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'Rules' for the boys, 'guidelines' for the girls: a qualitative study of the factors influencing gender differences in symptom reporting during childhood and adolescence.

F. Alice MacLean

Thesis submitted for the degree of Doctor of Philosophy at the University of Glasgow

**MRC Social and Public Health Sciences Unit
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Abstract

Research into child and adolescent health has found that the distribution of illness reverses from a male excess in childhood to a female excess in early-mid adolescence. Although gender differences in adult health have been widely discussed and investigated, comparatively little attention has been devoted to explaining changes in the gender patterning of ill-health during childhood and adolescence. However, further research is warranted to improve understanding of this phenomenon and possibly to shed light on gender patterns in adult health. Research in this area has been mainly quantitative and concentrates on investigating changing gender patterns in relation to psychological conditions. This study uses qualitative methods to improve understanding of the changing gender patterns in respect of both physical and psychological symptoms. Specifically, it explores how boys' and girls' symptom reporting may be influenced by their perceptions of societal gender- and age-related expectations, their conceptualisations of symptoms, and the social context of symptom experiences.

Twenty five focus groups were conducted with girls and boys aged 10, 13 and 15. These took place in one primary and one secondary school, both located in central Scotland, between June 2004 and January 2005. Focus groups were composed of pupils who were the same age and gender. To stimulate discussion and aid comparison across groups, focussing exercises were designed and put into practice. Symptom cards were used to investigate pupils' conceptualisations of symptoms. Vignettes encouraged pupils to explore how same- and opposite-sex peers might react to a 'physical' and 'malaise' symptom in different social contexts. Histograms displaying gender differences in symptom reporting were used as a basis for exploring pupils' explanations for these patterns.

This study found that experiences of illness are integral to boys' and girls' presentations of themselves and their performances of gender and age. Their efforts to conform to gender- and age-related expectations have a significant influence on their reactions to illness, their conceptualisations and assessments of symptoms, and also their perceptions of the consequences of seeking help for illness in different

social contexts. Societal expectations can be seen as representing strict 'rules' for boys, which substantially restrict their reactions to 'physical' and especially 'malaise' symptoms, whereas they can be viewed as more lenient 'guidelines' for girls which are more permissive of their help-seeking for either 'physical' or 'malaise' symptoms. The 'rules' and 'guidelines' for boys and girls are not as polarised as gender stereotypes would lead us to expect. This study suggests that seeking help for illness can pose a serious threat to boys' constructions of themselves as 'successfully masculine', but it also has a negative impact upon girls' presentations of themselves as strong and independent. Pupils' accounts suggest that the stricter expectations on boys' behaviour and more severe consequences for their help-seeking may contribute to their lower rates of symptom reporting, both in survey settings and their everyday lives.

Boys and girls also argued that the transition from childhood to adolescence is more stressful for girls. They portrayed the advent of puberty and menarche, as well as mounting academic pressures, as stressors likely to lead to girls' increasing experiences of 'physical' symptoms and 'psychological' distress. Thus, both sociological and biological explanations were constructed by pupils in order to make sense of gender differences in symptom reporting.

The findings of this study highlight the need to be critical of, and de-stabilise gender stereotypes which restrict boys' abilities and willingness to seek help for illness and reinforce the misconception that girls find it easy to report both 'physical' and 'psychological' symptoms. In order to reduce help-seeking barriers and improve boys' and girls' perceptions of the consequences of reporting symptoms, there needs to be an erosion of the idea that illness signifies weakness or deficiencies of character. Campaigns to reduce the stigma of mental illness would benefit from incorporating boys' and girls' conceptualisations of 'malaise' symptoms and aiming to change misconceptions which act as barriers to help-seeking.

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Chapter One: Introduction

1.1 Study background

Research into child and adolescent health has reported evidence of changes in the male-female patterning of illness over the course of this life stage. Significantly, the distribution of illness reverses from a male excess in childhood to a female excess in early-mid adolescence (Cohen, Brownell et al. 1990; Cohen, Cohen et al. 1993; Eiser, Havermans et al. 1995; Sweeting 1995; Allard 1996; Eminson, Benjamin et al. 1996; Klepp, Aas et al. 1996; Haugland, Wold et al. 2001a; Hetland, Torsheim et al. 2002; Sweeting and West 2003a; Torsheim, Ravens-Sieberer et al. 2006). Whilst gender¹ differences in adult health have been widely reported and discussed (Nathanson 1975; Gove and Hughes 1979; Verbrugge 1985; Verbrugge and Wingard 1987; Macintyre, Hunt et al. 1996; Gijsbers Van Wijk and Kolk 1997; Moynihan 1998; Gijsbers Van Wijk, Huisman et al. 1999; Barsky, Peekna et al. 2001), comparatively little research has been devoted to explaining changes in the gender patterning of ill-health during childhood and adolescence (Sweeting 1995). Further research is warranted, not only because it is important to deepen our understanding of the influences which cause these changes, but also because these findings suggest that the gender differences found in adult health first emerge at this earlier stage of the life-course. Thus, understanding the male-female reversal in ill-health which occurs during adolescence may also help to account for the gender differences which have been found in adult health (Sweeting 1995; Hetland, Torsheim et al. 2002; Viner and Barker 2005).

Research to date suggests that biological factors, such as the differing effects of puberty on boys' and girls' health, as well as social influences, such as the impact of societal gender- and age-related expectations on illness behaviours, may contribute to gender patterning in health during the transition from childhood to adolescence (Prout 1989; Prout 1992; Sweeting 1995; Angold, Costello et al. 1999; Siegel, Yancey et al. 1999; Williams 1999; Simpson 2000; Williams 2000; Barsky, Peekna et al. 2001; Haugland, Wold et al. 2001a; Sweeting and West 2003a; Lien, Dalgard et al. 2006).

¹ Throughout the thesis, the term 'gender' is mainly used instead of 'sex' to refer to the differences between boys' and girls' health. However, the terms 'opposite-sex' and 'same-sex' are used when referring to participants' comparisons of males and females as groups. For a more detailed outline of the distinction between the terms 'sex' and 'gender' see p.20 for a discussion of recent debates around the distinction see Howson's *Embodying Gender* (2005).

It has also been suggested that self-report symptom checklists and health assessment scales might not accurately reflect 'real' levels of symptom experience and that response biases, driven by efforts to conform to social expectations (Mechanic 1976; Mechanic and Hansell 1987; Alexander 1989; Mirowsky and Ross 1995; Eminson, Benjamin et al. 1996), may accentuate gender differences in symptom reporting and self-assessed health status.

Although similar changing gender patterns have been reported in respect of physical and psychological illness, most research with adolescents has concentrated on investigating gender differences in psychological conditions, such as depression and anxiety disorders (e.g. Kandel and Davies 1982; Allgood-Merten, Lewinsohn et al. 1990; Petersen, Sarigiani et al. 1991; Cohen, Cohen et al. 1993; Nolen-Hoeksema and Girgus 1994; Angold, Costello et al. 1998; Schraedley, Gotlib et al. 1999; Cyranowski, Frank et al. 2000; Marcotte, Fortin et al. 2002; Bennett, Ambrosini et al. 2005). However, some (Rauste-Von Wright and Von Wright 1981; Sweeting 1995; Sigmon, Dorhofer et al. 2000; Williams, Colder et al. 2002) have implied that exploring gender differences in the aetiology of physical and psychological symptoms separately may result in a failure to investigate the significance of any causal relationship between the two. Most research has also investigated gender differences whilst employing quantitative methodologies (Sweeting 1995), thus over-looking the potential of qualitative methods to explore children and adolescents' experiences of illness and their thoughts on the influences which may affect their health and their illness behaviours.

Although informed by the broader research findings outlined above, the central aim and design of this study follows more specifically from analyses of data from the 'West of Scotland 11 to 16 Study: Teenage Health' (hereafter referred to as the '11-16 study'), an MRC-funded longitudinal study carried out in schools in Glasgow and its surrounding areas between 1994 and 1999. The '11-16 study' aimed to investigate the health problems, and factors influencing the health, of children and adolescents living in and around Glasgow. School pupils were administered surveys at ages 11 (final year of primary school), 13 and 15 (second and fourth years of secondary). The surveys questioned them on health, health behaviours and various factors which may have an influence on their health, such as socioeconomic circumstances, family life,

peer relationships and lifestyles (West and Sweeting 1996). During the completion of each survey, participants were asked to report which of a variety of 'physical' and 'malaise'² symptoms they had suffered within the past month (Table 1.1 lists these symptoms).

Not only did the results of the '11-16 study' refute assumptions that people within this age group generally have very few health complaints (Sweeting and West 1998); they also highlighted how symptom reporting rates fluctuate according to age and gender. The general trend was that age-related increases in symptom reporting rates were more marked for girls than for boys. Table 1.1 provides a summary of these findings.

Table 1.1 Percentage of girls and boys reporting symptoms in the last month
Source: (Sweeting and West 2003a, p.35)

	Males			Females		
	Age 11	Age 13	Age 15	Age 11	Age 13	Age 15
'Physical' Symptoms						
Headache	47.7	61.6	63.4	57.7	70.4	80.6
Stomach ache	56.4	59.3	52.4	65.8	75.1	77.7
Cold/flu	51.8	57.0	58.3	62.7	66.0	63.2
Aches	38.9	49.2	53.6	32.8	45.8	53.9
Spots/rashes	20.5	32.4	46.9	30.7	46.4	50.9
Dizzy/faint	20.7	24.4	25.9	17.7	28.7	36.8
Asthma/wheeze	18.6	21.6	18.9	15.1	17.1	19.3
'Malaise' Symptoms						
Nervous/worried	38.6	42.7	49.6	44.9	60.5	69.8
Irritable	43.3	43.9	48.7	37.6	51.8	62.2
Sad/unhappy/low	32.9	32.0	32.1	36.9	49.1	55.7
Sleep problems	38.4	31.7	35.2	35.7	34.5	47.7

² When referring to symptoms of a more psychological nature which featured in both the '11-16 study' and the current study, the term 'malaise' is used and inverted commas denote an awareness of the difficulty in drawing a definite distinction between 'physical' and 'malaise' symptoms. As many other studies referred to here, and in Chapters 2 and 3, investigate gender differences in relation to more serious psychological conditions, such as depression or anxiety disorders, the term 'psychological' will be used when discussing the wider literature.

Analyses of these findings, via 95% confidence intervals and logistic regression, showed that, for boys, statistically significant increases occurred in reporting rates of headaches and aches between ages 11 and 13, of nervousness between 13 and 15, of colds and flu between 11 and 15, and of spots or rashes at each age. Decreases were evident in boys' rates of difficulty sleeping between 11 and 13, and of stomach aches between 13 and 15. For girls, rates of headache, aches, dizziness, nervousness, irritability and sadness increased significantly at each age, whereas stomach aches and spots or rashes increased between ages 11 and 13, and difficulty sleeping between 13 and 15. In terms of gender differences, analyses showed that any male excesses in reporting at age 11 (aches, asthma and irritability) had disappeared by age 15 and no male excesses emerged during this time. In contrast, increases in gender differences occurred in symptoms for which female excesses were already evident at age 11 (headaches, stomach aches, nervousness and sadness) and a female excess emerged in respect of dizziness, irritability and difficulty sleeping. Only colds or flu and spots or rashes showed a reducing female excess between 11 and 15 years (Sweeting and West 2003a). Increases in symptom reporting which occurred with age were greater for girls than they were for boys and other recent research is consistent with these findings (Haugland, Wold et al. 2001a; Hetland, Torsheim et al. 2002; Torsheim, Ravens-Sieberer et al. 2006).

1.2 Aims and research questions

The changing gender patterns evident in the symptom reporting rates of the '11-16 study' provide the central "intellectual puzzle" (Mason 2002, p.13) for the current study and its main aim is to develop a deeper understanding of these trends. Although gender differences in the health of children and adolescents have been found in relation to a range of measures, including both the prevalence of various conditions and disorders as well as self-assessed health status, this study focuses specifically on understanding gender differences in relation to symptom experiences and symptom reporting. The rationale for this focus is based mainly on matters of practicality and specifically the idea that because symptoms are perhaps the most visible and tangible predictors of ill-health, talking to boys and girls about their experiences of, and reactions to, a range of symptoms provides the most concrete way of eliciting their ideas with regards to health and illness. In addition, a specific focus on symptoms is warranted because little is known about how children and adolescents understand

symptom checklists which are designed by adults and used to measure and compare boys' and girls' levels of symptom experiences. Thus, investigation specifically focuses on the ways in which boys' and girls' symptom reporting may be influenced by their perceptions of societal gender- and age-related expectations, their conceptualisations of symptoms, and the social context of symptom experiences. The research questions used to guide the investigation reflect these main areas of enquiry:

- 1: Do gender- and/or age-related expectations influence boys' and girls' illness behaviours and symptom reporting?
- 2: Are there gender and/or age differences in the ways that boys and girls conceptualise symptoms?
- 3: Are there gender and/or age differences in how boys and girls decide whether or not to report symptoms in different social contexts?

It is important, at this point, to note the philosophical and theoretical foundations which have influenced me³ in designing, conducting and writing up this research. In line with researchers who promote the sociology of childhood (Mayall 1996; Pole, Mizen et al. 1999; Roberts 2000; Scott 2000), a central concern was to design and conduct the research whilst recognising children and adolescents as active social agents who are capable of interpreting their experiences and enabling them to express their opinions in their own words. Social constructivist theories were also very influential in informing my understanding of 'childhood' and 'adolescence' as socially constructed and historically bound concepts which are used to describe the early stages of the life-course. West and Zimmerman's (1987) conceptualisations of gender as a social construction were also key in developing my thinking around the ways in which gender is 'achieved' in everyday life and these ideas were crucial in helping me position the empirical findings of this research within a theoretical framework.

³ The majority of the thesis is written in the third person narrative voice, but when talking about my personal experiences and choices as a researcher I have used the first person.

1.3 Thesis outline

Chapter 2 begins by reviewing the literature on gender patterns found in the ill-health and symptom reporting rates of children and adolescents. The main purpose of the chapter is to set the theoretical context for an investigation of the factors influencing these patterns and this is done by taking a historical approach in tracing the development of theories of gender and adolescence. These theories are then brought together as the chapter closes by considering the ways in which adolescence is a particularly salient time for the development of young femininities and masculinities.

Chapter 3 continues the review of literature by concentrating on the possible explanations for the gender patterns found in the symptom reporting rates of children and adolescents. Explanations of a biological, sociological and methodological nature are each considered in turn. The chapter draws to a close by highlighting areas of the literature which require further investigation and which this study aims to address.

Chapter 4 provides an exploration of the methodological considerations taken into account whilst designing this study and details the empirical research conducted, from early ethical procedures to the specific methods used. Also included are reflections on the experience of conducting research in schools. The main aim of the chapter is to give the reader an accurate impression of the empirical research which was conducted and a clear understanding of the rationale behind this.

Chapters 5, 6 and 7 present the main findings of the study. The first of these chapters explores the ways in which the illness behaviours of children and adolescents may be affected by societal gender- and age-related expectations and stereotypes. Chapter 6 examines the ways in which symptoms are conceptualised by boys and girls of different ages. Chapter 7 investigates the factors considered by boys and girls of different ages when deciding whether or not to report symptoms in different social contexts.

Chapter 8 discusses the main findings of the study in relation to previous research and current social theory. As well as considering the strengths and limitations of the study, this chapter outlines the main conclusions and discusses their implications for policy and future research.

Chapter Two: Setting the theoretical context: gender and the child-adolescent transition in relation to health

2.1 Introduction

This chapter gives an overview of the literature which has described gender differences found in the ill-health and symptom reporting rates of children and adolescents. Following on from this, a wider discussion of the literature on gender, adolescence, and young masculinities and femininities is provided as a means of setting the broad theoretical context of this study, before Chapter 3 picks up the focus on gender differences in symptom reporting rates across the child-adolescent transition and by considering a number of explanations for these patterns.

2.1.1 Search strategy

The literature discussed in this and the following literature chapter was searched for and selected in a number of ways. Initially, in order to learn more about the gender differences in child and adolescent health and any proposed explanations for these, I ran searches in the Web of Knowledge, Medline and PsycINFO databases for any articles published whose titles or abstracts featured the following keywords (various combinations were searched): young person, child, teenager, adolescent, adolescence, boy, girl, gender, sex, difference, health, illness, symptom, unwell, behaviour, report, self-report, express, display, disclose, headache, stomach, pain, mental and emotional. A coding sheet was used to screen abstracts and help decide which articles were relevant. The main selection criteria were that articles presented data on child and adolescent health, symptom reporting and/or illness behaviours which had been analysed for differences and/or similarities according to gender and/or age. Upon reading selected articles, additional articles or books deemed relevant to the topic were retrieved using bibliographic details. At this stage, additional keywords were also used to run more searches in order to investigate areas which original searches did not take into account. These included: peer, friend, coping, stigma, puberty, menarche, periods, menstrual, expect, anticipate, masculine and feminine. These initial searches yielded the bulk of the literature presented in the literature review chapters.

More generally, various types of books, from general textbooks to those specifically theory-based, were retrieved by searching departmental and university library catalogues using keywords such as gender, gender theory, symptoms, illness, children, and so on. Additionally, some of the articles and books referred to were recommended by colleagues. It is hoped that both the targeted and more general search strategies used have led to a broad ranging but sufficiently detailed reading of the literature.

2.2 Gender differences in health in childhood and adolescence

Sweeting's (1995) review of research findings on gender differences in child and adolescent health represents one of the first and most comprehensive reviews of its kind. In examining and summarising the findings from a broad range of research on the physical health, psychological well-being and health service utilisation of those aged between 7 and 15 years, the review provides evidence of a 'gender reversal' in the distribution of ill-health across the transition from childhood to adolescence. Significantly, Sweeting notes that "female excess morbidity is smallest" (p.77) prior to adolescence, highlighting childhood as being when the gap between male and female morbidity is smallest. Gender and age differences in rates of asthma are referred to in the review as one example of this reversal in physical health. It is documented that in children less than 10 years old, rates of asthma are highest among boys but by adolescence boys' and girls' rates converge and after this time higher rates of asthma are often found among girls. A similar picture is presented in relation to psychological well-being; overall rates of psychiatric disorders are more prevalent amongst boys until early adolescence, however the referral rates for girls with psychiatric disorders have been found to rise after 12 years of age and exceed those of boys by age 15-16 (Sweeting 1995).

Since this review, little has been written specifically on the 'gender reversal' in child and adolescent health. However, studies which include children as young as 10 and 11 years old have found evidence of this pattern. For example, one survey of children aged between 11 and 16 found no significant differences in boys' and girls' rates of reporting physical symptoms in the youngest age groups (11-13 years), but thereafter, significant gender differences emerged, with girls reporting significantly more symptoms than boys (Eminson, Benjamin et al. 1996). A study investigating age

trends in the prevalence of major depressive disorder among children and young people aged between 10 and 20 years found similar patterns in that late childhood was characterised by low and comparable prevalence for boys and girls, but “the immediate post-puberty years”, between 12 and 13, featured a sharp increase in prevalence among girls (Cohen, Cohen et al. 1993). Therefore, such studies also provide evidence of a reversal in the male-female patterning of illness as they show the ways in which boys’ higher morbidity rates are replaced by girls’ during the transition from childhood to adolescence.

The emergence of female excess morbidity during adolescence is increasingly becoming recognised as a central feature of adolescent health in “a large proportion of the world’s industrialised countries” (Torsheim, Ravens-Sieberer et al. 2006, p.823). Surveys including children and adolescents aged between 11 and 16, which have been conducted in up to 29 European and North American countries using the Health Behaviours in School-aged Children (HBSC) or similar symptom checklists, have reported comparable patterns of an overall emerging and increasing excess in girls’ rates of reporting physical and psychological symptoms (Eiser, Havermans et al. 1995; Eminson, Benjamin et al. 1996; Haugland, Wold et al. 2001a; Hetland, Torsheim et al. 2002; Watson, Papageorgiou et al. 2002; Sweeting and West 2003a; Torsheim, Ravens-Sieberer et al. 2006). It is therefore important to investigate and gain a deeper understanding of this widespread phenomenon which suggests that a deterioration of girls’ physical and psychological well-being takes place during adolescence.

2.3 Background theories

The following sections discuss the broader theories which feature in the research around gender, adolescence, and young masculinities and femininities, and which can be used to inform our understanding of gender differences in health during the child-adolescent transition.

2.3.1 Gender: biological and sociological accounts

This section is by no means an attempt to write a comprehensive history of the development of gender theories. However, drawing on general textbooks and secondary sources, I have attempted to trace the main debates so as to provide a broad

description of the way in which theoretical understandings of gender have developed. As I go on to talk in more detail about specific theories, such as the social construction of gender or embodiment theory, I refer to and quote from primary sources which were used to help develop my thinking.

At the beginning of the Twentieth century, Western society's understandings of the relations and perceived differences between men and women were conceptualised by an approach known as 'biological determinism', sometimes also referred to as 'biological essentialism' (Stainton Rogers and Stainton Rogers 2001; Whitehead 2002). Within this model, physical differences between women and men, and their different roles in the reproductive system, were used to construct a biological basis to explain characteristics and traits, such as men being 'rational' and women 'irrational', which were seen as 'essential', 'fixed' and 'true' of every man and woman (Sharpe 1976; Fausto-Sterling 1985; Kessler, Ashenden et al. 1985; Moynihan 1998). Following on from these assumptions, the relations between men and women, and their traditionally differing roles in society, were rationalised as being dictated by biology and necessary in order for society to function whilst accommodating the different personalities and aptitudes of men and women (Sharpe 1976; Fausto-Sterling 1985; West and Zimmerman 1987; Hoffman and Hurst 1990; Connell 1995; Stainton Rogers and Stainton Rogers 2001; Whitehead 2002). Whitehead (2002) uses the term "biology is destiny" (p.9) to encapsulate one of the key concepts of this model which is that, from birth onwards, biology determines every aspect of people's lives.

The anthropological work of Margaret Mead and Ruth Benedict in the 1920s and 1930s first challenged the central tenets of biological determinism by highlighting that other cultures exist without the same divisions of labour and strictly defined roles for men and women (Sharpe 1976; Stainton Rogers and Stainton Rogers 2001). Such research suggested that what it means to be a man or a woman is not biologically defined but is influenced by cultural expectations as to the ways in which men and women should behave. These ideas led theorists, when discussing the differences between women and men, to begin drawing less from biological and more from sociological discourses. Indeed, in the 1950s, Talcott Parsons rejected biological determinism and was among the first, through his theory of structural functionalism, to view the differences between men and women as social practices and customs

which have evolved because they “benefit the cohesion and smooth working of social groups and communities” (Stainton Rogers and Stainton Rogers 2001, p.42). Therefore, instead of viewing social structures as responsive to and created by biological differences between men and women, he suggested that their differing social roles are created as, from a young age, boys and girls are socialised to take on and internalise appropriate and complementary roles which will maintain their different positions in, and the overall workings of, the social system (Goffman 1977; Kessler, Ashenden et al. 1985; Charles 2002). As Connell (2000, p.7) puts it:

[sex] roles were understood as patterns of social expectation, norms for the behaviour of men and women, which were transmitted to youth in a process of ‘socialization’.

Within this model, therefore, the maintenance of men and women’s differing roles was attributed mainly to the motivations and actions of individuals in living up to the roles that they had been taught (Kessler, Ashenden et al. 1985).

During the 1970s, second-wave feminist theorists radicalised Parson’s claims as they sought not only to elucidate but also to change the ways in which sex role socialisation was resulting in the perpetuation of differential sex roles and, in turn, sexual inequality and exploitation of women in society (Sharpe 1976; Hoffman and Hurst 1990; Connell 2000; Howson 2005). Indeed, Goffman (1977, p.302) argues that:

...the chief consequence of the women’s movement is not the direct improvement of the lot of women but the weakening of the doctrinal beliefs that heretofore have underpinned the sexual division of deserts and labor.

In particular, the entrenched ideologies that society is organised around the dictates of biology and that the consequent inequalities between men and women exist for the common good were weakened. In place of these ideas, feminist activists and pro-feminist theorists argued that social structures, such as the labour market or political systems, are designed by dominant groups, mainly men, to privilege men, to subordinate women and to fix each in these positions whilst reinforcing the ideology that this is the ‘natural’ state of affairs (Sharpe 1976; Connell 2000; Howson 2005;

Young 2005). Annandale and Clark (1996, p.19) define the importance of these ideas for health as they state that:

...patriarchy privileges men by taking the male body as the 'standard' and fashioning upon it a range of valued characteristics (such as good health, mastery, reason and so on) and, through a comparison, viewing the female body as deficient, associated with illness, with lack of control and with intuitive rather than reasoned action.

They highlight one of the goals of feminism as being the identification and destabilisation of ideas which draw on biological frameworks to "construct the female body as inferior" (p.19).

As it became a more widely accepted concept, that the societal roles of men and women do not stem directly from their biological make-up, there became a need to develop language which could be used to differentiate between references to male and female as either biological or social distinctions. 'Sex' came to be the term used to refer to the "determination made through the application of socially agreed upon biological criteria for classifying persons as male or female" (West and Zimmerman 1987, p.127) or, put simply, the sex categories of male and female became used to differentiate between men and women on the basis of what were at one time thought to be irrefutable and unchanging biological differences between the two. 'Gender', on the other hand, became the concept used to refer to the socially and "culturally constructed notions of masculinity and femininity" (Emslie, Hunt et al. 1999, p.34). Thus, 'gender' represents the lived social and cultural aspects of what is expected of, what it means to be, and what it takes to live as a man or a woman. In addressing the relationship between the concepts of 'sex' and 'gender', Goffman (1977) described 'gender' as society's way of elaborating on sex-class- or sex category-based distinctions by subjecting males and females to "differential socialization" (p.303). However, both the distinction between 'sex' and 'gender', and theories of sex role socialisation came to be considered problematic. To name but a couple of criticisms in each case, the distinction between 'sex' and 'gender' has become less useful because the terms are often used interchangeably, thus losing their meanings and values as different concepts (Emslie, Hunt et al. 1999; Kirkpatrick 2003). In addition, the link between 'sex' as a biological fact and 'gender' as the social embodiment of attitudes and behaviour appropriate to one's sex category came to be seen as too

simplistic with the recognition that people's sex category and gender identity can be at odds with one another, such as is the case for transsexuals (West and Zimmerman 1987; Emslie, Hunt et al. 1999). Sex role and socialisation theories were criticised for depicting children as merely passive adopters of norms and expectations (Bem 1983; Connell 2002), for conceptualising masculine and feminine gender identities as singular and not plural in form (Connell 1995) and also for neglecting to recognise gender roles and relations as power relations (Charles 2002). These are short-comings which social constructivist and post-modernist theorists attempted to address.

A seminal example of social constructivist gender theory is West and Zimmerman's 'Doing Gender' (1987). In this paper, the authors redefine the concept of gender by rejecting notions that this represents a role which is passively learnt and adopted, and instead arguing that gender is a status which is 'achieved' as it is 'done' in all social interactions by all those involved. To elucidate this concept further, it is useful to draw on extracts from the original paper:

When we view gender as an accomplishment, an achieved property of situated conduct, our attention shifts from matters internal to the individual and focuses on interactional and, ultimately, institutional arenas [...] We argue instead [of adopting gender roles] that participants in interaction organize their various and manifold activities to reflect or express gender, and they are disposed to perceive the behavior of others in a similar light [...] If we do gender appropriately, we simultaneously sustain, reproduce, and render legitimate the institutional arrangements that are based on sex category. If we fail to do gender appropriately, we as individuals – not the institutional arrangements – may be called to account (for our character, motives and predispositions). (pp. 126, 127 & 146).

According to this conceptualisation, gender is something which people do, both consciously and subconsciously, as they present themselves to, and interact with, others. Thus, gender can be seen as a status which, instead of being ascribed, individuals have a degree of control over, yet whose achievement also depends on the reactions and interpretations of others. Drawing on Goffman's ideas of "essential nature" and "gender display", the authors discuss the ways in which individuals assume that others have essential sexual natures and learn both to demonstrate and identify these using conventionalised masculine and feminine gender displays. It is through compliance to the rules and norms considered conventionally masculine or

feminine, or gender-appropriate, that boys and girls, men and women create and reinforce the ideology of essential gender differences and distinct gender roles in society. If the rules are flouted, however, and an individual engages in behaviour not normatively associated with their gender, they will challenge the gender order and idea of essential sexual natures, and in turn risk being perceived as 'unnatural' (West and Zimmerman 1987).

By highlighting knowledge and identity as being culturally and historically constructed (Stainton Rogers and Stainton Rogers 2001), social constructivist theorists also brought about the idea that the formation of gender identities is subject to "the interplay of gender with race, sexuality, class and nationality" (Connell 2000, p.8). Connell draws on this and post-modernist concepts and, instead of advancing the idea that singular, 'true' forms of masculinity and femininity exist, he constructs a relational approach to Western society's gender order which draws out the linkages between men and women whilst also highlighting the plurality of masculinities and femininities, and how they are related. In doing so, he draws attention to the overall subordination of women by men (power relations), the gender divisions in the labour market which also favour men (product relations), Western models of heterosexual love which marginalise homosexual relationships (emotional relations), and the symbolic oppositions inherent in cultural images and language which serve to dichotomise men and women (symbolic relations). Most significantly, Connell's work concentrates on theorising the social construction of masculinity and highlighting that there exists not one, but multiple forms and that power relationships exist between masculinities, especially those perceived as hegemonic and those seen as subordinate.

In line with Connell's ideas, it is no longer popular to conceive of gender in terms of the simply defined, distinct and fixed categories of masculine and feminine. Accordingly, Kirkpatrick (2003) argues that "[g]ender cannot be described by a check mark on a questionnaire!" (p.560). Instead, a wide range of social institutions and processes, from the family to the state, have been identified as contributing to the construction of "a complex differentiation of people around the axes of masculinity and femininity" (Kessler, Ashenden et al. 1985, p.44). Thus, gender identities have come to be viewed as fluid states of being which are influenced by historical, social

and cultural factors and achieved as individuals adapt to these changing influences by drawing on different aspects of masculinity and femininity (Kessler, Ashenden et al. 1985; Moynihan 1998; Connell 2000; Kirkpatrick 2003).

A consideration of embodiment theory is also important, especially when relating the lived and material aspects of the body, such as experiences of pain or illness, to the construction of gender identities. Many researchers who contribute to embodiment theory have drawn on Foucault's conceptualisations of discourses as having the power to "bring into existence the phenomena they are apparently describing" (Alsop, Fitzsimons et al. 2002, p.167) and have used these ideas to suggest that gendered bodies are moulded and disciplined according to what social discourses construct as ideally masculine or feminine, with "trouble" arising if bodies appear to be at odds with these norms (Connell 2000; Alsop, Fitzsimons et al. 2002; Whitehead 2002; Howson 2005). Research has highlighted the ways in which men and women strive to regulate their bodies in order to construct themselves as acceptably masculine or feminine; diet, exercise, clothing and comportment are but a few of the means highlighted as being used in the construction of gender identities and gendered bodies (Connell 2000; Alsop, Fitzsimons et al. 2002). This presents a view of gendered bodies as being socially constructed instead of biologically determined. Indeed, within this conceptualisation, the body is viewed as "a product", an inscribable surface disciplined and carved whilst under the critical gaze of dominant ideologies (Whitehead 2002; Howson 2005). The suggestion is that there is nothing inherent to the body which contributes to the achievement of masculinity or femininity (Alsop, Fitzsimons et al. 2002).

Recently, however, embodiment theory has been criticised for only conceptualising the body's surface as a social creation whilst the influence of the internal workings of the body are ignored and, by implication, constructed as "presocial" (Birke 2003). Some have argued that a new dialogue is needed between the sociological and biological, or constructivist and essentialist viewpoints, and that such a dialogue should highlight their interrelatedness instead of their dualisms (Fausto-Sterling 1985; Alsop, Fitzsimons et al. 2002; Howson 2005). For example, Fausto-Sterling (1985, p.8) is among those who have called for:

...a more complex analysis in which an individual's capacities emerge from a web of interactions between the biological being and the social environment. Within this web, connecting threads move in both directions. Biology may in some manner condition behavior, but behavior in turn can alter one's physiology.

This "more complex" understanding of the inter-connections between the biological and the social appears especially important in examining the ways that health and illness are experienced, embodied and incorporated into constructions of masculinity and femininity (Birke 2003; Fausto-Sterling 2003). Indeed, Alsop and colleagues (2002, p.170) highlight a short-coming of conceptualising the body as wholly socially constructed when they highlight the impact of illness on the body. Specifically, they draw attention to:

...the apparent bruteness of some bodily facts which no social modifications seem to allow us to conceptualize away. Arms and legs cannot work, and pain is part of the daily reality for many.

Thus, theories around the embodiment of gender need to incorporate the materiality of bodies and consider the ways in which injury or illness might subsequently affect the construction of gender identities and subjectivities. For example, when considering the male body in relation to health and illness, Moynihan (1998, p.1074) states that "health is inextricably tied up with the image of the perfect man" and implies that illness threatens men's constructions of their bodies as masculine or "machines" which they can always control. Although not an illness, menarche can also be seen as a way in which functions of the biological body impact upon, and bring about significant changes to, girls' understandings of their embodied femininity (Prendergast 2000). If studies of the body take both their material and representational aspects into account, this could provide a way of studying the embodiment of gender identity which does not revert to binaries of biology and sociology (Howson 2005; Robertson 2006).

In relation to gender differences in health, the debates outlined so far have played an important part in advancing explanations based solely around biological and anatomical differences, to considering the impact of social roles and gender identities on the body, as well as addressing the impact of the body on social roles and gender identities. However, it is perhaps time, especially in relation to the gendered

embodiment of health and illness, that the dualistic and dichotomous ways of conceptualising gender, as either a product of biology or society, are put aside whilst a more dynamic and holistic approach is taken to investigating the ways in which biological bodies are also experienced as gendered. Without reverting to biological determinism, 'biology', as the socially and culturally embedded study of living organisms, cannot and should not be completely rejected as contributing to our understandings of gender differences in health (Wizeman and Pardue 2001; Annandale 2003; Birke 2003; Rutter, Caspi et al. 2003). Nevertheless, as it has been suggested that there "is no such thing as a pure biological effect" and the 'biology' of individuals "includes genetic, physiological, and hormonal effects as well as the environmental, behavioural and societal influences that shape [those individuals]" (Wizeman and Pardue 2001, p.14), it is important when investigating the possible causes of gender differences in health that the social and biological are conceptualised as mutually influential factors.

