucial for enhancing the transparency and interpretation of findings, particularly in qualitative research (Mruck & Breuer, 2003). Thus, in the interview situations, a conscious choice was an empathetic listening position with open questions and a curious approach without the use of force or coercion.

Because the interview studies were conducted in one Swedish town, the findings might be limited regarding transferability (Lincoln & Guba, 1985). However, the findings can still be transferred to similar social and cultural contexts.

Validity and reliability

While validity determines whether the research truly measures what it was intended to measure, reliability refers to the quality of measurement, such as the consistency and stability of the measurement over time (Creswell, 2009; Golafshani, 2003).

The questionnaire (papers III-IV) was a postal questionnaire with a response rate of 67 %, which we consider as an acceptable rate. The use of the postal questionnaire was a strength in the sense that answering the questionnaire at home offered confidentiality (Joffer et al., 2016).

We used parental educational level as a proxy for SES (paper IV), which might not to be a comprehensive measure of SES. On the other hand, educational attainment is a concept easy to transfer to other settings (i.e. countries) and, unlike income, it is a stable measure across the lifespan with expected effects on health (Padilla-Moledo et al., 2016; Thrane, 2006). Furthermore, data on SES were obtained from the official national statistical database Statistics Sweden, which is a reliable data source.

The pride-shame model (paper III) was constructed based on sex questions aimed to measure pride and shame. In relation to internal validity, one weakness may be whether the six questions really corresponded accurately to the content of the concepts. Another weakness is that there were four questions designed to measure shame, but only two questions to measure pride. The validity and reliability of these questions have not been tested. For improved construct validity (Sullivan et al., 1995) the stability of the pride and shame questions and the internal consistency would need to be tested in a test-retest design in future studies. Further, a potential weakness pertains to how some variables were dichotomised. After careful consideration and with the goal to obtain clarity of presentation, we dichotomised the variables measuring pride and shame into high and low categories. We based the division on the sample mean, but this procedure implicated reduced nuances regarding outcome. A relatively small number of adolescents with a foreign born background may affect the external validity and generalisability of the findings. Even though cross-sectional studies provide noteworthy information, a longitudinal design would provide stronger evidence for how experiences of pride and shame are related to SRH over time. Important to note is that it may be difficult to measure shame because it can be connected with painful emotions. Emotions are deeply embedded in context where they occur and many words signal and indicate shame without calling it by name (Retzinger, 1995). Retzinger suggests that shame can therefore be detected and investigated using other words than shame.

The instrument to measure SSS among adolescents (paper IV) is considered to be reliable and reflect social stratification (Goodman et al., 2001). The validity and reliability of the SRH-question (papers III-IV) was tested in test-retest (Jerdén, 2007) and the meaning of the wording of the SRH question

was explored and found to capture the concept of holistic health (Joffer et al., 2016).

The importance of context

Regardless of design, there are other aspects that should be considered in the interpretation of the results. In this respect, the importance of context emerged in several situations. First, in my understanding, sexual health is an important part of young people's lives in general and should be an important part of adolescent boys' health. However, when conducting the interviews (papers I-II), only a few boys discussed sexuality as an important part of health. Bodies were discussed in terms of the body's ability to do things, but the boys' own sexuality was hardly mentioned. Only two boys briefly mentioned topics related to sexuality. One possible explanation could be the context in that the interviews were conducted at schools. Young people spend more time at school than anywhere else, and school as an everyday occurrence may have impacted and framed the narratives. If the interviews had been conducted at, e.g., a youth clinic, which is the natural place for social and medical discussions about sex and health, there might have been other descriptions. Although very few participants mentioned their own sexuality or sexual health, they did have opinions about the sexuality of others and how it was related to status. They also had opinions about how sexuality should be expressed (paper IV). The findings showed a reproduction of rather traditional Swedish gender norms with restricted sexuality for young women and how sexuality and status were related. However, even here we should consider the possible impact from school as an institution. The respondents were asked to place themselves in relation to peers at school in the interviews, and school may be a traditional arena with preserved gender pattern, which not fully reflects the dynamics of relationships and gender outside the given context. The traditional gender norms in school were rather strong and limited the behaviours of both boys and girls. Both sexuality and status were thus embedded in context.

The importance of context also emerged from the present findings and health proved to have a contextual dimension. I attended several conferences during my PhD studies. In one conference in the United Kingdom I was asked a question after telling about the WHO health question that I posed in the interviews. The participants were asked to value and rank the different health dimensions consisting of physical, mental and social wellbeing according to WHO. A researcher from Pakistan asked the following question: *Did the boys not talk about spiritual health?* I replied that Sweden is a secular society where the everyday meaning of religion is largely lost for

many, especially for young people. The researcher was a bit surprised and claimed that if "the health question" had been posed in Pakistan, the young people had surely highlighted the spiritual health aspect. This question emphasises the contextual and complex nature of knowledge: that it is always embedded in the surrounding society and framed by a social pattern. Thus, our models are not always transferable.

Conclusions

This thesis contributes to increase our knowledge and understanding of how health and gender and related factors are experienced and perceived by adolescent boys. It not only shows the complexity of health as a concept, but also the complexity of how health is experienced and what influences health. This thesis reveals how health is experienced and perceived and how it is strongly connected to values, emotions, gender and one's subjectively perceived position in relation to others. Perceived health among adolescent boys was a gendered emotional and relational concept.

The way in which health was perceived was complex: on a conceptual level, the participants' understanding was rather holistic but when dealing with health they were prone to differentiate between body and mind in a more dualistic manner. Health was mainly experienced in an emotional and relational manner, whereas the body was perceived as a tool and had a more subordinate role. Trustful relationships and positive emotions were valued mostly.

The current findings indicate that young, masculine health is largely experienced through emotions and relationships. Our findings support theories on health as a social construction of interconnected processes.

Two main categories of masculine conceptions in adolescent boys were identified: gender-normative masculinity and non-gender-normative masculinity. Gender-normative masculinity comprises two types of emotional orientation towards masculinity: towards toughness and towards sensitivity. These two orientations, although opposed to one another, were affected by the group norm and the collective value base. Further, we found that the performance of the boys with these orientations was connected to contextual and situational demands. The orientation towards sincerity was more non-gender-normative, focusing on the individual's views and the personal values of the adolescent boys, which were less influenced by peer group norms. Masculinity and expressions of emotions were strongly

intertwined and therefore it is difficult to describe and understand masculinity without taking into account emotional expressions.

A large proportion of the boys were able to express their emotions openly. What was important for these adolescents' wellbeing was their ability to recognise, control and express their emotions, as well as their access to close and protective relationships that was crucial for sharing specific emotions. It seemed that those boys who experienced difficulty showing and sharing their concerns are more prone to compromise their health. Managing emotions was critical for health and wellbeing.

Experiencing shame and pride were significantly associated with SRH in adolescence. Experiences of shame were associated with lower SRH and experiences of pride with higher SRH. The pride-shame model shows that lower pride-higher shame is associated with lower SRH, even when confounding factors are controlled. Experiencing pride can be protective for SRH among those exposed to shame.

Even though socioeconomy has been shown to be significant for health, the present study found that SES (measured as parental educational level) was not associated with either SRH or SSS in school. This finding was supported from the interviews in which SES had limited impact on adolescents' positioning. The results suggest that SSS in school may be an important measure of social position in adolescents as it is closely related to SRH (high SSS is associated with good health). The impact of gender was prominent in this study and traditional gender norms shaped the participants' position. Adolescents' SSS in school was tied to the individual and to the groups in the gendered space. Academic and vocational school programmes placed adolescents within a school hierarchy, but a high positioning in the closest group belonging seemed to be very important compared with having a high status in the school. Belonging to a high status group did not in itself place the individual on a top position, nor did having attractive personal qualities. Rather, it is the individual and the group in interaction that shape the position.

In conclusion, the lack of social support and not having access to a social network and feeling forced to perform a masculine role play were identified as causes of ill-health. In contrast, having confidence in self-esteem, having access to trustful relationships and daring to resist masculine norms while still reinforcing and maintaining social status are conducive to good health. The adolescent boy experiences good health when he feels good in relation to mind and body and interpersonal relationships, feels himself to be someone of value and status and feels pride as opposed to shame.

