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Young women facing multiple and intersecting stressors of modernity, gender orders and youth

Maria Wiklund [a,b,*], Carita Bengs [c], Eva-Britt Malmgren-Olsson [b], Ann Öhman [a,d]

[a] Department of Public Health and Clinical Medicine, Epidemiology and Global Health, Umeå University, Umeå, Sweden
[b] Department of Community Medicine and Rehabilitation, Physiotherapy, Umeå University, Umeå, Sweden
[c] Department of Sociology, Umeå University, Umeå, Sweden
[d] Umeå Centre for Gender Studies, Umeå University, Umeå, Sweden

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ABSTRACT

This article aims to explore stressors experienced by Swedish adolescent girls and young women, specifically understood in relation to social context and gender theory. Interviews were conducted with 40 young Swedish women, aged 16–25 years, who had sought help at a youth health centre for stress problems. Using qualitative content analysis we identified three clusters of stressors: "the stressors of modernity", "the stressors of gendered orders", and "the stressors of youth". The results revealed that multiple and intersecting discourse-shaped stressors and demands connected to essential life spheres contribute not only to experiences of distress but also to feelings of constraint. Gendered individualism and healthism proved to be essential in understanding the young women's experienced stress. Failing social support from adults, gendered demands and responsibility taking were also illuminated. This calls for a broad contextualized and gender-sensitive approach to young women's stress and health problems.

Introduction

Subjective, mental and stress-related health among adolescents and young adults constitute significant public health concerns in Sweden and internationally (Michel, Bisegger, Fuhr, Abel, & The Kidscreen Group, 2009; Patel, Flisher, Hetrick, & McGorry, 2007; SOU, 2006). A shift in gender-related mental and subjective health occurs between childhood and adolescence (Ravens-Sieberer et al., 2009). Although longitudinal studies remain scarce, the gender-related gap seems to persist into early adulthood (European Commission, 2000). In Europe, adolescent girls report lower subjective health and health-related quality of life than other groups, particularly regarding physical and psychological well-being, emotions, mood and self-perception (Michel et al., 2009). Likewise, Swedish adolescent girls and young women report greater stress, anxiety and depression than boys and other age groups (Hagquist, 2009, 2010; SOU, 2006). Similar gender patterns of mental and stress-related problems are seen in adult Swedish women (National Board of Health and Welfare, 2009). An increase in illness related to tiredness and exhaustion has also been observed (Widerberg, 2006).

Accordingly, studies have put forward a variety of possible stressors and explanatory social factors, at individual, group and societal level. Financial stress and higher youth unemployment have been suggested as macro-level explanations, reflecting social change (Lager & Bremberg, 2009; Östberg, Alfven, & Hjern, 2006). Societal processes of individualization and differentiation are other potential factors highlighted (SOU, 2006). Academic orientation, educational expectations, strained social relations, peer hierarchies, bullying and harassment have further been found to impact subjective health and stress in young people (Brolin Låftman & Östberg, 2006; Gillander Gådin & Hammarström, 2005; Hagquist, 2007; West, Sweeting, Young, & Kelly, 2010). Regarding gender differences, explanatory factors at individual level are commonly cited, including girls' pubertal timing, negative body-image, poor self-esteem and vulnerability to relationship stress (Hetland, Torsheim, & Aarø, 2002; Lien, Dalgard, Heyerdahl, Thoresen, & Bjertness, 2006; Rudolph, 2002; Sweeting, West, & Der, 2007). Factors related to stereotyped social constructions of masculinity and femininity are also problematized in relation to differences in symptom reporting (Maclean, Sweeting, & Hunt, 2010). Although sociocultural and gender aspects have been raised in relation to young people's subjective health and stress problems, age and gender-related patterns need to be further

* Corresponding author. Department of Public Health and Clinical Medicine, Epidemiology and Global Health, Umeå University, Umeå, Sweden. Tel.: +46 90 785 2704; fax: +46 90 13 89 77.
E-mail address: maria.wiklund@physiother.umu.se (M. Wiklund).

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addressed and contextualized (Hagquist, 2009, 2010; Michel et al., 2009; Ravens-Sieberer et al., 2009).

Individualization, mobility, uncertainty and risk are all central features of late modern Western societies. Modernity, or late modernity, is described as a post-traditional period characterized by personal freedom and own decision making in a less predetermined and more precarious society, where individual autonomy, reflexivity and agency are emphasized (Beck, 1992; Giddens, 1990, 1991). Rose (1999) characterizes the closing decade of the twentieth century as an acute "ethicalization of existence" which has "intensified the demand that citizens do not devolve responsibilities for health, welfare, security and mutual care upon 'the state', but take responsibility for their own conduct and its consequences in the name of their own self-realization" (p. 263–264). This emphasis on individual choice, freedom and responsibility may be particularly distressing for young people, who are constantly encouraged to work on their self-identity and make the "right choices" for their future. However, young women are sometimes highlighted as potential "winners" in individualistic and neoliberal Western societies (Anoop & Kehily, 2008; Harris, 2004). Similarly, McRobbie (2009) identifies "responsibility", "capacity" and "success" as some of the key features of youthful femininity, while Harris (2004) talks of the "future girl" constructed as a "vanguard" of new subjectivity (p. 1). Nevertheless, it is important to note that only a minority of girls are able to live up to such images of success. Harris highlights two contrasting discourses of young 21st-century women: the successful "can-do" girl with the "world at her feet", and the "at-risk" girl representing the alienated, powerless and problematic girl who fails to move ahead (p. 13–14). Further, Annandale (2009) argues that young women's health problems have commonly been used as metaphors for social processes and change – a connection that emphasizes the interwoven links between health, youth, gender and societal contexts. Recent social and cultural studies on multiple young femininities, gender and class have highlighted the diversity in young women's social positions and living spaces in relation to post-feminism and developments in late modern contemporary Western societies (Aapola, Gonick, & Harris, 2005; Harris, 2004; McRobbie, 2009; Skeggs, 1997; Walkerdine, Lucey, & Melody, 2001). However, the main focus of this body of literature is not health issues.