2.3.2 Conceptualisations of the child-adolescent transition

'Childhood' and 'adolescence' are concepts used to represent the earliest stages of the life-course and age is most commonly used as an indicator of an individual's status along this trajectory. The World Health Organisation, for example, defines 'adolescence' as the stage between ten and twenty years of age (Viner and Barker 2005), thus suggesting that 'childhood' ends at nine, and 'adulthood' begins at twenty-one, years of age. However, transitions between different stages of the life-course, which are in themselves socially constructed and shifting concepts (James and Prout 1997), are not as determined or neat as this implies. Indeed, the use of age to classify individuals as either 'child' or 'adolescent' has been criticised for implying that the definitions and experiences of childhood and adolescence are universal and timeless whereas in reality they vary across time and space as well as according to culture (Brannen 1996; James and Prout 1997; Prout and James 1997; Christensen and James 2000a). This section looks at the changing ways in which adolescence has been conceptualised by Western societies.

Academic conceptualisations of adolescence date back to the early 1900s and the work of G. Stanley Hall. Using the onset of puberty as marking the beginning of adolescence, his understanding of this age stage was rooted in biological determinism

and depicted adolescence as a period of turmoil made necessary by biological changes, which came to be conceptualised as ‘storm and stress’ (Oldham 1978). It is said that Hall compared infancy, childhood and adolescence to the primitive nature of pre-historic cultures and likened the progression towards adulthood to that of such primitive cultures towards the “pinnacle of civilized life” (Griffin 1993, p.16). These early conceptualisations have informed psychological understandings of adolescence which are rooted in the importance of biological events for individual development (Brannen, Dodd et al. 1994; Williams 2002). These understandings of the meaning and experience of the child-adolescent transition as biologically determined contributed to this life-stage being constructed as a scheduled progression which is universal and unchanging (Brannen 1996; Christensen and James 2000a).

However, conceptualisations of adolescence began to change as anthropological research conducted in the 1920s and 1930s, in particular Margaret Mead’s study of the peaceful transition of Samoan teenagers to adulthood, contradicted the idea that biological changes cause all adolescents to go through a period of ‘storm and stress’, and instead highlighted the impact of social and cultural influences in mediating the experience of adolescence (Oldham 1978; Griffin 1993). Just as with the changes in debates around gender, adolescence came to be understood as a socially and culturally bound experience, rather than one which is purely biologically determined. A good example of the potential for social shifts to impact upon the experience of adolescence is provided as Brannen (1996) highlights that increases in youth unemployment, mainly among working class young people, have resulted in the prolonging of adolescence as entry into the more ‘adult’ world of work is delayed.

As a result of shifts in the conceptualisation of adolescence, sociological considerations of adolescence tend to place a greater emphasis on investigating the influence of the social and structural, rather than the biological, context of youth. In their review of the literature on adolescent development, Steinberg and Morris (2001) note that the focus on psychological and psychosocial development during adolescence has waned considerably as attention has turned to social and contextual influences and has resulted in a collection of “mini-theories” or frameworks which depict small pieces of the larger picture of adolescence. However, Griffin (1993) seems to welcome these changes as she highlights the way in which the ‘storm and

stress' model "submerged relations of sex/gender, 'race' and class behind the raging hormones theory of adolescence" (p.22) and implies that as well as having overarching concepts of 'youth' it is helpful to construct young people as "racialized, gendered and sexualized beings set in specific class positions" (p.1). Indeed, some authors have rejected biological models of adolescence to such an extent that they have claimed that:

...the 'turmoil' caused by bodily changes in 'adolescence' does not exist independently of the discourses and their attendant social practices which mark this as a significant (and easily identifiable) stage in a person's development towards adulthood (Epstein and Johnson 1998, p.152).

However, just as it is unwise to omit the biological from understandings of gender, we should also exercise caution against "cultural determinism" whereby attempts are made to deny any and all effects of our biological and physical bodies on our experiences as social beings (Timpanaro 1975, cited in Prout and James 1997). Therefore, current and future conceptualisations of adolescence would benefit from exploring an 'and/both' instead of an 'either/or' approach when considering the impact of biological and social factors on experiences of adolescence. Having outlined the development of theories around gender and adolescence, the next and final section in this chapter brings these together by exploring the ways in which adolescence is an especially salient time for the construction of gender identities.

2.3.3 Young masculinities and femininities: growing up gendered

The first step in the formation of gender identity occurs at birth, and even prior to this, as babies and unborn foetuses, on the basis of their genital anatomy or chromosomes, are labelled either male or female. However, gender identity is not defined simply with the giving of this label; on the contrary, gender identities are continually shaped and produced in all social situations from the family to the peer group, and from school to the workplace (Goffman 1977; Kirkpatrick 2003). Throughout life, gender remains one of the most socially significant attributes that an individual is ascribed and one of the most complex arenas they will be required to negotiate. Adolescence is a particularly important time for the development of gender identities. During this period clearer gender identities are formed as the physical and physiological changes of puberty take place at the same time as distinction is marked between boys and girls by means of the differing social expectations placed on them (Burke and Weir 1978).

To begin looking at the ways in which children form gender identities, it has often been suggested that they learn to take on gender roles and gender-appropriate behaviour as these are taught to them within the family context by parents and siblings (Goffman 1977; Kessler, Ashenden et al. 1985; Stainton Rogers and Stainton Rogers 2001). This is commonly known as the theory of socialisation and it is based on the idea that children follow social cues in order to learn and internalise the gender-specific ways in which they are expected to behave. For example, they may be encouraged to adopt gender-appropriate behaviour and either ignored or reprimanded for gender-inappropriate behaviour (Holstein-Beck 1995; Eisenberg, Cumberland et al. 1998).

Although it should be acknowledged that parents' views and behaviour can contribute to their children developing essentialist understandings of gender (Frosh, Phoenix et al. 2002; Gelman, Taylor et al. 2004), on the whole, socialisation theories have been widely criticised for casting children as wholly passive in the absorption of gender identities and for constructing mothers as predominantly responsible for teaching gender roles (Bem 1983; Thorne 1993; Holstein-Beck 1995; Connell 2000; Stainton Rogers and Stainton Rogers 2001). Instead of being seen as the passive receivers of socialisation, children and young people are now more commonly conceptualised as active participants in the construction of their gender identities, their cognitive processes searching for and making sense of gender-related cues present in their social environments, allowing them to regulate and construct their gender identities accordingly (Thorne 1993; Epstein and Johnson 1998; Duncan 1999; Frosh, Phoenix et al. 2002; Gelman, Taylor et al. 2004; Martin and Ruble 2004; Montgomery 2005). In terms of cognitive processes, research has found that children's understandings of gender go through developmental changes which mean that the rigidity of their gender-related beliefs and the degree to which these are influenced by essentialist ideas increase until they reach a peak at around age seven, and from then on decrease with age (Martin and Ruble 2004; Montgomery 2005). This means that as children get older, their ideas about gender become more sophisticated and instead of believing that gender is innate and there are specific traits which only boys or girls have, their understandings begin to incorporate flexibility and allow for similarities between boys and girls as well as for differences within the categories of male and female. The processes behind these cognitive developments are not yet clearly understood (Martin

and Ruble 2004), therefore the remainder of this section looks in more detail at the ways in which gender identities can be constructed, both actively and passively, within the social contexts of the school, the peer group and transitions to the world of work.

Schools have been described as “society in microcosm [whose] purpose is to achieve the values and ideologies dominant in society” (Askew and Ross 1988, p.106). In support of this idea, recent ethnographies and research projects conducted within schools have highlighted the active part which they, as physical settings and structures of systems and rules, play in producing and affirming dominant definitions of masculinity and femininity as oppositional and dichotomous (Kessler, Ashenden et al. 1985; Mac an Ghail 1994). Indeed, traditional gender roles have been described by some as embedded within the school system, be this formally as in the gendered divisions in the allocation of staff, or symbolically as differences in school uniform denote and reinforce the ideology that ‘essential’ differences exist between boys and girls (Kessler, Ashenden et al. 1985; Thorne 1993; Connell 2000). Schools have also been said to work under the “presumption of heterosexuality” (Epstein and Johnson 1998, p.153), as sex education is generally based around discourses of heterosexual reproduction, and the result is that heterosexual masculinity and femininity are naturalised whilst the possibility of homosexual gender identities is at best ignored and, at worst, condemned (Mac an Ghail 1994; Epstein and Johnson 1998; Young 2005).

Thus, both gender and sexual identities are seen as being policed by school rules and systems and, overall, the literature depicts schools as being extremely powerful in constructing the types of masculine and feminine identities available to pupils. Kessler and colleagues (1985) provide an example of this power as they highlight the way that changes in education for girls, such as the increased emphasis in the curriculum on academic competition and achievement over preparations for domesticity, have resulted in the construction of new models of femininity which make it possible, or even desirable, for young women to integrate professional careers with the demands of marriage and motherhood. The repercussions of these new models of femininity are discussed later in this section.

Research has also identified the ways in which some pupils manage to construct alternative gender identities in spite of and in conflict with school systems (Thorne 1993; Duncan 1999; Connell 2000). As examples of this, Kessler and colleagues (1985), Connell (2000) and Swain (2004) each highlight ways in which aggressive forms of masculinity are constructed as boys react angrily to school-enforced restrictions, rules and expectations which they believe to be unfair. Maintenance of this tough form of masculinity is achieved by publicly challenging and defying school rules and authority figures. The construction of such resistant masculinities highlights the agency of individuals, albeit limited at times, to create their own gender identities whilst adapting to the constraints of their immediate environment. The types of gender identities available have been found to vary from one school to another in accordance with the gender regime, that is the gender relations and hierarchies built into each school's rules, routines, and culture, which is in operation at any one time (Kessler, Ashenden et al. 1985; Gilbert and Gilbert 1998; Swain 2004).

Researchers who have investigated the workings of boys' peer groups have described them as competitive and unsupportive environments (Askew and Ross 1988; Frosh, Phoenix et al. 2002). Membership of a peer group is seen as a social 'must' for boys, and entry into a popular group often relies on evidence of typically masculine attributes, such as 'hardness' and sporting prowess, and, in turn, serves to boost boys' constructions of themselves as occupying high positions in the masculine hierarchy (Duncan 1999; Frosh, Phoenix et al. 2002; Swain 2003; Swain 2004). Boys' peer groups have been conceptualised as having their own gender regimes which are collectively negotiated and projected by means of various gendered performances that draw on a variety of cultural resources. Among these resources, authors have highlighted the importance of being sporty or athletic, acting tough or hard, using humour or wit, having a fashionable image, and being knowledgeable in culturally esteemed topics, such as football or computer games (Mac an Ghail 1994; Connell 2000; Frosh, Phoenix et al. 2002; Swain 2003; Swain 2004). Of the resources which can be drawn upon to produce gendered performances and in turn construct masculine identities and hierarchies, that viewed as most crucial is the projection of the body as physically superior and athletic (Connell 2000; Swain 2003; Swain 2004). Swain (2003) highlights the ways in which hierarchies of physicality are created by and between boys as they constantly classify and rank one another in terms of football

skills, speed, bodily strength and endurance in physical fights. On the whole, success in any or, indeed, all of these 'skills' is interpreted as a key signifier of "successful masculinity" (p.302) and as such leads to high peer group status. Thus, the "physical capital of the body" (p.309) can be seen as being used to construct hierarchies of dominant and subordinated masculinities. In particular, admissions of pain or displays of weakness, such as crying or losing a fight, are seen as being reflective of inadequate or even failed masculinities. This demonstrates the importance and agency of boys' bodies in creating masculinities through their actions, rather than enacting innate gender identities (Connell 2000; Swain 2003).

Boys' ritualised forms of humour, including name-calling and retelling others' experiences of humiliation, are also seen as important in regulating masculinities and constructing hierarchies. In effect, the high position of those telling the stories or calling the names are confirmed whilst the behaviour of those being laughed at is policed and punished for having strayed too far from the dominant masculine ideal (Mac an Ghail 1994; Kehily and Nayak 1997; Duncan 1999; Connell 2000; Frosh, Phoenix et al. 2002). Not only are these forms of humour used to embarrass some boys whilst exalting others, Kehily and Nayak (1997) argue that competitive name-calling, or "cussing" matches, are often used by boys to test one another's wit and strength of character. The belief is that only 'real' boys will be able to withstand the insults and terms of abuse thrown at them without giving in or crying. Homophobia is another dominant feature of boys' humour and accusations of being 'sissy' or 'gay' are used specifically to police gender transgressions and departures from the rules of masculinity set out by the peer group (Epstein and Johnson 1998; Duncan 1999; Frosh, Phoenix et al. 2002; Chambers, Tincknell et al. 2004; Plummer 2005).

Within boys' peer groups, femininity and homosexuality are closely associated; both are constructed as 'other' and used as derogatory concepts by which to measure boys' masculinity and with which to shame those who fail to meet even the lowest standards of this (Duncan 1999; Frosh, Phoenix et al. 2002; Plummer 2005). Although the humour used by boys is not always intended to be hurtful and can sometimes be interpreted as bonding relationships between, and promoting camaraderie among, boys (Kehily and Nayak 1997; Blatchford 1998; Swain 2004), overall it is argued that strict adherence to the rituals performed in this context means that boys become

caught in the cycle of “[p]utting others down to keep [themselves] up” (Duncan 1999, p.27). As a result, boys learn not to trust their friends nor to confide to them their anxieties or insecurities lest such attempts at emotional or relational conversations should be construed as signifying weakness or homosexual tendencies (Askew and Ross 1988; Mac an Ghail 1994; Frosh, Phoenix et al. 2002; Swain 2004).

Consequently, the homophobia with which boys’ humour is imbued and the importance which is placed on the physicality of their bodies, both serve to rule out any masculinities other than those viewed as dominant or hegemonic. In turn, boys and young men may be driven towards “extreme masculinities which despite being more dangerous, are...valorised” (Plummer 2005, p.1). Moynihan (1998) highlights similar ideas as she states that Western constructions of masculinity make it hard for boys and men to incorporate illness into their identities or to express any physical or emotional needs. Although boys’ and men’s agency is acknowledged in developing renegotiated or ‘alternative’ versions of masculinity (Mac an Ghail 1994; Epstein and Johnson 1998; Frosh, Phoenix et al. 2002; O’Brien, Hunt et al. 2005; Emslie, Ridge et al. 2006), research also highlights the fact that only a small minority of them seem able to do this (Duncan 1999; O’Brien, Hunt et al. 2005; Emslie, Ridge et al. 2006), which suggests that the majority live within gender identities that have the potential to be physically and emotionally harmful.

Studies of girls’ peer groups depict them as far more likely than boys to invest time in talking and emotional work (Griffiths 1995; Hey 1997; Frosh, Phoenix et al. 2002; Rose 2002). Indeed, Griffiths (1995) claims that the central characteristics of girls’ friendships are physical closeness (displayed through hugging and physical contact), “having a laugh” or having fun, talking (both ordinary talking and “confiding talk” involving the sharing of deeper feelings and inner thoughts), as well as reciprocal loyalty and support. However, girls’ friendships and peer groups have also been found to have ‘rules’ and power relationships which serve to include some girls whilst excluding others. Hey (1997, p.130) suggests that, for girls, belonging to a friendship group requires “the performing of appropriate forms of femininity”. Therefore, ‘doing gender’ in appropriate ways might also be important for membership in girls’ peer groups. Pressures most often referred to in the media and popular culture are

those which dictate that in order to 'fit in', girls should dress fashionably and appear feminine, both in terms of attractiveness and body shape.

The policing of girls' sexual identities is most commonly cited in the literature as one of the ways in which girls' femininity is regulated by their peers (Griffiths 1995; Hey 1997; Duncan 1999; McRobbie 2000; Charles 2002) Within a culture of 'compulsory heterosexuality', which presumes the pursuit of heterosexual love, marriage and motherhood (Griffin 1985; Hey 1997), girls are pressurised to prove their femininity by establishing and maintaining romantic relationships with boys. Girls who fail or choose not to do this risk being labelled "frigid" or "lesbian" and may be seen as 'abnormal' for not succeeding to conform to heterosexuality as one of the norms of femininity. However, if girls are viewed as enjoying their sexuality or as being (too) sexually experienced, they are then branded "slags" or "tarts" and these types of slurs also serve to tarnish their femininity (Griffiths 1995; Duncan 1999; McRobbie 2000; Charles 2002). Indeed, Hey (1997, p.139) suggests that the gossiping and scandalising which can go on amongst girls' peer groups "represents a social strategy strongly motivated by the desire for uniformity amongst group members". It is also important to highlight the double-standard involved in the regulation of girls' sexual identities.

As opposed to boys' social capital being strengthened with the growth of their sexual, and in turn masculine, reputations, the opposite is the case for girls (Duncan 1999; McRobbie 2000; Chambers, Tincknell et al. 2004). As a result of this contradiction, on the one hand the pressures of compulsory heterosexuality and on the other the policing of their sexualities, girls are forced to negotiate a position between being labelled a "slag" and "frigid" in order to be viewed as successfully, or "passively" (Chambers, Tincknell et al. 2004), feminine. In comparison to girls' same-sex friendships and relationships, however, those with boyfriends are portrayed in the literature as being more transient, less intense and perhaps not as important to girls (Griffiths 1995; Duncan 1999; McRobbie 2000; O'Connor 2006). Recent research also suggests that girls may now feel less pressurised by the most traditional forms of compulsory heterosexuality and are placing marriage much further down, or have even struck it off, their list of priorities and life plans (Prendergast and Forrest 1997; Chambers, Tincknell et al. 2004).

The contradiction involved for adolescent girls in becoming sexualised and objectified as a result of bodily changes, but having regulations placed on their sexuality (Griffiths 1995; Duncan 1999; McRobbie 2000) is not the only contradiction which they may have to negotiate during adolescence. Some researchers have constructed adolescence and the forming of feminine identities as being very confusing for girls (Sharpe 1976; Mac an Ghail 1994; Frosh, Phoenix et al. 2002). Hudson (1984), for instance, proposes that the discourses of 'adolescence' and 'femininity' make conflicting demands of young women. She argues that popular images of adolescence, for example of "the restless, searching youth, the Hamlet figure; the sower of wild oats, the tester of growing powers" (p.35), are masculine images which serve to conceptualise this age stage as a time when masculine characteristics are brought to the fore. Thus, she argues that if young women are to satisfy the demands of adolescence they will fail to meet the ideals of femininity, outlined here as involving "the skill to make lasting relationships, with the ability to care very deeply for very few people" (Hudson 1984, p.47). Burke and Weir (1978) make a similar argument as they state that prior to puberty girls are raised with a "bisexual identity", in that they are rewarded for traditionally feminine characteristics but also allowed to participate in masculine activities. During adolescence, however, the demands on girls become contradictory and diffuse as the demands of femininity come to the fore, yet masculine traits are not as strictly prohibited for girls at this time as feminine traits are for boys. It is possible that these uncertainties delay girls' formation of a clear sense of self and mean that they place greater emphasis on their relationships with friends, peers and parents as a means of defining their identities (Burke and Weir 1978).

Contradiction in young women's lives is also seen as arising from the historic changes to their social and economic positions and prospects brought about, in part, by the feminist movement. Although these changes have radicalised the opportunities available to women and have improved their positions in enabling them greater individual freedom and providing opportunities to develop all aspects of their lives, they also represent a burden as many young women strive for economic equality and independence yet feel unable to completely reject the more traditional feminine roles of home-maker and mother (Sharpe 1976; Holstein-Beck 1995). Therefore, attempts to succeed in both these aspects of their lives have the potential to put young women

under greater pressure than they may have experienced in their more traditional feminine roles.

It is perhaps because of these conflicting pressures that numerous studies have found that, as compared to boys, girls are reporting greater levels of psychological distress and these are increasing over time (Burke and Weir 1978; West and Sweeting 2003; Wilson, Pritchard et al. 2005). Recent increases in the emphasis on and expectations of high educational attainment have also been credited as having a negative impact on girls' psychological well-being. Indeed, West and Sweeting (2003) found that deteriorations over time in young people's mental health were more marked in recent years for girls from middle-class (non-manual) and skilled manual backgrounds, and that they were specifically related to girls' worries about doing well at school and in exams. From these findings, the authors suggest that "[f]emales now appear to experience more worries of this sort [school, exams] than their male counterparts and, over time, to have become distressed by the experience" (p.408). These findings therefore support the idea that certain social changes may well have resulted in new stressors and challenges which girls and young women must learn to face (West and Sweeting 2003; Sweeting and West 2003b).

Although historic social changes, such as girls being encouraged academically and being treated more equally in the workplace, have opened up opportunities and provided young women with the choice of traditional or more modern feminine roles, they may also have resulted in there being a clash of old and new expectations, resulting in it having become confusingly unclear as to what now constitutes femininity. In turn, this may make it more difficult for young women to know what is expected of them and how to construct their feminine identities according to changing social trends (Mac an Ghail 1994; Frosh, Phoenix et al. 2002). McRobbie (2000, p.201) reminds us of claims she made in 1994 that the lives of young women:

...were experiencing an unprecedented series of dislocations, their identities were becoming unfixed from what traditionally it meant to be a girl and then a woman. At that time [mid-1990s] it seemed that where women's lives were increasingly characterised by change and by unpredictable futures, the lives of men and boys seemed still more rooted in tradition. This was bound to produce a clash of expectations. Since

then various writers have described how equally unfixed men's lives and boys' futures have become.

McRobbie's concept of the 'clash of expectations' is significant. On one hand it suggests that because men and women, boys and girls now have the same expectations for their lives they are seen as being in competition and the success of one is viewed as heralding the demise of the other (as seems to be the case with claims of a 'crisis of masculinity', discussed below). On the other hand, however, the 'clash of expectations' could be interpreted as only affecting girls and representing the idea that although social and structural changes have opened new opportunities and subject positions for them, girls and women are also still influenced by "old gender discourses" (Bjerrum Nielsen 2004).

It has been argued that the changes which have occurred for women and the de-traditionalising of expectations have made it "more necessary for contemporary girls than for boys to ask who they are and what they want to become" (Bjerrum Nielsen 2004, p.9). Again, this suggests that adolescence and the forming of a sense of identity has perhaps evolved into a more confusing but perhaps more creative and empowering period in girls' lives. However, there is still a suggestion that, although they have been found as better at "reflexively constructing a sense of self" (O'Connor 2006, p.107) and no longer recognise gender as affecting their life choices, girls are still affected by gender expectations, be they old or new (Bjerrum Nielsen 2004; O'Connor 2006). Indeed, it is perhaps the combination of both types of expectations and perceived pressures to reject the traditional ones which have caused some to claim that "a divide has opened up between how they [young women] feel they ought to identify themselves and how they actually identify themselves" (Bjerrum Nielsen 2004, p.21). An example of this is evident in O'Connor's (2006) study of how Irish teenagers construct their sense of identity and whether this is differentiated by gender. With respect to aspirations for the future, O'Connor found that girls portrayed their main priority as being the pursuit of a career over the search for a romantic partner. However, she also noted that girls who included the prospect of marriage and motherhood in their life plans, "were almost embarrassed to have such 'old dreams'" (O'Connor 2006, p.116). This displays the kind of gap which Bjerrum Nielsen highlighted between girls knowing what they ought, or are now expected, to want

(educational achievement, successful careers) and the fact that they are embarrassed to admit it if they also want to include more traditional elements in their lives. These ideas lead us to question whether young women now feel under less or more pressure as a result of changing expectations and new constructions of femininity.

Changes in the labour market, as a result of women's entry to this sphere and the decline of traditional industries, have had an adverse impact on the job opportunities of young men and in particular those in the lower social classes who may have depended on traditional industries for employment (Griffin 1985; Wilkinson and Mulgan 1995; Thomas 1996). As opposed to the well-publicised changes being made by young women to adjust their constructions of femininity in order to accommodate such social changes (Wilkinson and Mulgan 1995; Stainton Rogers and Stainton Rogers 2001; Sweeting and West 2003b; Bjerrum Nielsen 2004; O'Connor 2006), the fact that representations and constructions of masculinity have remained more stereotyped than those of femininity means that young men may be finding it harder to adapt to social changes, such as those in the labour market, whilst preserving a traditionally masculine identity (Thomas 1996; Connell 2000; Stainton Rogers and Stainton Rogers 2001). These changes, and the inability of some groups of young men to cope with them, have led many authors to debate the idea that a 'crisis of masculinity' is occurring, whereby men are suffering psychologically from the social changes which have impacted upon their abilities to construct traditionally masculine identities (Connell 2000; Frosh, Phoenix et al. 2002). The debates around this idea are too lengthy to discuss here, but many authors have discredited the idea of a crisis of masculinity by highlighting the continuing dominance of men in positions of power and control both at state and global levels, and by suggesting that the crisis of masculinity thesis represents a backlash against the changes that feminism has brought about in women's interests (Whitehead 2002). On the whole, it appears that it is girls and women who have had to make most changes to their lives and constructions of themselves as gendered beings so as to adapt to and succeed within a changing society (Holstein-Beck 1995; Wilkinson and Mulgan 1995).

2.4 Chapter summary

This chapter has described evidence of a 'gender reversal' in the ill-health and symptom reporting rates of children and adolescents which suggests that a

deterioration of girls' physical and psychological well-being takes place over the child-adolescent transition. As a means of setting the theoretical context for an investigation of the factors which influence this reversal, the chapter has taken a historical approach in tracing the main debates which have contributed to the development of theories of gender and adolescence. In particular, it highlighted the ways in which understandings of both gender and adolescence have changed over time from being conceptualised as biologically fixed and determined, to being understood more as 'experiences' which are socially constructed and subject to variation across space and time. By looking at research on the development of masculinities and femininities during adolescence, the final section of the chapter brought theories of gender and adolescence together and considered various structures which are unique to this time of life (e.g. school and peer group cultures) and which variously contribute to it being especially salient for the construction of gender identities. Although the chapter placed emphasis on a rejection of biological determinism in favour of social constructivist understandings of gender and adolescence, the importance of not completely eliminating considerations of biology and functions of the physical body from conceptualisations of the meanings and experiences of gender and adolescence was also highlighted. Thus throughout the chapter, elements of the nature/nurture and structure/agency debates were rehearsed and calls were made for new and less dichotomous ways of conceptualising the place of the biological and the social in shaping human experience.

Chapter Three: Considering possible explanations for gender differences in symptom reporting during childhood and adolescence

3.1 Introduction

To go back to the original intellectual puzzle set out at the beginning of the thesis, that of the changing gender patterns in symptom reporting during childhood and adolescence, this chapter presents research findings which may help contribute to understandings of the causes of these trends. On the whole, the literature surrounding these findings has attempted to explain them in terms of the differing and changing biological and social factors which affect boys and girls at this stage in their lives (Cohen, Cohen et al. 1993; Sweeting and West 2003a). The explanations which are initially discussed in this chapter are based on genetic and biological differences between boys and girls which suggest that, from the outset and even before birth, males and females are differentially susceptible to certain illnesses or that differences in their biological development lead to them experiencing distinct types and rates of symptoms. Next follows a consideration of the impact of various social factors on children's and adolescents' experiences of illness and their tendencies to seek help for symptoms. This includes an exploration of the ways in which society instils in children various age- and gender-appropriate ways of reacting to illness and also considers the ways in which the 'requirements' of boys' and girls' differing gender roles may impact upon their experiences of, and reactions to, symptoms. Finally, some more general methodological issues around the reliability of self-report surveys are discussed in terms of the impact they could have upon gender differences in symptom reporting.

3.2 Explanations based on genetic and biological differences between boys and girls

There is a huge amount of research into the biological determinants of gender differences in health. Such research investigates whether the genetic and biological make-up of males and females may result in them being differentially susceptible to illness which, in turn, would help to explain gender differences in symptom reporting. The following sections will give a broad summary of these arguments. Also within this section on biological determinants, the possibility that gender- and age-based

differences in cognitive development may contribute to gender differences in their symptom reporting rates is also considered.

3.2.1 Explanations based on differences in genetics and the biological development of boys and girls

Attempts to explain gender differences in the symptom reporting rates of boys and girls in terms of differences in their genetic and biological make-up are based on the principle that gender differences in symptom reporting are caused by ‘real’ differences in symptom experiences. Thus, they imply that differences in the physiology of boys and girls can result in them being differentially susceptible to certain illnesses and symptoms. Rutter and colleagues (2003), for example, argue that genetic differences between males and females provide the first level of possible causes that must be considered when trying to understand sex differences in rates of various mental-health disorders. They claim that genetics must be considered because they “define the biology of the difference between the sexes” (p.1098), but show that any possible genetic basis for sex differences in psychopathology is more complicated than the simple possession of XY or XX sex chromosomes.

Also drawing on biological explanations, Sweeting (1995) outlines hypotheses which have been proposed to explain the higher incidence of childhood asthma in boys in terms of differing patterns of lung growth and the susceptibility of boys to develop all types of allergy because of their higher cord-blood concentrations of gamma-E globulin. Although these authors refer to genetics and biology as a means of explaining sex differences in relation to certain health conditions or disorders, a consideration of basic genetic and biological differences between males and females is also relevant when attempting to understand sex patterns in symptom reporting rates. For example, Barsky and colleagues (2001) propose biological explanations for gender differences in the perception and reporting of pain. In particular, they draw on research which has suggested that neuroanatomical, neurophysiological, and neurobiological differences between males and females “may give rise to differences in the perception, processing, and modulation of noxious somatic and visceral stimuli” (p.268). On the whole, they suggest that girls and women are inherently more sensitive to pain and because of this they may report pain more frequently and describe it as being more intense than do boys and men.

Differences in the biological developments which occur as males and females mature are referred to by Rutter and colleagues (2003) as one of “the consequences of being male or female” and are described as differentially exposing males and females to factors which could pose risks for their mental health. Such differences in the biological development of boys and girls might therefore help to explain gender differences in symptom reporting across the child-adolescent transition. For example, the advent of puberty is often proposed as contributing to gender patterns in symptom reporting during childhood and adolescence. The morphological changes brought about by puberty are commonly conceptualised as being positive for boys but negative for girls (Martin 1996; Siegel, Yancey et al. 1999; Williams and Currie 2000; Sweeting and West 2003b). This is because male puberty brings about increases in height and muscle mass that are thought to move boys towards an idealised male body image (Peixoto Labre 2002; Sweeting and West 2003b), whereas female puberty causes girls to gain fat and change shape in ways that remove them from the thin feminine ideal which has come to be valued in Western culture (Angold, Costello et al. 1998; Angold, Costello et al. 1999; Martin 1999; Siegel, Yancey et al. 1999; Williams and Currie 2000; Peixoto Labre 2002; Lien, Dalgard et al. 2006). These opposing movements of boys and girls, in terms of being nearer or further from the culturally ideal body shape, are thought to contribute to the gender gap in body satisfaction and self-esteem levels which emerge during this life stage (Siegel, Yancey et al. 1999; Steinberg and Morris 2001; Benjet and Hernandez-Guzman 2002; Franko and Striegel-Moore 2002; Peixoto Labre 2002).

Indeed, the degree to which poor body image can predict levels of depression is important in assessing the gender-specific impact which these morphological changes might cause. A study by Siegel and colleagues (1999) found that controlling for body image eliminated observed gender differences in rates of low self-esteem and depression. These findings highlight the importance of appearance in adolescent girls’ sense of their own self-worth. Therefore, we might argue that the sex-specific morphological changes brought about by puberty, and the differing reactions to these of boys and girls, have the potential to contribute to our understandings of gender differences in perceptions of health, particularly if self-esteem and self-worth are factors which impact upon such perceptions. In relation to changes in body shape and their significance to levels of self-esteem, research should consider the recent

valorisation of stereotypically feminine figures, demonstrated largely through the widespread use of cosmetic surgery for breast augmentation, and investigate whether the morphological changes of female puberty might be viewed more positively in view of this. Also of significance here may be the alleged changes in the extent to which boys and young men are now concerned about their appearance and body shape. Such secular changes may influence the extent to which body image contributes to both boys' and girls' overall psychological well-being.

It has also been argued that changes in hormone levels might help explain why puberty may be a more negative experience for girls (Angold, Costello et al. 1998; Angold, Costello et al. 1999; Cyranowski, Frank et al. 2000; Benjet and Hernandez-Guzman 2002). For example, a study by Angold and colleagues (1999), which investigated whether actual hormonal changes had more impact upon rates of depression than did the psychosocial effects of the morphological changes which occur during puberty, concluded that the higher levels of androgens and oestrogen in adolescent girls could explain increases in levels of depression to a greater extent than could low levels of self-esteem or poor body-image due to changes in shape or weight. However, Rutter and colleagues (2003) argue that the causal processes involved in the emergence of a female excess in depression during adolescence are likely to consist of an "interplay among hormones, genetic influences and psychosocial risk/protective factors" (p.1106).

Puberty might also impact upon girls' physical symptom reporting rates as a result of the occurrence of menarche and the onset of menstrual symptoms. For example, it is well known that menarche increases girls' experiences of stomach cramps (Haugland, Wold et al. 2001a). Nevertheless, although the occurrence of menstrual symptoms may contribute to adolescent girls' increased rates of symptom reporting, there is no evidence to prove that they are the only factor influencing the increasing gap between boys' and girls' symptom reporting during adolescence (Eminson, Benjamin et al. 1996; Sweeting and West in progress). Indeed, none of the biological factors discussed above have been proved to definitively explain gender patterns in symptom reporting. However, it is also important to consider the role of cognitive developments in shaping boys' and girls' understandings of illness and symptom reporting behaviours, and these are discussed next.