Implications for practice

Improve the body-mind interconnectedness
Although the findings show that many boys perceived that they had good health and were able to talk openly and share their worries, some boys were affected by a 'manage it yourself attitude' in which they tried to conceal emotionally related problems. These same boys would put themselves through challenging and even dangerous situations when dealing with difficult emotions, and there were some boys who even harmed their bodies. For them, the body became the place of escape when it was too demanding to feel the presence of mind. Thus, this division between body and mind was an effective strategy of immediate relief but contributed to the separation of the body and mind. Those working with youths should show sensitivity to the emotional and social needs of adolescent boys and encourage the boys to integrate physical, social and emotional aspects of health.

Influence attitudes concerning gender equality in emotional expressions
More needs to be done to increase wellbeing in adolescent boys (e.g., in schools, leisure activities and youth health care institutions). Through influencing attitudes and values, schools and other institutions are important arenas to address healthy masculinities and gender equality in emotional expressions. Schools are an important learning environment for health promotion and it seems valuable to involve the boys in the process, i.e so they can emphasise their own agency and discuss their choices and values. The adolescent boys should be invited reflect on masculinity norms and health. It is also important to emphasise the gender equality in sharing worries and in help-seeking behaviours on equal terms to close the gap between genders.

Gender-specific interventions
Information about how adolescent boys perceive health in general and what they consider contributes to health and wellbeing is especially useful in addressing future interventions. Adolescent boys' understanding of the interconnectedness of body-mind when dealing with health can be improved through health interventions that raise awareness and enable a holistic approach. Essential to future health promotion is that schools adopt a gender-specific understanding and that interventions meet the needs of both adolescent boys and girls.

Being aware of the strong connection between SSS and SRH and use the knowledge about protective effect of pride

There is a need to be aware of the strong relation between SSS in school and SRH in adolescence. Because high SSS was strongly associated with high SRH and low SSS with low SRH, more attention should be given to those with low status. The results showed that experiences of pride can have a protective effect for SRH. Many adolescents receive derogatory and shameful comments that may contribute to their feeling worthless and powerless. These comments have a negative effect on their health. An environment characterised by lack of positive comments is unfavourable to anyone's health. Accordingly, knowledge about the protective effect of pride could be useful in adolescent health promotion. For example, school personnel could make efforts to consciously work with positive feedback aiming to raise the self-esteem and status of adolescents. Being subjected to genuine positive opinions might reduce the negative effects of shame and alleviate the adverse associations they have with health.

Encourage collaboration between different professional competencies with an aim to offer holistic health support for adolescent boys

For health institutions, an important goal should be to view the health 'situated' within the person, view the person in the environment, and see health as holistic to prevent the division of health into physical and mental compartments. Thus, collaboration between different professional competencies should be encouraged (e.g., by creating multidisciplinary teams with an aim to offer health support for adolescent boys). Continuing discussions within different institutions are needed concerning how to create a supportive environment in schools and municipalities that can be beneficial to the health of adolescent boys. Efforts are needed within school health care and youth clinics to improve a "male-friendly" support system.

Future research

There is a need for more interdisciplinary and gender-specific research to target adolescent health. SRH in adolescence is a concern for several sectors in society, including health care, education and social work. In addition, further knowledge is needed to explore ways to collaborate and reach out to adolescent boys. Professionals and researchers need to consider the complexity of adolescent and gendered health. Research is also needed on the construction of future masculinities and health. The relevance of the *model of adolescent boys' perceptions of health* that was developed in this study could be investigated in larger adolescent populations and in different

contexts. Furthermore, it is important to understand the role of socially produced conditions and the societal changes that impact the health and construction of young masculinities. A useful theoretical frame within the context of adolescents can be the bioecological approach that links the micro, meso, exo and macro levels of understanding on human development (Bronfenbrenner & Ceci, 1994), as health promotion can include both individual and system levels.

The health of younger adolescents is already regularly monitored by the WHO. In addition, longitudinal studies are needed to monitor the development of those in late adolescence entering adulthood. Future research should focus more on the older adolescents' transition to adulthood. More interventions and research are needed concerning the impact of gender norms on health, as well as managing health and masculinities. As we know from research, shaming experiences can lead to aggressivity, and persistent shaming experiences, such as being bullied for a significant period of their childhood could lead to an overwhelming desire for revenge. Shame and pride are important emotions that can contribute to enhancing or lowering health. It would be of value to conduct further international and longitudinal research in order to describe how experiences of pride and shame are related to SRH over time in adolescent female and male populations.

Construction of gender is an ongoing process. During the time I have worked with this thesis, great changes have taken place in Europe. Steady streams of refugees and unaccompanied minors, of which the great majority are boys, have come to Sweden mostly from Afghanistan, Syria and Somalia. Right now there are a large number of young boys with traumatic experiences in many municipalities. The society's ability to contribute to the health and wellbeing of these young people is a challenging task. Research is needed concerning experiences of health in these foreign-born boys.

More research is needed concerning relational aspects of health, i.e. social health. Although the holistic health and interconnectedness between body and mind is important, it may be difficult to study holistic health without dividing it into smaller units. Of physical, mental and social aspects of health and wellbeing, I would like to emphasise the importance of social health, perhaps the least common health aspect in many health studies, but maybe the most significant aspect for adolescent boys in a Nordic context.

Acknowledgements

First, I would like to thank all 33 teenage boys who participated in the study. You all contributed so wholeheartedly to research by your willingness to share your personal experiences.

This thesis was produced through shared affiliation to two departments: the Department of Public Health and Clinical Medicine, Epidemiology and Global Health at Umeå University and School of Education, Health and Social Studies, Dalarna University. Although I only have visited Umeå occasionally, I have always enjoyed the warm and international environment at EPI.

Thank you, Birgitta Åström, for always being so helpful and friendly. For me, you symbolise the heart of EPI.

Thank you, Hans Löfgren, for the cover that captured the spirit of this thesis.

Thanks to all members of the multidisciplinary BUU net in Umeå for intriguing and inspiring discussions and presentations concerning the health of children and young people. It is always a pleasure to attend these meetings with researchers from many disciplines.

During my doctoral years, I have mostly been in Falun and I would like to thank all my colleagues, former and current doctoral colleagues and friends at Dalarna University. I wish I could name you all but you are so many. Still, I would like to express special gratitude to the following: Anna, Eva, Fatumo, Helén, Janeth, Jennie, Johan, Kari, Kevin, Lena O, Lisa, Magdalena, Maria, Mari-Cristin, Marie, Pernilla, Peter J, Peter N, Sanna, Stina, Therese and Ulf.

Thanks to Maria Pilawa and CKF (Centrum for Clinical Research) where this doctoral journey was first initiated.

Thank you, Paul Flack, for excellent help at the library in Falun and for saving my EndNote three times! What could I have done without you?

Many thanks to Janne Florin and Camilla Udo for all their valuable comments during my cover story seminar. And Camilla, you have continuously encouraged me!

Thank you, Ulla-Karin Schön and Lena Dahlberg, for excellent comments and a first-class discussion at my pre-defence; you are both thorough at your work but also great colleagues.

In particular, I want to express especial gratitude to:

Renée Flacking, my brilliant supervisor. All I can say is that I love you; I love you for your positive energy, brightness, empathy, creativity, patience and always being so deeply human! My deepest gratitude - I have been lucky to have you!

Lars Jerdén, my wise, encouraging, reliable and stable, positive, statistics-loving (Italian speaking) assistant supervisor, I have been just as happy to have you by my side!

Ann Öhman, my assistant supervisor, for your superb competence in qualitative research and your vast knowledge in the field of gender and masculinities. Not least, I thank you for your good advice.

Bengt Starrin, my inspiring co-author, for your superior knowledge in grounded theory, masculinities and emotions. Thank you for your theoretical sharpness and splendid comments that contributed to open my eyes.

Junia Joffer, my wonderful, positive, extremely talented PhD colleague. You are so fun to be with and bright in all ways.

All other members in our research team VIP, Erik, Gunilla and Lars, thank you.