Thus, sociocultural and gender aspects have not yet been fully explored in relation to girls' and young women's stress problems and self narrated experiences. Many public health studies have been epidemiological, using gender merely as a statistical variable. To our knowledge, few qualitative public health studies have explored young people's own experiences and identification of stressors in life, and analysed these from sociocultural and gender-theoretical perspectives. Furthermore, there has been little or no theory integration of sociocultural and gender perspectives into public health sciences (Hammarström & Ripper, 1999; Kolip & Schmidt, 1999; Öhman, 2008) and, parallel to this, few youth health studies in feminist research.

The aim of the current study is to explore experienced stressors among Swedish adolescent girls and young women who sought help for stress-related problems at a youth health centre. We analyse these stressors in the light of an interdisciplinary theoretical framework, with a specific focus on social context and gender.

Concepts of stress and gender

The concept of stress is highly time and context-bound, as the meanings and status of stress and stress diagnosis vary (Becker, 2010). Stress is commonly defined as subjective experiences arising when environmental demands exceed an individual's perceived ability to cope (Lazarus & Folkman, 1984). The concept of stress can include stressors as well as stress responses, and is often studied from a biomedical viewpoint (McEwen & Gianaros, 2010). In this study we wish to widen the perspective of stress to focus on social, cultural and contextual factors, as we believe that these are essential to understanding contemporary young women's experiences of stress and stressors. Young women's subjectivities are located and produced within complex and changing sociopolitical landscapes (Harris, 2004; McRobbie, 2009; Skeggs, 1997; Walkerdine et al., 2001), which also influence relations to body and health (Aapola et al., 2005; Annandale, 2009; Bengs, 2000). Thus, we apply a social constructionist perspective that takes social processes and interaction into account without denying the impact of biological and material aspects on health and illness. In accordance with Lupton (2003), we view "the body and its ill not as universal biological realities but as a combination of discursive processes, practices and physical matter which have symbiotic and symbolic relationship with the discourses and ideologies governing societal regulation" (p. 53).

Gender, as a social construction, can be understood in relation to social structures, norms, values and practices connected to cultural beliefs about femininity and masculinity in a certain context and time – produced or reproduced in ongoing social processes and actions of "doing gender" (Connell, 2002; West & Zimmerman, 1987). Gender relations between individuals in everyday life, as well as gender regimes on organizational and institutional levels, interplay with wider gender patterns in society, so-called gender orders (Connell, 2002, p. 53–55). Health can be related to interactive processes of social and gendered "embodiment" (Connell, 2002; Nettleton & Watson, 1998), often connected to social constructions of gender and unequal power relations (Courtenay, 2000; Hammarström & Ripper, 1999). Gendered living conditions and gender socialization during youth can therefore be related to the development of health or ill-health (Gillander Gådin & Hammarstrom, 2000; Landstedt, Asplund, & Gillander Gådin, 2009; Wiklund, Malmgren-Olsson, Bengs, & Öhman, 2010). Ideal images of young people are "constructed" and "produced" through popular culture, media, medical or political ideologies and influence young people's self-perceptions, the expectations they perceive and the actions they take (Bengs, 2000; McRobbie, 2009; Wright, O'Flynn, & Macdonald, 2006). Young women of the 21st century are expected to be "self-inventing" (Harris, 2004), and to produce themselves according to ideal images of the "category" of young woman and the norms of what it is to be a woman (McRobbie, 2009). Similarly, Petersen and Lupton (1996) define the ideal images of women in public health discourses as "responsible" and "caring" healthy citizens who seek both soundness and physical attractiveness, including a slim, physically fit and youthful body (p. 72–80).

Even though Sweden is regarded as one of the most gender-equal countries in the world, clear divisions between the sexes remain, affecting essential domains in life such as economic situation and health outcomes (World Economic Forum, 2009). Substantial gaps remain between men and women in income, work and economic power (Statistics Sweden, 2008). By international comparison, Sweden has a strongly gender-segregated labour market: women still do most of the unpaid household work and men take only a small proportion of the parental leave. There are suggestions that these gendered patterns will change as new generations enter the labour market, yet there are few signs of such a change. A national survey of young health professionals found a traditional gender pattern in the division of labour, both in paid work and in unpaid duties (Enberg, Stenlund, Sundelin, & Öhman, 2007). Gendered patterns and practices, mirroring an unequal division of power, have also been described in children and young people (Landstedt et al., 2009). Equal opportunities projects have been set up in Swedish schools, aiming to reconstruct power relations (Gillander Gådin & Hammarstrom, 2000), as well as government initiatives focusing