3.2.2 The influence of cognitive development on understandings of illness and symptom reporting

Recent examinations of the development of children's concepts of illness have been placed in the context of Piaget's theory of cognitive development (Wadsworth 1979; Kister and Patterson 1980; Perrin and Gerrity 1981; Brewster 1982; Hergenrather and Rabinowitz 1991; Hansdottir and Malcarne 1998). Generally, the acquisition of perspectives on illness is seen as a developmental process (Campbell 1975) and three of Piaget's periods of cognitive development are used to characterise the stages which children go through in their thoughts about health and illness (Wadsworth 1979; Kister and Patterson 1980; Perrin and Gerrity 1981; Brewster 1982; Hergenrather and Rabinowitz 1991).

Piaget suggests that the period of 'preoperational thought', which is experienced by children between the ages of two and seven, is one in which they are increasingly able to think, speak and behave in a socialised way (Wadsworth 1979). As the child moves on to the next period, 'concrete operations', experienced between the ages of seven and eleven, they develop logical thought processes, improved concepts of causality, space and time, and can engage in co-operative communication. The final period of Piaget's theory of cognitive development, 'formal operations', is experienced between the ages of eleven and fifteen years. By this stage, the abilities to use logic and reasoning make it possible to solve all classes of problems. Although not all adolescents or adults fully develop 'formal operations', those who do are able to organise data, reason scientifically and generate hypotheses (Wadsworth 1979).

Several studies have found that children's thoughts on the origins of illness can be slotted into these three stages (Perrin and Gerrity 1981; Brewster 1982; Hergenrather and Rabinowitz 1991; Hansdottir and Malcarne 1998). For example, a study by Hergenrather and Rabinowitz (1991) demonstrates that children's thoughts on illness change from being based on vague, non-illness related concepts to a more specific and sophisticated comprehension of illness (Campbell 1975; Hergenrather and Rabinowitz 1991). Their understandings of the origins and causes of illness display this shift particularly well. Younger children, in the preoperational thought period, ascribe the cause of an illness mainly to behavioural actions. This can either be seen as the outcome of wrongdoing on their part, interpreting the illness as a punishment

(Brewster 1982), or as the outcome of receiving treatment, such as getting an injection or an x-ray (Hergenrather and Rabinowitz 1991). At this stage it is obvious that the child's understanding of the cause of illness is not logical. As children get older, however, logical thought processes begin to be employed. They no longer believe that illnesses are caused by wrongdoing, but that all illnesses are contagious and caused by germs (Kister and Patterson 1980; Perrin and Gerrity 1981; Brewster 1982; Hergenrather and Rabinowitz 1991). This displays an improving acquisition of knowledge and a shift towards logical thought. The oldest age cohort in this study, thirteen and fourteen year olds, exemplifies the final stage of Piaget's theory, their causal concepts of illness having expanded to include notions of infection, genetics and health behaviours (Kister and Patterson 1980; Perrin and Gerrity 1981; Brewster 1982; Hergenrather and Rabinowitz 1991). This acknowledgement that illnesses can have multiple causes demonstrates more sophisticated understandings, in which logical reasons, such as contagion, and more abstract ideas, such as health behaviours, are both taken into consideration (Perrin and Gerrity 1981). Therefore, this evidence suggests that "children's understanding of illness is primarily determined by cognitive maturation" (Brewster 1982, p.361).

Related to these ideas, Martin and Ruble (2004) highlight the ways in which the development of gender concepts and identities goes hand in hand with cognitive development. In particular, they claim that children's behaviour is influenced by their developing understandings of gender and their "recognition that there are two gender groups and that they belong to one of them" (p.68). Thus, when children identify themselves with one gender group they are motivated to act like group members. The fact that gender-related cognitive developments possibly occur at the same time as improvements in understanding of illness may mean that illness behaviour and symptom reporting are impacted by both developmental processes. However, there is little research which has specifically looked at the relationship between cognitive development and gender differences in symptom reporting or other illness behaviours.

Nevertheless, studies which have attempted to gain a deeper understanding of the determinants of adolescent symptom reporting and assessments of health have discovered gender differences in the types of concerns which influence their perceptions of their health (Mechanic 1976; Rauste-Von Wright and Von Wright

1981; Pennebaker 1982; Mechanic and Hansell 1987; Alexander 1989; Vinglis, Wade et al. 1991; Millstein 1993; Gijsbers Van Wijk, Huisman et al. 1999; Hetland, Torsheim et al. 2002). For example, a study by Alexander (1989) which surveyed 745 thirteen-year-old adolescents on self-reported measures of health status, needs, concerns, perceptions and behaviour found that, for boys, physical health concerns exerted greater influence on self-assessed health status. For girls, however, the strongest influences were emotional and social concerns. Alexander suggests that these differences may be related to cognitive development in that boys' greater concerns with physical health may reflect more concrete conceptions of health, whereas the girls' ideas incorporate more abstract and sophisticated health concepts since at 13, girls may be more mature than boys and may have developed well into puberty. Considering that serious physical health problems are minimal during adolescence and as these are given more importance by boys when assessing their health status, it would follow that boys will perceive themselves as being in relatively good health. However, the fact that girls take both social and emotional factors into consideration when assessing their health means that their perceptions of their health are subject to a greater number of factors than are boys'; this may contribute to girls' tendencies to view their health in poor terms (Millstein 1993; Haugland and Wold 2001b; Hetland, Torsheim et al. 2002).

It would be naïve, however, to assume that it is only children's changing understanding of illness and gender which contribute to their illness behaviours. In fact, Piaget's theory of cognitive development has been criticised for its emphasis on the "predetermined 'logical' aspects of children's thinking" (Seifert, Hoffnung et al. 2000, p.47) and neglect of the social, emotional and cultural factors which may also influence this. Recently, cognitive developmentalists have been more supportive of the concept of "domain-specificity", which proposes that children's learning is directly related to what they are exposed to, and that their knowledge will be more in-depth the more that they have been exposed to certain experiences (Adams and Berzonsky 2003). Thus, the possible impact of various social influences upon children's perceptions of, and reactions to, illness are considered next.

3.3 Explanations based on social factors which influence boys' and girls' symptom reporting

In order to understand how symptoms and experiences of illness are reacted to, it is important to consider the social factors and health beliefs which impact upon the ways that they are perceived and understood. The following sections therefore investigate the social factors which may influence the help-seeking and symptom reporting of children and adolescents. Firstly, some general theories around these factors are described. Following on from this is an exploration of the means by which children are socialised to react to illness with age- and gender-appropriate behaviours and a consideration of the ways in which perceived consequences of age- and gender-*inappropriate* behaviours may act as barriers to help-seeking for children and adolescents.

3.3.1 Deciding to seek help for symptoms: the influence of social factors and health beliefs

As part of this investigation of the factors which may influence gender differences in symptom reporting, it is key to understand something of the processes which inform people's beliefs about their health and their decisions whether or not to seek help for symptoms or illnesses they may experience. This section gives consideration to the impact of social factors in informing and influencing help-seeking and health beliefs.

In his 1973 paper, Zola considers the processes by which individuals decide that the bodily discomforts they label as symptoms should be brought to the attention of a medical professional. Thus, he explores the ways in which people *become* patients. Significantly, he finds that a range of factors influence this process and that individuals do not necessarily have to be at their physically sickest point when they decide to seek help for symptoms, nor is it always the worsening of symptoms per se which prompts people to seek help for them. Indeed, Zola identifies a number of "non physiological patterns of triggers to the decision to seek medical aid" (p.683), such as the occurrence of an interpersonal crisis related to the symptom(s) or the perceived interference of the symptom(s) with social and personal relations or with work-related and other physical activities. From these findings Zola suggests that "unexplained epidemiological differences" may be due to differentiation in the types of factors which lead people to seek help, and in turn into medical statistics, rather than to any

'true' or 'real' difference in the prevalence and incidence of symptoms and illness. Therefore, on concluding that "the very labelling and definition of a bodily state as a symptom as well as the decision to do something about it is in itself part of a social process" (p.687), he highlights help-seeking for illness as a far more intricate and complex process than simply recognising and reporting a change in bodily state. In fact, he argues that it can often be the social implications and consequences associated with a symptom which are more likely than the physical effects to lead people to seek professional medical help.

Cornwell (1984) also found that, as opposed to being based around value-free observations of changes in bodily state, understandings of illness and attitudes towards help-seeking are complex and heavily influenced by social and cultural health beliefs. In her study of the commonsense ideas and theories about health, illness, and health services of twenty-four people living in East London, she found health and illness to be "morally problematic conditions" (p.123) in relation to which respondents were keen to position themselves as "morally correct" or, in other words, as being 'healthy'. If experiences of illness were acknowledged, respondents went to various lengths to prove that they were 'real', thus legitimating their position as a patient and clearing themselves of any culpability. It was also important for them to highlight ways in which they had resisted and not 'given in' to illness whilst they questioned the strength and morality of people they considered to be hypochondriacs. It is noteworthy that, as with Zola's findings, Cornwell's respondents' beliefs about health and illness seemed to be informed just as much, if not more, by the moral implications and social norms surrounding illness within that particular cultural context rather than by considerations of the physical effects of illness. This delineates the importance of understanding the social and cultural context in which illness is experienced and where the decision whether or not to seek help for this is made.

The following sections now look at the ways in which children are socialised to behave in age- and gender-appropriate ways and they help to depict the cultural contexts within which children and adolescents experience illness and highlight the social norms and expectations which they learn to take into consideration when deciding whether or not to seek help for illness.

3.3.2 Socialisation of age-appropriate illness behaviour

As discussed in Chapter 2, socialisation or social learning is said to be the process by which children learn, initially from their parents or family environments and subsequently through school, peer and all social interactions, about how society expects them to behave (Stephenson 1983; Fuchs and Thelen 1988; Kerns, Southwick et al. 1991; Eisenberg, Cumberland et al. 1998). This is a continuing process and the objectives and expectations of parents and others involved are thought to be linked to sex-typing and age-grading (Mechanic 1964; Campbell 1978). In respect of illness behaviour, socialisation processes teach children gender- and age-appropriate behaviours as defined by adults and society as a whole. The way that children are socialised and taught to react to illness is highly dependent on individual factors such as the health-relevant experiences of the child, the socio-economic status, values and role expectations pertaining to parents and parental responses when children express symptoms (Mechanic 1964; Mechanic 1965; Campbell 1978; Fuchs and Thelen 1988; Zeltzer, Barr et al. 1992; Crane and Martin 2002). As children get older they are then thought to take part in “self-socialization” (Campbell 1978) as they fit their own behaviours to their progressively refining conceptions of what is appropriate.

The literature which deals with the socialisation of age-related behaviour generally concludes that socialisation processes work to influence the illness behaviours of children to move in the direction of the self-discipline displayed by most adults (Mechanic 1964; Mechanic 1976; Campbell 1978; Prout 1986; Fuchs and Thelen 1988; Prout 1989; Zeltzer, Barr et al. 1992; Fearon, McGrath et al. 1996). A study by Fuchs and Thelen (1988), which examined the factors influencing children’s expression of emotions and looked at how this changes with age, concluded that the socialisation experience affects the expression of negative affective states (sadness, anger etc.) more than other emotions and brings about the increased suppression and regulation of emotion with age (Fuchs and Thelen 1988; Eisenberg, Cumberland et al. 1998).

Showing emotions is not the only area of behaviour that children learn to regulate as they get older. A study which observed nursery children, aged between three and seven years, and which aimed to determine the prevalence and incidence of everyday pain, found that help-seeking behaviours decreased in frequency with increasing age

(Fearon, McGrath et al. 1996). This was found despite the fact that no age differences in the incidence or severity of everyday pain were evident. These findings suggest that even by age seven, children are learning to be less dependent on adult caregivers as they seek help less and increasingly perform comforting and protective rituals, such as rubbing the injured area, for themselves (Fearon, McGrath et al. 1996). In terms of illness behaviours and symptom reporting, socialisation according to age expectations is significant. If children are taught to be more stoic and autonomous as they get older then, with age, a reduction in help-seeking behaviours seems inevitable. One would also expect a change in the actual articulation of symptoms, from more to less expressive, as children get older and become more aware of what is expected of them.

Prout (1986) warns, however, that children's responses to age-related expectations and processes of socialisation should not be seen as "a 'smooth' maturing of the individual personalities of the children towards an 'adult' view of sickness but [that it should be seen as] a complex and uneven struggle to *produce* children" (p.131, emphasis in original). Thus, he outlines the roles of parents and teachers in enforcing age-related expectations but also highlights the significance of children's own roles in resisting or complying with these processes. In relation to the link between illness and age-related expectations, Prout (1989; 1992) suggests that we can view sickness as a symbol used at points of transition in the life-cycle to highlight the need to move on to the next stage. He highlights the intense meaning which illness takes on during pupils' transition between primary and secondary school and looks at how this is used as a powerful means of socialising children into, and making them "fit" for, this key phase in their transition to adulthood. For example, he shows how parents begin to voice concern about their children's immature attitudes towards illness and how they feel that this may signal the fact that they are not "properly prepared" for secondary school. One mother tells of how she had asked the teacher to outline age-related expectations to her son:

...she (the teacher) said that at this age they've got to learn that if you've got a cold you can't simply sit down like some children do and give in (Prout 1989, p.342).

This demonstrates the way in which symptoms and illness may be used to highlight the need for a change in attitude and behaviour, in order to move onto the next phase

of life and conform to age-related expectations. Prout (1986; 1988; 1989) outlines the ways in which this process not only places children under pressure but also shows how the need for parents, especially mothers, to 'prepare' their children in such ways grows out of complex sets of pressures which ultimately equate child health with 'good mothering'. Thus, reactions to illness in their children can be seen as important exercises in 'impression management' for mothers and, somehow, they must try to negotiate an identity which falls between being seen as neglectful and over-protective in their reactions to their children's complaints (Prout 1988). Recent research shows how these pressures and negotiations are sharpened and made more difficult for working mothers as instances of child sickness, which require them to take time off work to care for children, are experienced as direct clashes of family and work commitments (Cunningham-Burley, Backett-Milburn et al. 2006). Thus, working mothers have talked about how they also try to instil stoicism in their children in order to avoid having to make the decision to stay off school (and work) unless absolutely necessary (Cunningham-Burley, Backett-Milburn et al. 2006).

Simpson (2000) also talks about the transition from primary to secondary school and points to the importance which teachers place on children's abilities to restrain and control their bodies, by sitting still at their desks or managing increasingly skilful tasks, in order to successfully make this transition. She claims that before and after the transition to secondary school, teachers use stereotypical images of body size, age and academic ability to prepare and train pupils for new age-related expectations (Simpson 2000). This research on the transition from primary to secondary school is enlightening for the purposes of this study as it displays the ways in which the body and experiences of illness take on extra significance at points of change and sheds some light on the processes and demands which arise at such times and have to be navigated by children.

Obviously, these age oriented changes in displays of emotion, help-seeking and illness behaviours are significant in investigating the factors affecting children's symptom reporting. It is evident that behaviours which alert others to the presence of distress, pain or illness are at a maximum in early childhood and then decrease as children grow older, are socialised and begin to judge for themselves what is expected of someone their age. Coinciding with these behavioural changes, are changes in

parental control over the use of health care services. When children are young they are less likely to suppress their feelings and they also rely on parental perception to tell them that they are unwell. However, as children get older, their understandings of social expectations and their abilities to perceive symptoms increase at the same time as they take on the responsibility of deciding whether or not they should consult a doctor. For these reasons we should expect to see a decrease in help-seeking behaviours as children mature, yet this does not help to explain age-related increases in the rates of symptoms reported in survey situations. As well as learning behaviour which is appropriate for their age, children are also taught gender-appropriate behaviours. The next section looks at how being socialised to take on gender-appropriate behaviours may impact upon the illness behaviours of children and adolescents.

3.3.3 Socialisation of gender-appropriate illness behaviour

The socialisation processes which serve to instil gender stereotypes and expectations are said to be at work from infancy (Hoffman and Hurst 1990) and it has also been postulated that children develop a gendered identity by four to five years of age (Bem 1983). It is plausible, therefore, that gender expectations will impact upon illness behaviours learnt and adopted by children from a young age (Jacobs and Eccles 1992; Bartle-Haring 1997; Polce-Lynch, Myers et al. 1998; Bergman and Scott 2001; Bayrakdar Garside and Klimes-Dougan 2002). This means that if parents, or others involved in the up-bringing of young children, reinforce specific gender-related traits, such as vulnerability and sharing of feelings in girls and autonomy and regulation of emotions in boys (Polce-Lynch, Myers et al. 1998; Bayrakdar Garside and Klimes-Dougan 2002), the outcomes of this on illness behaviours and symptom reporting will be significant.

Researchers have suggested that socialisation processes may profoundly influence bodily experience as well as the willingness to express and communicate distress to others (Mechanic 1980; Barsky, Peekna et al. 2001). Studies which have looked at gender specific socialisation processes have found that girls and boys are socialised differently (Jacobs and Eccles 1992; Bartle-Haring 1997; Eisenberg, Cumberland et al. 1998; Morrongiello and Dawber 1999; Bayrakdar Garside and Klimes-Dougan 2002), as girls are taught to attend to their bodies and to express their emotions more

freely than are boys (Beiter, Ingersoll et al. 1991; Eisenberg, Cumberland et al. 1998; Morrongiello and Dawber 1999; Bayrakdar Garside and Klimes-Dougan 2002).

The extent to which a child is taught to fulfil a gender role, if they are at all, is dependent on parental values and beliefs, outside influences (peers, media) and the resistance of the child to being moulded into such a role (Mechanic 1964; Hoffman and Hurst 1990; Eisenberg, Cumberland et al. 1998). As children get older and more socially aware they commonly use past socialisation experiences along with present understandings in order to regulate their behaviour according to the conventions of socially accepted gender expectations (Carter and Patterson 1982; Stephenson 1983; Fowler-Kerry and Lander 1991). A study by Polce-Lynch and colleagues (1998) demonstrates this increasing regulation of behaviour to accord with gender expectations as children get older. The authors suggest that the ability to report feelings about the self may be a function of culturally prescribed gender roles, and males' tendency to be less expressive when disclosing feelings may reflect a need to act out the stereotyped masculine gender role, whereas stereotypes of femininity encourage girls to partake in "girl talk". A pattern of increased difficulty in expressing emotions occurred amongst males as they approached adolescence, whilst the opposite pattern was found for females. This suggests that in relation to the expression of emotions and symptoms, boys and girls follow socially prescribed display rules that are gender specific (Polce-Lynch, Myers et al. 1998) and implies that many children are still raised with the "boys don't cry" doctrine (Gijsbers Van Wijk and Kolk 1997, p.243).

Studies by Prout (1989) and Williams (1999; 2000; 2002) explore the idea of ill-health being seen by adolescent boys as something which could threaten their masculinity and, for this reason, should be hidden. Williams looked at the ways in which adolescents managed chronic illnesses such as diabetes and asthma, paying particular attention to the impact of this on their gender identities. Unlike the girls in the study, who took their medication in public and incorporated their condition into their identities by telling people about it, the majority of the boys preferred not to make their conditions publicly known and restricted their medication to only ever being taken at home. On the whole, the boys refused to incorporate their asthma or diabetes as a part of their identity. This was perhaps due to the fact that they saw their

conditions as stigmatising, signs of weakness and, in turn, threatening to their status within the masculine hierarchies at school (Williams 1999; Williams 2000). Similarly, Prout found that boys' experiences of illness and days off school because of this, were viewed as isolating events which disrupted the flow of school-life and threatened their position within the masculine hierarchies of their peer group (Prout 1989). Both studies highlight that for boys, to be in control of their social and gender identities is perhaps more important than controlling and treating illness (Williams 2000). Indeed, boys' concerns with hiding and carrying on regardless of their conditions or symptoms show how incompatible the sickness role is with their attempts to construct themselves as successfully masculine. That is, because the ideology of hegemonic masculinity serves to idealise male bodies which are strong and fit, those which are weakened by illness or injury are more likely to be conceptualised as representing subordinate or failed masculinities. The boys in Williams' study also demonstrate their agency in constructing their own identities whilst responding to their understandings of gender-related norms. This shows how socialisation processes and individual agency can combine in the construction of gender identities.

The socialisation of children into gender roles could have a significant effect on their symptom reporting and illness behaviours. The way that girls are taught to be cautious, aware, and open about their emotions, influences them to be more sensitive to both their physical symptoms and emotions at the same time as encouraging them to share these feelings and experiences. Conversely, boys are more likely to be encouraged to be independent, stoic and less emotional, and for this reason they may find talking about their feelings and symptoms particularly difficult. It is likely that with age, as understandings develop and as socialisation processes influence children into taking on age- and gender-appropriate roles, the illness behaviours of children will change. Not only are they increasingly aware of how they are expected to behave when ill, with respect to their age and gender, but their comprehension of the cause of their ill health is also heightened. It is likely that the influence of both gender- and age-related expectations will result in boys being increasingly less likely than girls to report symptoms as they get older. The following section considers the ways in which the consequences of gender- and age-inappropriate illness behaviour may affect boys' and girls' responses to symptoms.

3.3.4 The consequences of gender- and age-inappropriate illness behaviour

Symptom reporting is not only influenced by long- or short-term antecedents, such as the perception of symptoms or the influences of social learning, but thoughts of the physical and social consequences of symptom reporting also come into play (Cornwell 1984; Zola 1973). Levine (1999) claims that the role of the immediate social context is central to symptom evaluation and goes so far as to say that contextual changes can be more central to the way that people make sense of their symptoms, than physiological changes. Levine suggests that people can have a variety of social group memberships open to them at any one time. For example, a boy can be 'son', 'friend' and 'footballer', all at the same time. However, when a certain social identity becomes salient, the individual will assess their symptoms according to the norms and expectations relevant to that particular social identity. These ideas relate to Williams' (1999; 2000; 2002) work, discussed above. She found that adolescent boys' subscription to a strong masculine identity when in school prevented them from treating their asthma or diabetes whilst in this context. Nevertheless, they would treat their conditions when at home, suggesting that in this context their masculine social identity is neither as salient nor at as much risk if they admit to being ill. Therefore, in different contexts these boys took on different social identities and, as a result, assessed their symptoms upon different bases. Thus, it is important to think about the way in which particular identities will be affected by a shift from a 'healthy' to an 'ill' image (Levine 1999) and, in turn, how this shift will impact upon illness behaviour and symptom reporting.

The disclosure of psychological distress is also viewed as having negative consequences for social identities (Goffman 1963; Williams and Healy 2001; Lauber, Nordt et al. 2004). A survey of 488 12-18 year old Scottish school pupils, revealed that 48% of those who took part agreed with the statement, "if I was suffering from a mental health problem, I wouldn't want people knowing about it" (See Me Scotland 2005). The same study also found that 47% of the respondents felt that if people their age were to suffer from mental health problems, it would be likely that their peers would ignore them. Thus, it appears that a large number of children and adolescents believe that the disclosure of psychological distress would have particularly negative consequences such as social exclusion and peer alienation.

Various, and significant, gender differences have been found in perceptions, and the disclosure, of psychological distress. For example, Williams and Pow (in press) report that:

...boys have lower reported levels of knowledge and understanding, have more negative attitudes to people with mental health problems and are less likely to see the importance of, or need for, more information...

In relation to the disclosure of mental health problems, Biddle and colleagues (2004) highlight that young men are more likely than young women to reach high levels of mental distress before seeking help and are less likely than their female counterparts to confide in friends or family. Similarly, findings from a qualitative study which investigated Scottish school pupils' perceptions and understandings of mental health and illness showed that boys were more likely to claim that they would internalise any feelings of distress and were less likely than the girls to say that they would discuss problems with friends or family (Armstrong, Hill et al. 2000). From these ideas it is possible to suggest that although mental health problems are seen as stigmatising by both boys and girls, the consequences of reporting these may be less punishing for girls as emotional and psychological distress do not contradict their gender identities in the same way that they threaten boys' constructions of themselves as masculine. Indeed, recent research with men suggests that boys' concerns about the impact of the disclosure of mental health problems on their masculinity continue into adulthood (Emslie, Ridge et al. 2006; O'Brien, Hart et al. in press). Thus, in relation to mental health, shifts from 'healthy' to 'ill' may also have important consequences for social and gender identities and it appears that these consequences are taken into consideration by children and adolescents.

3.4 Are gender differences in symptom reporting 'real' or an artefact of self-report survey methods?

The completion of symptom checklists and health assessment scales is a process likely to be influenced by some of the same factors which impact upon symptom reporting in naturalistic settings and which have gender-specific effects. For example, the influences of socialisation might result in girls disclosing their symptoms more readily and in more detail than boys (Mechanic 1976; Gijsbers Van Wijk and Kolk 1997; Barsky, Peekna et al. 2001). Thus, gender differences in symptom reports may

be accentuated by the fact that boys are less likely to report symptoms in either naturalistic or survey interview settings. As they discuss the different levels of psychological distress reported by men and women, Mirowsky and Ross (1995) refer to this phenomenon as the “response-bias view” and claim that “women’s greater *apparent* distress flows largely or strictly from differences in reporting and not from differences in experience” (p.450, emphasis in original). Thus, many researchers suggest that differences in symptom reporting rates may not reflect ‘real’ differences, because it is likely that a response bias has occurred as boys and men have been less likely than girls and women to accurately report their symptom experiences. It is significant, however, that few researchers have considered the possibility that the privacy of reporting symptoms in the survey setting might serve to decrease the need to conform to social expectations as compared to illness and help-seeking behaviours in more ‘public’ and ‘naturalistic’ settings.

Some authors claim that gender differences in symptom reporting are not only influenced by the actual occurrence of bodily cues but also by environmental and psychological factors which impact upon the perception of these cues, especially those which affect males and females to different degrees (Gijsbers Van Wijk and Kolk 1997; Gijsbers Van Wijk, Huisman et al. 1999). Gijsbers Van Wijk and Kolk (1997), combining the theories of Pennebaker (1982), Cioffi (1996) and others, propose a symptom perception model which aims to encapsulate the processes at work at each stage of symptom perception and experience, and which can be used to contribute to our understanding of gender differences in symptom reporting.

One of the key claims of this complex and comprehensive model is that the recognition of bodily cues depends on the quantity and quality of internal information (any change within the body that triggers receptors e.g. drop in blood glucose due to hunger) as compared to the quantity and quality of external information (sights, sounds, smells and so on). Thus, if external information is lacking, such as in the case of boredom, there is an increased likelihood that more attention will be paid to internal information, thus facilitating the detection of symptoms. Similarly, an excess of external information, such as when highly stressed, may also cause symptom perception as, “under stressful conditions, there is an increase in internal, physiological arousal to be processed” (Gijsbers Van Wijk and Kolk 1997, p.237).

The authors relate this theory to gender differences in symptom reporting by suggesting that women are more likely than men to either experience a lack of external information, if carrying out repetitive and boring tasks within the home, or to experience an excess of external information, if coping with the dual burden of working full-time and managing a household. Thus, they argue that women are more susceptible to the detection of somatic sensations. There are parallels here with suggestions that the co-rumination, defined as “excessively discussing personal problems” (Rose 2002, p.1830), which takes place within girls’ friendships may lead to anxiety, depression and other internalising problems and this theory would help to explain the contradiction in the way that girls are conceptualised as having closer and stronger friendships, but instead of these acting as a buffer to psychosocial stress, girls also report higher levels of psychological difficulties (Rose 2002).

Gijsbers Van Wijk and Kolk (1997) also argue that the way in which women’s bodily processes receive so much medical and social attention, a phenomenon they term the “medicalisation of the female body” (p.242), serves to increase the amount of attention which females pay to changes within their bodies and may also affect the meanings they attribute to these and the degree to which they perceive them as symptoms. Indeed, whether pre-menarchal girls construct negative menstrual-related beliefs, attitudes and expectations as a result of cultural learning, is also thought to be important with regards to subsequent menstrual experiences and symptom reporting. Studies which have examined the relationship between menstrual-related expectations and ‘actual’ experiences have found that negative reports of menstrual experiences are related to negative expectations (Clarke and Ruble 1978; Brooks-Gunn and Ruble 1982; Janes and Morse 1990; Anson 1999; Marvan, Espinosa-Hernandez et al. 2002; Marvan, Vacio et al. 2003).

Thus, Gijsbers Van Wijk and Kolk (1997), using Pennebaker’s (1982) theories of hypotheses, schemas and selective search processes, suggest that it is possible that the emphasis placed on the female body by the processes of socialisation, “medicalisation” and actual reproductive experiences, all act as ‘priming’ devices which serve to provide females with hypotheses and schemas about their physical state. The adoption of these hypotheses may lead girls and women to draw their attention inward, resulting in them being increasingly likely to attribute somatic

meanings to vague bodily sensations and to interpret these as symptoms. Therefore, it is possible that these processes may contribute to the 'gender reversal' in symptom reporting rates which occurs during adolescence.

The symptoms reported in self-report surveys might also be affected by respondents' knowledge of socially desirable responses and desires to conform to these norms (Alexander 1989; Eminson, Benjamin et al. 1996). Mechanic and Hansell (1987) propose that this phenomenon may account for children's and adolescents' high rates of somatisation, the process of reporting physical complaints that are not associated with any detectable organic disease but are chiefly considered to be expressions or manifestations of psychological and psychosocial difficulties (Tamminen, Bredenberg et al. 1991; Zwaigenbaum, Szatmari et al. 1999). He suggests that reporting physical symptoms may be seen as more socially acceptable by the reporter than reporting psychological complaints. For this reason, children and adolescents might express their psychological problems as physical symptoms in order to avoid the greater stigma that they perceive to be attached to the former. As noted earlier, however, rates of psychological complaints have also been found to vary according to gender, and in fact differences are greater than for physical complaints, with adolescent girls being twice as likely as boys to report feeling depressed by the age of fifteen (Eiser, Havermans et al. 1995; Burns, Andrews et al. 2002; Williams, Colder et al. 2002). This suggests either that girls' responses to self-report surveys might be less restricted by social expectations or that social expectations differ for girls and boys, making it easier for girls to report psychological symptoms. Indeed, perhaps both of these hypotheses are true.

A relationship has also been identified between the reporting of physical symptoms and the experience of depressive or negative mood states (Williams, Colder et al. 2002). Levels of both measures are higher amongst adolescent females and this has led researchers to question the direction of the causal relationship between the two. Williams and colleagues (2002, p.510) summarise the problem as follows:

...it may be that girls report more depression because of poorer perceived health, or it may be that their higher rates of depression lead to greater reports of physical symptoms, or both.

Some researchers have argued that the preceding existence of certain stressors for girls, such as difficulties with social relationships or academic pressures, along with the tendency to be anxious or dominated by negative mood states, leads to introspection, a sensitivity to bodily changes and, as a result, to their increased reports of physical symptoms (Rauste-Von Wright and Von Wright 1981; Vassend 1989; Tamminen, Bredenberg et al. 1991; Garralda 1996; Sigmon, Dorhofer et al. 2000; Hetland, Torsheim et al. 2002). Others maintain that adolescent girls' increased tendency to report higher rates of physical symptoms and to view their general health as poor lead them to restrict social or academic activities and to increase self-focussed attention. In turn these tendencies are thought to lead to increases in depressive or negative mood states and further increases in symptom reporting (Zwaigenbaum, Szatmari et al. 1999; Williams, Colder et al. 2002).

It has also been suggested, particularly in relation to measures of psychological distress, that gender differences in symptom reporting may be accentuated or underestimated depending on the screening instruments and even the language used in questionnaires (Mechanic 1976; Mirowsky and Ross 1995; Salokangas, Vaahtera et al. 2002). Specifically, researchers have highlighted the possibility that differential socialisation has resulted in males and females learning to deal with and express their emotions or distress differently. On the whole, men are thought to display distress outwardly as expressions of anger or hostility, whereas women are said to internalise their emotions, resulting in feelings of failure and depression. Accordingly, it has been argued that female levels of psychological distress may be over-estimated because self-report surveys tap only 'feminine' expressions of this by asking mainly about feelings of sadness, anxiety or depression (Mirowsky and Ross 1995). Hence, there have been calls for the broadening of self-report measures to incorporate expressions of distress that may be viewed as more typically 'masculine', such as measures of anger, violence and substance use, and which may help reflect a more accurate picture of the differences in the levels and types of distress experienced by males and females (Mechanic 1976; Mirowsky and Ross 1995).

It is clear that symptom reporting via self-report surveys is not straightforward. Indeed, subtleties such as reporting biases or differences in the meanings attributed to bodily cues may mean that symptom reporting rates do not directly reflect levels of

symptom experiences. However, Watson and Pennebaker (1991, p.73) argue that symptom scores gained through self-report assessments “are best viewed as measures of subjectively perceived illness rather than objectively defined diseases per se”, and they go on to say that “the individual’s subjective experience of pain and discomfort is an interesting and important variable in its own right”.

3.5 Chapter summary

The wide range of literature referred to in this and the previous chapter reflects the numerous factors which could potentially influence the health and illness behaviours of boys and girls as they move from childhood into adolescence. This chapter has considered potential explanations for gender differences evident in the symptom reporting and ill-health of children and adolescents, looking in turn at those based on biological, sociological and methodological factors. In doing so, the chapter has presented competing explanations for gender differences. On the one hand, it has highlighted arguments which propose that gender differences in health are genetic and, therefore, biologically ‘real’. Yet on the other hand, it has also considered arguments which suggest that gender differences in symptom reporting are not necessarily ‘real’ but are caused by differences in societal expectations which result in boys and girls reacting to symptoms and illness in opposing, and gender stereotypical, ways. Nevertheless, the chapter has not advocated the credibility of one type of explanation over another, indeed attention has been drawn to the ways in which biological and social factors interact in complex ways when individuals make decisions about whether or not to seek help for symptoms. Thus, in the absence of data which might quantify the part which biology plays in explaining gender differences, it appears impossible and unwise to separate the biological and social when considering their potential contribution to gender difference in symptom reporting across the child-adolescent transition.