Finally, I want to thank my beloved family:

Pirkko Randell, my mother, for endless love, engagement and encouragement through the years and for always being there for me.

Minna, Hanna, Paul & Mårten. Although research is interesting and one of the best things I have done in my life, you are the 'backbone' and anchor of my life! Thank you for your love and support that gives wings.

Appendices

Appendix 1. Interview guide used in study I

The interview started with the following questions:

Tell me something about yourself. Where did you grow up? How was the neighbourhood? How do you like your school?

What do you think of when you hear the word 'health'? What's in it for you?
What does health mean to you?
How important is your health?
Which factors affect your health and how you feel?
How is your health?
What do you do in order to feel well?
What do you think about regarding your future health?
Have you experienced periods of poor health or when you did not feel well?
How did you deal with those periods of poor health?
Do you talk about health-related issues with your friends/family/others/professionels?
Who do you usually turn to if you need support?
What do you perceive of as good support?
What do you think about the support given by school nurses/school counsellors?
How should the support be organised to reach out to boys?
Do you think that it is acceptable for boys to express emotions?
How do you manage emotions?
What do you think of when you hear the words masculinity – masculine/male?
What is an ideal young man according to you?
Is there a boy code that affects you? How?
What kind of man would you like to be?

Examples of the probes used by the interviewer:
Can you tell me more about it?
How did you experience that?
What did you think?
What/how did you do?

References

Adler, N. E., Boyce, T., Chesney, M. A., Cohen, S., Folkman, S., Kahn, R. L., & Syme, S. L. (1994). Socioeconomic status and health: the challenge of the gradient. *American psychologist, 49*(1), 15.

Adler, N. E., Epel, E. S., Castellazzo, G., & Ickovics, J. R. (2000). Relationship of subjective and objective social status with psychological and physiological functioning: Preliminary data in healthy, White women. *Health Psychology, 19*(6), 586-592.

Alonso, Y. (2004). The biopsychosocial model in medical research: the evolution of the health concept over the last two decades. *Patient Education and Counseling, 53*(2), 239-244.

Anderson, E. (2008). Inclusive masculinity in a fraternal setting. *Men and Masculinities, 10*(5), 604-620.

Andrew, S., & Halcomb, E. (2009). *Mixed methods research for nursing and the health sciences*: Wiley Online Library.

Armstrong, C., Hill, M., & Secker, J. (2000). Young people's perceptions of mental health. *Children & Society, 14*(1), 60-72.

Arnett, J. J. (1999). Adolescent storm and stress, reconsidered. *American psychologist, 54*(5), 317.

Attride-Stirling, J. (2001). Thematic networks: an analytic tool for qualitative research. *Qualitative Research, 1*(3), 385-405.

Bannon, S., McGlynn, T., McKenzie, K., & Quayle, E. (2015). The positive role of Internet use for young people with additional support needs: Identity and connectedness. *Computers in Human Behavior, 53*, 504-514.

Berger, P. L., & Luckmann, T. (1967). *The social construction of reality : a treatise in the sociology of knowledge*. New York: Anchor books.

Bertolote, J. M., & Fleischmann, A. (2015). A global perspective in the epidemiology of suicide. *Suicidologi, 7*(2).

Black, C. F. (2016). Global Gender Gap Report *Encyclopedia of Family Studies*: John Wiley & Sons, Inc.

Boorse, C. (1977). Health as a Theoretical Concept. *Philosophy of Science, 44*(4), 542-573.

Boutelle, K., Eisenberg, M. E., Gregory, M. L., & Neumark-Sztainer, D. (2009). The reciprocal relationship between parent—child connectedness and adolescent emotional functioning over 5 years. *Journal of Psychosomatic Research, 66*(4), 309-316.

Boyle, C. A., Boulet, S., Schieve, L. A., Cohen, R. A., Blumberg, S. J., Yeargin-Allsopp, M., Visser, S., & Kogan, M. D. (2011). Trends in the Prevalence of Developmental Disabilities in US Children, 1997–2008. *Pediatrics, 127*(6), 1034-1042.

Bradburn, N. M., Sudman, S., & Wansink, B. (2004). *Asking questions: the definitive guide to questionnaire design--for market research, political polls, and social and health questionnaires*: John Wiley & Sons.

Brannon, R., & David, D. (1976). The male sex role: Our culture's blueprint of manhood, and what it's done for us lately. *The forty-nine percent majority: The male sex role*, 1-48.

Breidablik, H. J., Meland, E., & Lydersen, S. (2009). Self-rated health during adolescence: stability and predictors of change (Young-HUNT study, Norway). *Eur J Public Health, 19*(1), 73-78.

Breland, D. J., & Park, M. J. (2008). Depression: focus on the adolescent male. *Am J Mens Health, 2*(1), 87-93.

Bronfenbrenner, U., & Ceci, S. J. (1994). Nature-nurture reconceptualized in developmental perspective: a bioecological model. *Psychological review, 101*(4), 568-586.

Bronfenbrenner, U., & Morris, P. A. (2007). The Bioecological Model of Human Development *Handbook of Child Psychology*: John Wiley & Sons, Inc.

Burkitt, I. (1998). Bodies of Knowledge: Beyond Cartesian Views of Persons, Selves and Mind. *Journal for the Theory of Social Behaviour, 28*(1), 63-82.

Burn, S. M., & Ward, A. Z. (2005). Men's Conformity to Traditional Masculinity and Relationship Satisfaction. *Psychology of Men & Masculinity, 6*(4), 254-263.

Burr, V. (2003). *Social constructionism*. London: Routledge.

Butler, E. A. (2011). Three Views of Emotion Regulation and Health. *Social and Personality Psychology Compass, 5*(8), 563-577.

Butler, J. (1990). *Gender trouble : feminism and the subversion of identity*. New York: Routledge.

Caldwell, T. M. (2016). Dualism, Physicalism, and Professional or Alternative Health Seeking: A Gendered Perspective.

Carlerby, H., Viitasara, E., Knutsson, A., & Gillander Gadin, K. (2012). How discrimination and participation are associated with psychosomatic problems among boys and girls in northern Sweden. *Health, Vol.04No.10*, 4.

Cavallo, F., Dalmasso, P., Ottová-Jordan, V., Brooks, F., Mazur, J., Välimaa, R., Gobina, I., Gaspar de Matos, M., & Raven-Sieberer, U. (2015). Trends in self-rated health in European and North-American adolescents from 2002 to 2010 in 32 countries. *The European Journal of Public Health, 25*(suppl 2), 13-15.

Chandler, A. (2012). Self-injury as Embodied Emotion Work: Managing Rationality, Emotions and Bodies. *Sociology, 46*(3), 442-457.

Chaplin, T. M., & Aldao, A. (2013). Gender differences in emotion expression in children: A meta-analytic review. *Psychological Bulletin, 139*(4), 735-765.

Charles, S. T. (2010). Strength and vulnerability integration: a model of emotional well-being across adulthood. *Psychol Bull, 136*(6), 1068-1091.

Charmaz, K. (2006). *Constructing grounded theory : a practical guide through qualitative analysis*. London: SAGE.

Charters, E. (2003). The use of think-aloud methods in qualitative research an introduction to think-aloud methods. *Brock Education Journal, 12*(2).

Chu, J. Y., Porche, M. V., & Tolman, D. L. (2005). The Adolescent Masculinity Ideology in Relationships Scale: Development and Validation of a New Measure for Boys. *Men and Masculinities, 8*(1), 93-115.

Ciarrochi, J., Deane, F. P., Wilson, C. J., & Rickwood, D. (2002). Adolescents who need help the most are the least likely to seek it: The relationship between low emotional competence and low intention to seek help. *British Journal of Guidance & Counselling, 30*(2), 173-188.

Cleary, A. (2012). Suicidal action, emotional expression, and the performance of masculinities. *Soc Sci Med, 74*(4), 498-505.

Coleman, D. (2015). Traditional Masculinity as a Risk Factor for Suicidal Ideation: Cross-Sectional and Prospective Evidence from a Study of Young Adults. *Archives of Suicide Research, 19*(3), 366-384.

Coleman, J. C. (2010). *The nature of adolescence* (4th ed.). New York, NY: Routledge.

Connell, R. (1996). Teaching the boys: New research on masculinity, and gender strategies for schools. *Teachers College Record, 98*(2), 206-235.

Connell, R. (2005). *Masculinities*. Cambridge: Polity Press.

Connell, R. (2008). Masculinity construction and sports in boys' education: a framework for thinking about the issue. *Sport Education and Society, 13*(2), 131-145.

Connell, R., & Messerschmidt, J. W. (2005). Hegemonic masculinity - Rethinking the concept. *Gender & Society, 19*(6), 829-859.

Conway, C. N., Cohen-Tanugi, S., Barbour, D. J., & Bell, D. L. (2016). Caring for the Adolescent Male. In J. J. Heidelbaugh (Ed.), *Men's Health in Primary Care* (pp. 89-101). Cham: Springer International Publishing.

Correa-Velez, I., Gifford, S. M., & Barnett, A. G. (2010). Longing to belong: Social inclusion and wellbeing among youth with refugee backgrounds in the first three years in Melbourne, Australia. *Social Science & Medicine, 71*(8), 1399-1408.

Cosma, A. (2016). Boys' health-what may be learned from three decades of HBSC Survey. *European Health Psychologist, 18*(1), 18-21.

County Council of Västmanland. (2009). [Liv och Hälsa ung 2008] Life and Health among young 2008 *Rapport, Landstinget Västmanland [Report, County Council of Västmanland].*

Courtenay, W. H. (1998). College men's health: An overview and a call to action. *Journal of American College Health, 46*(6), 279-290.

Courtenay, W. H. (2000). Constructions of masculinity and their influence on men's well-being: a theory of gender and health. *Social Science & Medicine, 50*(10), 1385-1401.

Courtenay, W. H. (2003). Key determinants of the health and well-being of men and boys. *International Journal of Men's Health, 2*(1), 1-30.

Courtenay, W. H., & Keeling, R. P. (2000). Men, gender, and health: toward an interdisciplinary approach. *J Am Coll Health, 48*(6), 243-246.

Creswell, J. W. (2007). Designing and conducting mixed methods research.

Creswell, J. W. (2009). *Research design : qualitative, quantitative, and mixed methods approaches*. Thousand Oaks, Calif.: Sage.

Currie, C., & Alemán-Díaz, A. Y. (2015). Building knowledge on adolescent health: reflections on the contribution of the Health Behaviour in School-aged Children (HBSC) study. *The European Journal of Public Health, 25*(suppl 2), 4-6.

Curtis, A. C. (2015). Defining Adolescence. *Journal of Adolescent and Family Health, 7*(2), 2.

Dahl, R. E. (2004). Adolescent brain development: a period of vulnerabilities and opportunities. Keynote address. *Annals of the New York Academy of Sciences, 1021*(1), 1-22.

Dahlgren, L., Emmelin, M., Winkvist, A., & Lindhgren, M. (2007). *Qualitative methodology for international public health* (2. ed. ed.). Umeå: Epidemiology and Public Health Sciences, Department of Public Health and Clinical Medicine, Umeå University.

Danielson, M., & Marklund, U. (2000). Svenska skolbarns hälsovanor 1997/98 [Health Behavious in School-aged Children 1997/98]. Stockholm: Folkhälsoinstitutet [National Institute of Public Health].

Davis, J. R., & Reyna, C. (2015). Seeing red: How perceptions of social status and worth influence hostile attributions and endorsement of aggression. *British journal of social psychology, 54*(4), 728-747.

De Rubeis, S., & Hollenstein, T. (2009). Individual differences in shame and depressive symptoms during early adolescence. *Personality and Individual Differences, 46*(4), 477-482.

De Visser, R. O., Smith, J. A., & McDonnell, E. J. (2009). 'That's not masculine': masculine capital and health-related behaviour. *J Health Psychol, 14*(7), 1047-1058.

Demetriou, D. Z. (2001). Connell's concept of hegemonic masculinity: A critique. *Theory and society, 30*(3), 337-361.

Denzin, N. K., & Lincoln, Y. S. (2013). *The landscape of qualitative research*. Los Angeles, Ca.: SAGE.

Dey, M., Jorm, A. F., & Mackinnon, A. J. (2015). Cross-sectional time trends in psychological and somatic health complaints among adolescents: a structural equation modelling analysis of 'Health Behaviour in School-aged Children'data from Switzerland. *Social psychiatry and psychiatric epidemiology, 50*(8), 1189-1198.

Dickerson, S. S., Gruenewald, T. L., & Kemeny, M. E. (2004). When the Social Self Is Threatened: Shame, Physiology, and Health. *Journal of Personality, 72*(6), 1191-1216.

Dodge, R., Daly, A. P., Huyton, J., & Sanders, L. D. (2012). The challenge of defining wellbeing. *International Journal of Wellbeing, 2*(3).

Duncan, G. (2000). Mind-Body Dualism and the Biopsychosocial Model of Pain: What Did Descartes Really Say? *Journal of Medicine & Philosophy, 25*(4), 485-513.

Eckersley, R. (2011). A new narrative of young people's health and well-being. *Journal of Youth Studies, 14*(5), 627-638.

Elgar, F. J., Pförtner, T.-K., Moor, I., De Clercq, B., Stevens, G. W. J. M., & Currie, C. Socioeconomic inequalities in adolescent health 2002–2010: a time-series analysis of 34 countries participating in the Health Behaviour in School-aged Children study. *The Lancet, 385*(9982), 2088-2095.

Else-Quest, N. M., Higgins, A., Allison, C., & Morton, L. C. (2012). Gender differences in self-conscious emotional experience: a meta-analysis. *Psychological bulletin, 138*(5), 947.

Engelsrud, G. (2005). The lived body as experience and perspective: methodological challenges. *Qualitative Research, 5*(3), 267-284.

Eriksen, I. M., & Lyng, S. T. (2016). Relational aggression among boys: blind spots and hidden dramas. *Gender and Education*, 1-14.

Eriksson, K. (1989). *Hälsans idé [The idea of health]*. Stockholm: Almqvist & Wiksell.

Estes, D. (2006). Evidence for early dualism and a more direct path to afterlife beliefs. *Behavioral and Brain Sciences, 29*(05), 470-470.

Euteneuer, F. (2014). Subjective social status and health. *Current Opinion in Psychiatry, 27*(5), 337-343.

Evans, J., Frank, B., Oliffe, J. L., & Gregory, D. (2011). Health, Illness, Men and Masculinities (HIMM): a theoretical framework for understanding men and their health. *Journal of Mens Health, 8*(1), 7-15.

Fausto-Sterling, A. (2008). The bare bones of race. *Soc Stud Sci, 38*(5), 657-694.

Fayers, P., & Sprangers, M. (2002). Understanding self-rated health. *Lancet, 359*, 187 - 188.

Flacking, R., Jerdén, L., Bergström, E., & Starrin, B. (2014). 'In or Out'—On the Dynamic between Acceptance and Rejection and its Influence on Health in Adolescent Girls. *Young, 22*.

Forstmann, M., Burgmer, P., & Mussweiler, T. (2012). "The mind is willing, but the flesh is weak": the effects of mind-body dualism on health behavior. *Psychol Sci, 23*(10), 1239-1245.

Gillander Gådin, K., & Hammarström, A. (2000). 'We won't let them keep us quiet ...' Gendered strategies in the negotiation of power—implications for pupils' health and school health promotion. *Health Promotion International, 15*(4), 303-311.

Gillander Gådin, K., & Hammarström, A. (2002). Can school-related factors predict future health behaviour among young adolescents? *Public Health, 116*(1), 22.

Gillander Gådin, K., & Hammarström, A. (2005). A possible contributor to the higher degree of girls reporting psychological symptoms

compared with boys in grade nine? *The European Journal of Public Health, 15*(4), 380-385.

Gillander Gådin, K., Weiner, G., & Ahlgren, C. (2011). School Health Promotion to Increase Empowerment, Gender Equality and Pupil Participation: A Focus Group Study of a Swedish Elementary School Initiative. *Scandinavian Journal of Educational Research, 57*(1), 54-70.