Reviewing the literature around gender differences in the symptom reporting of children and adolescents has highlighted a number of gaps in this body of knowledge. For example, although some studies have investigated the ‘gender reversal’ in relation to psychological conditions, there was no evidence of research which has explored and compared boys’ and girls’ understandings and experiences of both ‘physical’ and ‘malaise’ symptoms, nor any which has looked specifically at the factors which they

feel influence their illness behaviours in response to both types of symptom experience. Although some research has suggested that the pressures associated with conforming to traditional gender expectations may contribute to gender differences in experiences of, and tendencies to report, symptoms, few studies have explored boys' and girls' awareness or perceptions of gender-related expectations, how these might change with age and the extent to which they help to explain gender differences in symptom reporting. Likewise, there was little evidence of research into boys' and girls' perceptions of the consequences of seeking help for both 'physical' and 'malaise' symptoms in different social contexts. This study aims to address these gaps in knowledge by exploring the views of children and adolescents to inform and deepen our understanding of the ways that they experience health and illness as they move from childhood to adolescence.

Chapter Four: Methodology

4.1 Introduction

This chapter details the methodological issues taken into consideration whilst designing the study and describes the conduct of it. It is organised so as to represent the chronological order in which various issues were considered and dealt with. Therefore, issues of a more theoretical nature which influenced the study design are discussed first and practical aspects of conducting the study are described later.

4.2 Terminology

4.2.1 Age and school year-groups

In an attempt to ensure that participants would be as close in age as possible to those interviewed in the '11-16 study', I decided to recruit 11-, 13- and 15-year old pupils. In terms of school year-groups, 11-year olds were recruited from primary seven (P7), 13-year olds from secondary two (S2) and 15-year olds from secondary four (S4) for the pilot field work. In the main study, 10/11-year olds were recruited from primary six (P6) because of the timing of the fieldwork¹. Throughout the thesis I will use the abbreviations of the school year-groups, P6, P7, S2 and S4, in order to distinguish between pupils of different ages.

4.2.2 Children or young people?

As pupils who took part in this study ranged from 10 to 15 years of age, I have struggled to find a suitable term to refer to them collectively. Being under 16 years of age, they are legally classed as children and could rightfully be referred to in this way. Nevertheless, I feel that it would be patronising to refer to the more mature 15-year olds as children. However, it would also be misleading to talk about 10-year old pupils as 'young people' because of the adult-like competencies which can be associated with this term. Instead I have decided to use the following terminology:

¹ Fieldwork with P7 pupils would have taken place in June when they attend induction days at secondary school. Because pupils' concerns may have varied considerably depending on whether they took part in the research before or after their induction day, to avoid any such biases this may have caused across the sample of P7 pupils it was decided that P6 pupils should be recruited instead.

- ‘children’ will be used when discussing the methodological literature because this is the term generally used by these authors.
- ‘pupils’, ‘participants’ or ‘respondents’ will be used when collectively referring to those who took part in this study.
- ‘P6 boys’, ‘S2 girls’, and so on will be the terms used when referring to specific age and gender sub-groups within the study sample.

4.3 Philosophical underpinnings

4.3.1 Qualitative and quantitative research

There are many differences between qualitative and quantitative research and each research methodology has its merits depending on the subject being studied (Silverman 2000). Qualitative research is concerned with “how the social world is interpreted, understood, experienced, produced or constituted” (Mason 2002, p.3) and because of this it aims, through the analysis of words or images, to achieve in-depth understandings of social phenomena. The emphasis in quantitative research can also be on understanding specific social factors but these are investigated using statistical analyses which examine possible relationships between variables (Silverman 2000). Nevertheless, as opposed to the qualitative aims of exploration and interpretation, the quantitative aim is statistical explanation or description (Robson 2002). Holliday (2002, p.5) claims that qualitative and quantitative research each “represent very different ways of thinking about the world” and argues this is because quantitative research is based on the (positivist) philosophy that “there is a normality that we can fathom and understand, and master by statistics and experiment”. On the other hand, he describes qualitative research as being interpretive in its philosophy and based on the belief that social reality can never be known but can be subjectively interpreted through exploration of people’s understandings of their world (Holliday 2002). Although Holliday’s description goes some way to conceptualising the differences between the philosophical underpinnings of quantitative and qualitative research, it is important to note that many quantitative researchers may be more reflexive in their thoughts on how data are constructed, whereas it is also possible that some qualitative researchers are less interpretive than his ideas suggest.

4.3.2 Why use qualitative methods?

My philosophical approach in designing, conducting and writing up this study has been based on an interpretive framework which conceives of the social world as constructed by people through their interactions in it and their understandings of it (Holliday 2002; Mason 2002). To fulfil the main aim of this study from this philosophical stance, I believed that the research needed to explore pupils' understandings and interpretations of symptoms and to investigate the factors which they believed to be influential in their decisions about whether or not to report these. I approached this task with the understanding that participants' ideas were the product of contextually situated accounts (Frosh, Phoenix et al. 2002) and not 'facts' which I could use to generalise to the views of all school pupils. Thus, my main aim was to interpret the meanings which participants gave to their experiences in an attempt to understand symptom reporting from their various points of view.

Qualitative methods were also chosen as a means of addressing the dearth of this type of research in relation to the 'gender reversal' in symptom reporting during childhood and adolescence. Despite calls for further qualitative and quantitative research into "the ways in which influences on the health of children and young people differ and change according to sex and age" (Sweeting and West 2003c, p.39), literature searches of published articles in the past five years show that studies remain predominantly quantitative, and are mainly concerned with the psychological well-being of children and teenagers (Lawlor and James 2000; Haugland and Wold 2001b).

4.4 Research with children

4.4.1 The development of a sociology of childhood

As a 'sociology of childhood' has been constructed, children have been recognised as a social group affected by the same forces as other groups and equally worthy of study (Mayall 1996). Prior to the 1980s, researchers investigating issues of childhood rarely considered children as having the potential to be competent or valid research participants. Rather, they were conceptualised as being "emotionally incomplete" (Bendelow and Brady 2002) and as "adults in training" (Shucksmith and Hendry 1998). Instead, researchers learned about the lives of children by proxy, through parents, teachers and other adults deemed capable of speaking for them (Lloyd-Smith and Tarr 2000; Christensen and James 2000b).

In the past twenty years, sociologists of childhood have emphasised the need to recognise children as social actors (Pole, Mizen et al. 1999; Roberts 2000; Scott 2000) who are capable of commenting on their own experiences and who have a basic right to be heard (Ireland and Holloway 1996; Shaw 1996; Lloyd-Smith and Tarr 2000; Roberts 2000; Bendelow and Brady 2002). These assertions have caused a shift from thinking of children as the recipients of research to viewing them as active agents in research (Shucksmith and Hendry 1998; Pole, Mizen et al. 1999). As more researchers have changed their ways of thinking about children, there has not only been a rise in the number of studies which feature them as active participants but also an increase in the use of methodologies thought to help take advantage of their skills and insights (Dockrell, Lewis et al. 2000; France, Bendelow et al. 2000; Lewis and Lindsay 2000).

4.4.2 Ethical considerations in conducting research with children

Orb and colleagues (2001) claim that the research process creates a tension between research for the good of others and the rights of the participants to privacy and fair treatment. They suggest that, to prevent participants coming to any harm, all research must adhere to ethical principles which uphold basic human rights. Researchers who intend to work with children should apply these same principles but should give special consideration to gaining informed consent, protecting confidentiality where appropriate, and dissipating power relationships (Ireland and Holloway 1996; Mahon and Glendinning 1996; Morrow and Richards 1996; Christensen and James 2000b). The following sections detail the ways in which these factors were considered in relation to this study and how they were implemented in the field. The specific ethical procedures completed during the course of the study are detailed in Section 4.8.1.

Informed consent

The essence of the principle of informed consent is that human subjects of research should be allowed to agree or refuse to participate in the light of comprehensive information concerning the nature and purpose of the research (Homan 1991, p.69).

Although parents are permitted and required by law to give consent on behalf of a child, in order to treat children as competent actors capable of making their own decisions, researchers are recommended to also seek their agreement to participate (Ireland and Holloway 1996; Morrow and Richards 1996; Roberts 2000; Christensen and James 2000b). In this study, to ensure informed consent was gained, leaflets which explained the study and outlined details of involvement were distributed to potential participants and their parents (Appendix A). This was done to aid pupils' understanding of the purposes of the study (Alderson 1995), to help them decide whether they wanted to take part and to give them my contact details should they wish to ask any questions. As pupils can be put under pressure by teachers or parents to participate in such studies (David, Edwards et al. 2001), I also used the process of permission and assent whereby pupils were asked to sign a consent form when they arrived at the research setting. This was done to ensure pupils knew that taking part in the study was voluntary, to give them final say over whether or not they wanted to do so (Morrow and Richards 1996) and also to gain their permission for the research to be tape-recorded. All interviews and focus groups were tape-recorded as a result of all pupils consenting to this.

Confidentiality

Protecting the confidentiality of participants is essential in most research. However, the seemingly clear-cut issue of confidentiality can be a grey area when it comes to children's participation in research. Mahon and colleagues (1996, p.151) discuss the fact that there seems to be a growing "consensus amongst researchers that complete confidentiality can never be guaranteed to child research subjects". They refer to the view of the National Children's Bureau that if a child were to reveal they were at risk, the researcher has a duty to pass this information on to the appropriate professionals. In this study, all respondents (and people mentioned by respondents, e.g. teachers) have been given pseudonyms to protect their identity. Before taking part in the research pupils were made aware of this and assured that if they were to be quoted in future reports of the research that information would not be presented in ways which would allow it to be traced back to any individual. In order to avoid false promises of confidentiality, at the beginning of each focus group and interview I explained that if any participants were to disclose that they were being caused serious harm by another person or that they had caused serious harm to someone else, I would be required to

talk to them about this and to tell an appropriate adult. As another means of improving confidentiality, pupils were asked not to talk about anything which had been disclosed in the discussion when outside of the group.

Power relationships

The inequalities of status and age which exist between adults and children make the divide between researcher and researched all the more difficult to bridge (Morrow and Richards 1996; Mauthner 1997; Shucksmith and Hendry 1998; Christensen and James 2000b). The main issue of concern is that this imbalance of power poses a risk to the validity of data gathered. Mahon and colleagues (1996) argue that the researcher may be seen by children as an 'expert' on the research topic. As a result of their own perceived lack of knowledge on the subject there is a danger that they will give the researcher 'public' accounts or those that they think are most acceptable (Cornwell 1984), as opposed to their own thoughts on the matter. To avoid this, an important part of the research process requires the researcher to think about how they will present themselves to respondents who are younger and how they can make them feel at ease to say what they want. In doing so, the researcher must think about a number of factors ranging from being approachable and non-authoritative in appearance to demonstrating a respectful attitude to their respondents (Allard 1996; Graue and Walsh 1998; Krueger and Casey 2000).

As research which takes place in schools may be imbued with the conventions of teacher-child relationships (Dockrell, Lewis et al. 2000), when conducting fieldwork I made conscious attempts not to present myself as a figure of authority. To do this, during focus groups and interviews, I introduced myself as a research student, used my first name and dressed in a casual manner. I also attempted to create a rapport with participants by speaking to them in an informal manner, letting them know that they did not have to raise their hands before speaking and not reacting if they swore. I also pointed out that I was not an expert on the topic and that none of the questions had right or wrong answers. In taking these steps I hoped that the pupils would not view me as a teacher and would feel it relatively easy to talk freely in my company.

4.5 Deciding on methods

The “methods selected for a particular study should be based on how well they meet specific goals” (Bergin, Talley et al. 2003, p.15). In accordance with this, I thought hard about the goals of my study and which qualitative data generation methods might best achieve them. I wanted both to talk to pupils about their experiences of different symptoms and to explore the group norms surrounding symptom reporting in different social contexts. As I learnt more about different qualitative methods it became clear that I should conduct both focus groups and interviews.

4.5.1 Focus groups

Focus groups have been used by market researchers since the 1920s. More recently, social scientists have begun to use them to explore people’s attitudes and values (Hill, Laybourn et al. 1996; Large and Beheshti 2001). Focus groups can vary in composition and duration but they are generally made up of a group of people, targeted because their opinions are specifically sought, who are encouraged to discuss a certain issue as a facilitator asks them open-ended questions (Hill, Laybourn et al. 1996; Pugsley 1996). The goals of this research method have been outlined as the elicitation of participants’ perceptions, attitudes and ideas through the facilitation of group discussion and interaction (Vaughn, Schimm et al. 1996; Wood Charlesworth and Rodwell 1997; Large and Beheshti 2001; Heary and Hennessy 2002).

It is the interaction of participants which makes focus groups unique. It enables participants to generate ideas in reaction to one another and strengthens their voices in the research process as they have more control over the topics discussed (Watts and Ebbutt 1987; Wood Charlesworth and Rodwell 1997; Bergin, Talley et al. 2003). Participant interaction also allows researchers to examine different people’s perspectives and the ways that these operate and influence others within a social situation (Gibbs 1997; Kitzinger and Barbour 1999). Bergin (2003, p.15) claims that focus groups “approximate meaning making within naturally occurring social interaction”. Others agree with these sentiments in acclaiming focus groups as the preferred method with which to investigate group norms because of the way in which they play on social context as a factor which can alter and shape beliefs (Lewis 1992; Kitzinger and Barbour 1999; Heary and Hennessy 2002).

Focus groups with children

Much has been written in relation to children and focus groups. Some of the literature debates the appropriateness of this as a method to research children and some exemplifies the rich data which can be generated in this very way. As children are able to account for their thoughts and experiences from as young as six years old (Scott 2000; Kennedy, Kools et al. 2001), there should be no reason why successful focus groups cannot be carried out with children (Large and Beheshti 2001).

One of the main concerns when conducting research with children is that the researcher-child power relationships may result in the intimidation and limited participation of younger participants (Morrow and Richards 1996; Mauthner 1997; Shucksmith and Hendry 1998; Christensen and James 2000b). However, Heary et al (2002, p.48) claim that “in removing the emphasis on the adult-child relationship” focus groups eliminate or at least lessen the gap between researchers and researched. Kennedy and colleagues (2001) support this view, claiming that as children are more comfortable in the company of their peers, this enhances their group involvement. They also highlight that it is from “listening in” (p.185) to this social interaction, such as the challenging of one another’s ideas, that researchers not only discover the meanings that children attach to certain issues but can also explore the ways in which their understandings have been reached.

Limitations of focus groups with children

Focus groups have also been acknowledged as having limitations when used to research children. As their success is dependent on group interaction, this could lead to bias if only the views of the more confident group members are elicited (Lewis 1992; Pugsley 1996). Linked to this, Horner (2000, p.156) has suggested that the desire to fit in with peers can lead to “group think” as participants strive to reach a consensus rather than face peer rejection by voicing a dissenting opinion (Bergin, Talley et al. 2003). Confidentiality has also been highlighted as at greater risk in focus groups generally, and this is especially the case when groups are carried out within schools or when they are composed of people who already know one another (Lewis 1992; Michell 1999). Michell (1999) highlights that when carrying out focus groups in schools it is harder for participants to voice certain opinions due to the threat of peers who participated in the group later repeating something which was said to others

who were not there. To avoid this, some suggest that focus groups conducted in schools should be composed of small friendship groups. This is based on the premise that such participants will trust one another and know each other so well that they will be less reticent to voice an alternative opinion (Morrow 1999). The merits and possible disadvantages of this will be discussed later in relation to focus group design (Section 4.6).

To minimise the impact of these limitations on the focus group data, those being conducted with children should be designed and organised to take account of their specific vulnerabilities and skills. For example, the composition of the group should take into consideration the effect of the presence of friends (Lewis 1992; Horner 2000; Heary and Hennessy 2002), whereas the duration and content of the groups should also recognise differences in the cognitive development levels and social skills of those taking part (Vaughn, Schimm et al. 1996; Wood Charlesworth and Rodwell 1997; Heary and Hennessy 2002). A detailed discussion of such issues is given when outlining the factors taken into consideration whilst designing the focus groups to be used in this study (Section 4.6).

Why use focus groups in this study?

Insights into pupils' awareness of gender- and age-related expectations, their understandings of symptoms and how they decide whether or not to seek help when feeling unwell were essential to this study. Focus groups were chosen as one method of investigating such perceptions because they provide opportunities to ask open-ended questions around this topic and to learn from the issues raised, and deemed important by the participants. Being particularly interested in the types of behaviour perceived as acceptable in relation to symptom reporting, I was also motivated to use focus groups as I anticipated that participants would be more likely to give responses which would be accepted and endorsed by their peer groups whilst in their company.

4.5.2 Interviews

As a method of acquiring information, interviewing is central to qualitative research and is perhaps the most frequently employed method to learn about people's thoughts and experiences (Antle May 1989; Denzin and Lincoln 2000). Interviews can vary in composition, from individual to group, and can also differ in structure, with

qualitative interviews being more flexible, enabling interviewees to tell their own stories in detail (Antle May 1989; Denzin and Lincoln 2000; Bryman 2001). Qualitative interviews have been described as 'guided conversations' (Lofland and Lofland 1995). Although they may involve some pre-planned open-ended questions, they make a definite departure from the more precise formats of questionnaires and quantitative interviews in order to highlight and follow the interviewees' interests (Antle May 1989; Denzin and Lincoln 2000; Bryman 2001). In general, the aim of qualitative interviews is to impose as little as possible of the researcher's prior thoughts on the subject of study in order to emphasise the meanings this might have for interviewees and to let them demonstrate the ways in which they frame their understandings (Britten 1995; Barbour and Featherstone 2000; Bryman 2001). Barbour and Featherstone (2000, p.78) state that such "research encounters involve a departure from the model of researcher as expert" and because of this interviewees are valued as those most able to detail the important issues in their lives.

Although it is suggested that interviewers should attempt to put themselves in the position of 'conceptual stranger' and learn wholly about the research topic from the interview participant, it is also acknowledged that this is not an easy thing to do (Barbour and Featherstone 2000). Antle May (1989, p.191) argues that:

Since human interaction is based on a culturally derived structure of meanings that is shared to some extent, it would be extremely difficult for the investigator to approach any interview as a completely neutral element.

Interviewers may have to rely on shared meanings just to engage in the interview conversation and as such cannot estrange themselves completely from the concepts being discussed. To resolve this difficulty the literature suggests that interviewers should subordinate their own experiences in order to remain sensitive to their interviewee's language, to assume nothing and to delve into their explanations in as much detail as possible (Antle May 1989; Britten 1995).

Interviews can be seen as "interactional exchange[s] of dialogue" which result in the generated meanings, understanding and perspectives being a "co-production, involving researcher and interviewees" (Mason 2002, p.63). As it is inevitable that

the researcher's presence will have an impact upon the data generated, they become a factor in the data generation process (Lee 2000). At the most basic level, the success of the interview will depend on the interpersonal skills of the researcher and their ability to create a rapport with the interviewee (Bryman 2001). Other factors such as the race and gender of the interviewer will also impact upon the data generated (Denzin and Lincoln 2000). As a result, interviews cannot be treated as neutral tools in the production of data but, instead, great attention should be paid to the potential impact of their "contextual, societal, and interpersonal elements" upon the data generated (Fontana and Frey 2000, p.647). Therefore, by taking account of factors which are situational, conditional and complex, qualitative interviews help us to understand how meanings are made and understandings are framed in the social world.

Interviews with children

Child interviews may be subject to influences such as age-related power relations and differences in cognitive abilities. However, the basic requirements of successful interviews are the researcher's interest in the children's stories and their view of children as being competent interpreters and reporters of their own worlds (Deatrick and Faux 1989; Shucksmith and Hendry 1998; Kortessluoma, Hentinen et al. 2003).

Interviewing children thus requires the researcher to treat them as experts on their own experiences and values them as active participants in research, rather than the subjects of it (Shucksmith and Hendry 1998; Pole, Mizen et al. 1999). Just as qualitative interviewing with adults is successful if the skills and needs of the participants are considered, this is also the case when interviewing children. Not only should factors such as gender and race be considered, but to demonstrate a sensitivity to the specific needs of children at different stages of development, interviewers should modify language use and question structure in a way appropriate to each child (Mauthner 1997; Kortessluoma, Hentinen et al. 2003). In order to equalise power relations, researchers should work hard to establish a rapport with their interviewees and reassure them that they can withdraw from the interview at any point (Kortessluoma, Hentinen et al. 2003). Interviewers should also aim for a more flexible approach to the interview questions and structure, thus enabling the children more freedom to "set their own agendas" (Mauthner 1997, p.20). When planning to

interview children, specific factors should be given careful consideration. These will be discussed in more detail when outlining the interview design (Section 4.7). Nevertheless, when remaining sensitive to these issues and interested in what children have to say, child interviews can generate rich data which give insight into their experiences.

Why use interviews in this study?

To fulfil the aims of this study I wanted to speak to boys and girls of different ages about their own experiences of symptoms and how they went about dealing with these. As it would be unethical to ask participants to disclose such personal details in a group situation, I decided that individual interviews would be the most appropriate method to use when asking specifically about participants' views on symptoms and ill-health. I did not consider asking parents or teachers as proxy-reporters because I believed that the pupils would be the most expert at describing their own experiences of illness.

The combined use of focus groups and interviews is not unusual and is often recommended when focus groups are being conducted with existing peer groups or when it is thought that the group situation might inhibit individuals from disclosing certain opinions (Michell 1999). Punch (2002) reports that whilst participants in her mixed-methods study found the group situation to be fun, they felt more comfortable talking about personal thoughts and experiences when being interviewed individually. Lewis (1992) also highlights that because group and individual interviews often elicit different ideas from the same respondents, employing both methods can lead to a more comprehensive understanding of the topic being researched (Lewis 1992; Michell 1999; Punch 2002). Therefore, I decided to conduct interviews as well as focus groups to ensure that participants had opportunity to voice personal thoughts as well as to investigate whether boys and girls raise different issues within the two contexts.

4.6 Focus group design considerations

Designing and planning focus groups to be carried out with children requires that attention is paid to their developmental needs and abilities (Heary and Hennessy

2002). Practical issues, such as the composition and location of the groups, also warrant careful thought.

4.6.1 Group composition

Age and gender characteristics

Krueger (2000) advises researchers wishing to compare the views of different types of people that they should compose their focus groups so as to keep these types separate. As I wanted to compare the views of boys and girls in P6, S2 and S4, my aim was to organise focus groups which would be homogeneous both in terms of age and gender. Not only would this enable comparisons across age- and gender-groups, but it would also prevent difficulties caused when focus groups are made up of children at different stages of development.

In addition to allowing boys' and girls' views to be compared, homogeneity in terms of gender is advised by many researchers who have found that because boys and girls tend to have different communication styles as well as alternative coping strategies, mixed-gender groups tend to inhibit discussion (Horner 2000; Punch 2002; Bergin, Talley et al. 2003). Horner (2000) also highlights that whether participants are "same-gender" should depend on the focus group topic and states that this should be the case when "the research topic focuses on issues affected by pubertal changes" (p.513). Therefore, focus groups were organised to be homogeneous in terms of gender so as to maximise participant interaction and to enable them to raise sensitive, gender-specific issues, but crucially to aid cross-gender comparisons.

Friendship groups

I had decided to recruit via mainstream primary and secondary schools as a way of accessing a large number of pupils of varied academic ability and from a range of social backgrounds. As I also intended to conduct the focus groups in schools, consideration was given to the proximity of peers and the impact this may have upon the data gathered. The presence of friends or peers in focus groups can have both detrimental and positive effects upon group interaction (Michell 1999; Morrow 1999; Horner 2000; Scott 2000): On the one hand, "friendship groupings may be the most important single criterion to use for selecting groups" (Lewis 1992, p.418) because children may feel most at ease with their peers and, as a result, their participation in

the group will be enhanced (Lewis 1992; Morgan 1997; Morrow 1999; Heary and Hennessy 2002). On the other hand, peer presence also has disadvantages. Succumbing to peer pressure in order to gain approval is seen as one factor which might prevent the expression of dissenting viewpoints (Horner 2000; Heary and Hennessy 2002), whilst another is the pre-existence of hidden or shared meanings amongst long-established friendship groups which serve to silence certain members (Kitzinger and Barbour 1999; Morrow 1999). Remaining aware of both the advantages and disadvantages I decided to aim to recruit friendship groups for this study. I did this in an effort to create an environment in which participants would feel safe and comfortable in sharing their thoughts, even if divergent from others in the group (Morgan 1997; Horner 2000). Although I had made this decision I did not take it for granted that all groups of friends would interact in the same ways. To account for differences, I knew I would have to pay attention to the various types of group interaction, even the silences, as clues to the dynamics at work within each group.

Number of pupils per group

The size of focus groups can also be seen as having a bearing on the types of responses which will be generated (Lewis 1992). It is recommended that focus groups with children should be composed of fewer participants than the 8 to 12 normally recommended for adult focus groups (Kitzinger and Barbour 1999). This is so as to encourage participation whilst allowing control to be maintained (Lewis 1992; Heary and Hennessy 2002). Some feel that smaller groups help to encourage participation, allow for the expression of in-depth insights and keep younger children on task (Lewis 1992; Morgan 1997; Krueger and Casey 2000; Heary and Hennessy 2002). Others, however, have warned that small numbers can limit interaction and that a high quality discussion will only be generated if the group consists of at least three “talkers” (Wood Charlesworth and Rodwell 1997; Bloor, Frankland et al. 2001; Heary and Hennessy 2002). Vaughn and colleagues (1996) recommend that focus groups with children should be made up of five to six participants. In line with these recommendations I decided to form groups made up of at least four or five pupils. It was hoped that this would avoid the cancellation of groups in cases of pupil absence whilst ensuring enough pupils to generate a discussion and helping to represent the ‘normal’ types of settings in which pupils might usually have such conversations (Bloor, Frankland et al. 2001).

4.6.2 Duration of groups

Limitations specific to children

Focus groups being carried out with children should be shorter than those conducted with adults (Vaughn, Schimm et al. 1996; Heary and Hennessy 2002). Vaughn and colleagues (1996) recommend that, depending on whether children are younger or older than 10 years, focus groups should last approximately 45 or 60 minutes respectively. The maximum amount of time which children should spend in a focus group discussion is suggested as being 90 minutes (Heary and Hennessy 2002).

Limitations specific to research in schools

Bloor and colleagues (2001) state that the size of groups may be dictated by logistics, and this is also very much the case in terms of the time allocated to conduct each focus group when these have to be slotted in to a school timetable. I hoped that the primary school would be less rigid about time-slots and that this might allow for discussions of around 50 minutes. As secondary school lessons are normally given in periods lasting between 40 and 50 minutes, I intended to ask if it would be possible to speak to pupils for two periods. In case this request was declined I designed the focus group materials to address key areas within 40 minutes, which could be expanded upon if more time was allocated.

4.7 Interview design considerations

Dockrell and colleagues (2000) state that special attention should be paid to the format of interviews to be carried out with disempowered groups such as children. Factors ranging from question format to the appearance of the interviewer need to be carefully considered in order to ensure a fair and comfortable interview experience for younger participants (Rubin and Rubin 1995; Dockrell, Lewis et al. 2000; Harden, Scott et al. 2000).

4.7.1 Considerations specific to children

Creating a rapport

When talking about one-to-one interviews, Shucksmith and Hendry (1998) state that the imbalance of power is particularly “acute” when children are being interviewed. To equalise power relations and help pupils feel at ease in the individual interviews, I often started these by chatting informally, asking them what subject they had been in

and how they were enjoying their day at school. To help make pupils feel valued and competent as participants I often mentioned the part they had played in their focus group and said that I had found their discussion interesting (Rubin and Rubin 1995).

Asking questions

Before beginning the interview its purpose was outlined and, as was the case at the start of the focus groups, participants were told that none of the questions had 'right' or 'wrong' answers so they should answer in any way they chose. Keeping in mind that repeating a question in the teacher-pupil relationship can be indicative of a wrong answer (Dockrell, Lewis et al. 2000), I also assured participants that if I asked them to elaborate on certain points, this would be because it was an interesting or new idea and not because it was a poor response.

Researchers should always be wary of posing leading questions, but because this is especially the case when participants may be more vulnerable to these (Dockrell, Lewis et al. 2000), I devised open-ended questions in advance of the interviews. During the interviews I tried not to word any follow-up questions or probes in ways which may have led participants to think I was looking for a certain response and to give me this in an attempt to answer 'correctly'.

Timing of interviews

I decided to conduct the individual interviews after the focus groups in the hope that potential interviewees would feel less intimidated by this time as they would be more familiar with both me and the research topic. During the pilot phase I varied the recruitment procedures for the interviews. It became obvious that it was important to have the option of only taking part in the focus group as, when given the option on the pupil consent form, the majority of prospective participants ticked this box as opposed to volunteering for both the focus group and the individual interview. For this reason I decided to include these tick-box options and to hand these forms out at the beginning of the focus groups, stressing that participants would have an opportunity to change their mind about their preferred option at the end of the discussion. This was useful as on a few occasions people who had only ticked the focus group option did put themselves forward for an individual interview at the end. On the other hand, there were also a couple of occasions when boys, on finding out that they were the

only ones to have volunteered for interview, changed their minds at the end of the focus group.

4.8 Negotiating access to conduct research in schools

The methodological literature warns that access negotiations to schools are unlikely to be speedy because of positioning of schools, and their staff, within larger bureaucracies whose timetables are not likely, or able, to take a researcher's needs or time constraints into consideration (Delamont 1992). This is a fair reflection of my overall experiences of negotiating access to schools for the purposes of this study. These experiences taught me that teachers and schools have very little time in which to accommodate researchers, and when they do, the researcher must be prepared to compromise some of their study design considerations in order to adjust to the practical limitations of the school context.

4.8.1 Ethical procedures

Disclosure Scotland

Before being able to contact schools directly a number of legal and ethical approvals had to be sought, and as it was necessary to do this in a particular order, the progress of the study was subject to gaining several layers of permission. In the first instance I was required to apply for a 'disclosure' certificate from the government organisation 'Disclosure Scotland', who check the criminal history information of those seeking to work regularly with children or vulnerable adults. As I was intending to carry out individual interviews, and would be alone with children while doing so, I applied for Enhanced Disclosure which meant that even "non-conviction" information (that which is known to the police and is considered relevant to the disclosure application) would be disclosed if present on any criminal records.

University of Glasgow ethical approval

On being granted Enhanced Disclosure I applied for ethical approval for my study to the University of Glasgow's Faculty of Law and Financial Studies and Social Sciences Ethics Committee. Securing the appropriate ethical approval is a prerequisite of the Faculty for any staff or students wishing to conduct research involving human participants. The process involves outlining the purposes, methodology and research procedures of the study. Once again, the fact that I was proposing to

interview children meant that I was required to justify the need for their involvement and to emphasise that they would come to no physical or psychological harm through taking part in the research.

Local Education Authorities

In advance of being able to contact specific schools, I also had to seek permission from the schools' governing education bodies. The two education authorities whom I had decided to contact, one urban and one predominantly rural, requested the submission of application forms which again required a detailed outline of the aims of the study, the methods involved and the implications of participation on staff time and school facilities. Both authorities granted approval but highlighted that the participation of individual schools would be dependent on the approval of their head teachers.

4.8.2 Contacting school gatekeepers

Over the course of this study I made contact with, and negotiated access to, pupils from five schools. Three of these, one primary school and two secondary, were located in an urban area and were accessed for pilot fieldwork. Initial contact was made via a letter to the head teacher which detailed the research study plus permissions received and enclosed examples of pupil and parent information sheets. Seven days later I made telephone contact to ask whether I would be permitted to ask pupils to participate. In relation to all three urban schools this initial stage of contact proved frustrating and time-consuming. In one particular case I spent a week trying to contact the head teacher before being able to speak to him. During the conversations with these teachers it became apparent that schools, particularly secondary schools, within this urban area were inundated with research requests and studies, and as a result lacked enthusiasm to partake in any more. Although all three schools agreed to take part in the study, it soon became clear that research fatigue had affected both staff and pupils. This will be discussed in more detail in relation to the pilot study (Section 4.9).

As a result of the response from schools in the urban area, for the main study I contacted a primary and secondary school situated in a town within a predominantly rural area. The negotiation of access to schools in this area was less time-consuming

and more promising. Instead of displaying research fatigue, the teachers I spoke to, especially those from the primary school, seemed interested in the study and keen for their pupils to participate. What did become apparent when negotiating access with these schools was the differences in flexibility they could each afford. It seemed that because I could liaise directly with the P6 class teachers, and because their timetable was not split into periods or dictated by looming exams, it was much easier to set starting dates and to conduct the research without interruption. Organising the research at the secondary school took longer because of the heavy workload of the teacher with whom I liaised and because of the need to slot the research into periods normally given to subjects not examined, such as Social Education (SE).

4.8.3 The school year

Depending upon the pupils to whom access is being sought, the timing of this in relation to the school year may impact upon whether access is granted and this is especially true of pupils who are involved in formal examinations. As S4 pupils sit their preliminary exams between November and December, and their formal exams between the following May and June I tried to avoid asking for access to S4 pupils around these times. This was both to avoid being rejected by the school and to ensure that participation in the study would cause minimum disruption to participants' school work. When I did contact schools quite near to exam times, I stressed that I could wait until after exam periods before conducting the research.

4.9 The pilot study

The main aims of the pilot fieldwork were to test and refine the topic guides which had been designed, as well as to practice conducting focus groups and interviews with boys and girls in the specified age groups. Nevertheless, conducting pilot fieldwork taught me many more valuable lessons about doing research in schools.

4.9.1 The pilot study sample

To achieve the aims of the pilot, a small target sample was defined. This consisted of one focus group with boys and one with girls in each P7, S2 and S4 age-groups. Therefore, a maximum of six focus groups were planned, with a maximum of five participants in each. As I was undecided at this stage whether or not interview participants should be drawn from the focus groups, I hoped that being able to

compare interviews of those who had taken part in a focus group with those who had not would help me to make this decision. Therefore, I planned to interview one participant from each focus group as well as a boy and a girl from each age-group who had not taken part in a focus group. Thus, twelve interviews were planned to take place during the pilot. Table 4.1 displays the number of focus groups and interviews which I had planned to conduct during the pilot study.

Table 4.1 Numbers of focus groups and interviews planned to take place during pilot

Methods	P7		S2		S4		Total
	Girls	Boys	Girls	Boys	Girls	Boys	
Focus groups (max. of 5 participants in each)	1	1	1	1	1	1	6
Interviews (one participant from, and one not from, focus groups)	2	2	2	2	2	2	12

4.9.2 Timing of the pilot study

Initial contact was made with one primary and one secondary school in December 2003 and Table 4.2 displays the number of focus groups and interviews which were carried out by mid-February 2004. It also details the number of boys and girls from each age-group who took part in pilot focus groups and interviews.

Table 4.2 Numbers of focus groups and interviews conducted during pilot

Methods	P7		S2		S4		Total
	Girls	Boys	Girls	Boys	Girls	Boys	
Focus groups (and N participants)	2 (6)	1 (4)	1 (3)	1 (3)	1 (4)	1 (4)	7 (24)
Interviews	4	0	1	2	0	0	7

Although both pilot schools agreed to use opt-out parental consent, whereby parents were only required to return a signed consent form if they wished to withdraw their child from the study, there was insufficient pupil interest in the study to achieve the number of interviews which had been planned. In the primary school there was a distinct gender difference in the numbers of participants who volunteered and in the types of research situation that they chose. There were volunteers for interview from both P6 girls' focus groups and because two girls volunteered only to take part in an interview, this resulted in four pilot interviews being conducted with P6 girls.

I had asked the deputy head teacher at the secondary school to recruit volunteers by handing out the information packs (see Appendix A) and letting interested pupils come forward. However, it later transpired that he had only asked a small number of S2 and S4 pupils who were perceived as "chatty" and good in group situations. In terms of the S2 interviews, these had been arranged as requested but on the day these interviews were conducted one of the girls was absent from school. I had also asked to interview S4 pupils and the teacher had said he would get back to me if there was any interest. As he failed to do so, I presumed that the S4 pupils did not want to be interviewed.

4.9.3 Extended pilot work

At the end of February 2004 I contacted another school within this urban area with the aim of conducting the main study fieldwork in this location. Despite being granted access to pupils and personally handing out 116 pupil information packs (52 to S2 and

64 to S4 pupils), there was an extremely low response rate from this school. Table 4.3 displays the details of this fieldwork, carried out in March 2004.

Table 4.3 Extended pilot fieldwork

Methods	P7		S2		S4		Total
	Girls	Boys	Girls	Boys	Girls	Boys	
Focus groups (and N participants)	N/A		1 (4)	2 (7)	2 (5)	0 (-)	5 (16)
Interviews (one participant drawn from each focus group)	N/A		1	2	2	0	5

One explanation for the low response rates was the school's insistence on the use of opt-in parental consent, whereby all pupils wishing to participate must return a signed parental consent form. It is also possible that the pupils I wished to speak to were experiencing research fatigue as they were already involved in two large Scottish Executive-funded research studies. The small amount of fieldwork which was conducted in this school was carried out with difficulty as the teacher I liaised with lacked the time required to organise room space or recruit pupils. When it became clear that she was unwilling for me to try and interest further pupils I decided to treat these data as extended pilot work and to pursue the main study by contacting less researched schools in a different education authority.

4.9.4 Lessons learnt

Despite the low response rates at this stage, the pilot phase of the fieldwork taught me many invaluable lessons about negotiating access to schools, dealing with their gatekeepers and generating data with pupils of a range of ages.

Interview participants

I decided that interview participants should be drawn from the focus groups because their increased familiarity with the topic had aided their participation and knowledge of the topic during the pilot individual interviews.

Talking to school gatekeepers

Gaining access to school pupils is a lengthy process which should not be underestimated in terms of the effects it can have on the timing of a study or the enthusiasm of the researcher. Not only did I find it frustrating when trying to make contact with the appropriate gatekeepers but it was also disappointing to hear their despondence in reaction to the prospect of yet another research study. However, having learnt that secondary schools in urban areas can receive seven research letters per week and having seen how busy teachers are in dealing with their own workloads, I began to understand their reluctance to take part in such studies.

When my study had been delegated to the relevant teachers I had difficulty explaining its requirements and how I wanted to organise it in the brief telephone conversations which I was able to have with them. Indeed it often seemed that control of the study was being taken out of my hands as the teachers went about organising the fieldwork as they thought best. To address these concerns I decided that in future I should send a concise letter to the head teacher with an accompanying leaflet that would more specifically outline the requirements of school and pupil involvement, as well as the organisation of the study (Appendix B shows an example of the letter and leaflet sent to secondary schools). This would allow the head teacher to assess whether the school could devote the time and facilities needed. In addition, I felt that it would be preferable to set up a meeting with the relevant gatekeeper, so that the proposed arrangements could be discussed and agreed by both parties.

Administration

The pilot also taught me useful lessons about aspects of the administration of the study. The fact that I had not included a male/female tick box on either the parent or pupil consent forms posed problems when the child's sex was not obvious from their name, as I could not assign pupils to relevant groups. In addition, I realised that the wording on the pupil consent forms should be changed from 'signature' to 'name'. This came to light when participants had filled in the form and said that they did not "really have a signature". This was an issue I had not anticipated but which demonstrates the need to take the age and ideas of the research participants into account at each stage of research design.

Focus group and interview materials

As different ideas were tested and either discounted or included, the specific tasks designed for the focus groups and interview guides changed considerably. For example, following the pilot focus groups, it was decided that each participant should fill out a symptom checklist at the start to allow for a comparison of the symptoms reported by this sample and the '11-16 study' sample, and also to help judge to what extent participants' comments were hypothetical or based on their experiences of symptoms. Tasks which failed to generate discussion were also abandoned. One example was one of the original opening exercises which used cards with people on them (parents, friends, doctor etc.) to ask the group who they would tell about each of the ten symptoms. Participants often gave the same one-word answers and the task was replaced when it became clear that it was unlikely to generate interesting or useful data.

The interview topic guide also changed substantially as a result of the pilot interviews. This was because the data generated during these pilot interviews were disappointing in that they consisted of mainly hypothetical and superficial discussions. It was decided that the individual interviews in the main study should build on and explore issues which had been brought up in the focus group discussions. In particular, an emphasis was to be placed on seeking narratives of personal experiences of illness and specific symptoms by using the symptom checklist which each participant had completed at the beginning of the focus group. Although I could have decided at this stage to abandon plans to conduct interviews in the main study, I felt there was insufficient pilot interview data to warrant this decision. I also knew that I would only be given one opportunity to conduct the research in the schools and felt I should use this to conduct both interviews and focus groups, even if there was a chance that not all of the data would be analysed.

Considerable effort, thought and time were spent designing, testing and altering the research methods for this study (see Sections 4.11 and 4.12 for a detailed outline of the final materials used and description of how the design of the focus group and interview guides was influenced by various considerations specific to children). As a result, I felt that those used for the main research represented the best combination

both to interest pupils of varying ages and to generate the data required to explore the outlined research questions.

4.10 The main study

4.10.1 Timing

The main study fieldwork began with the primary school pupils in June 2004. Fieldwork with S2 and S4 pupils was conducted between October 2004 and January 2005 (see Appendix C for composition of focus groups and participant pseudonyms).

4.10.2 Sampling considerations

Although qualitative studies are small in scale and do not aim for statistically representative samples, the sampling strategies adopted should still be rigorous and systematic (Mason 2002). The aim of qualitative sampling should be to ensure that a rich and diverse data set is gathered. Nonetheless, sampling decisions should also recognise practicalities such as constraints of time or finances (Miles and Huberman 1994; Silverman 2000). To achieve these goals, qualitative researchers often recommend theoretical or purposive sampling. This strategy entails the selection of the particular people or groups who are believed to have the most illuminating experiences and thoughts in relation to the puzzles posed by the research questions (Curtis, Gesler et al. 2000; Hakim 2000; Silverman 2000; Mason 2002). The adoption of this strategy not only helps to focus the research on its basic questions, but by speaking to those deemed to have the most in depth or interesting insights into the subjects under investigation, it also aims to answer these in as much detail as possible.

4.10.3 Defining the sample

Who to target?

One of the main aims of this study was to compare the accounts of boys and girls in P6, S2 and S4 in an attempt to understand the changes in gender and age differences in symptom reporting which have previously been found to exist across this age-range. For this reason it made sense to try and speak to equal numbers of boys and girls from each of these age-groups in order to compare and contrast their experiences of symptoms and symptom reporting.

How many focus group and interviews should be conducted?

To allow for analyses across gender and age groups, and because it had worked well during the pilot study, I decided to organise single-sex focus groups with boys and girls from the same school years. This would mean that the sample would comprise six sub-groups (P6 girls, P6 boys, S2 girls, S2 boys, S4 girls, S4 boys). It is recommended in the methodology literature that, if sub-groups are to be compared, between three and five focus groups should be conducted with each (Krueger and Casey 2000). In line with this I decided to aim to conduct a maximum of five focus groups with each sub-group, yielding a maximum of 30 in total and, if focus groups were composed of a maximum of five participants in each, a maximum of 150 participants. As it was hoped that one interview participant would be drawn from each focus group, I also planned to conduct five interviews with participants from each sub-group, bringing the maximum number of individual interviews to 30, see Table 4.4.

Table 4.4 Number of focus groups and interviews planned to take place during the main study

	P6		S2		S4		Total
Methods	Girls	Boys	Girls	Boys	Girls	Boys	
Focus groups (maximum of 5 participants in each)	5	5	5	5	5	5	30
Interviews (1 participant drawn from each focus group)	5	5	5	5	5	5	30

4.10.4 The main study sample

In terms of the broad socio-economic context of the study, both schools draw pupils from a large and mixed catchment area which means that the sample population for the study would have included pupils from both working class, farming backgrounds as well as more middle class backgrounds. As the secondary school is the only state secondary in the area, it serves the whole community and is where pupils from the area's poorest families are most likely to attend school. Along with this, the fact that

there are two private schools within the local area would suggest that pupils from the most affluent families are unlikely to have been over-represented in the study sample. National statistics show that free meal entitlement at the study secondary school is higher than the education authority's average but less than half that of the Scottish average, whereas that of the primary school is less than the education authority's and substantially less than the Scottish average (Scottish Schools Online 2006). However, it has been suggested that free school meal entitlement rates may not accurately reflect levels of socio-economic disadvantage in an area as some families who are eligible may not apply on account of the perceived stigma associated with this (Seaman, Turner et al. 2005). To help ensure diversity within the sample, both with regards to social class and academic abilities, the teachers at each school were asked to distribute information packs to as wide a range of pupils as possible. However, since individual socioeconomic status was not included within the analysis, details of parental occupation were not gathered. It is recognised that this may limit the generalisability of the study since it is not possible to say whether or not the findings are class specific.

In terms of the ethnicity of respondents, all pupils were white and, judging by their accents, the majority were Scottish. This reflects the broad ethnic status of the local population where 0.97% of people living within the local authority area described themselves as belonging to an ethnic group other than white in the 2001 Census. As a result, the findings of this study cannot speak to gender differences in symptom reporting and help-seeking across different ethnic groups.

In terms of the number of pupils who took part, Table 4.5 displays the achieved sample for the main study and it shows that the number of primary pupils who took part (42) was nearly double that of each the S2 (23) and S4 (25) pupils.

Table 4.5 Number of focus groups and interviews conducted during the main study

Methods	P6		S2		S4		Total
	Girls	Boys	Girls	Boys	Girls	Boys	
Focus groups (and N participants)	5 (21)	5 (21)	3 (10)	4 (13)	4 (13)	4 (12)	25 (90)
Interviews (volunteers for interview did not come forward from all groups)	5	5	3	3	3	1	20

As both the primary and secondary school agreed to the use of opt-out parental consent, the disparities in numbers were probably a result of the fundamental differences in the schools' priorities, the structure and constraints of their timetables and the autonomy of their pupils. The differences between the primary and secondary schools are discussed below in more detail.

4.10.5 Differences between the primary and secondary schools

Timetables

It was not only when negotiating access to the schools that fundamental differences in their structures were highlighted. A major difference was the level of flexibility they had to accommodate the research into their respective timetables. Due to the absence of a rigid timetable, the primary teachers were able to organise the study as a class activity involving as many of the P6 pupils as desirable. When the research was being conducted, the primary teachers were not strict about the time spent with each group and the only restriction ever placed was that nothing should be scheduled to take place on the school sports days. On my request, teachers at the primary school were willing, and seemed to find it relatively easy, to arrange groups consisting of pupils whom they knew to be friends with one another. As only one pupil had been opted out of the study by their parents, the teachers drew groups of 3, 4 or 5 friends from the

remaining pupils who wanted to take part in the research and whose parents had granted consent.

In contrast to the flexibility of the primary school timetable, the teacher who facilitated access at the secondary school, when trying to accommodate the study, had to weigh up issues such as which lessons it would be possible for pupils to miss, the amount of disruption this may cause to these lessons and what degree of absence and disruption would be tolerated by class teachers. As a result of these pressures she asked for the number of groups carried out with each sub-group to be decreased from five to four and also for individual interviews to be conducted at lunch-time or after school. In addition, the secondary school teacher felt that it would not be possible to arrange S2 and S4 focus groups consisting of friendship groups. This was because pupils were to be drawn only from SE (Social Education) classes and she felt that friendship groups would be scattered across different classes and that pupils might not always attend SE classes with those who would normally feature in their friendship groups. As a result, if pupils in S2 and S4 focus groups were close friends with one another outside of the research setting it was more by chance than design that this occurred.

Once the focus groups had been scheduled they were restricted to the 40 minute period-length used in the secondary school. As had been the case in the pilot study, by the time that rooms had been allocated and pupils had made their way from previous classes, less than 40 minutes was available to spend on the discussion. As a result, the majority of the S2 and S4 focus groups were shorter than desirable. The progress of the research was also subject to various timetable changes and the number of pupils present could vary depending on the willingness of their class teacher to let them attend. For example, a group with S4 girls had to be re-arranged because of an extended assembly and on one occasion an S4 girl was not permitted to leave class because the teacher felt that the work being done was too important for her to miss. Such context-specific factors meant that the progress of the research was subject to many more delays and limitations than I had expected.

Availability of appropriate spaces

There were also differences between the primary and secondary schools in terms of the amount of physical space available in which to conduct the research. At the primary school I was allocated the library for the focus groups and an office for the interviews. As all members of staff had been alerted that these rooms were in use, the focus groups and interviews were rarely interrupted and on the occasions when this did occur, teachers immediately left the room on realising it was being used.

The secondary school was extremely short of spare rooms and because of this, many of the focus groups and interviews had to be conducted in the medical room. Spatially, the room was ideal for the research as it was much smaller than a classroom and this helped to set an informal tone. Nevertheless, this room provided access to the school's disabled toilet, which led to practical problems when access was required.

Autonomy of pupils

At the primary school the recruitment of sufficient volunteers was never a problem and it is possible that because the study was treated as a mainstream activity, all pupils were keen to participate. The interviews were also conducted during class time, a week or so after the focus groups, and as I had agreed with the teachers that I would come to the classroom to collect each interviewee and would take them back when we had finished, this may have helped to ensure attendance. Only one pupil (a boy) changed his mind about being interviewed and another from his group volunteered to go in his place, enabling me to carry out all ten interviews that I had aimed to do.

Participant numbers were more of a problem at the secondary school. It is unclear whether this was due to insufficient numbers having received the information packs or whether the increased autonomy of the older pupils meant that there was more reticence in taking part. Regardless of the cause, the decreased numbers meant that participants had to be spread very thinly to meet the renegotiated number of focus groups. In relation to the S2 girls, I was not able to achieve four groups as numbers only allowed for three to be conducted. In cases where groups had been composed of just three pupils and one was absent, it was difficult to conduct a 'focus group' with two pupils. This happened on three occasions. The achieved numbers for the

individual interviews also fell far short of the desired maximum, particularly for the S4 boys. Despite being given appointment cards and reminded via the school “notices” (read out each morning at registration), six pupils failed to attend arranged interviews. It is possible that pupils were less willing to attend interviews because they had been scheduled in their free time. Attendance might also have been poorer because of the increased independence of the secondary pupils which meant that if they had changed their minds they were not as easy to find and could not be ‘collected’ for an interview in the same way that the primary pupils had been. One final thought regarding the interview attendance, particularly in relation to boys, is that those who had volunteered were teased for doing so. This impression was given when at the end of a couple of focus groups some boys sniggered when I arranged an interview with the volunteer. On one occasion I heard a boy who had volunteered for interview asking his friends to keep this a secret. After hearing this I asked for the interviews not to be included in the school notices in case this acted as a way of ‘naming and shaming’ prospective interviewees and preventing them from taking part.

Although accessing research participants through schools can provide a practical way of generating a mixed sample and providing a location in which to conduct the research, my experiences of this have taught me that there are also context-specific limitations to this approach.

4.10.6 Being a researcher in schools

...there are multiple roles that a researcher assumes in a school setting and this will be influenced by the age, gender, ethnic background, [and] personal style of the researcher... (Morrow 1999, p.310).

Relations with teachers

In dealing with primary and secondary school teachers over the course of the fieldwork I found that they reacted to me, as a researcher, in interesting ways. As opposed to the informal, non-authoritative self that I presented to pupils, when meeting school gatekeepers I attempted to present myself in a professional manner. Accordingly I dressed smartly, addressed them formally, using their surname, and conducted myself in a similar way as I might when attending a job interview. Teachers’ reactions to me varied depending on the teacher and the stage of the research. During the pilot, some teachers plainly seemed to regard me as a nuisance

for whom they had little time. In contrast, I felt that the teachers at the main study primary school treated me as an expert on the study and looked to me for guidance as to how they should go about organising it. This change in attitude may either have resulted from these teachers' enthusiasm for the study or as a reaction to my own growth in confidence as the research progressed. Although the teacher at the secondary school was always friendly and welcoming, I was conscious of power differentials between us when negotiating access and participant numbers. In this situation I felt unable to assert much influence over the decisions being made and was wary that doing so may jeopardise the possibility of conducting the research in this school.

Relations with pupils

By dressing less formally than the majority of their teachers, I wanted pupils to view me as 'other' than a teacher or figure of authority and hoped this would help them do so. It was only on a couple of occasions, and mainly as participants in older groups swore or attempted to give shocking answers, that I felt the pupils were testing whether I would assert authority over them. In such cases I tried not to react to these 'tests'.

In relation to the individual interviews, I feel that age-related power differences did have some influence on the data gathered. This was especially the case when interviewing the P6 participants. Despite being as informal as possible and highlighting that they could skip questions they did not want to answer, a number of the participants appeared to be very uncomfortable in the interview situation. In such cases I tended not to probe their responses as I felt it of lesser importance to lose data than to make sure pupils did not feel intimidated by the interview experience. As the pupils seemed to be more comfortable in the focus groups, I also found these easier and more rewarding to conduct. Secker and colleagues (1999) also report that the young people in their study were more reserved during individual interviews as compared to focus groups and they propose that this may have been due to them being "less certain about talking to a strange adult without peer support [and] unused to one to one discussions with an adult" (p.732).

Whether my gender helped me to establish good relations inevitably varied depending on whether I was speaking to girls or boys. In general, female pupils of all ages seemed to be more comfortable talking to me than did their male counterparts. The fact that girls in S2 and S4 felt able to talk about period pains, but stated that they would not report these to males, directly suggests that a male researcher would not have gathered the same data from these girls. The flip-side of this is that the boys I spoke to may have felt unable to raise issues specific to their gender as a result of me being female. In some of the focus groups with boys I made a point of telling them that I would not be offended by their opinions on girls' behaviour so that they would not allow such fears to prevent them from voicing their opinions. On the other hand, evidence suggests that when accessing health services young males prefer to talk to female GPs because of their concerns that male doctors may be homosexual (Richardson and Rabiee 2001). Therefore, it is possible the boys may have felt more comfortable talking to me than they would have a male researcher. Overall, I feel that I was able to relate most naturally to the S4 girls and they seemed to be the participants most responsive to me. Perhaps being of the same gender and closest in age meant that I was seen as less of an 'outsider' by this group and was instead viewed as someone who would understand them as a result of having gone through similar life experiences.

4.10.7 Moving from 'ideal' to 'real world' research

In stating that research cannot be "brought as a whole concept to be planted within the setting", Holliday (2002, p.157) makes a point which resonates with my fieldwork experiences. When I started to conduct my research I thought that my original study design would remain intact and that school gatekeepers would be able to organise pupils and school facilities to accommodate this. Nevertheless, when teachers tried to negotiate aspects of the study to meet with the limitations of the school context, I sometimes felt that they were not taking the subtleties of the research design, which I had agonised over, into sufficient consideration. In fact, I came to realise that they were making an effort to realistically accommodate the study within the constraints of their own timetables, demands, accountabilities and workloads. As the research progressed it became apparent that the 'ideal' research study can never be achieved due to the inevitability that the complex and unpredictable nature of the 'real world' will intervene. My experiences in the field have taught me that instead of clinging to

this 'ideal', a productive alternative is to work within the limitations of the research context and to compromise in ways which will ensure that research which is conducted is realistic for all involved.

4.11 The focus group guide

4.11.1 Considerations specific to children

When designing focus groups to be conducted with children, attention should be paid to their changing developmental needs and social skills and to engaging their interest in the topic. In recognition of these considerations I decided to make the focus groups task-centred, using visual aids such as symptom cards, vignettes and listing exercises. It was intended that the use of such focussing exercises would help to render symptom reporting less abstract whilst allowing for the comparison of ideas across age and gender groups. Although the same exercises were used with all pupils, the language and questions used in association with these could easily be changed to suit the needs yet challenge the skills of the pupils in each age group.

The use of specifically designed research methods for children is something which researchers have debated. Some argue that the use of child- or task-centred methods can help to harness young people's views by rendering the research topic more concrete whilst utilising the diverse abilities and skills with which children are taught to communicate (Graue and Walsh 1998; Morrow 1999; France, Bendelow et al. 2000; Harden, Scott et al. 2000; O'Kane 2000; Scott 2000; Punch 2002). On the other hand, some see this approach as defeating the purpose of including children in research as it undermines the idea that they are as capable as adults of taking part in interviews, focus groups and other standard methods of research (Shaw 1996; Harden, Scott et al. 2000; Christensen and James 2000b).

Those who recommend the use of special research methods for children suggest they can be effective if this is done in a sensitive, non-patronising way. Harden and colleagues (2000) emphasise the importance and potential success of such methods when used as a stimulus for talk, but not when presented as research evidence in their own right. In the same vein, Morrow and Richards (1996) highlight the ways in which drawing on the skills with which young people feel more competent and confident, for example drawing or storytelling, can serve to empower these respondents. Therefore,

it is important to remember that such methods should not be used with the intention of compensating for the perceived lesser capabilities of children, but only as a way of harnessing their 'different' competencies so that they are given a voice in research (Morrow and Richards 1996; Pole, Mizen et al. 1999; France, Bendelow et al. 2000; Harden, Scott et al. 2000; Christensen and James 2000b).

4.11.2 Outline of focus group guide

Focus groups can be used to inform the design of questionnaires as they provide explorations of the meanings which people attach to the language used and the questions asked (Heary and Hennessy 2002). With this in mind I designed focus group exercises featuring ten symptoms featured in 'The West of Scotland 11-16 Study' in an attempt to shed meaning on the ways in which these symptoms are interpreted and whether gender or age differences might help understand the changing differences in symptom reporting rates.

The final topic guide (Appendix D) used in the main study focus groups was made up of the following three exercises.

1) Symptom Cards

This opening task was designed to investigate the factors which influence boys' and girls' decisions as to whether or not they should report a symptom. Firstly, the participants were asked if they understood what I meant when talking about 'symptoms' and were asked to explain this in their own words. This was to ensure that the concept was understood by the participants and that they had an idea of what the discussion would be focussed around. Participants were then asked to look at ten cards which had symptoms written on them and to state which ones they would be most and least likely to seek help for, if they were experiencing them. The symptoms featured were: headache; stomach ache or feeling sick; cold or flu; aching back, legs or arms; feeling dizzy or faint; asthma or wheezy chest; feeling nervous, worried or anxious; irritable or bad tempered; sad, unhappy or low; and difficulty getting to sleep. Following on from this, participants were asked to talk about the symptoms that they thought their opposite-sex peers would be most and least likely to report. Any differences in the types of symptoms they thought would be reported or the reasons for doing so were then explored.

The symptom cards were also used to conduct a categorisation task. Participants were asked to list the symptoms under either of the following headings: 'Symptoms which girls are more likely to get' or 'Symptoms which boys are more likely to get.' If they saw fit, participants were told that they could put symptoms under both headings. After completing this task, participants were asked why they thought boys/girls were more likely to get certain symptoms and how they thought a boy/girl would react if they were experiencing a symptom which was commonly perceived as being a feminine/masculine problem. Due to time constraints when conducting the focus groups in the secondary school, this task was altered slightly. Instead of asking the group to list the symptoms in two columns on a piece of paper, which often caused disagreements about who would write, they were asked to talk about whether they thought boys or girls were more likely to get certain symptoms and to comment on whether they thought specific symptoms were seen as being more masculine or feminine.

The main aims of the symptom cards activities were a) to start a discussion about the specific symptom-related factors that are considered when deciding whether to report a symptom; b) to investigate whether certain symptoms are perceived as being more/less masculine/feminine and how this might affect symptom reporting; c) to begin to explore whether certain symptoms are perceived as being easy/difficult to disclose; d) to find out whether girls/boys think girls/boys would be most/least likely to report certain symptoms and to discuss any gender differences in symptom reporting.

This exercise served as a good introduction for the groups during both the pilot and the main study. Not only did it give some initial ideas as to how certain group members perceived certain symptoms and how these perceptions might contribute to whether they would tell someone about such symptoms, it also gave an insight into how they felt their opposite-sex peers viewed specific symptoms and opened up discussions into why boys and girls might differ in their views and behaviour.

2) Vignettes

Vignettes can be described as short, hypothetical stories which feature characters in particular circumstances. They are presented to respondents who are then asked to

comment on particular aspects of the story, usually to predict the character's course of action (Finch 1987; Hughes 1998). Vignettes have been acclaimed as valuable research tools because in asking about concrete, 'real life' situations they enable participants to reflect and base ideas on their own experiences as opposed to thinking abstractly (West 1982; France, Bendelow et al. 2000). At the same time they provide a less threatening way for participants to voice their ideas. Instead of being forced to refer to themselves, participants are distanced from the issue as they talk about it only in relation to the vignette character (Finch 1987; Hazel 1995; Hughes 1998). I decided to use vignettes in this study because I felt they would help participants to envisage symptom reporting scenarios and allow them to talk about these without fearing breaches of confidentiality. Vignettes have also been highlighted as tools which recognise the importance of social context on behaviours (Hughes 1998) and which elicit data on "commonly understood norms" (Finch 1987, p.107). Therefore, I also used them in the hope that they might help to shed light on both of these factors in relation to symptom reporting.

The participants were presented with a series of four vignettes (see Appendix E for example of vignettes used with P6 pupils). The first two featured a character, named either Sarah or Steven, who was the same age and gender as those in the group and who, in the first instance, was suffering from a stomach ache and in the second scenario was suffering from a malaise symptom ('feeling like she/he is going to cry all the time'). The third and fourth vignettes featured the same symptoms in the same order, but this time experienced by the character of the opposite sex (but still the same age) to those in the group. Participants were asked to discuss what Sarah/Steven's thoughts might have been from the moment they first began to feel unwell, and what they thought Sarah/Steven would do if they were in class, at home, or out with friends.

Stomach ache² and 'feeling like crying all the time' were chosen so as to explore any

² It is difficult to classify stomach ache as either 'physical' or 'malaise', as is the case with many of the 'physical' symptoms featured in the '11-16 study' symptom checklist. Stomach ache was used as an example of a 'physical' symptom because the rates of reporting stomach aches are highly gendered and it was thought that talking about reactions to stomach ache might help explain this. It is important to note that despite the potential ambiguity surrounding this symptom, pupils always referred to stomach ache as a 'physical' symptom.

differences in attitude towards 'physical' and 'malaise' symptoms and, in particular, how the pupils thought boys and girls would react to these different symptoms. In contrast to the format of some vignettes, participants were not given optional answers from which to choose. This was to prevent groups from picking answers that they thought were 'correct'. Instead, I emphasised that I was not looking for their ideas on what they thought Sarah/Steven *should* do, but rather what they thought the characters *would* do about each symptom in each social context. The vignettes were designed to be open-ended and they lacked detail in order to ensure participants applied as many as possible of their own meanings to the vague scenarios they had been given (Finch 1987). West (1982, p.1) describes this approach as being "deliberately fuzzy or equivocal in order to permit maximum respondent interpretation".

The main aims of this task were a) to explore the participants' ideas on whether symptom reporting varies according to gender and/or age; b) to look at whether the perceived cause and type of symptom influence symptom reporting and whether this further varies by gender; c) to investigate whether the social context in which a symptom is experienced has any impact upon the action which is taken and whether this varies according to gender.

One of the most interesting points to emerge from the vignette data was that presenting the participants with 'real life' situations seemed to force them to think about what they actually would do if they were experiencing such a symptom and as a result they talked about more complicated options which had more provisos than they had initially presented when asked which symptoms they thought boys/girls would be most/least likely to report during the symptom cards task. Nevertheless, the literature on vignettes warns that they cannot be interpreted as predictions of the participants' own actions (Finch 1987; Bendelow 1993; Hughes 1998). In other words, they are not the same as asking participants what *they* would do in the same situations and unless pupils specifically refer to themselves, their responses should be taken as reflections of cultural norms rather than disclosures of their own behaviour. This is a consideration I remained aware of when interpreting the vignette data.

3) Histograms

To finish off the focus groups I explained to participants that past research had found changing gender differences in the symptom reporting of people their age. I showed them four histograms which depicted the percentage of boys and girls who reported having stomach aches, headaches, feeling irritable or bad tempered and sad or low at ages 11, 13 and 15 (Appendix F). These figures were drawn from '11-16 study' data (see Table 1.1 on p.12 or Sweeting and West 2003a, p.35). The groups were asked to look at the four histograms and after I had highlighted their main features (the changing gender patterns in reporting rates and overall differences in reporting rates for 'physical' and 'malaise' symptoms), they were asked to suggest possible explanations for the gender differences, for the way the gender gap increased with age and for the overall differences in rates of reporting for the 'physical' symptoms compared to the 'malaise'. Older groups in particular were asked to comment on the data in the light of their own experiences.

The main aims of this activity were a) to get participants to suggest explanations for gender differences in each symptom; b) to explore whether these results surprised the participants or if they represented their own experiences; c) to investigate ideas around the ways in which growing up can affect your everyday health and whether these differ for boys and girls; d) to utilise the older groups' increasing abilities to think reflectively and to interpret such material.

This task worked well in that it gave the participants something visual to concentrate on and served as a way of pulling together lots of the hypothetical ideas which had been talked about earlier in the group, either supporting or contradicting ideas which had been expressed. However, due to time constraints it was not always possible to discuss the histograms with the oldest pupils. This was unfortunate given that they may have had most to say on this.

4.12 The interview guide

It has been suggested that concentrating on daily events and asking children to describe these is conducive to drawing out their subjective experiences (Mauthner 1997; Kortessluoma, Hentinen et al. 2003). Accordingly the individual interviews were designed to elicit pupils' accounts of their own experiences of illness. To begin

each interview (see Appendix G for full topic guide), I asked interviewees to talk about one of the 'physical' and one of the 'malaise' symptoms which they had indicated on the symptom checklist as having experienced in the last month. I tried to get them to describe as much as possible about the whole process of recognising, experiencing and managing the 'physical' and 'malaise' symptoms which they had recently experienced. This was done by asking them to tell me about the last time that they had the symptom and to describe how it started or how they knew they had it, how it had felt or how it had affected them, how bad it had been, what their initial thoughts were in response to feeling this way and how they had decided to manage the symptom. During this part of the interview I was trying to explore the different levels of feeling and recognition which boys and girls go through with different types of symptoms, at the same time as trying to investigate the processes behind how they decide to manage each symptom, whether they decide to report them and who they decide to tell.

I also tried to get interviewees to comment on any interesting aspects of the group discussion in the light of their own experiences. For example, I often asked questions that I could not ask in the groups, such as whether interviewees would talk to their parents or their friends if they were feeling sad/low and how they thought their parents or friends might react to this as compared to being told about a physical symptom. Further to this there were also occasions when I asked interviewees if they could expand upon a comment or a point that they had made during the group discussion. This was particularly useful if I had not picked up on the comment or had not had time to explore it further within the group.

Although the interview data generated in the main study were an improvement on pilot data, initial analyses revealed that they did not provide as rich or as complex an exploration of the processes involved in recognising, experiencing and managing 'physical' and 'malaise' symptoms as was hoped. I had anticipated that pupils would expand much more on ideas that had been raised during the focus groups and might be more inclined to give 'private' accounts, but this was not the case. The interviews may have been less successful than the focus groups because it was harder in the interviews to break down age-related power relations and to help the pupils feel at ease (see Section 4.10.5). Also, it is possible that pupils found it hard to be reflexive

about their experiences of illness, which, because they were often trivial or passing, they may have viewed as particularly mundane events in their lives. Alternatively, pupils may have felt that they had said all they wanted to on the research topic during the focus group discussion. Thus, after initial analyses, and in view of time constraints and insufficient interview data to compare across gender and age, I decided that only the focus group data should be analysed in detail. Thus, the findings chapters are based solely on these. Nevertheless, the interview data were influential in guiding the generation of data and because they were not included in the systematic analysis does not mean that they did not inform the analysis of the focus group data on some level. Thus, although the main findings of the study do not draw directly upon the interview data, it is difficult to definitively eliminate them from the overall research process.

4.13 Analysis

...there are multiple practices, methods, and possibilities of analysis that qualitative researchers may employ. What links all the approaches is a central concern with transforming and interpreting qualitative data – in a rigorous and scholarly way – in order to capture the complexities of the social worlds we seek to understand. (Coffey and Atkinson 1996, p.3)

Having said at the beginning of this chapter that its structure would follow the chronological progression of my research, writing about analysis at the end of the chapter implies that this was the last task that I approached. On the contrary, analysis began after the first focus group had been conducted and continued until drafts of the findings chapters were finalised. Nevertheless, progressing with my analyses in a thorough and systematic fashion was the aspect of this study which I found most daunting and for which I felt least practical guidance was offered in the methodological literature. Detailed in the sections below are the analytical processes which were utilised and developed over the course of the study.