Glaser, B. G. (2011). *Getting out of the data : grounded theory conceptualization*. Mill Valley: Sociology Press.

Goffman, E. (1959). *The presentation of self in everyday life*. New York: Doubleday.

Golafshani, N. (2003). Understanding reliability and validity in qualitative research. *The qualitative report, 8*(4), 597-606.

Goldshmidt, O. T., & Weller, L. (2000). "Talking emotions": Gender differences in a variety of conversational contexts. *Symbolic Interaction, 23*(2), 117-134.

Goodman, E., Adler, N. E., Kawachi, I., Frazier, A. L., Huang, B., & Colditz, G. A. (2001). Adolescents' perceptions of social status: Development and evaluation of a new indicator. *Pediatrics, 108*(2).

Goodman, E., Maxwell, S., Malspeis, S., & Adler, N. (2015). Developmental Trajectories of Subjective Social Status. *Pediatrics, 136*(3), E633-E640.

Gough, B. (2006). Try to be healthy, but don't forgo your masculinity: Deconstructing men's health discourse in the media. *Social Science & Medicine, 63*(9), 2476-2488.

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today, 24*(2), 105-112.

Granvik, M. (1998). *Hälsa och levnadsvanor bland niondeklassare i Dalarna höstterminen 1997 [Health and lifestyle among children in 9th grade in the county of Dalarna 1997]*. Falun: Landstinget Dalarna [County Council of Dalarna].

Griffith, D. M. (2016). Biopsychosocial Approaches to Men's Health Disparities Research and Policy. *Behavioral Medicine, 42*(3), 211-215.

Gross, J. J. (2002). Emotion regulation: Affective, cognitive, and social consequences. *Psychophysiology, 39*(3), 281-291.

Gudlaugsdottir, G. R., Vilhjalmsson, R., Kristjansdottir, G., Jacobsen, R., & Meyrowitsch, D. (2004). Violent behaviour among adolescents in Iceland: a national survey. *Int J Epidemiol, 33*(5), 1046-1051.

Hagquist, C. (2009). Psychosomatic health problems among adolescents in Sweden--are the time trends gender related? *European journal of public health, 19*(3), 331-336.

Hagquist, C. (2010). Discrepant trends in mental health complaints among younger and older adolescents in Sweden: an analysis of WHO data 1985-2005. *The Journal of adolescent health : official publication of the Society for Adolescent Medicine, 46*(3), 258-264.

Hamilton, E., & Klimes-Dougan, B. (2015). Gender Differences in Suicide Prevention Responses: Implications for Adolescents Based on an Illustrative Review of the Literature. *International Journal of Environmental Research and Public Health, 12*(3), 2359.

Hankin, B. L., Abramson, L. Y., Moffitt, T. E., Angell, K. E., Silva, P. A., & McGee, R. (1998). Development of depression from preadolescence to young adulthood: Emerging gender differences in a 10-year longitudinal study. *Journal of Abnormal Psychology, 107*(1), 128-140.

Hardy, G. E., Shapiro, D. A., Haynes, C. E., & Rick, J. E. (1999). Validation of the General Health Questionnaire-12: Using a sample of employees from England's health care services. *Psychological Assessment, 11*(2), 159.

Hare, I. (2004). Defining social work for the 21st century - The International Federation of Social Workers' revised definition of social work. *International Social Work, 47*(3), 407-+.

Haugland, S., Wold, B., Stevenson, J., Aaroe, L., & Woynarowska, B. (2001). Subjective health complaints in adolescence. *Eur J Public Health, 11*(1), 4 - 10.

Hausmann, R. (2013). *The Global Gender Gap Index 2012*. Paper presented at the World Economic Forum. Web. Date unavailable.

Hearn, J., Nordberg, M., Andersson, K., Balkmar, D., Gottzen, L., Klinth, R., Pringle, K., & Sandberg, L. (2012). Hegemonic Masculinity and Beyond: 40 Years of Research in Sweden. *Men and Masculinities*.

Heaven, P. C. L., Ciarrochi, J., & Leeson, P. (2009). The longitudinal links between shame and increasing hostility during adolescence. *Personality and Individual Differences, 47*(8), 841-844.

Heywood, A. (1998). *Political ideologies : an introduction*. Basingstoke: Macmillan.

Hochschild, A. R. (1979). Emotion Work, Feeling Rules, and Social Structure. *American Journal of Sociology, 85*(3), 551-575.

Hochschild, A. R. (1983). *The managed heart : commercialization of human feeling*. Berkeley: Univ. of California Press.

Hochschild, A. R. (1990). Ideology and emotion management: A perspective and path for future research. In T. D. Kemper (Ed.), *Research agendas in the sociology of emotions* (Vol. 117, pp. 117-142).

Idler, E., & Benyamini, Y. (1997). Self-rated health and mortality: a review of twenty-seven community studies. *Journal of health and social behavior, 38*(1), 21-37.

Idler, E., Hudson, S., & Leventhal, H. (1999). The meanings of self-ratings of health. *Res Ageing, 21*(3), 458 - 476.

Jackson, B., & Lurie, S. (2006). Adolescent depression: challenges and opportunities: a review and current recommendations for clinical practice. *Adv Pediatr, 53*, 111-163.

Jerdén, L. (2007). *Health-promoting health services : personal health documents and empowerment*. Umeå: Univ.

Jerdén, L., Burell, G., Stenlund, H., Weinehall, L., & Bergstrom, E. (2011). Gender Differences and Predictors of Self-Rated Health Development Among Swedish Adolescents. *J Adolescent Health, 48*(2), 143 - 150.

Joffer, J., Jerdén, L., Öhman, A., & Flacking, R. (2016). Exploring self-rated health among adolescents: a think-aloud study. *BMC Public Health, 16*(1), 1-10.

Johansson, A., Brunnberg, E., & Eriksson, C. (2007). Adolescent Girls' and Boys' Perceptions of Mental Health. *Journal of Youth Studies, 10*(2), 183-202.

Johansson, T. (2000). Makten, härligheten och kärleken. *Socialvetenskaplig tidskrift*.

Johansson, T. (2011). Fatherhood in Transition: Paternity Leave and Changing Masculinities. *Journal of Family Communication, 11*(3), 165-180.

Johansson, T., & Ottemo, A. (2015). Ruptures in hegemonic masculinity: the dialectic between ideology and utopia. *Journal of Gender Studies, 24*(2), 192-206.

Jylhä, M. (2009). What is self-rated health and why does it predict mortality? Towards a unified conceptual model. *Social Science & Medicine, 69*(3), 307-316.

Kieling, C., Baker-Henningham, H., Belfer, M., Conti, G., Ertem, I., Omigbodun, O., Rohde, L. A., Srinath, S., Ulkuer, N., & Rahman, A. (2011). Child and adolescent mental health worldwide: evidence for action. *The Lancet, 378*(9801), 1515-1525.

Kimmel, M. (2010). *Boys and School: A Background Paper on the Boy Crisis*. (SOU 2010:53). Stockholm: Swedish Government Official Report.

Kimmel, M. S. (2009). *Guyland : the perilous world where boys become men*. New York: Harpercollins.

Koivusilta, L. K., Rimpela, A. H., & Kautiainen, S. M. (2006). Health inequality in adolescence. Does stratification occur by familial social background, family affluence, or personal social position? *BMC Public Health, 6*, 110.

Kõlves, K., & De Leo, D. (2016). Adolescent Suicide Rates Between 1990 and 2009: Analysis of Age Group 15–19 Years Worldwide. *Journal of Adolescent Health, 58*(1), 69-77.

Krieger, N., Williams, D. R., & Moss, N. E. (1997). Measuring social class in US public health research: concepts, methodologies, and guidelines. *Annual review of public health, 18*(1), 341-378.

Lagattuta, K. H., & Thompson. (2007). The development of self-conscious emotions: Cognitive processes and social influences (pp. 91).

Lager, A., Berlin, M., Heimerson, I., & Danielsson, M. (2012). Young people's health: Health in Sweden: The National Public Health Report 2012. Chapter 3. *Scand J Public Health, 40*(9 Suppl), 42-71.