4.14.1 Watching, listening and taking notes

During and immediately after each research encounter I wrote extensive field notes on what had taken place. Not only was it important to record the initial ideas and themes coming out of the discussions, but it was imperative at this stage to capture all elements of the interactions which would not otherwise have been conveyed in a straight forward audio transcription (Krueger 1998). Krueger (1998, p.12) claims that

along with “obvious body language” and instances of “silent agreement”, the “sense of the group, the mood of the discussion and the eagerness with which the participants talk to one another” are all critical “background factors” that should be recorded immediately to aid in-depth understanding and analysis of the discussions. However, it was also important to think reflexively about my role within the research encounters and how my own behaviour may have impacted upon the data generated.

From the early stages of data gathering, then, I was conducting analyses by listening closely to the recordings, taking notes on developing themes and thinking about ways in which emergent ideas should be investigated further in future focus groups/interviews. This cycle of thought continued throughout the duration of my fieldwork and in the latter stages helped me begin to think about possible links between particular ideas or themes.

4.14.2 Audio transcription of interviews and focus groups

All interviews and focus groups during both the pilot and main studies were tape-recorded. Although I transcribed a small number of recordings, the majority were transcribed by a team of professional audio-typists employed at a local business. Transcribers were asked to include all audio aspects of the recordings, such as pauses, laughter and instances of over-talking, and this was done so that transcripts would convey in as much detail as possible the mood of the research encounter and the type of interaction which took place in each interview and focus group. All transcripts were checked for accuracy and to anonymise any identifying information by reading through each transcript carefully whilst listening to the original tape-recording. This was a time consuming task and, in particular, the focus group transcripts required a considerable amount of work after initial transcription. This was because instances of over-talking were much more frequent and also because of the need to identify each new speaker, often not an easy task given that groups were composed of pupils who were the same age and sex. Thus, a significant amount of time in the research process was spent ‘tidying’ the transcripts for various purposes, yet this was time well spent in order to achieve an accurate record of the research which took place.

4.14.3 Descriptive analyses

When initially faced with my data in their entirety, I found the thought of beginning a more systematic and thorough analysis, both within each and across all transcripts, an overwhelming prospect. Instead of attempting to code for themes at this stage, I found it easier to approach the data by looking at specific sections in turn (e.g. discussions initiated by symptom cards, vignettes and histograms), and by describing the nature of the discussions in each group and across the pupil sub-groups. This seemed the most appropriate approach to analysis given the distinct types of data which each focussing exercise appeared to have generated. For example, whereas the symptom cards yielded discussions of a more general nature which featured stereotypical ideas, discussions generated by the vignettes were the closest to experiential accounts and, instead of stereotypes, they yielded more subtle gender differences. As pupils discussed the histograms they drew on biological and essentialist frameworks as a means of explaining gender differences in symptom reporting. At this early stage of analysis I paid attention to the intricate detail of group dynamics and, as Kreuger (1998) suggests, began my analysis with the consideration and discussion of the words and language used by the participants. Writing these descriptive analyses enabled me to build up an understanding of important themes and allowed me to compare these across age- and gender-groups, taking note of consistencies as well as irregularities. They also allowed me to look across the data and, instead of thinking about codes in terms of the structure set out for the focus groups, I began to think about coding for the main themes that were actually emerging from the data. I feel that this was a crucial step in moving from close readings of the data to thinking more conceptually about their contents and how these might be related back to my research questions.

4.14.4 Coding

Broad beginnings

I began to code my data around three broad themes: firstly, interpretations and experiences of symptoms; secondly, gender- and age-related expectations; and thirdly, physical and social consequences of symptom reporting. Coding can be described as a way of organising your data so as to bring together fragments containing similar elements and aid the organisation and retrieval of these different parts (Coffey and Atkinson 1996; Mason 2002). Nevertheless, this procedure is far from merely

mechanical. Instead, coding is an analytical process which involves the linking of original data with the researcher's theoretical concepts (Coffey and Atkinson 1996). As such, assigning codes is the researcher's way of adding meaning to the data and moving beyond basic readings of them to more conceptually and theoretically informed interpretations (Coffey and Atkinson 1996; Basit 2003).

Using the computer software program, NVivo, I coded my data around the above themes in a very broad and inclusive manner. This was to avoid removing pieces of data from their context, so losing the essence of their meanings particular to that context (St John and Johnson 2000) or disregarding the "triggering stimulus" (Krueger 1998, p.33) which may help to interpret the situated meaning of specific comments. I also coded inclusively so as to leave room for multiple interpretations of ambiguous sections of data. These were then analysed systematically at the next stage of coding (Frankland and Bloor 1999). It is important to note that I found NVivo an extremely useful tool in the management and organisation of my data. However I was aware that the program could not understand the data nor 'do the thinking for me', it was mainly a tool to speed up and organise the mechanical side of the coding process (Catterall and Maclaran 1997; Webb 1999). Early in the coding phase my supervisors and I conducted joint readings of transcripts and discussed the main themes and codes as a means of increasing the validity of the analytical process.

Refining codes using 'Framework'

Using a system based on 'Framework', described as "a matrix based method for ordering and synthesising data" (Ritchie, Spencer et al. 2003, p.219), I began to analyse within each of my broad codes. Firstly, this involved refining the codes to highlight the patterns and themes running through each. I then returned to each transcript and created grids or "thematic charts" (Ritchie, Spencer et al. 2003) in which I listed the narrower themes, belonging to each code, horizontally and the participants vertically. I took note of whether and how each participant had spoken about each theme, taking care not to lose meaning, context or respondents' original language. I felt that this was the most rigorous and systematic way of looking at the interaction between every participant and every theme, as well as of enabling comparisons across all participants and themes. By identifying patterns, consistencies and anomalies, I was able to start moving from the accounts, to making sense of them

in the light of the research questions. This system therefore provided me with a “mechanism for moving back and forth between [the] intellectual puzzle, [the] research questions, and [the] data” (Mason 2002, p.159). It was this process that enabled me to begin constructing my own knowledge and theories as to the higher and broader meanings within the respondents’ accounts. It was at this stage that I began drafting the findings chapters.

4.14.5 Explaining, arguing and theorising

Our task as qualitative researchers is to use ideas in order to develop interpretations that go beyond the limits of our own data and that go beyond how previous scholars have used those ideas. It is in that synthesis that new interpretations and new ideas emerge. (Coffey and Atkinson 1996, p.158)

Having identified and described the various patterns, associations and irregularities within the data, it is then necessary to explore possible reasons and explanations for their occurrence. This involves going from the emerging theories, back to the original data to verify and enhance possible explanations. This has been described as a process of going up and down the ‘analytic hierarchy’ to investigate assumptions and assess the degree to which the emerging theories represent the data (Spencer, Ritchie et al. 2003). This process should be continued “until the pieces of the puzzle clearly fit” (Ritchie, Spencer et al. 2003, p.252). In tandem with this process, and so as to achieve wider encompassing explanations, it is necessary to draw upon general and specialised knowledge when thinking about ways in which the data should be interrogated and how valid explanations may be constructed (Coffey and Atkinson 1996). To develop the ideas, explanations and theories emerging from my analyses, I attempted to follow the processes just described. It was at this stage that I spent a substantial amount of time reading the theoretical literature around gender, health and young masculinities and femininities. This was greatly influential and beneficial to the development of my thinking and meant that I felt able to conduct a more theoretically informed second stage of analysis. This involved going back to the data, analysing more specifically for the absence or presence of gender and/or age differences, and forming interpretations and explanations which were framed in terms of my own thoughts, existing social theory and the degree to which they may shed light on the conceptual frameworks used by the respondents. I feel that both the

practical and more abstract foundations of the 'Framework' approach allowed me to view the data from a number of analytical standpoints. As my analyses progressed, the view at each standpoint was further from the original data but closer to a theoretically informed understanding of them. Nevertheless, I was able to ensure that my ideas did not stray too far from the data as at any point I could retrace the steps of my analyses to make certain I was developing accurate and valid explanations. It was through the adoption of this approach that I aimed to conduct rigorous and systematic analyses of my data which would, in turn, enhance the quality and reliability of the explanations formed.

4.14.6 From research questions to research findings

Before outlining the findings of this study it is important to reiterate the research questions addressed in the following three chapters and highlight the rationale behind the order in which they are presented. As pupils' ideas were strongly influenced by gender- and age-related expectations, Chapter 5 begins the presentation of findings by exploring pupils' perceptions of these expectations, looking specifically at whether and how they might affect boys' and girls' illness behaviours. Although the data presented in this chapter draw mainly from pupils' general and more stereotypical discussions, data from the vignette and histogram tasks were included where relevant. The chapter addresses the following research question:

- 1: Do gender- and/or age-related expectations influence boys' and girls' illness behaviours and symptom reporting?
 - a) What are the gender- and age-related expectations that boys and girls feel are placed upon them by society?
 - b) Are there gender or age differences in the extent to which these expectations impact upon boys' and girls' illness behaviours and symptom reporting?
 - c) How might any gender and/or age differences in the perception and influence of societal expectations help to explain the changing gender patterns in symptom reporting?

Chapter 6 goes on to look at the ways in which boys and girls conceptualise symptoms and refers to findings outlined in relation to pupils' perceptions of gender- and age-related expectations as a way of making sense of any gender or age

differences in pupils' conceptualisations. This chapter, which features data that were mainly generated in relation to the symptom cards task, addresses the second of the three research questions:

2: Are there gender and/or age differences in the ways that boys and girls conceptualise symptoms?

- a) How do boys and girls conceptualise symptoms and show what they understand them to mean?
- b) How might any gender and/or age differences in boys' and girls' conceptualisations of symptoms help to explain the changing gender patterns in symptom reporting?

The final findings chapter addresses the following research question:

3: Are there gender and/or age differences in how boys and girls decide whether or not to report symptoms in different social contexts?

- a) What factors do boys and girls highlight as being most important when deciding whether or not to report symptoms?
- b) Are there gender and/or age differences in terms of the factors which pupils consider important when deciding whether or not to report symptoms?
- c) How might any gender and/or age differences in the ways that boys and girls decide whether or not to report symptoms help to explain the changing gender patterns in symptom reporting?

Chapter 7 brings together concepts which were introduced in Chapters 5 and 6 as it demonstrates the ways in which pupils' perceptions of gender- and age-related expectations as well as their conceptualisations of symptoms influence their decisions about whether or not to report symptoms in different social contexts. In this case, the data presented are drawn entirely from the vignettes exercise and represent pupils' experiential accounts of symptoms most closely.

Chapter Five: The impact of gender- and age-related expectations and stereotypes on boys' and girls' symptom reporting

5.1 Introduction

This chapter addresses the themes of gender- and age-related expectations and stereotypes as they arose during pupils' discussions. The findings presented here highlight their perceptions of the 'expected' or 'correct' ways of 'doing gender' (West and Zimmerman 1987), specifically in relation to illness behaviour and symptom reporting. The chapter also draws attention to the various ways in which pupils used the discussions as opportunities to construct their own, and police one another's, gender identities.

5.2 What are gender- and age-related expectations, and how do they impact upon boys' and girls' symptom reporting?

This section deals with pupils' perceptions of gender- and age-related expectations placed upon boys and girls. It outlines their views on how boys and girls might react to various symptoms and highlights the ways in which they used these discussions to construct their own gender identities and to portray themselves as 'doing gender' in the 'correct' way.

5.2.1 Gender- and age-related expectations of boys

All pupils displayed a clear awareness of society's expectations of boys. In terms of boys' reactions to symptoms, they generally felt that stereotypically masculine responses would be expected. For example, Gareth (S4b16) suggested that boys would be made fun of if they were to "whinge about a cold". Ideas like this suggest that stereotypically masculine reactions to symptoms would take the form of displays of stoicism, independence, control and strength.

Expectations of boys were either mentioned explicitly, using phrases and words like "meant to", "supposed to", "have to", "need to" and "shouldn't", or more implicitly as pupils spoke about behaviours which boys "prefer", "like", "want" or "try" to adopt. Typical examples of explicit references to expectations are provided below:

Andrew: ...boys are supposed to be stronger

(P6b8)

Tara: ...they're [boys] and they're supposed to be [...] tough and hard

(S2g22)

Kenny: ...boys are meant to play like football and...do lots of sports

(S2b20)

Sheena: ...boys are supposed to be macho and not show emotion

(S4g13)

These quotes indicate pupils' awareness of societal expectations which outline the 'correct' ways for boys to behave. Although awareness of these expectations was fairly evenly spread across all three age-groups, it is surprising that S4 boys and girls referred *least* frequently to expectations in these explicit ways. It is also significant that expectations were outlined most explicitly and emphatically in relation to 'malaise' symptoms or instances of crying.

Expectations of boys were also highlighted implicitly and the statements below are characteristic of ways in which this was done:

Gary: [boys] try not to [show emotions] we just try to, be like...untouchable

(S2b24)

Isla: [boys] like to act all tough and...don't let their feelings...go against them

(S2g22)

These statements suggest that boys are aware of gender-related expectations and the use of phrases like "try to" and "like to" highlight pupils' recognition of boys' efforts

to comply with expectations and to 'do boy' (Frosh, Phoenix et al. 2002) in the 'correct' ways.

Gender- and age-related expectations were often discussed simultaneously. The following extracts exemplify ways in which this generally occurred:

Kenny: ...you shouldn't really show your feelings at school [...] other people don't so you don't.

Adam: Especially when you're like a boy that's thirteen...

(S2b20)

Sharon: [...] cos...he's a boy and he's got to be tough [...] That's what they expect him to be.

[...]

Leigha: And when they're older they're meant to be even more tough.

(P6g10)

In these examples, the S2 boys suggested, and the P6 girls stated, that the pressure on boys to behave in masculine and "tough" ways increases as they get older. This idea also came across implicitly. For example, P6 boys showed their awareness of age-related expectations as they claimed that "only wee boys... cry" (Tom, P6b7) or it is "babyish" (Hamish, P6b5) for boys to cry. Amy (S4g26) was even more specific about when boys begin to feel the pressure of age- and gender-related expectations, claiming they "want to be more macho and manly" when they go to secondary school.

5.2.2 Talking about symptoms and 'doing boy'

The following sections detail pupils' perceptions of how boys would be most likely to react to symptoms, highlighting specifically how these discussions may have been used by boys to construct, or enhance their constructions of, masculine identities. Unless age-based differences are specifically mentioned, the following sections outline ways in which boys from all age-groups portrayed their reactions to symptoms.

Boys concealing symptoms

Boys frequently referred to ways in which they would conceal their symptoms. Often they did this using simple statements, such as Nick's (S2b12) claim that Steven (male vignette character) would "hide it" if he had a stomach ache when out with friends, or Robert's (P6b5) that he would "lock himself in [the toilet]" if he was at home and felt like crying. On occasion, boys went into more detail by discussing ways in which, when out with friends, they would "try and get home without saying anything" (Josh, S4b19) about their symptoms. Thus, boys spoke about how they would conceal symptoms and, by doing so, would conform to the expectation that boys are strong and not affected by illness. In fact, James' (S4b17) opinion, that there is a "subconscious thing for guys that when they tell they feel ill it makes them look weak", sheds further light on boys' concealment of, or claims to conceal, their symptoms. It suggests that they do this to avoid being seen as weak and, in turn, failing to fulfil society's expectations of them. Indeed, it is possible that within the research setting, the boys were also conscious of the ways in which their responses would reflect on their masculine identities. Thus, they may have tailored their responses in order to portray themselves as "tough" and able to cope with illness without help.

Although the majority of boys' groups, of all ages, spoke about ways in which they would conceal symptoms, P6 boys did so most explicitly. In particular, when asked how they would react to certain symptoms, their initial responses tended to suggest that they would hide them and they did so using imperative forms of speech. For example, when asked how Steven might react if he felt like he was going to cry, initial responses were offered quickly:

Calum: Hold it in, try and not let it out

(P6b3)

Hamish: Don't speak to anyone

(P6b5)

Gordon: Not tell anyone, go to the toilets

(P6b3)

The boys' responses were short and sharp, as if reiterating orders or a code of behaviour and, in doing so, telling Steven how to respond to the symptom at the same time as displaying that they knew the expected way to react. As it was in relation to 'malaise' symptoms that their language became marked in this way, it suggests that the rules of behaviour are particularly clear in relation to these. Indeed, the fact that boys immediately responded using this 'language of rules', in respect of the male but not female vignette character, suggests the degree to which they were aware that 'malaise' symptoms should be responded to in distinct and gender-distinguishing ways which enable the suppression of the symptoms and fulfilment of masculine expectations. It is significant that it was P6 boys who were most likely to use this 'language of rules' and this may suggest that gender-related expectations peak around this age. However, this idea is contradicted by the way that P6 boys suggested that Steven could cry in private or isolated spaces, such as his bedroom or the bathroom, or he "could maybe tell the teacher [that he felt sad]" (Connor, P6b7), but that neither suggestion was made by S4 boys. Instead, although the oldest boys were less likely to outline expectations in explicit ways, their accounts implied that Steven would stop himself from crying, even in secret, and telling the teacher about the 'malaise' symptom was rarely entertained as a possibility. Indeed, Joe (S4b11) asserted that if Steven felt like crying in class, "he wouldn't say anything, guaranteed". The very reluctance of S4 boys to even talk about what boys might do when they feel like crying suggests that gender-related expectations may have resulted in them not feeling able or being willing to talk about emotions, either in the research setting or their everyday lives. Thus, it is probable that gender-related expectations increase steadily with age and either that the P6 boys' language was more heavily dominated by the 'rules' implicit in gender-related expectations because of age-related differences in language skills or because, at their age, it was less risky for them to talk about these 'rules' more explicitly and a sign that they were perhaps less practised at 'doing boy'.

The majority of the girls also believed that boys would hide their symptoms. As they speculated about the ways in which boys "pretend [...] they're absolutely fine" (Tess, P6g1) and "hide everything away" (Isla, S2g22), they highlighted ways in which they

thought that boys would conceal their symptoms and feelings. Girls also alluded to what they thought were boys' reasons for hiding their symptoms. Jennifer (P6g2) suggested that "they keep it all bottled up so that they seem cooler and better than everybody else" and, along similar lines, Rose (S4g26) said they are not "keen to show they're not well cos they think they might not look as tough". On the whole, although girls' ideas seem to be based more on stereotypes than observation, they accorded with the boys' ideas as they also claimed that boys conceal their symptoms in order to conform to societal expectations which outline the need for boys to appear stoic and independent.

Boys disguising symptoms

Boys also claimed that they would disguise certain symptoms or present them instead either as those they deemed less threatening to their masculinity or as feelings they believed to be more acceptable. As an example, these groups discussed what they might do if they felt like crying when out with friends:

Craig: Yeah. But if it was, like, in a big [football] match where there's like people, some people I don't even know, I wouldn't like to ...

[...]

Hamish: I wouldn't go out and play, so ...

Mark: Pretend I'm injured.

(P6b5)

So what if [Steven] was out with friends [and felt like he was going to cry]?

James: I don't think he'd say anything, and if he did, it'd be "I'm not feeling well." He wouldn't say "I feel like I'm gonna cry" [...] he'd just say "I'm not feeling well, I'm just gonna head."

(S4b17)

The boys, both in these groups and generally, demonstrated that their main concern would be to remove themselves from public contexts, especially those involving sport or other 'masculine' activities, when feeling emotional or upset. The fact that Mark

(P6b5) said he would pretend he was injured shows how he would disguise his symptom as being 'physical' instead of 'malaise'. Obviously he felt that a 'physical' symptom would be seen as a more acceptable reason for not playing in the football match. James (S4b17) also suggested that Steven would hide his true feelings under a vague description which others might interpret as a complaint of physical illness. S2 boys also spoke about ways in which they would conceal their symptoms and true feelings by disguising them and making them conform to more masculine expectations. In one group, Gregor (S2b24) claimed that if he felt like crying when out with his friends he would pretend to have "laughed so hard" that it had made him cry. These examples demonstrate boys' attempts to disguise 'malaise' symptoms as other symptoms or behaviours which they viewed as having clearer masculine connotations. It is possible that they would do this, or said they would do this, so as to prevent their masculine identities coming into question if it became known that they were suffering from a symptom perceived as trivial or having feminine connotations.

Girls also speculated about the ways in which boys would disguise their symptoms. They highlighted sporting injuries or expressions of anger as disguises boys may use to hide their real symptoms. As a typical example, the girls in an S2 group suggested that:

Amanda: [...] they could just be saying something really bad to cover up what they really had wrong with them.

Gemma: Yeah, if like a boy -

Nadine: Because if someone had been teasing them or something like that, they wouldn't want to say that.

Gemma: ...started crying. Yeah, boys wouldn't want to say that, I don't think. They'd just say "Oh, em... I've hurt my ankle" or something.

[...]

Amanda: Cos a lot of boys do sport and they can sort of go "Oh, I've hurt my ankle doing this".

Gemma: Because they can go "Oh, I was in a fight and I hurt my hand" or something [...] and then it still sounds like they're being tough.... (S2g23)

These girls also saw it as being a priority for boys to cover up any symptoms which could be perceived as trivial or 'feminine' with other symptoms which were more likely to be seen as "really bad" or the result of masculine activities. During an S4 group, Zoe expressed similar ideas and tried to explain boys' motivations for disguising their symptoms:

Zoe: [guys] don't want to show they're upset. They just kind of hide it within their anger [...] It's still showing that they're vulnerable but it's like [...] a macho sort of vulnerable [...] cos they think crying's, like, really girly and stuff. But whereas, like, if you're just trying to act, like, angry, then...people sometimes respect you more [...] I don't think that, but some people do.

(S4g21)

Zoe's ideas are more sophisticated than any other explanations offered as they highlight the possibility that boys disguise symptoms which may be perceived as trivial or "girly" in order to salvage as much as possible of their masculine dignity.

Boys distancing themselves from, or identifying with, symptoms

Linked to the concealing and disguising of certain symptoms, boys also attempted to distance themselves from symptoms with feminine connotations, usually 'malaise' symptoms, or identify themselves with symptoms they saw as having masculine connotations. In the most basic sense, boys attempted to distance themselves from certain symptoms by claiming that they did not suffer from them. This was particularly the case in relation to P6 boys and 'malaise' symptoms:

Mark: I'm not usually sad.

Hamish: I'm not usually but-

Craig: I'm not usually.

[...]

Hamish: I've only cried...

Craig: Hamish, we don't have to count it up.

Mark: Hamish!

[Laughter]

Hamish: ...three times since I came to this school.

(P6b5)

As soon as they could, the boys in this group, as in most, were keen to distance themselves from having experienced being sad, unhappy or low. To prove his stoicism, Hamish went so far as to count the few occasions on which he had cried in school. Significantly, the others in his group laughed at him for doing this, claiming it was unnecessary and perhaps trying to show that they had less need than Hamish to prove their masculinity. In another P6 group, similar claims were made but on this occasion the boys were keen to show how they had overcome their sadness:

Jack: I'm never really ever sad.

Andrew: Mhmm, barely ever sad.

[...]

Jack: Cos when my first dog got put down and I was walking out of the vet I just kept holding like and I...held it in and I never started crying.

Andrew: Yeah, when my granny had fallen down the stairs and I was, like, sad in case she was going to die, it was just, like, trying to keep it in, not make myself look like a wussy in front of my sister.

(P6b8)

Although these boys initially conformed to expectations by distancing themselves from being affected by feelings of sadness, by the end of the discussion all of them had recounted times when they had felt so sad that they were close to tears. Nevertheless, they continued to construct typically masculine identities as they each explained how they had “held it in” and had been strong enough to overcome and control their emotions.

Boys in S2 and S4 groups sometimes distanced themselves further from ‘malaise’ symptoms by questioning the very fact that boys might feel like they were going to cry, laughing at scenarios in which Steven had the ‘malaise’ symptom and giving minimal information as to how he or they might react to this. Derek (S2b20) and his group provide a good example. When they were shown the ‘malaise’ vignette card, Derek started to read it out but stopped half-way through to exclaim, “Cry?!”, making

the others in his group laugh. Presumably it was in an attempt to distance himself from the 'malaise' symptom that Derek stopped reading the card and expressed his surprise at any boy being affected by this. Responding with laughter, whether overt or suppressed, was also a common technique used by older boys to show their distance from and lack of empathy for boys with 'malaise' symptoms. Overall, boys seemed to use this technique of distancing themselves from certain symptoms so as to claim either that they were unaffected by, or could control and overcome, their emotions, thereby enhancing their projections of themselves as 'successfully masculine' (Swain 2003).

In addition to distancing themselves from 'feminine' symptoms, boys also attempted to identify themselves as having experienced symptoms which they perceived to be 'masculine'. Symptoms they were most likely to admit to having experienced were aching back, legs or arms and feeling irritable or bad tempered. This extract is taken from an S4 group:

What about boys? Are there symptoms that they get more than girls?

Matthew: Aching back, legs and arms.

Gareth: Aye, I get that all the time.

(S4b16)

Significantly, once it was suggested, during the symptom cards task, that aching back, legs or arms is a symptom which boys are more likely to get, Gareth was keen to highlight, not only that he suffers from this, but that he does so "all the time". In doing so, he was perhaps trying to identify with this symptom so as to put himself forward as a typical boy. Jack's (P6b8) claims that "I get really, really bad tempered", after this too was identified by his group as a 'masculine' symptom, illustrates how boys in P6 groups went to similar lengths to identify themselves with symptoms that were seen to have masculine connotations. In another P6 group, Craig compared being irritable or bad tempered to other symptoms:

Craig: Well, I think boys probably do get quite sad and unhappy and low and all that, but em, they don't like admitting it. And the same with stomach ache, and...same with headache as well, I think. I think this

[feeling irritable or bad tempered] is the only one that they would actually maybe tell or show.

(P6b5)

As opposed to not wanting to admit to symptoms such as feeling sad, unhappy or low, or having a stomach ache or headache, Craig implied that being irritable or bad tempered is viewed by boys as being more acceptable and is therefore a symptom that they would feel able to report or 'show'. In fact, the way in which some boys seemed keen to portray themselves as irritable or bad tempered suggests that this may even have been seen as a desirable symptom to report and one, because of its associations with masculine traits such as aggression and the potential for violence, which would boost attempts to construct a masculine identity. An example of this is found during another of the P6 boys' groups:

Andrew: Boys just like... fight with people that are annoying them but girls they just like...

Jack: Fall out.

Andrew: Slap them and go all the time.

Jack: Just run away

Andrew: And then their anger just keeps on building and...

Jack: And boys just let all their anger go and like... do fifty punches or a broken leg...

(P6b8)

In this instance the boys were keen to associate themselves, and boys in general, with violent behaviour, and in an attempt to prove boys' connection with this symptom they questioned the idea that girls would experience higher rates of irritability or bad temperedness.

Girls also noted ways in which they thought that boys would not admit to certain symptoms but would play up others so as to conform to masculine expectations. Again, they were accurate in predicting that boys "wouldn't tell about emotional ones" (Amy, S4g26) yet would "show when they're bad tempered" (Alison, P6g10).

In fact, Pamela (S4g13) reasoned that boys would not tell about feeling sad but would report a cold or flu because “it’s just the chance of getting, like, sympathy and stuff like that without actually hurting their pride or anything”. Pamela implied that symptoms of the cold and flu, perhaps because they are caused by germs which are external to the body, are seen as gender-neutral by boys and because of this they can be reported without risking their efforts to construct a masculine identity. The flip-side of this, in accordance with boys’ discussions, is that reporting symptoms with feminine connotations can have detrimental effects on boys’ attempts to conform to societal expectations and portray themselves as ‘successfully masculine’.

Boys reporting symptoms

As well as identifying themselves with certain ‘masculine’ symptoms, boys also spoke about reporting symptoms, such as stomach ache, when they had become so severe that they could no longer cope with them on their own (see Chapter 7, Section 7.2). Some girls also referred to exceptional cases when they thought that boys would report ‘physical’ symptoms. Specifically, they suggested that boys “do go home if they’re ill” (Sheena, S4g13) or will tell someone if they feel “really, really sick” (Isla, S2g22). Generally, it was suggested that these exceptions to reacting to symptoms in typically masculine ways, such as telling someone they felt ill or going home from school, would only arise when boys felt seriously ill.

Across the groups, some boys described a minority of circumstances in which they would feel able to report ‘malaise’ symptoms and, thus, would be able to ‘do boy’ in a different way. During their discussions, three P6 boys, Jason (P6b6), Connor (P6b7) and Tom (P6b7), admitted to sometimes feeling sad and related this to the fact that their parents had either recently divorced or re-married. Perhaps these boys felt that they could admit to these feelings without risking their masculine identities because they had a clear reason for feeling sad and it was something which was out of their control.

A small number of boys across all age-groups also said they would tell someone if they felt sad or felt like crying and they seemed to feel that they could do so only because of the particular context they were in or the nature of their relationship with the person they would tell. For example, Andrew (P6b8) said that he would tell

Angus (another boy in his group) if he felt like he was going to cry because “we’ve known each other for a long time and like we live really close together”. Thus, he described a close relationship with Angus which would allow him to be more open about his feelings. Aside from Angus, when asked about the prospect of confiding in friends about this symptom the majority of the boys seemed sceptical and portrayed this as being conditional on a number of factors, including whether or not they deemed their friendships to be close enough to do this and whether they felt that the group of friends they were with was small enough to risk disclosing their feelings. Most boys portrayed themselves, and Steven, as reluctant to tell even “close friends” if they felt sad or like crying. However, it is important to bear in mind, given the presence of their male peers within the focus groups, that boys may have consciously framed their responses in these ways if they feared that talking to other boys about their feelings may be construed as ‘feminine’ or even ‘homosexual’ behaviour.

In relation to feeling like crying at home, James (S4b17) suggested that “you would tell your mum [because] I think it’s more of a mental thing that you can tell your mum”. This implies that at home different rules and expectations might apply because in this context you can report the symptoms for which efforts would be made to conceal elsewhere. James also implied that a special relationship existed between himself and his mother which allowed him to confide in her. Apart from James, most older boys portrayed the option of telling their parents about this symptom as being heavily conditional on their relationship with them and how comfortable they would be in talking to them about their feelings. As Joe (S4b11) said, “you could tell your parents, but you still might not be completely comfortable with it”, he summed up the sense of ambiguity around whether older boys would be able or willing to confide in their parents. Significantly, P6 boys were more likely to spontaneously suggest that Steven would “speak to his mum” (Hamish, P6b5) about the ‘malaise’ symptom. Perhaps the older boys were more likely to under-emphasise the ‘public/private’ distinction as a means of constructing themselves as independent regardless of the context.

It is significant that all boys who admitted to feeling sad, unhappy or low and most of those who said they would tell someone about these feelings were in the youngest age-group and perhaps not under as much pressure as older boys to conform to

masculine expectations at all times. However, when any boys suggested that they would disclose this symptom they alluded to special circumstances, such as parental divorce or close relationships (friends or family), which would allow them to express feelings of sadness without as much fear for their masculine identities as they would have in most other circumstances.

5.2.3 Gender- and age-related expectations of girls

In relation to girls, pupils spoke less about expectations in terms of strict rules and prohibited behaviours. As compared to the ways in which expectations were talked about in relation to boys, there was less of a sense that for girls there are certain behaviours or emotions which they are “not meant to” adopt or display. Instead, pupils tended to highlight behaviours which were prohibited for boys, as being permitted, although not completely socially acceptable, for girls. For example, pupils commonly referred to expectations in implicit ways, saying, for example, that “everyone thinks girls are really sensitive” (Amanda, S2g23) or “[people] don’t really think of girls crying [as] being a silly thing” (Adam, S2b20). When expectations were referred to more explicitly or claims were made that girls are “expected”, “meant” or “supposed” to behave in certain ways, this was mostly done by boys as they spoke about girls’ reactions to ‘malaise’ symptoms. Often they asserted that “girls are expected to cry” (Calum, P6b3) and allowed to behave in more emotional ways.

However, it is hard to summarise the girls’ perceptions of and reactions to gender expectations placed on girls, especially in relation to ‘malaise’ symptoms. This is because the expectations that they highlighted and the reactions to symptoms they said they or their same-sex peers would have, often contradicted one another. Despite acknowledging similar superficial stereotypes to those outlined by boys of girls, for example that it is “accepted that girls can [...] cry all the time” (Rose, S4g26), most girls also spoke emphatically about ways in which they would *hide* their emotions and *stop* themselves from crying in public so as to avoid being “really embarrassed” (Hazel, S2g25) and seen as “stupid” or “babyish”. Thus, despite the fact that many girls highlighted the expectation that girls are more emotional, and implied that displays of emotion are not prohibited for them in the way that they are for boys, it seems some also felt that it would not be acceptable for them to cry or show emotion in public. One explanation for this contradiction may be that girls initially drew upon

stereotypical ideas as to what all girls are 'supposed' to be like and it was not until they were asked to put themselves in the position of Sarah (female vignette character) that they thought, without relying on stereotypes, about how they might actually react. It is also possible that the girls highlighted a range of ways in which they might react to 'malaise' symptoms because, although old stereotypes about girls being more sensitive and emotional still exist, expectations of girls have changed in tandem with the changing position of women in society. Thus it appears that there are now less clear expectations and more ways for adolescent girls to 'do girl'.

In terms of age-related expectations of girls, an awareness that stoicism should increase with age was evident during girls' discussions, especially when these touched upon what Sarah might do if she felt like crying. For example, Rhona (P6g2) said that "if girls get older [they don't] cry as much" and, in another P6 group, the discussion of this symptom also highlighted, albeit implicitly, girls' recognition of age-related expectations:

...so what do you think might be putting [Sarah] off actually telling the teacher [that she feels like she is going to cry]?

Sandra: In case she does just burst out in crying and her friends say something to her.

Lisa: Or if she burst out crying to the teacher and some people who don't like her saying like whisper to each other, "She's a big cry-baby", or something.

(P6g9)

S2 and S4 girls also displayed an awareness of these expectations and this was displayed particularly well by the girls in S2g22:

And what's the difference, then, between the stomach ache and ['feeling like crying all the time'], do you think?

Jill: Cos crying's more ... people would more think it was ...

Tara: Babyish.

Jill: Yeah.

Tara: More personal and like... you can't really do that in high school, that's like the way they make it, make it out.

(S2g22)

In this example, the notion that the 'malaise' symptom would be perceived as "babyish" is once again raised and compounded by the idea that not being in control of your emotions is particularly looked down upon "in high school". This suggests that the transition to secondary school may be seen as a landmark beyond which more adult-like behaviour is expected. It appears, therefore, that girls are aware of age-related expectations which call for them to cope with symptoms in more independent and stoic ways as they get older. Because most boys tended to endorse the stereotypes that girls are expected to cry and always moan about being ill, none of them explicitly suggested that girls need to show increasing stoicism as they get older. Nevertheless, it was more common for boys in S4 groups to say that boys and girls would react to symptoms in similar ways, thus implicitly suggesting that girls' stoicism does increase with age in order to be similar to that of boys by age 15.

5.2.4 Talking about symptoms and 'doing girl'

Girls' reactions to symptoms were also discussed in ways which suggest that girls often conform to gender-related expectations and, whether consciously or unconsciously, react to symptoms in ways which allow them to 'do girl'. During the groups, girls also spoke about their reactions to symptoms in ways which allowed them to identify themselves with key 'feminine' characteristics.

Girls reporting symptoms

The majority of the girls' groups agreed that girls were more likely than boys to report symptoms, both in their everyday lives and when completing symptom checklists. In fact, even within the focus group setting, girls were more likely than boys to talk about their symptom experiences. Becky provides a good, but also the most extreme, example of this:

Becky: [...] like I worry, like, quite a lot because I'm highly strung and, you're just lying in your bed and you can't get to sleep [...] cos I'm anaemic. When my period comes, like, I get really, really dizzy and I also suffer from migraines [...] and I get headaches nearly everyday.

(S4g14)

Few pupils, regardless of age or gender, spoke as frequently as Becky did about their own experiences of illness. However, girls were both more likely to talk about their symptoms within the focus groups and to claim that girls are more likely to report more symptoms in their everyday lives. When talking about why they would report their symptoms, most girls alluded to key 'feminine' characteristics in order to portray symptom reporting in a positive light.

One of the main ways that girls did this was by laying claim to close and mutually supportive friendships which enabled them to tell their "best" friends about most symptoms and, in return, receive the understanding and support of these friends. The ability to establish and uphold close relationships can be seen as a key characteristic of traditional femininity and many of the girls were keen to highlight their possession of these abilities, thus constructing themselves as 'doing girl' successfully. The extracts below show the various ways in which this was done:

Tess: Like, well, if I were [Sarah and had a stomach ache], like... it depends like where, if like I was her, it depends where I'd be with my friends. If I was, like, with my friends in town, like up in town shopping or something, I'd say, like... cos like, well, all my friends are kind of close to me. I don't really have like friends that are just friends. All my friends are like kinda my best friends, they're all, like, equal.

Eve: That's kind of the same with me because I'm...

Myra: Same here.

Tess: And so, like-

Eve: Cos it's like me and Tess and Anna mostly, like Megan mostly hang out and that and like we're just like all best friends. There's not, like, one of us that, like, is not like, that's very close. We're just, like, all sorta pally-pally.

[...]

Myra: I have a best, best, best, best friend and em, if I had a sore tummy I think she'd just... take me home and then we'd probably just play at home and then if it was really bad she'd go home and then... play again another day, cos she's really supportive.

(P6g1)

[What do you think Sarah would do if she was out with friends and felt like she was going to cry?]

Amy: Em... she'd just be like "I'm feeling really sad" and then her friends would just give her, like, a hug, and just say "It's okay." But if she didn't have any friends then she would probably just... [laughs] go to the toilet and cry.

Rose: That's probably why she's crying.

[Laughter]

(S4g26)

In the first of these quotes, there is a sense of competition as Myra, Tess and Eve were all keen to talk about the close nature of their relationships with their friends and to portray themselves as successful in building friendships and, therefore, able to confide in their friends about their symptoms. In the second extract, Amy and Rose also implied that they would be able to confide in their friends and receive support from them. What is more, however, the way that they laughed at the prospect of a girl not having any friends to talk to, suggests that they viewed this as a form of failure. The majority of the girls also talked about ways in which they would express concern and understanding for friends who felt unwell. It was common for girls to imitate the exclamations of sympathy and offers of help which they or their friends would make, as well as to describe the way in which girls would hug each other and collectively seek help. Thus, they displayed the mutually supportive element of their relationships and, across all age-groups, conceptualised close friendships as something which most girls have and which facilitates their symptom reporting.

There were also suggestions that girls become increasingly dependent on their female friends as they get older. Indeed, Collette's (S4g21) statement, that she would "feel very comfortable crying around [her] friends", is poles apart from any of the tentative suggestions made by boys that they *might* be able to confide in a *very* close and trusted friend, but would still be reluctant to do so. Indeed, her apparent comfort and assuredness in making the statement was not even characteristic of younger girls, who seemed relatively wary about which friends they could trust. The fact that other S4 girls had also said that, when 'out with friends', Sarah would "just cry" (Rose, S4g26) or at least confide in them about her feelings suggests that as they get older, girls may

form closer and more stable bonds with their friends. In fact, it was explicitly suggested that, as they get older, girls get better at knowing which friends they can trust:

Ruth: If you've been friends, eh, with someone for a long time, then you get to know them and know things about them and you know that you can trust them.

(S4g13)

Perhaps it is because of girls' improving judgement of which friends they can trust that, by S4, they appear to confide in them and rely on them more for support. However, there was no evidence that the same occurs for boys and their same-sex friendships as they get older.

Another way that girls portrayed symptom reporting as a means of 'doing girl', was by portraying themselves, and girls in general, as honest in their reactions to symptoms. For example, the majority felt that when completing symptom checklists girls would "tell the truth" (Tara, S2g22) about symptoms they had experienced. Thus, in constructing girls as "more open" (Sheena, S4g13) and "more likely to be honest" (Carrine, S4g14), they implied that these values are typical of all girls and, once again, conceptualised symptom reporting as a positive outcome of their 'feminine' characteristics. Similarly, girls also constructed themselves as being responsible in their reactions to symptoms. In particular, P6 girls did this as they implied that 'doing girl' is better for girls' health than 'doing boy' is for boys' health:

Tess: ...like, if I'm feeling really upset, I'll, like, get it out of me. Like, I'll cry or I'll do something or like, I'll, like... go and lie on my bed and, like, do something. And em... like, boys'll just like keep it all bottled up inside them and they, like, they don't like sharing it with people. Cos they think...

Eve: I think that's quite bad because I mean, like... cos we were talking about, like, feelings once and the teacher was saying it's best to, like, get it out, it's best to, like, cry and that. But I mean when the boys, like, keep it bottled up, they just, it's like if they're getting, if somebody's calling them names and that and they get really upset about it, they'd like try and act like he is not actually upset, that he's staying tough and that but he'd be like... he would be really upset and like he feels like he's gonna cry.

[...]

Tess: And like [girls] don't care what people are gonna say. They just want to get it sorted.

(P6g1)

The majority of the P6 girls talked about boys as being more likely to “bottle up” their feelings and, in turn, portrayed this as being “a bad thing” (Ellie, P6g2). In contrast, they spoke about girls being more likely to express their feelings or cry, and this was constructed as how it is “best to” cope when feeling upset. Therefore, across all age-groups, girls implied that reporting symptoms is one way of ‘doing girl’ and, indeed, that ‘doing girl’ is good for girls’ health and psychological well-being.

Across all of the girls’ discussions, girls in general were attributed with a number of characteristics which may result in them being more likely than boys to report symptoms. Alongside positive characteristics, such as being labelled more “honest”, “brave” and “confident”, some girls also portrayed themselves, or girls in general, in more negative terms as “moany”, “fragile” and dependent on others. The fact that they were able to draw on such a range of characteristics whilst continuing to project feminine identities, highlights the diversity of behaviours available to girls and also suggests that they are faced by contradictory expectations as femininity is both valued and devalued at the same time. Indeed, the naming of “brave” and “confident”, two characteristics not traditionally associated with femininity, as ways of ‘doing girl’ may signal girls’ awareness of, and reactions to, changing societal expectations of what it means to be feminine in the twenty-first century. It is possible that girls have recognised that being female now means taking on a diverse range of roles and adopting a wide range of behaviours. Alternatively, girls may simply have conceptualised their symptom reporting as “brave” and “confident” in order to portray typically feminine behaviour, such as depending on others for help, in a more positive light.

Boys also portrayed girls as being more likely to seek help and, indeed, their accounts implied that girls could be overly attentive to their symptoms. Regardless of the type of symptom, the phrases below were commonly used in relation to girls when feeling ill:

Craig: ...they're a bit more fussier [...] more likely to tell the teacher

(P6b5)

Keith: ...if they've got something they'll maybe make it more dramatic

(S2b24)

Adam: ...they usually moan more and try to get something to help it quicker

(S2b20)

Evidently, most boys also felt that girls would conform to gender-related expectations by not coping independently and stoically but, instead, asking for help earlier than boys would. It was also common for boys to discuss the ways in which girls would rally round when their friends felt unwell:

Robert: ...if a boy wasn't feeling well, I don't think another few boys would go up to the teacher.

[...]

Hamish: The boy would have to go up by himself.

[...]

Craig: But the girls, they would prefer to be in a big group.

Mark: Big huddle.

(P6b5)

The images conjured of girls huddling together and "all cuddl[ing] each other" (Jack, P6b8) when feeling out of sorts, highlight boys' awareness of the ways in which girls share their problems. Interestingly, boys did not portray girls' tendency to report their symptoms in a positive light. Instead, they conceptualised girls as weak and dependent on others and, by implication, highlighted the strength and independence of boys.

Girls concealing symptoms

Significantly, girls also spoke about occasions on which they would hide their symptoms. In fact, the majority felt that in public contexts they would be likely to hide it if they felt sad, unhappy or low, and irritable or bad tempered. With regards to feeling sad, unhappy or low, most girls thought that if Sarah felt this way in class she would react by “hold[ing] it back” (Elaine, P6g4), “ask[ing] to go to the toilet” (Gemma, S2g23), and trying to “get the red puffiness to stop” (Carla, S4g13). Thus, they described ways in which she would, like boys, try to contain these feelings within herself or would physically hide in spaces where she could express them privately and then attempt to hide the signs. As was the case with the boys, P6 girls were more likely than those older than them to suggest that “[Sarah] might ask to talk to the teacher out in the corridor alone” (Sandra, P6g9).

In relation to what the girls thought Sarah would do if she felt like crying when at home, there were also similarities between what they and the boys said. Nearly all girls initially suggested that Sarah would “cry in her bedroom and lock the door” (Sandra, P6g9). However, P6 girls seemed most comfortable with the prospect of confiding in their parents, whereas older girls portrayed themselves as being more hesitant in taking this course of action:

What about if [Sarah] was at home [and she felt like she was going to cry]?

Nina: She could tell her mum.

Jane: Yeah.

(P6g4)

So what about if [Sarah] was at home [and she felt like crying]?

Zoe: Em, probably just would cry.

Collette: Yeah, me too. I would... I'd just go to my room and cry.

Would she say anything, do you think, or... to, like, her parents or anything or...?

Zoe: Eh, depends, like, how her relationship is with her parents. Like... I don't usually talk to my parents. I usually just call on my friends.

Mhmm.

Zoe: But it depends. If she's, like, really close to her parents, then she might go and talk to, like, her mum or her dad about it.

(S4g21)

Thus, S2 and S4 pupils were more likely to construct themselves as reluctant to tell their parents about the 'malaise' symptom unless they had a "really close" relationship with them. Instead of reliance on their parents, S4 girls highlighted that they had begun to "call on" their friends for emotional support.

The fact that a lot of the girls believed that feeling sad, unhappy or low should be concealed suggests that, although they highlighted the stereotype that girls are more emotional than boys, most were aware that it is not viewed as completely acceptable for girls to cry in public. In fact, older girls spoke more often about ways in which they might prevent themselves from crying in public. These ideas imply that there is increasing pressure on girls to be able to conceal and control their emotions as they get older. However, the fact that some of the oldest girls still felt they would be able to cry in certain company or spaces (with close friends or in the toilet) again suggests that boys and girls are impacted upon by age- and gender-related expectations to different degrees. Although both boys and girls acknowledged crying as being socially unacceptable after a certain age or in particular contexts, and clearly this 'rule' has an impact upon the ways in which they both respond to 'malaise' symptoms, it is evident that boys' behaviour is still affected by this to a greater extent than girls'. This is displayed particularly well by the fact that none of the S4 boys admitted that they would cry at all, even in the most isolated and private of spaces.

Girls also implied that feeling irritable or bad tempered would be a symptom that they would conceal. In one S4 group, it was explicitly suggested that girls would hide this:

Sheena: I always think boys as more bad tempered than girls most of the time. But maybe they just do it in more anger, whereas girls hide it or

something like that [...] they don't want people to know what they're feeling, or...

Pamela: I think girls get upset and boys get angry.

(S4g13)

Sheena's suggestion implies that displays of irritability and bad temperedness may be unacceptable for girls, in a similar way to that of showing emotion through sadness for boys. In one S2 girls' group it was also highlighted that "girls aren't really expected to...punch and stuff" (Jill, S2g22). This suggests that the majority of the girls also saw feeling irritable or bad tempered as having 'unfeminine' connotations. Therefore, the implication is that girls would "not want people to know" that they felt irritable or bad tempered because displaying this would go against traditional expectations around what it is to be female.

In highlighting their perceptions that these two symptoms, feeling sad, unhappy or low and irritable or bad tempered, should be concealed because they are not acceptable behaviours, girls drew attention to the ways in which they are affected by both new and traditional gender-related expectations. Indeed, these ideas also imply that the combination of traditional and new expectations can place contradictory pressures on girls, possibly resulting in them finding it hard to know what is expected from them. However, it is hard to say that the girls' opinions are definitely influenced by societal changes given that there are no similar previous studies to compare these findings to.

5.3 Gender stereotypes: age and gender differences in how these were used by pupils

This section examines the differences and similarities in the ways that gender stereotypes were used during the discussions. Specifically, it highlights the degree to which stereotypes seemed to be an unconscious element in pupils' conceptualisations of gender and draws attention to the use of stereotypes to create humour as a means of controlling gender identities.

5.3.1 Using stereotypes to portray boys and girls as opposites

Stereotypical ideas were used to portray boys and girls as opposites of one another and to claim that they are so different that it is hard for one to understand the other. P6 pupils were those most likely to make statements which implied that because they would do one thing, their opposite-sex peers would do the reverse. Neil (P6b3) did exactly this as his group moved on from talking about the symptoms boys would report to those they thought girls would. He claimed that girls would talk about “what we [boys] wouldn’t talk about” and, in doing so, used stereotypical ideas to suggest that boys and girls would act in opposing ways with regards to symptom reporting. This idea was often taken further as pupils claimed it was hard to imagine being in the position of their opposite-sex peers, thus conveying a sense that boys and girls, and their experiences, are so different from one another that a leap of imagination has to be made just to speculate on what symptom experiences and reporting are like for the opposite sex. Some P6 girls provide a good example of this:

So why do you think, you said there that you thought it was, it’s hard to imagine a boy like, telling someone that he feels like crying or a boy crying? Can you say why you think it’s hard to imagine that?

Kirsten: Erm, because I’ve never been in a boy’s situation cos -

Rhona: Cos you’re a girl.

Jennifer: You’re not exactly a boy. So it’s harder to imagine what they’d do.

So it’s harder to put yourself in their shoes kind of thing?

Jennifer: Yeah.

Kirsten: Yeah.

Ellie: Than in any other girl’s shoes.

(P6g2)

Not only did these girls suggest that there is a clear distinction between being a boy and being a girl, but they also lumped all girls, and presumably all boys, together in assuming that they will behave in the same specific and predictable ways. These ideas draw heavily on gender stereotypes by suggesting that all boys and girls behave in gender-specific and gender-distinct ways. In fact, boys and girls were believed to

be so distinct from one another that they would each find it hard to imagine themselves in the other's position. Pupils' efforts to portray boys and girls as opposites can be seen as another way in which they were constructing their own gender identities during the discussions. To take the boys as an example, in constructing their behaviour as the opposite of girls', they are perhaps trying to demonstrate how successfully they are 'doing boy'. The same can be said of girls' efforts to portray themselves as the opposite of boys.

Significantly, there were far fewer occasions on which S4 pupils portrayed boys and girls as opposites. This was because a higher proportion believed that boys and girls "all get the same" symptoms (Collette, S4g21) and, when they do feel ill, "there isn't much difference between what a girl would do [...] and what a guy would do" (James, S4b17). This suggests that S4 pupils were less reliant on stereotypes to explain gender differences, to predict the reactions of their opposite-sex peers, or to construct their own gender identities. Perhaps older pupils were more likely to view one another as individuals rather than members of gender-distinct groups. It is possible that this is the case because, by S4, friendship groups may be more mixed in terms of their gender composition, making it easier for boys and girls to imagine symptom reporting from the point of view of their opposite-sex peers.

5.3.2 Stereotypes as a source of humour

Stereotypical ideas and images were also used by pupils to make their group members laugh. Often pupils laughed at their opposite-sex peers, but on occasion girls also laughed at the stereotypical ways in which they and other girls sometimes behave. It seems that pupils invoked humour in these ways in order to police others' behaviour or pass comment on their gender identities. At the same time, however, most pupils who used stereotypical humour, by implication, portrayed their own gender identities in a positive light.

Using stereotypes to mock opposite-sex peers

Stereotypes were used in particular to belittle or mock opposite-sex peers. Neil for example, impersonated the typical response of girls if a friend was to tell them she felt like crying:

Calum: Yeah, [she'd] probably cry, cos girls will just pat her on the back and...and see what's wrong.

Gordon: Yeah.

Neil: "Oh no, look, what's wrong?" [imitating girl's voice]

(P6b3)

In impersonating a feminine and almost sickly sweet voice, Neil seemed to be mocking this show of concern as being an over the top and laughable reaction to a display of emotion. It is possible that he made fun of girls' reactions in this way so as to distance himself from such empathic and emotional behaviour, thus portraying himself as typically masculine.

Also using stereotypes, S4 girls made fun of boys' concerns. In one of their groups, Pamela made other members laugh as she explained why she thought boys would hide it if they had asthma:

Pamela: Well if they're sporty they might like, and if they admit that they've got asthma or a wheezy chest they might think that it's pathetic or, em...

Carla: Yeah.

Pamela: ...that they just won't get as much chance of being in the football team or something [speaks last part in a dramatic voice]

Sheena: Yeah.

[Laughter]

(S4g13)

Pamela drew on the stereotype that all boys love football and, by adopting a dramatic voice to express what she thought they would be most worried about, she also mocked their concerns and belittled boys by implying that they would see the possibility of not getting on to the football team as the worst thing that could happen to them. Obviously the girls found it amusing to rehearse the stereotype that boys only worry about football. However, just as Neil had done, it is possible that Pamela used this stereotypical humour to say something about her own gender identity and to imply

that girls have far more serious problems to worry about because they are more mature than boys.

The abilities of boys and men to give advice or offer comfort and support were also questioned as girls laughed at stereotypical portrayals of their attempts to do so. For example, it was common for girls to talk about how they would prefer to confide in their mothers instead of their fathers. In a P6 group, the girls explained their reasons for this:

Kirsten: I think she [Sarah, female vignette character] would probably tell her mum [if she felt like she was going to cry] because dads don't exactly get the picture of a girl.

Rhona: Yeah, cos they're-

Kirsten: Dads!

[Laughter]

[...]

Ellie: Mums seem more understanding.

Jennifer: I don't think it's so much that, but I think, I think it's that they can comfort you more [..] but it's just if your dad's working around the house and you say "Dad, I keep bursting into tears", he goes "Oh, go tell your mum".

[Laughter]

(P6g2)

Underlying their laughter seems to be an assumption that men are unable to understand, or respond to, others' experiences and problems for the simple reason that they are men. The girls made fun of their fathers by drawing on the stereotypical idea that men feel awkward about discussing emotions and suggesting that they would avoid having to do this. As opposed to the picture painted of men, Jennifer claimed that mothers "can comfort you more". Implicit here is the idea that women are both more able to provide comfort and, according to gender-related expectations, are 'allowed', if not expected, to be good at, and constantly available for, this kind of 'emotional work'. Thus, it is perhaps not the case that men are inherently less able to

offer advice and support but that they are less comfortable doing so because they have been brought up to think that this goes against masculine expectations.

In an S4 group, girls also made fun, in a similar way, of boys' efforts to comfort their friends:

And what about if a boy was feeling unwell with his friends?

Rose: Em...some of them might just...be sympathetic. Others might just...take the mickey out of them for a little while, but I don't...if they're his friends, then I don't really think they'd say much about it really.

Amy: They'd just be like [impersonating a boy's voice] "Oh, mate, maybe you should go home."

[Laughter]

(S4g26)

Initially, Rose seemed to be rejecting ideas that all boys would react to their friends' illness in typically masculine and uncaring ways and instead she suggested that some boys would be sympathetic. Nevertheless, Amy's impression of a boy's attempt to be sympathetic served to undermine this by portraying it as inadequate and amusing. This demonstrates the way in which even S4 girls, who were least likely to portray boys and girls as opposites, seemed unable to escape the impulse to revert to stereotypes when talking about boys. In this particular instance, Amy contradicted Rose's claim, that some boys would be sympathetic to their friends, by drawing on the stereotype that boys are incapable of talking about emotions or being empathic. Humour is invoked as Rose impersonates a boy's attempt to be understanding and portrays this as an inarticulate and pathetic attempt at doing so. Such comments serve to undermine any efforts made by boys to be understanding and they act as examples of the types of reactions boys might face if they try to adopt this type of behaviour. Indeed, in this example, Rose and Amy's laughter could be seen as policing boys' behaviour and serving as a warning to boys of the reaction they may receive if they stray too far from typically masculine forms of behaviour. Thus, across all age-groups it was common for girls to find amusement in the stereotypical portrayal of boys and men as emotionally awkward and incapable of providing support. By

contrast, girls perhaps wanted to portray themselves as skilled in building mutually supportive relationships.

Girls' use of stereotypes to laugh at girls/themselves

There is also evidence, however, that S4 girls found amusement in portraying stereotypically feminine reactions and offerings of support. For instance, when Zoe and Collette were asked how their friends would react if they were to cry in their company, they said:

Collette: Very supportive.

Zoe: Yeah. Most probably go "Aaw! What's wrong?"

[Laughter]

(S4g21)

In this case the girls seemed to be laughing at the overly sympathetic response that they would receive from their female peers and perhaps at how clearly this behaviour accords with feminine stereotypes. Thus, older girls, in particular, also used feminine stereotypes as a source of humour and, in doing so, showed that there were elements of their behaviour that they took less seriously. It is also possible that girls laughed at stereotypically feminine behaviour in this way because of their awareness of changing expectations for girls. Thus, they may have been showing their embarrassment at how stereotypically girls can sometimes behave and implicitly acknowledging that the changing demands on girls mean they should behave in less overtly feminine ways. Significantly, none of the boys used stereotypes to laugh at themselves in similar ways. Perhaps this is because stereotypes and expectations have not changed or become any less rigid for boys in the way that they have for girls and, as a result, the degree to which they continue to be entrenched in boys' thoughts and behaviour may mean that boys are less able to stand back and see their adherence to expectations and stereotypes as amusing or anything other than critical to their construction of a masculine identity.

5.3.3 Believing, understanding and questioning stereotypes

Stereotypes: from belief to understanding

The pupils' uses and understandings of stereotypes changed according to age-group. Thus, while it was often the case in P6 pupils' discussions that stereotypical ideas were stated as factual descriptions of the ways that boys and girls behave, this was much less likely among S2 and S4 participants. In addition, P6 pupils were rarely able to explain their reasons for believing boys' and girls' behaviour to be the opposite of one another. In one P6 group, for example, the girls were asked why they thought boys and girls would experience different symptoms:

Alison: Well, I don't really know.

Sharon: I think em, the nervous and anxious, the boys are more tougher and the girls are just a bit...

Leigha: They worry about things.

(P6g10)

The fact that Alison was initially unable to explain her beliefs, suggests that, without thinking, she had reiterated stereotypical ideas around the symptoms that boys and girls get. In an attempt to explain this further, Sharon referred to further stereotypes as she implied that girls get nervous and boys are "tougher". Nevertheless, this served to set up further oppositional stereotypes and shows pupils' inability to get beyond these when talking about the differences that they felt were evident in boys' and girls' behaviour. P6 boys also portrayed boys' and girls' behaviour as oppositional, and when asked to explain this made comments like "boys are boys and girls are girls" (George, P6b6) or girls "are more likely to cry cos they're not like boys" (Liam, P6b3). Again, these ideas fail to explain their beliefs that boys and girls would react to symptoms in different ways. Instead they state the same stereotypes more firmly and perhaps demonstrate the degree to which stereotypical ideas informed these pupils' conceptualisations of gender and particularly gender differences.

Although S2 and S4 pupils also voiced stereotypical ideas, an increasing number of them appeared more able to explain their origins. For example, Adam's group implied that there are different rules for girls and boys, which mean girls are expected to cry but boys are not allowed to, and he attempted to explain the reasons for this:

Adam: And also when people, like a long time ago, when people were growing up the women had to respect the man and the man did all the more macho things and stuff and went to do the hunting and not seen to be a wimp.

(S2b20)

Instead of reiterating further stereotypes, Adam traced the 'rules' around boys' and girls' behaviour as originating from times when traditional gender roles were more deeply entrenched in the structure and workings of society. Carrine explained the idea that girls are more sensitive than boys in a similar way:

Carrine: It's just been like since the dawn of time it's been the strong man hunter, you know, he's strong mentally and physically, and the woman's the one who stays at home, the emotional woman, weak and all that. It's still stereotypes.

(S4g14)

Thus, Carrine outlined the stereotypical male and female ideal types which the majority of the pupils had alluded to in their discussions and also emphasised the origin and survival of these stereotypes as being from prehistoric times when traditional gender roles were very distinct. Both Adam and Carrine's ideas show broadening understandings of stereotypes, seeing them not just as predictors of behaviour but rather as mechanisms used by society to preserve traditional gender roles. This change is perhaps related to general age-related changes in cognitive development which mean that older pupils' reasoning and explanatory skills were more developed. It is also possible that older pupils had learnt about gender stereotypes at school.

Questioning stereotypes

On occasion, stereotypes and gender expectations were also questioned by pupils, both in terms of their utility in representing boys and girls, and in relation to their potential to restrict behaviour and expression. During P6 groups this was only done in simple ways after generalisations were made about all boys or all girls and were qualified as someone suggested that the statement would not apply to "some" boys or girls. S2 and S4 pupils were often more explicit and complex in their questioning of stereotypes. For example, they were more likely to suggest that boys and girls would

react, at least to 'physical' symptoms, in "the same" ways (Joe, S4b11), implying a rejection of stereotypical generalisations that boys and girls behave in distinct and contrasting ways. Nevertheless, even when older pupils seemed to be allowing for individual differences and suggesting the existence of different types of boys and girls, their ideas still seemed to revolve around gender stereotypes. An interesting example of this is Zoe's response when asked how a boy might react to a stomach ache:

Zoe: It depends what sort of person he is. If he's, like, someone who just, like, fancies a skive, he'll probably just like exaggerate it. But I mean, a girl might do that as well. He might exaggerate it and just be like "Oh yeah, I feel really ill, I need to go home" or I think he would just sort of like, keep quiet cos he doesn't want to like ... show people...

(S4g21)

Zoe started questioning stereotypes in acknowledging the existence of different types of boys who would react to a stomach ache in different ways, some of whom might even react in similar ways to girls. Nevertheless, as all pupils did when they spoke about different types of boys, Zoe highlighted these as being boys who would exaggerate their symptoms in order to go home from school or those who would hide their symptoms in order to be seen as stoic. Thus, despite implying that she was going to portray boys in less stereotypical ways, Zoe seemed unable to do so. Once again, this implies that stereotypes are so pervasive that they have become an unconscious element in conceptualisations of gender. In fact, Kevin (S4b17), who said "there will be some boys that are very open and some girls that are not", was one of the few pupils to suggest that some boys would challenge stereotypes. Nevertheless, there is a sense even here that he is referring to a minority of atypical boys.

Some pupils also spoke out against gender-related expectations. This occurred mostly among S4 girls in relation to the potentially harmful restrictions which stereotypes place on boys' behaviour. For example, Emily (S4g14) claimed that "it's not fair that boys are stereotyped that they can't cry because they are still human and they still do need to". The implication here is that gender stereotypes and expectations prevent boys from fulfilling a basic human need. Very few boys questioned gender stereotypes, but those who did went about this in more subtle ways. For example, as

Gareth (S4b16) stated that “for some odd reason [crying is] perceived as not really bein’ a manly thing to do”, the language he used, and particularly the phrase “for some odd reason”, suggests that he is questioning the reasoning behind this perception and subtly implying that it is wrong to place such expectations on boys. Similarly, as Adam (S2b18) said that “a lot of boys think they need to be tough... they don’t have to be”, he also questioned gender-related expectations in a very subtle way and implied that boys do not, and perhaps should not, have to conform to these. However, none of the boys were as explicit in suggesting that gender-related expectations placed on boys may be harmful to their health and psychological well-being. Perhaps any more overt attempts by boys to question expectations in this way would lead others to question the validity of their masculine identities.

Nevertheless, some pupils who questioned gender stereotypes, at the same time, and seemingly unwittingly, also reinforced them. This example is taken from an S4 girls’ group:

So if it was [Steven] who was feeling like he was going to cry, what do you think he would do?

Rose: He definitely wouldn’t cry in class, apart from-

Amy: He’d probably go straight to the toilets.

Rose: ... apart from maybe one or two individuals in our school.

[Laughter]

[...]

Rose: [...] it’s just kinda like, it is kind of a shame because it’s just, like, how like, society’s kinda like... got this idea that boys shouldn’t really cry that much in public cos it’s seen as a bit of a wussy thing to do.

(S4g26)

In the latter part of this quote, Rose gave the impression that she is against the way in which society portrays it as unacceptable for boys to cry. However this compassion was not conveyed earlier in the discussion as Rose and Amy subtly reinforced gender stereotypes by implying that crying would be an atypical male reaction and suggesting, through their laughter, that they looked down on the few boys who were

known to do, or have done, this. Despite speaking out against society's unfair treatment of boys, Rose had already played a part in this and the fact that she seemed to do so unwittingly suggests that she is unaware of the degree to which her ideas are informed by, and indeed serve to reinforce, stereotypes.

Significantly, neither girls nor boys claimed that the gender-related expectations placed on girls might be harmful to them. In addition, there were no examples of boys trying to question but unwittingly reinforcing stereotypes of girls in the same way that girls had done this in relation to boys. The absence of both these features in relation to girls suggests that 'feminine' stereotypes are not perceived to be as harmful, nor appear to be as pervasive, as 'masculine' stereotypes.

5.4 Girls' and boys' experiences and expectations of 'growing up gendered'

This section outlines pupils' descriptions of the ways in which gender- and age-related expectations are learnt, paying specific attention to the impact of social influences on the construction of gender identities. Also highlighted are pupils' own expectations and experiences of puberty, looking particularly at how they constructed this as more of a 'female' than 'male' experience.

5.4.1 What causes gender differences in behaviour?

When pupils were asked what they thought might cause the differences which they perceived to exist between boys' and girls' behaviour, the majority of the ensuing discussions served to outline social influences. These included observing and copying parental, sibling and peer behaviours as well as those viewed in the media. However, a minority of pupils suggested that gender-related behaviours are not a reaction to social expectations but are the result of genetic or biological differences between males and females.

Social influences on the development of gender identities

The majority of the pupils suggested that boys and girls behave in different ways because this is what they observe and are taught as they grow up. Hence, they believed that children are socialised through various means to act in gender-specific ways. For example, James (S4b17) claimed that gender-specific behaviours are learnt as children observe the "way guys and girls act differently around each other", and

Zoe was articulate in expressing her views on the ways in which children are socialised into gender roles:

Zoe: I think, em... I don't think we're born with it [tendency to behave in gender-specific ways] but from, like, a very early age you sort of, like, see sometimes, like, dads, like, in a park with, like, their little boy, and like, their little boy, like, falls over and starts crying or something, and they're like "Oh, come on, get up! Don't be so silly, come on!" I mean if it's a little girl, they always, like, comfort them and stuff. I think it's sort of like... you're influenced by it around you from a very young age but I don't think you're born with it. I don't think it's, like, biological.

(S4g21)

Whether it be parents, siblings, peers or the media, the majority of the pupils felt, like Zoe and James, that social influences are responsible for any gender differences in boys' and girls' behaviour. Significantly, Zoe only implicitly referred to the ways in which girls are socialised, by being comforted and reassured, but highlighted more explicitly the means by which boys are taught to behave in more masculine ways. Indeed, it is important to point out that this represents a general pattern found across the majority of the groups. Specifically, as pupils discussed various processes of socialisation, the majority mainly spoke about these in relation to boys. For this reason, the following discussion concentrates mainly on processes of socialisation which pupils highlighted as impacting upon the development of boys' gender identities.

Girls were often referred to as negative reference points from which boys could learn how they should and should not behave. As one instance of this, Kirsten (P6g2) suggested that boys would learn how not to behave "if there's a girl in [their] class that cries all the time and they find out that that's just silly [...] that it's just a girl thing". In this case, the girl is seen as demonstrating the ways in which boys *should not* behave. Along similar lines, Andrew described an occasion on which he had learnt how he *should* behave from a girl:

Andrew: ...cos like once I- when I fell over, I started to cry, once then I saw this other girl fall over and then she just got back up and started running again, I thought, "Well, I'm a boy, boys are supposed to be stronger", so I started to like hold it in... (P6b8)

Andrew's description suggests that boys learn how to behave by observing others and also depicts a growing awareness that to behave in gender-distinguishing ways, boys need to rise above the levels of stoicism displayed by girls. It was also suggested by Gregor (S2b24) that "if you've got older brothers it's easier [...] but if you've got a sister then it's quite hard" for boys to learn how they should behave. Once again, this shows how girls' behaviour was used, by both girls and boys, as a negative reference point which is useful in highlighting the ways in which boys should and should not behave.