Landstedt, E., Asplund, K., & Gillander Gådin, K. (2009). Understanding adolescent mental health: the influence of social processes, doing gender and gendered power relations. *Sociology of Health & Illness, 31*(7), 962-978.

Landstedt, E., & Gillander Gådin, K. (2012). Seventeen and stressed-Do gender and class matter? *Health Sociology Review, 21*(1), 82-98.

Larson, J. S. (1999). The conceptualization of health. *Medical care research and review : MCRR, 56*(2), 123-136.

Laye-Gindhu, A., & Schonert-Reichl, K. (2005). Nonsuicidal Self-Harm Among Community Adolescents: Understanding the "Whats" and "Whys" of Self-Harm. *Journal of Youth and Adolescence, 34*(5), 447-457.

Lazarus, R. S. (1999). *Stress and emotion : a new synthesis*. New York: Springer.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York: Springer.

Legewie, J., & DiPrete, T. A. (2012). School Context and the Gender Gap in Educational Achievement. *American Sociological Review, 77*(3), 463-485.

Lengen, C., & Blasius, J. (2007). Constructing a Swiss health space model of self-perceived health. *Soc Sci Med, 65*(1), 80-94.

Lewis, M. (2003). The role of the self in shame. *Social Research: An International Quarterly, 70*(4), 1181-1204.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, Calif.: Sage.

Lupton, D. (2012). *Medicine as culture : illness, disease and the body*. Los Angeles, [Calif.] ;: SAGE.

MacLean, A., Hunt, K., & Sweeting, H. (2013). Symptoms of Mental Health Problems: Children's and Adolescents' Understandings and Implications for Gender Differences in Help Seeking. *Children & Society, 27*(3), 161-173.

MacLean, A., Sweeting, H., & Hunt, K. (2010). 'Rules' for boys, 'guidelines' for girls: Gender differences in symptom reporting during childhood and adolescence. *Social Science & Medicine, 70*(4), 597-604.

Makenzius, M., & Wamala, S. (2015). Swedish public health policy: Impact on regional and local public health practice and priorities. *Journal of public health policy, 36*(3), 335-349.

Malterud, K. (2001). Qualitative research: standards, challenges, and guidelines. *The Lancet, 358*(9280), 483-488.

Manderbacka, K., Lahelma, E., & Martikainen, P. (1998). Examining the continuity of self-rated health. *International Journal of Epidemiology, 27*(2), 208-213.

Marcell, A. V., Eftim, S. E., Sonenstein, F. L., & Pleck, J. H. (2011). Associations of Family and Peer Experiences with Masculinity Attitude Trajectories at the Individual and Group Level in Adolescent and Young Adult Males. *Men and Masculinities, 14*(5), 565-587.

Marcell, A. V., Ford, C. A., Pleck, J. H., & Sonenstein, F. L. (2007). Masculine Beliefs, Parental Communication, and Male Adolescents' Health Care Use. *Pediatrics, 119*(4), e966-e975.

Marcell, A. V., Klein, J. D., Fischer, I., Allan, M. J., & Kokotailo, P. K. (2002). Male adolescent use of health care services: where are the boys? *Journal of Adolescent Health, 30*(1), 35-43.

Marmot, M. (2004). *The status syndrome : how social standing affects our health and longevity*. New York, N.Y.: Henry Holt.

Marmot, M. (2005). Social determinants of health inequalities. *The Lancet, 365*(9464), 1099-1104.

Martens, J. P., Tracy, J. L., & Shariff, A. F. (2012). Status signals: Adaptive benefits of displaying and observing the nonverbal expressions of pride and shame. *Cognition and Emotion, 26*(3), 390-406.

Martinsson, L., & Reimers, E. (2008). *Skola i normer (Norm school)*. Malmö: Gleerup.

Maughan, B., Rowe, R., Messer, J., Goodman, R., & Meltzer, H. (2004). Conduct Disorder and Oppositional Defiant Disorder in a national sample: developmental epidemiology. *Journal of Child Psychology and Psychiatry, 45*(3), 609-621.

McCormack, M., & Anderson, E. (2010). 'It's Just Not Acceptable Any More': The Erosion of Homophobia and the Softening of Masculinity at an English Sixth Form. *Sociology, 44*(5), 843-859.

McDowell, L. (2002). Transitions to Work: Masculine identities, youth inequality and labour market change. *Gender, Place & Culture, 9*(1), 39-59.

McLoughlin, A. B., Gould, M. S., & Malone, K. M. (2015). Global trends in teenage suicide: 2003–2014. *QJM, 108*(10), 765-780.

McQueen, C., & Henwood, K. (2002). Young men in 'crisis': attending to the language of teenage boys' distress. *Social Science & Medicine, 55*(9), 1493-1509.

McWhinney, I. R., & Epstein, R. M. (1997). Rethinking somatization. *Annals of Internal Medicine, 126*(9), 747-750.

Mead, G. H. (1934). *Mind, self & society : from the standpoint of social behaviorist*. Chicago: University of Chicago Press.

Medical Dictionary. (Ed.) (2012) Medical Dictionary for the Health Professions and Nursing

Retrieved July 5 2016 from http://medical-dictionary.thefreedictionary.com/ health+status

Merleau-Ponty, M. (1962). *Phenomenology of perception*. London :: Routledge ;.

Messerschmidt, J. W. (2009). "Doing Gender": The Impact and Future of a Salient Sociological Concept. *Gender & Society, 23*(1), 85-88.

Mmari, K., Marshall, B., Lantos, H., & Blum, R. W. (2016). Who Adolescents Trust May Impact Their Health: Findings from Baltimore. *Journal of Urban Health, 93*(3), 468-478.

Molcho, M., Walsh, S., Donnelly, P., Matos, M. G. d., & Pickett, W. (2015). Trend in injury-related mortality and morbidity among adolescents across 30 countries from 2002 to 2010. *The European Journal of Public Health, 25*(suppl 2), 33-36.

Morgan, D. L. (1998). Practical Strategies for Combining Qualitative and Quantitative Methods: Applications to Health Research. *Qualitative Health Research, 8*(3), 362-376.

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of counseling psychology, 52*(2), 250.

Mossey, J. M., & Shapiro, E. (1982). Self-rated health: a predictor of mortality among the elderly. *Am J Public Health, 72*(8), 800-808.

Mruck, K., & Breuer, F. (2003). *Subjectivity and reflexivity in qualitative research—The FQS issues*. Paper presented at the Forum Qualitative Sozialforschung/Forum: Qualitative Social Research.

Muris, P., & Meesters, C. (2014). Small or big in the eyes of the other: on the developmental psychopathology of self-conscious emotions as shame, guilt, and pride. *Clin Child Fam Psychol Rev, 17*(1), 19-40.

Nobles, J., Weintraub, M. R., & Adler, N. E. (2013). Subjective socioeconomic status and health: Relationships reconsidered. *Social Science & Medicine, 82*, 58-66.

Nordenfelt, L. (1993). *Quality of Life, Health and Happiness*. Aldershot: Avebury.

Nordenfelt, L. (1995). *On the nature of health : an action-theoretic approach*. Dordrecht: Kluwer.

Nutbeam, D. (1998). Health promotion glossary. *Health Promotion International, 13*(4), 349-364.

Nyberg, A. (2012). Gender Equality policy in Sweden: 1970s–2010s. *Nordic Journal of Working Life Studies, 2*(4), pp. 67-84.

O'Neil, J. M. (2013). Gender Role Conflict Research 30 Years Later: An Evidence-Based Diagnostic Schema to Assess Boys and Men in Counseling. *Journal of Counseling & Development, 91*(4), 490-498.

O'Neil, J. M., Good, G. E., & Holmes, S. (1995). Fifteen years of theory and research on men's gender role conflict: New paradigms for empirical research. In R. F. L. W. S. Pollack (Ed.), *A new psychology of men* (pp. 164-206). New York, NY, US: Basic Books.

Oliffe, J. L., Kelly, M. T., Johnson, J. L., Bottorff, J. L., Gray, R. E., Ogrodniczuk, J. S., & Galdas, P. M. (2010). Masculinities and college men's depression: Recursive relationships. *Health Sociology Review, 19*(4), 465-477.

Oransky, M., & Marecek, J. (2009). "I'm Not Going to Be a Girl": Masculinity and Emotions in Boys' Friendships and Peer Groups. *Journal of Adolescent Research, 24*(2), 218-241.

Ott, M. A., Rosenberger, J. G., McBride, K. R., & Woodcox, S. G. (2011). How do adolescents view health? Implications for state health policy. *J Adolesc Health, 48*(4), 398-403.

Padilla-Moledo, C., Ruiz, J. R., & Castro-Piñero, J. (2016). Parental educational level and psychological positive health and health complaints in Spanish children and adolescents. *Child: Care, Health and Development, 42*(4), 534-543.

Patel, V., Flisher, A. J., Hetrick, S., & McGorry, P. (2007). Mental health of young people: a global public-health challenge. *The Lancet, 369*(9569), 1302-1313.

Patton, G. C., Coffey, C., Sawyer, S. M., Viner, R. M., Haller, D. M., Bose, K., Vos, T., Ferguson, J., & Mathers, C. D. (2009). Global patterns of mortality in young people: a systematic analysis of population health data. *The Lancet, 374*(9693), 881-892.

Pensola, T. H., & Valkonen, T. (2000). Mortality differences by parental social class from childhood to adulthood. *J Epidemiol Community Health, 54*(7), 525-529.

Petersen, S., Bergstrom, E., Cederblad, M., Ivarsson, A., Kohler, L., Rydell, A.-M., Stenbeck, M., Sundelin, C., & Hagglof, B. (2010). Stockholm: The Royal Swedish Academy of Sciences, The Health Committee.

Plant, E. A., Hyde, J. S., Keltner, D., & Devine, P. G. (2000). The gender stereotyping of emotions. *Psychology of Women Quarterly, 24*(1), 81-92.

Pleck, J. H. (1995). The gender role strain paradigm: An update. In R. F. Levant, W. S. Pollack, R. F. Levant & W. S. Pollack (Eds.), *A new psychology of men*. (pp. 11-32). New York, NY, US: Basic Books.

Pleck, J. H., Sonenstein, F. L., & Ku, L. C. (1993). Masculinity ideology: Its impact on adolescent males' heterosexual relationships. *Journal of Social Issues, 49*(3), 11-29.

Pollack, W. (1999). *Real boys : rescuing our sons from the myths of boyhood*. New York: Henry Holt & Company.

Pollack, W., & Schuster, T. (2000). *Real boys' voices: Boys speak out about drugs, sex, violence, bullying, sports, school, parents, and so much more*: Random House.

Presser, S. (2004). *Methods for testing and evaluating survey questionnaires*. New York: Wiley-Interscience.

Price, C. (2007). Dissociation reduction in body therapy during sexual abuse recovery. *Complementary Therapies in Clinical Practice, 13*(2), 116-128.

Ravens-Sieberer, U., Torsheim, T., Hetland, J., Vollebergh, W., Cavallo, F., Jericek, H., Alikasifoglu, M., Valimaa, R., Ottova, V., & Erhart, M. (2009). Subjective health, symptom load and quality of life of children and adolescents in Europe. *Int J Public Health, 54*, 151 - 159.

Reidy, D. E., Smith-Darden, J. P., Cortina, K. S., Kernsmith, R. M., & Kernsmith, P. D. (2015). Masculine Discrepancy Stress, Teen Dating Violence, and Sexual Violence Perpetration Among Adolescent Boys. *Journal of Adolescent Health, 56*(6), 619-624.

Reigeluth, C. S., & Addis, M. E. (2016). Adolescent boys' experiences with policing of masculinity: Forms, functions, and consequences. *Psychology of Men & Masculinity, 17*(1), 74.

Retzinger, S. M. (1995). Identifying Shame and Anger in Discourse. *American Behavioral Scientist, 38*(8), 1104-1113.

Rew, L. (2005). *Adolescent health : a multidisciplinary approach to theory, research, and intervention*. Thousand Oaks, Calif.: Sage Publications.

Rice, T. R. (2015). Violence among young men: the importance of a gender-specific developmental approach to adolescent male suicide and homicide. *Int J Adolesc Med Health, 27*(2), 177-181.

Robertson, S. (2007). *Understanding men's health : masculinities, identity and well-being*. Maidenhead: Open University Press.

Rolfe, G. (2006). Validity, trustworthiness and rigour: quality and the idea of qualitative research. *Journal of advanced nursing, 53*(3), 304-310.

Rosch, P. J., & Kearney, H. M. (1985). Holistic medicine and technology: A modern dialectic. *Social Science & Medicine, 21*(12), 1405-1409.

Rozemond, M. (1998). *Descartes's dualism*. Cambridge, Mass.: Harvard Univ. Press.

Rozemond, M. (1999). Descartes on mind-body interaction: What's the problem? *Journal of the History of Philosophy, 37*(3), 435-467.

Russell, R. D. (1973). Social health: an attempt to clarify this dimension of well being. *International Journal of Health Education, 16*(2), 74-84.

Sandelowski, M. (1993). Rigor or rigor mortis: the problem of rigor in qualitative research revisited. *Advances in nursing science, 16*(2), 1-8.

Sawyer, S. M., Afifi, R. A., Bearinger, L. H., Blakemore, S.-J., Dick, B., Ezeh, A. C., & Patton, G. C. (2012). Adolescence: a foundation for future health. *The Lancet*.

Scheff, T. J. (2000). Shame and the social bond: A sociological theory. *Sociological Theory, 18*(1), 84-99.

Scheff, T. J. (2003). Shame in self and society. *Symbolic Interaction, 26*(2), 239-262.

Scheff, T. J. (2014). A Retrospective Look at Emotions. In J. E. Stets & J. H. Turner (Eds.), *Handbook of the Sociology of Emotions: Volume II* (pp. 245-266): Springer Netherlands.

Sentse, M., Kretschmer, T., & Salmivalli, C. (2015). The Longitudinal Interplay between Bullying, Victimization, and Social Status: Age-related and Gender Differences. *Social Development, 24*(3), 659-677.

Silk, J. S., Steinberg, L., & Morris, A. S. (2003). Adolescents' emotion regulation in daily life: Links to depressive symptoms and problem behavior. *Child development, 74*(6), 1869-1880.

Sonmark, K., Godeau, E., Augustine, L., Bygren, M., & Modin, B. (2016). Individual and Contextual Expressions of School Demands and their Relation to Psychosomatic Health a Comparative Study of Students in France and Sweden. *Child Indicators Research, 9*(1), 93-109.

Stenmark, H., Bergström, E., Hägglöf, B., Öhman, A., & Petersen, S. (2015). Mental problems and their socio-demographic determinants in young schoolchildren in Sweden, a country with high gender and income equality. *Scandinavian Journal of Public Health*.

Stranden, V. (2015). Nordic Gender Equality in Figures 2015 (pp. 36). Copenhagen: Nordiska ministerrådet.

Strömbäck, M., Formark, B., Wiklund, M., & Malmgren-Olsson, E.-B. (2014). The Corporeality of Living Stressful Femininity: A Gender–Theoretical Analysis of Young Swedish Women's Stress Experiences. *Young, 22*(3), 271-289.

Sudman, S., Bradburn, N. M., & Schwarz, N. (1996). *Thinking about answers: The application of cognitive processes to survey methodology*. San Francisco: Jossey-Bass Publishers.

Sullivan, M., Karlsson, J., & Ware Jr, J. E. (1995). The Swedish SF-36 Health Survey—I. Evaluation of data quality, scaling assumptions, reliability and construct validity across general populations in Sweden. *Social Science & Medicine, 41*(10), 1349-1358.

Sweden, S. (2012). Statistics Sweden. from http://www.scb.se/Pages/GsaSearch 287280.aspx?QueryTerm =utbildningsniv%c3%a5+falun&PageIndex=1&hl=sv

Swedish National Institute of Public Health. (2011). Public health priorities in Sweden https://www.folkhalsomyndigheten.se/publicerat-material/publikationer/Public-health-priorities-in-Sweden/.

Sweeting, H., & Hunt, K. (2014). Adolescent socio-economic and school-based social status, health and well-being. *Soc Sci Med, 121*, 39-47.

Svensson, T., & Björklund, A. (2010). Focus on health, motivation, and pride: a discussion of three theoretical perspectives on the rehabilitation of sick-listed people. *Work, 36*(3), 273-282.

Tangney, J. P., Stuewig, J., & Mashek, D. J. (2007). Moral emotions and moral behavior. *Annu Rev Psychol, 58*, 345-372.

The National Board of Health and Welfare. (2009). *Public Health Report (Folkhälsorapport 2009)*. Stockholm: Socialstyrelsen.

The National Board of Health and Welfare. (2013). *Barns och ungas hälsa, vård och omsorg 2013 [Children's and young peoples' health and health care 2013]*. Stockholm: Socialstyrelsen [The National Board of Health and Welfare].

Thompson Jr, E. H., & Bennett, K. M. (2015). Measurement of masculinity ideologies: A (critical) review. *Psychology of Men & Masculinity, 16*(2), 115.

Thorpe, R. J., & Halkitis, P. N. (2016). Biopsychosocial Determinants of the Health of Boys and Men Across the Lifespan. *Behavioral Medicine, 42*(3), 129-131.

Thrane, C. (2006). Explaining educational-related inequalities in health: Mediation and moderator models. *Social Science & Medicine, 62*(2), 467-478.

Tischler, A., & McCaughtry, N. (2011). PE is not for me: when boys' masculinities are threatened. *Research quarterly for exercise and sport, 82*(1), 37-48.

Tolman, D. L., Davis, B. R., & Bowman, C. P. (2016). "That's Just How It Is": A Gendered Analysis of Masculinity and Femininity Ideologies in Adolescent Girls' and Boys' Heterosexual Relationships. *Journal of Adolescent Research, 31*(1), 3-31.

Tracy, J. L., Cheng, J. T., Robins, R. W., & Trzesniewski, K. H. (2009). Authentic and Hubristic Pride: The Affective Core of Self-esteem and Narcissism. *Self and Identity, 8*(2-3), 196-213.

Tracy, J. L., & Robins, R. W. (2004). Putting the Self Into Self-Conscious Emotions: A Theoretical Model. *Psychological Inquiry, 15*(2), 103-125.

Tracy, J. L., Robins, R. W., & Tangney, J. P. (2007). *Self-conscious emotions : theory and research*. New York: Guilford Publications.

Unicef. (2011). *The state of the world's children. 2011, [Adolescence: an age of opportunity]*. New York: Unicef.

Wade, T. J., & Vingilis, E. (1999). The development of self-rated health during adolescence: an exploration of inter- and intra-cohort effects. *Canadian journal of public health. Revue canadienne de sante publique, 90*(2), 90-94.

Wasserman, D., Cheng, Q., & Jiang, G. X. (2005). Global suicide rates among young people aged 15-19. *World psychiatry : official journal of the World Psychiatric Association, 4*(2), 114-120.

Way, N., Cressen, J., Bodian, S., Preston, J., Nelson, J., & Hughes, D. (2014). "It might be nice to be a girl... Then you wouldn't have to be emotionless": Boys' resistance to norms of masculinity during adolescence. *Psychology of Men & Masculinity, 15*(3), 241-252.

Webb, L., Stegall, S., Mirabile, S., Zeman, J., Shields, A., & Perry-Parrish, C. (2016). The management and expression of pride: Age and gender effects across adolescence. *Journal of Adolescence, 52*, 1-11.

Veldman, K., Bultmann, U., Almansa, J., & Reijneveld, S. A. (2015). Childhood Adversities and Educational Attainment in Young Adulthood: The Role of Mental Health Problems in Adolescence. *Journal of Adolescent Health, 57*(5), 462-467.

Verzeletti, C., Zammuner, V. L., Galli, C., Agnoli, S., & Duregger, C. (2016). Emotion regulation strategies and psychosocial well-being in adolescence. *Cogent Psychology, 3*(1), 1199294.

West, C., & Zimmerman, D. H. (1987). Doing gender. *Gender & society, 1*(2), 125-151.

West, C., & Zimmerman, D. H. (2009). Accounting for Doing Gender. *Gender & Society, 23*(1), 112-122.

West, P. (1997). Health inequalities in the early years: Is there equalisation in youth? *Soc Sci Med, 44*.

White, K. (2009). *An introduction to the sociology of health and illness*. Los Angeles ;: SAGE.

WHO. (1948). Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.: WHO.

WHO. (2004). Promoting mental health : concepts, emerging evidence, practice : summary report (pp. 70). World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland.

WHO. (2011). *Gender mainstreaming for health managers: a practical approach* (W. a. H. WHO; Department of Gender Ed.). World Health Organization.

WHO. (2014). *Preventing suicide: A global imperative*: World Health Organization.

WHO. (2016). *Growing up unequal: gender and socioeconomic differences in young people's health and well-being. Health Behaviour in School-aged Children (HBSC) study: international report from the 2013/2014 survey* (D. C. Edited by: Jo Inchley, Taryn Young, Oddrun Samdal, Torbjørn Torsheim, Lise Augustson, Frida Mathison, Aixa Aleman-Diaz, Michal Molcho, Martin Weber and Vivian Barnekow Ed.).

Wiklund, M., Bengs, C., Malmgren-Olsson, E., & Öhman, A. (2010). Young women facing multiple and intersecting stressors of modernity, gender orders and youth. *Soc Sci Med, 71*(9), 1567 - 1575.

Wiklund, M., Malmgren-Olsson, E.-B., Öhman, A., Bergström, E., & Fjellman-Wiklund, A. (2012). Subjective health complaints in older adolescents are related to perceived stress, anxiety and gender – a cross-sectional school study in Northern Sweden. *BMC Public Health, 12*(1), 1-13.

Wilde, M. H. (1999). Why embodiment now? *Advances in Nursing Science, 22*(2), 25-38.

Willis, P. E. (1977). *Learning to labour : how working class kids get working class jobs*. Farnborough: Saxon House.

Viner, R. M., Ozer, E. M., Denny, S., Marmot, M., Resnick, M., Fatusi, A., & Currie, C. (2012). Adolescence and the social determinants of health. *The Lancet, 379*(9826), 1641-1652.

Viner, R. M., Ross, D., Hardy, R., Kuh, D., Power, C., Johnson, A., Wellings, K., McCambridge, J., Cole, T. J., & Kelly, Y. (2015). Life course epidemiology: recognising the importance of adolescence.

Vingilis, E. R., Wade, T. J., & Seeley, J. S. (2002). Predictors of adolescent self-rated health. Analysis of the National Population Health Survey. *Can J Public Health, 93*(3), 193-197.

Wood, M. A., Bukowski, W. M., & Lis, E. (2016). The Digital Self: How Social Media Serves as a Setting that Shapes Youth's Emotional Experiences. *Adolescent Research Review, 1*(2), 163-173.

World Medical Association. (2001). World Medical Association Declaration of Helsinki. Ethical principles for medical research involving human subjects. *Bulletin of the World Health Organization, 79*(4), 373.

Wrench, A., Garrett, R., & King, S. (2012). Guessing where the goal posts are: managing health and well-being during the transition to university studies. *Journal of Youth Studies*, 1-17.

Wu, S., Wang, R., Zhao, Y., Ma, X., Wu, M., Yan, X., & He, J. (2013). The relationship between self-rated health and objective health status: a population-based study. *BMC Public Health, 13*(1), 1-9.

Åslund, C., Leppert, J., Starrin, B., & Nilsson, K. W. (2009). Subjective social status and shaming experiences in relation to adolescent depression. *Archives of Pediatrics & Adolescent Medicine, 163*(1), 55-60.

Åslund, C., Nilsson, K. W., Starrin, B., & Sjöberg, R. L. (2007). Shaming experiences and the association between adolescent depression and psychosocial risk factors. *European Child & Adolescent Psychiatry, 16*(5), 298-304.

Åslund, C., Starrin, B., Leppert, J., & Nilsson, K. W. (2009). Social status and shaming experiences related to adolescent overt aggression at school. *Aggressive Behavior, 35*(1), 1-13.