Older boys and men who behave in typically masculine ways, were seen, by both boys and girls, as role models for boys as they grow up. Instead of seeing their behaviour as something to oppose, as was the situation with girls' behaviour when, above, Kirsten suggested that boys would stop crying if they saw girls doing this, it was viewed as something that boys would strive to emulate. Generally, the male role models referred to ranged from "older brothers" (Jonathon, P6b7) and "high school boys acting all tough" (Sharon, P6g10) to "footballers" (Myra, P6g1) and men in films, like "Arnold Schwarzenegger" (Gareth, S4b16), who never cry. Although boys spoke a lot about older brothers and boys in school as people from whom they had learnt appropriate behaviours, the role models who seemed to carry most sway with them were their fathers. In one P6 group, for example, Craig said that boys get ideas about how they should behave from:

Craig: ...copying your dad. You never...well, I haven't seen my dad cry. I've never seen my mum cry, but...my mum just seems to be a bit more fussy. But my dad's a bit [...] He's cool [...] I don't know, just... I look up to him really, so...

(P6b5)

Because he viewed his father as being "cool" and someone to "look up to", Craig claimed to want to copy his stoicism and emulate his behaviour. As opposed to this he described his mother as "fussy" and, again, this is evidence of the way in which females were used as negative reference points to represent behaviour that boys should aim to reject. Gary also described the way in which boys would learn appropriate behaviours by watching their fathers:

Gary: Because you see your, like, dad, and if he cuts himself he doesn't really...cry, like, but if he's like...he was like, if he hit himself with a hammer he wouldn't really cry, but if you smacked yourself with a hammer you would hurt.

(S2b24)

By acknowledging the fact that these injuries would hurt, yet describing the ways in which men would not cry, Gary emphasised the stoicism of these reactions and implied that boys who witnessed such incidents would learn the appropriate ways to react and would change their behaviour accordingly. In general, boys often spoke about their fathers' behaviours as being the masculine ideal which they would strive to emulate and their accounts implied that they would fail their fathers' expectations for them, as their sons, if they did not do so.

Overall, the fact that pupils were more likely to talk about the ways in which boys become aware of masculine expectations may have stemmed from a number of factors. Firstly, they tended to conceptualise the behaviour of girls as being 'natural' whereas they were more likely to talk about boys as making conscious efforts to behave in stereotypically masculine ways. This example comes from one of the S2 girls' groups:

Mhmm. And what about boys? Do you think that they're just... born being like that, like having to be, act hard or...?

Tara: No, I think they're just like-

Grace: No.

Tara: ... make it be like that.

(S2g22)

As opposed to portraying boys as making conscious efforts to act in 'masculine' ways, the girls' accounts implied that girls' behaviour is 'natural' and the way that girls *and* boys would behave in a world where gender-related expectations did not exist. This suggests that the process of socialisation is more obvious in relation to boys, perhaps because, as compared to girls, there are more restrictions placed on the ways in which they are 'allowed' to behave. Alternatively, it is possible that a bias in questioning led to pupils' discussions mainly concentrating on boys' awareness of

expectations; the transcripts show that I asked pupils more about how boys learn what is expected of them and concentrated less on asking them to discuss this in relation to girls. Perhaps a lack of reflexivity led me to rely too much on my position as a female researcher and meant that I did not treat the girls, or the discussions of girls in general, as 'other' or foreign to me to the same degree as I did when asking questions about boys. Pupils may have had more to say about the ways in which girls become aware of expectations, but did not voice these ideas because they were not asked.

When do expectations become apparent?

As well as talking about the ways in which they had learnt about expectations, pupils were also asked at what age they had become aware of and begun to incorporate these into their behaviour. It was P6 and S2 boys who spoke about this in most detail, perhaps because they had clearer memories of these realisations than S4 boys. The youngest boys named P3/4 (age 7/8) as the time when they had first become aware of expectations:

[At what age] do you start thinking about "Oh, they're going to call me a wuss" or whatever?

Jack: It's like P3, 5.

Angus: Could be P3, 4, 5 ...until high school.

Andrew: Probably started about P4-ish cos that's when like...

Jack: Yeah. Coming up the end of P3 and P4 cos that's when we're seniors.

Andrew: Yeah, that's when like Gordon (another boy the same age as them) and everybody starts becoming cool and we're like geeks.

(P6b8)

P6 boys spoke about P3, 4 and 5 (age 7/8/9) as a transitional phase during which they became aware that they were getting older, becoming the senior pupils in the primary school and, perhaps with this, being expected to act as an example to their peers and younger pupils. Andrew also claimed that it was around this time that masculine hierarchies began to form, with certain boys being perceived as "cool" and others "geeks". Thus at this stage, not only do boys become aware of expectations, but being seen to conform to them becomes important in establishing or improving their

position in the male hierarchy. However, S2 boys commonly named P6/7 (age 10/11) as the time around which they had become more aware of expectations:

Lewis: Primary 6, primary 7 [...] When everyone's getting older.

And what is it about you getting older at that time, that you suddenly...your behaviour starts to change?

Lewis: You're more aware of people and what they might think, and as you get even older you're more aware about what girls might think.

(S2b18)

Lewis highlighted P6 and P7 as a time of boys' increasing awareness of other people's perceptions of their actions and behaviour, implying that around this age boys begin to adjust their behaviour to meet expectations and to judge one another's masculinity according to whether their behaviour matches up to these gender specific 'rules'. This links to P6 boys' ideas around the formation of masculine hierarchies and highlights boys' continuing efforts to affirm and improve their positions by being seen to conform to typically masculine expectations. Scott (S2b12) gave further insight into the idea that boys begin to worry about others' opinions of them after a certain age, saying, "when you go into high school [...] you want to know people and be popular, so you don't want to be, like, the one that always gets picked on". This implies that being seen to conform to masculine expectations is important in improving boys' positions in the masculine hierarchy at school and also protects them against being seen as an easy target for other boys to exploit. Undoubtedly, these 'rules' would also have applied to boys' presentations of themselves within the research setting and may have contributed to their efforts to portray themselves as 'successfully masculine' to others in their groups. Significantly, the majority of the boys referred to 'social thresholds', such as becoming a senior pupil in primary school or the transition to secondary school, as stages at which they had become aware of expectations. It is possible that age- and gender-related expectations became more salient at these times if parents, teachers and wider society also emphasise the importance of moving onto the next phase in life and, as part of doing so, adapting behaviour to suit new age- and gender-related expectations.

Genetic and biological influences on gender differences in behaviour

In a minority of boys' and girls' groups it was suggested that gender differences in behaviour are caused by innate differences between boys and girls and, thus, are "in their nature" (Keith, S2b24). A small number of pupils expressed this idea by referring either to genetics or biological processes as the cause of gender differences between boys and girls. The extracts below display the only two occasions on which genetics were referred to as explanations for the differences between boys and girls:

Sheena: I think girls are just more open than boys.

Pamela: Yeah.

Sheena: I don't know what it is.

Carla: They're more emotional as well.

Pamela: Yeah. It's like a genetic thing or something.

[Group laughter]

Pamela: Maybe!

(S4g13)

...where do you think you learn what boys are meant to do and what girls are meant to do?

Gordon: TV [others snigger]. No. I eh...

Liam: It's just like a feeling that you get and you just, like, know.

Gordon: Genes.

Liam: You just know that's...

Calum: What?

Gordon: Genes.

Liam: You just, like, know that's...

Calum: Yeah, probably on TV and in the playground, you know that boys are, like, tougher and that...

(P6b3)

Although, in the first extract, Pamela suggested that the differences between boys and girls are “a genetic thing”, the rest of the group’s laughter suggests that they did not take this idea seriously and she makes her suggestion more tentative, perhaps in response to this laughter, by adding “maybe”. A similar exchange occurred in the P6 boys’ group as no-one engaged with Gordon’s idea that differences between boys and girls are genetic, but Calum did endorse his original suggestion that girls and boys learn how to behave from what they see on television. In both examples, although it was suggested that differences between boys and girls may be genetic, the suggestion was given little credibility as other pupils either laughed at or ignored the idea.

On a couple of occasions pupils also suggested that boys and girls react differently to symptoms because of differences in their biological make-up and, specifically, because they are affected by different hormones:

Do you have any ideas why there’s that difference between boys and girls [that girls will report symptoms sooner than boys]?

Adam: Boys try to be macho sometimes.

Uh huh.

Adam: Some.

Any other ideas?

Kenny: We’ve got testosterone, I think it’s called.

Oh, right. So, like different hormones and things.

Kenny: Mhmm.

[Derek and Adam snigger.]

(S2b20)

Kenny’s suggestion attributes the differences in boys’ and girls’ behaviours to biological causes and, in particular, he backs up Adam’s claim that boys “try to be macho” by saying this is because of their higher levels of the testosterone hormone. The fact that Derek and Adam both sniggered at this suggestion, or at the introduction of the topic of hormones to the discussion, implies that they felt awkward and found it funny that a potentially embarrassing idea had been raised in this context. Regardless

of their reasons for giggling, it prevented Kenny from explaining his idea in more detail. During an S4 girls' discussion, Becky (S4g14) also referred to hormone levels as she argued that boys and girls are "totally different. Girls have got more hormones [and] are more sensitive than guys and that's like a known fact". Thus, Becky also put forward an essentialist argument by claiming that biological factors result in boys and girls being "totally different". However, it was also the case in Becky's group that her argument was left hanging as no-one took up the opportunity to talk further about the influence of biological factors on differences between boys and girls. Instead, Carrine changed the subject to talk about the impact of stereotypes on people's behaviour. Therefore, only a small minority of pupils suggested that genetic or biological factors may cause differences in boys' and girls' behaviour and the fact that these ideas received little support suggests that the majority of the pupils either felt they had limited knowledge to be able to comment or did not agree that the differences between boys' and girls' behaviour are caused by anything other than social influences.

5.4.2 Boys' and girls' experiences and expectations of puberty

Pupils also spoke of their experiences and expectations of the bodily and hormonal changes which occur during adolescence. The advent of puberty and the increases in symptoms that this can cause were commonly discussed during the histogram task and referred to in the majority of the groups, even if often only very briefly and with embarrassment. Pupils conceptualised puberty as affecting girls to a greater extent than boys. For this reason, their discussions of the effects of puberty on girls are discussed first.

Girls and puberty

Without exception the impact of puberty was seen to "affect [girls] more than it does boys" (Grace, S2g22) and to cause their bodies to go through a greater number of changes, possibly resulting in an increase in 'physical' and 'malaise' symptoms as well as morphological changes to their bodies. Although P6 girls were less likely to have been able to draw upon experiences of puberty, they made apparent their expectations of the changes which boys and girls go through at this time in their lives:

So what do you think it is that makes [boys] think... when you get to this age you'll... well, they're not just other people, they're girls?

Eve: Well, because, well, we get sort of... em... our, we talk about our body and stuff and then they start learning, they start learning, like, that we have different things and that.

Uh huh.

Eve: So they start knowing that, like, we're sort of different.

[Laughter]

(P6g1)

[You think girls are more likely to get] stomach aches [...] Why is it you think that they get these more?

[...]

Alison: And like everyone knows the girls get them. I don't know, we don't know if the boys get them, but they all find out somehow that the girls have sore stomachs and stuff.

(P6g10)

In the first of these extracts, Eve referred to the formal sex education which they had received in school just prior to their participation in the research and highlighted the way in which this makes children of their age aware that boys and girls have different bodies and should expect different changes to occur as they grow up. Similarly, in the second extract, Alison claims that "girls have sore stomachs" and, in doing so, implicitly conveys her expectations around the types of symptoms which girls are more likely to get as they go through puberty and menarche. At the same time, the fact that she said, "we don't know if boys get them", suggests that boys' experiences of puberty are less well known or not talked about as much as girls'.

S2 and S4 girls were able to talk about the changes brought about by puberty in more detail and this may have been because they were able to draw on their own experiences of puberty and menarche or because they had also learnt what to expect. Either way, older girls were quick to name the symptoms which they believed girls would be more likely to experience as they grow up:

And what about, how do you think, like, the changes you go through as you grow up, like the kind of bodily changes and everything like that, how do you think they... they affect your health?

Nadine: You might feel a wee bit... not as-

Gemma: Depressed.

Nadine: Yeah. You might feel like-

Amanda: And stomach aches and stuff.

Gemma: Yeah, and migraines if you're worried, and people are gonna tease you.

Amanda: And like, you get different feelings when you're coming up to getting your periods and that.

(S2g23)

Carla: ... like you start your period and you get a lot more aches and...

Pamela: Yeah. And also gets more... you're more likely to be irritable.

Sheena: Yeah.

Carla: Or emotional.

Pamela: And sad, unhappy or low.

Sheena: Cos it just changes the way you feel.

(S4g13)

These examples show how the girls described their experiences of their bodies changing as a result of puberty, menarche and menstrual symptoms. The range of symptoms and feelings that they outlined suggests that they believed that puberty has the potential to increase girls' experiences of symptoms and, in turn, their symptom reporting rates.

It was also common for boys to draw upon similar biological frameworks and to highlight the greater impact of puberty upon the emotions and overall health of girls. In general, boys in all age-groups claimed that girls' bodies change "quite a lot more" (Lewis, S2b18) than boys' and felt, as a result of "period pains" (Connor, P6b7) and

their hormones being “more mixed up than boys” (Oliver, S2b12), that girls would be more likely to experience stomach aches, mood swings and generally an increasing number of symptoms as they get older. Therefore, both boys and girls conceptualised puberty as being an experience that is more fraught for girls. When accounting for increases in girls’ symptom reporting rates, pupils based their explanations on biological constructions and it appears that this may have been as a result of being taught that boys and girls become biologically different after a certain age.

Boys and puberty

Although the idea that puberty affects girls’ health was raised spontaneously by pupils, the impact of puberty on boys’ health and lives was scarcely mentioned by either boys or girls. When one group of S2 boys did discuss this, they related the increases in boys’ reports of feeling irritable or bad tempered at ages 13 and 15 to their experiences of puberty:

Gary: Cos... they two [pointing to the histogram showing boys’ higher rates of feeling irritable and bad tempered at 13 and 15], the boys are going through, like, puberty and they like, want, they’re really just, like, pretty ups- upset and angry about stuff.

Keith: Yeah, it’s just hormones, really.

[...]

Gary: Yeah, mucking them up.

Keith: Going crazy.

Gary: And the girls are the same except they go a lot crazier.

(S2b24)

In this instance, boys are acknowledged as being affected by hormonal changes occurring at this time in their lives. However, it is significant that, even in this unusual instance of a discussion of boys and puberty, their experiences are immediately trivialised when compared to the impact of such changes upon girls. In this particular case, it is both the female body and mind which the boys portrayed as being affected by puberty. Emily was the only other person to refer to the impact of puberty on boys. She claimed that:

Emily: ...girls grow up quicker than boys, they're gonna like mentally develop more and like take more on and things, but then boys will then catch up and...just things will change with their hormones and that, just making them think different...in years.... (S4g14)

In this instance, Emily suggested that boys experience puberty at a later stage than girls. It is perhaps for this reason that pupils were less likely to discuss the impact of puberty on boys. However, it seems more plausible that they believed, perhaps because they had been taught, that puberty causes girls to experience more symptoms and generally has a greater impact on girls' health and bodies than it does on boys'.

5.5 Chapter summary

Throughout this chapter, gender- and age-related expectations and stereotypes have been discussed as they were perceived in terms of their effect on symptom reporting and as they were also drawn upon by pupils in order to construct their own, and police others', gender identities.

All pupils suggested that boys are expected to react to illness in stoic and independent ways, and these expectations were portrayed as 'rules' which are especially clear in relation to boys' reactions to 'malaise' symptoms. In terms of age-related expectations, pupils highlighted the idea that boys are expected to react to and cope with their symptoms in increasingly masculine ways as they get older. There was less of a consensus regarding gender-related expectations of girls. On the whole, boys endorsed stereotypical ideas that girls are "expected to cry". However, although many of the girls reiterated these same stereotypes, they also contradicted them by making emphatic claims that they would avoid showing their emotions in public and by implying that this would also be seen as socially unacceptable behaviour for girls. Overall, girls gave the impression that gender-related expectations represent 'guidelines' for them and they suggested that a wide range of behaviours are available to them whilst still allowing them to 'do girl'. Girls also displayed an awareness of age-related expectations which highlight the need for girls to react to symptoms in increasingly stoic ways as they get older. Significantly, boys did not explicitly mention this pressure in relation to girls. Indeed, boys were generally less accurate in predicting girls' thoughts and feelings on most issues, than girls were in predicting boys' ideas.

Pupils referred to illness behaviours as ways of conforming to gender- and age-related expectations and their narratives implied that performances of health are imperative to successful performances of gender and age. There was evidence that both boys and girls used the discussions to portray themselves as successfully 'doing boy' or 'doing girl' through their reactions to their symptoms. This involved boys constructing themselves as "tough" and independent in their abilities to conceal, disguise and overcome symptoms. Whilst girls also portrayed their attempts to conceal and overcome 'malaise' symptoms, they often acknowledged girls' increased likelihood to report symptoms and attempted to portray this in a positive light by constructing themselves as "honest" and conceptualising girls' symptom reporting as a responsible way to deal with illness. There was also evidence that girls are more likely to confide in their friends about 'malaise' symptoms and rely on their friends' support more as they get older.

The use of stereotypes played a large part in pupils' discussions. Although, on one level, pupils drew on stereotypes to construct boys and girls as opposites and to make one another laugh, it is also possible that they did so to enhance their constructions of their own gender identities and to police those of others. The pervasiveness of stereotypical ideas is evident in the way that none of the pupils, including even those who understood stereotypes as the continuation and reinforcement of traditional gender roles, were able to stop referring to them when judging their opposite-sex peers. As pupils stated stereotypical ideas without being able to explain the reasoning behind them, and only attempting to do so by referring to additional stereotypes, they highlighted the degree to which stereotypes have become an unconscious element in conceptualisations of gender. This constant recital and acceptance of stereotypical ideas serves to reinforce them, making it difficult to reject or even question these concepts.

Pupils suggested that various processes of socialisation instil gender- and age-related expectations from an early age. In particular, they highlighted parental, sibling and peer behaviour as sources which children learn from and use to develop their own gender identities. Although a small number of pupils suggested that gender differences in behaviour may stem from genetic or biological origins, these ideas were

given little credibility as they were either laughed at or ignored. As they discussed their expectations and experiences of puberty, pupils described the greater number of symptoms and changes which this can bring about for girls and, in doing so, conceptualised this as more of a 'female' than 'male' experience. Pupils' narratives suggest that they have been taught to understand health and illness in terms of biological frameworks and the fact that they drew on these when accounting for gender differences in symptom reporting demonstrates the social construction of understandings of differences between boys' and girls' experiences of health as biologically determined.

Chapter Six: Pupils' conceptualisations of symptoms: similarities and differences according to age and gender

6.1 Introduction

It is important that we be aware that illness is a social construction, and that how unorganized conceptions of illness become defined has an important effect on whether help will be sought and the type of practitioner that is likely to be consulted (Mechanic 1976, p.34).

This chapter is based on the premise that, like illness, understandings of symptoms are socially constructed and that in order to understand how they are dealt with, it is important to explore the ways in which they are understood. The chapter therefore explores the ways that symptoms were discussed during the various focus group tasks (see Chapter 4, Section 4.11.2 for list of symptoms and description of tasks). Specifically, the findings presented here outline the ways in which participants conceptualised symptoms, paying particular attention to any age or gender patterns.

6.2 Making sense of symptoms: gender and age patterns in pupils' conceptualisations of symptoms

Talking about how pupils conceptualised symptoms refers to the ways in which they made sense of them and how they showed what they understood them to mean. Across all groups, pupils did this by classifying symptoms in various ways. Indeed, it is possible to draw different conceptual continua from the ways that pupils spoke about symptoms. As an example of this, pupils often conceptualised and compared symptoms according to how 'painful' or 'painless' they perceived them to be. Several continua were evident across the discussions and generally these can be grouped under four over-arching themes: ways of experiencing; prevalence and frequency; severity, and controllability of symptoms. Figure 6.1 details the specific continua which relate to each of the over-arching themes.

Figure 6.1 Making sense of symptoms: over-arching themes and conceptual continua

<p>Ways of experiencing</p> <p>‘painful – painless’ ‘physical – emotional’</p>	<p>Prevalence & frequency</p> <p>‘ubiquitous – rare’ ‘normal – weird’</p>
<p>Severity</p> <p>‘worsening – passing’ ‘serious – trivial’ ‘cause unidentifiable – cause identifiable’ ‘real illness – not illness’</p>	<p>Controllability</p> <p>‘treatable – untreatable’ ‘involuntary – voluntary’ ‘acceptable – taboo’</p>

It is important to note that within the over-arching themes some of the individual continua are very closely inter-linked, making it difficult to draw distinct boundaries between them. The following sections address each over-arching theme, looking in more detail at the specific continua within each and how pupils conceptualised symptoms accordingly.

6.2.1 Ways of experiencing symptoms

One of the most common ways in which pupils conceptualised symptoms was by referring to the different ways of experiencing their effects. Across the majority of groups, two underlying continua can be drawn from pupils’ discussions: these are referred to here as ‘painful – painless’, and ‘physical – emotional’.

The ‘painful – painless’ continuum

Pupils commonly distinguished between symptoms by describing some as being “sore” (Ally, P6b6) and others as causing no pain. Interestingly, it was P6 pupils who were most likely to conceptualise symptoms in this way. For example, it was common for them to describe symptoms such as headache; stomach ache or feeling sick; and aching back, legs or arms, as those that “hurt you” (Tess, P6g1) or are

“actually sore” (Liam, P6b3). In contrast, they conceptualised feeling irritable or bad tempered; sad, unhappy or low; nervous, worried or anxious; dizzy or faint; and difficulty getting to sleep as symptoms that “don’t make you feel sore as much” (Leigha, P6g10). It may be that P6 pupils were most likely to conceptualise symptoms in this way because they were more likely to think about symptoms in terms of concrete notions, such as the amount of pain that they represent, whereas older pupils may have been more likely to conceptualise them in terms of more abstract ideas.

The few S2 pupils who referred to symptoms as either ‘painful’ or ‘painless’ did so in a similar way to those in P6. For instance, Keith (S2b24) described ‘feeling like crying all the time’, the ‘malaise’ symptom featured in the vignettes, as an “expressive feeling” but said that stomach ache is a “sore, painful thing”. Similarly, the girls in S2g22 claimed that asthma or wheezy chest; aching back, legs or arms; stomach ache or feeling sick; and headache are symptoms which mean “you’re in pain” (Jill, S2g22), implying that this is not the case with other symptoms.

The ‘painful – painless’ continuum was least applicable to S4 pupils’ conceptualisations of symptoms. However, in one S4 boys’ group, James (S4b17) highlighted a similar concept as he described symptoms such as headache; stomach ache or feeling sick; aching back, legs or arms; dizzy or faint; and cold or flu as “most irritating” and, in contrast, claimed that “you wouldn’t really notice” symptoms such as feeling nervous, worried or anxious; irritable or bad tempered; sad, unhappy or low; and difficulty getting to sleep. Although this is not exactly the same as saying that some symptoms are ‘painful’ and others are not, it is the closest that S4 pupils came to conceptualising symptoms in this way. It is also significant that the symptoms which James conceptualised as either ‘irritating’ or ‘unnoticeable’ included many of the same symptoms that P6 and S2 pupils had constructed as either ‘painful’ or ‘painless’. Thus, although the ‘painful – painless’ continuum was most applicable to the P6 pupils’ discussions, whenever similar ideas were evident in older pupils’ groups, there was a high degree of consistency in the symptoms which were conceptualised as either ‘painful’ or ‘painless’.

The 'physical – emotional' continuum

Pupils also conceptualised symptoms according to whether or not they perceived them to be 'physical' or 'emotional'. Again, pupils were extremely consistent in the ways that they did this across age and gender groups. Typically, symptoms which they conceptualised as being "physical" (Carrine, S4g14), or at least "[m]ore physical than mental" (Neil, P6b3), included headache; stomach ache or feeling sick; asthma or wheezy chest; dizzy or faint; and aching back, legs or arms. In contrast, symptoms such as feeling irritable or bad tempered; sad, unhappy or low; and nervous, worried or anxious were described as "feelings" (Ellie, P6g2) or "emotional sort of [symptoms]" (Amy, S4g26). Similarly, James (S4b17) made a distinction between feeling "just ill in general" and symptoms which make you feel "physically ill", such as "feeling sick and stomach ache, that kinda thing".

Therefore, to make distinctions between symptoms, most pupils, regardless of age or gender, tended to construct symptoms as either being 'physical' or 'emotional' and there were remarkable similarities in the sorts of symptoms that boys and girls conceptualised as being either 'physical' or 'emotional'. What is more, the symptoms which pupils conceptualised as 'physical' were often the same as those they had constructed as 'painful'. Likewise, symptoms which were conceptualised as 'emotional' had also been perceived by pupils as 'painless'.

6.2.2 The prevalence and frequency of symptoms

Pupils also conceptualised symptoms according to how prevalent or frequent they perceived them to be and their discussions of symptoms in relation to this theme can be conceptualised using the 'ubiquitous – rare' continuum. However, from a small number of girls' groups a further, more abstract, continuum can be drawn as they spoke about symptoms they perceived to be 'ubiquitous' as also being 'normal'. In opposition, symptoms which were conceptualised as 'rare' were constructed as 'weird'.

The 'ubiquitous – rare' continuum

In a large number of groups, pupils conceptualised symptoms according to how prevalent they perceived them to be. Typically, both boys and girls of all ages did this by highlighting certain symptoms as those that "[e]veryone gets" (Andrew, P6b8) and

contrasting them with others that “not everyone gets” (Sandra, P6g9). On the whole, symptoms which were consistently conceptualised as ‘ubiquitous’ across both age and gender groups were cold or flu; headache; stomach ache or feeling sick; and aching back, legs or arms. In most groups, these symptoms were described as “the most common” (Christian, S4b19), those that “happen to everybody” (Pamela, S4g13) or “day to day basis things” (Oliver, S2b12). However, other symptoms were conceptualised as ‘ubiquitous’ in some groups and ‘rare’ in others. Specifically, this was the case with asthma or wheezy chest; feeling irritable or bad tempered; nervous, worried or anxious; and difficulty getting to sleep. The following quote demonstrates how one group conceptualised these symptoms as ‘rare’:

Okay, so you’ve got two groups [of symptoms] there. So, eh... I just want you to kinda have a look. This group that you would be most likely [to report] are headache; dizzy, faint; stomach ache or feeling sick; sad, unhappy or low; aching back. And these ones [that you think you would be less likely to report are] nervous, worried or anxious; asthma or wheezy chest; irritable; difficulty getting to sleep. So what do you think these kind of symptoms [that you would report] have in common? Like, what makes them ones that you would tell about?

Nina: Most people get them.

Mhmm, yeah. So they’re kind of quite common in a way?

Nina: Yeah.

What about these [symptoms: nervous, worried or anxious; asthma or wheezy chest; irritable or bad tempered; and difficulty getting to sleep]? The ones that you’d be least likely [to report]?

Angela: Em, not many people get them.

Debbie: You’re less likely to get them.

(P6g4)

However, in P6b7 the boys contradicted the girls in this group as, instead of conceptualising these symptoms as ‘rare’, Cameron claimed that “[m]ost people have” asthma or wheezy chest; feeling irritable or bad tempered; nervous, worried or anxious; and difficulty getting to sleep. This type of contradiction also occurred between groups in respect of dizzy or faint and feeling sad, unhappy or low. Therefore, across the groups there was less consensus as to whether these symptoms

should be conceptualised as 'ubiquitous' or 'rare' and there were no clear gender or age patterns in how these contradictions became manifest.

Nevertheless, one symptom which was consistently conceptualised as 'rare' by both boys and girls was 'feeling like crying all the time'. As pupils compared this symptom to stomach ache, the 'physical' symptom used in the vignettes, their discussions can be conceptualised as positioning the two symptoms at either ends of the 'ubiquitous – rare' continuum. The following examples are typical of ways in which they did this:

Leigha: And cos not everybody starts crying all the time, but more people get that [stomach ache].

(P6g10)

Nick: Everyone gets a stomach ache but not everyone might - not everyone will get depressed.

(S2b12)

Clearly, the majority of the pupils viewed 'feeling like crying all the time' as a symptom which affects very few people. However, it is interesting that there was more of a general consensus on this than there had been regarding the conceptualisation of feeling sad, unhappy or low. Perhaps pupils found it harder to say whether feeling sad, unhappy or low is 'ubiquitous' or 'rare' because it is more of a vague symptom description and is more open to interpretation than is 'feeling like crying all the time'.

The 'normal – weird' continuum

Related to the prevalence and frequency of symptoms, a small number of girls' groups also conceptualised symptoms as either 'normal' or 'weird'. These extracts show how some girls did this as they spoke, during the symptom cards task, about symptoms they thought they would or would not report:

[...] which [symptoms] would you be most likely to tell someone about?

[...]

Becky: Like cold, just normal things like having a headache, or a cold and flu.

(S4g14)

[...] what do you think the main differences between this group [of symptoms] here that you probably would tell about and this group here that you might be less likely?

Alison: Because like, that's kinda normal. Like stomach ache and headache.

Mhmm.

Alison: But nearly everyone gets that.

Yeah. And what about the other ones that you wouldn't tell? Do you think people get them or, what do you think people think of them?

Sharon: People don't normally get them.

Mhmm.

Sharon: Like sad and unhappy and not getting to sleep.

(P6g10)

In saying that certain symptoms are "normal things" that "everyone gets", whilst others are those which people "don't normally get", the girls in these groups can be seen as conceptualising symptoms according to the 'ubiquitous – rare' continuum. However, as they used the words "normal" and "normally", they further suggested that symptoms which are 'ubiquitous' are also 'normal'. Another example of this occurred as, when comparing the two symptoms discussed in the vignette task, Rose (S4g26) claimed that "stomach ache's a bit more of a normal thing to get", before going on to say that crying in class "would seem a bit weird". The juxtaposition of the words "normal" and "weird" in this case also suggests that a more abstract level of conceptualisation was taking place in these girls' groups. Specifically, what their accounts implied was that symptoms which were conceptualised as 'ubiquitous' were consequently seen as 'normal' in the sense that they are ordinary because everyone gets them. However, symptoms that were perceived as 'rare' were also viewed as out of the ordinary, odd, or even 'weird'.

6.2.3 *The severity of symptoms*

Symptoms were also conceptualised by pupils in terms of their severity. Specifically, pupils spoke about symptoms in terms of their potential to either worsen or pass, and also in relation to how serious or trivial they perceived them to be. To conceptualise pupils' discussions when they had difficulty in deciding whether certain symptoms should be viewed as 'serious' or 'trivial', it is helpful to look at how they thought about the aetiology of the symptoms and how their ideas can be understood in terms of another continuum that is referred to as 'cause unidentifiable – cause identifiable'. Also in relation to the severity of symptoms, pupils sometimes made further distinctions as they conceptualised some as 'real illness' and others as 'not illness'.

The 'worsening – passing' continuum

Significantly, girls were more likely than boys to conceptualise symptoms as 'worsening', or as having the potential to become worse. Across all age-groups, it was common for girls to do this by claiming that certain symptoms could "end up getting worse" (Debbie, P6g4) or "be quite dangerous if you left them alone" (Vicky, S2g25). Many of the girls' groups were quite inclusive in their conceptualisations of symptoms as being likely to 'worsen'. For example, those in P6g2 claimed that headache; cold or flu; asthma or wheezy chest; stomach ache or feeling sick; and dizzy or faint were symptoms that could "turn into something more serious" (Rhona, P6g2). Similarly, the girls in S4g13 added feeling sad, unhappy or low, and nervous, worried or anxious to this list, claiming that all six symptoms "could result in something even worse" (Carla, S4g13). Thus, girls were not only more likely to conceptualise symptoms as having the potential to worsen, but when they did so they constructed a large number, if not the majority, of the symptoms in this way.

The conceptualisation of symptoms as 'passing' was less common across girls' groups. However, when this did occur, symptoms such as, aching back, legs or arms; feeling sad, unhappy or low; irritable or bad tempered; and difficulty getting to sleep were described as those that "might just pass over" (Rhona, P6g2) or would "get better over time" (Sheena, S4g13). The fact that certain symptoms, such as feeling sad, unhappy or low, were conceptualised in some girls' groups as 'worsening' and in others as 'passing', again highlights an inconsistency across groups in what pupils understood the symptoms to mean.

Boys were more likely to conceptualise symptoms as 'passing'. In particular, symptoms such as headache; stomach ache or feeling sick; aching back, legs or arms; feeling irritable or bad tempered; sad, unhappy or low; and nervous, worried or anxious were described as symptoms "that you could really just overcome quite quickly" (Keith, S2b24) or "usually [symptoms] that will go away" (Adam, S2b20). It is important to note that these boys conceptualised certain symptoms, namely headache; stomach ache or feeling sick; and feeling sad, unhappy or low as 'passing', yet these were constructed, at least sometimes in the case of feeling sad, unhappy or low, as 'worsening' by the girls. Therefore, this is one way in which the same symptoms were conceptualised by the boys and girls in opposing ways.

Although boys were less likely to conceptualise symptoms as having the potential to worsen, both boys and girls consistently conceptualised asthma or wheezy chest and dizzy or faint as symptoms that are likely to get worse. The extracts below are typical:

Nick: If you have like an - if you have asthma, it could make you like have an asthma attack if you don't tell anybody that you need your, like, inhaler or anything.

(S2b12)

Rhona: Erm, well asthma or wheezy chest could be more serious, cos it may not be serious at that point but it could get serious.

Mhmm.

Ellie: Mhmm. Asthma attacks.

Jennifer: Same with dizzy and faint, that would be you could faint.

(P6g2)

Jack: Like if you were like away up the bank [hill?] and you fainted and like you felt faint before you went out, didn't tell your mum...

Angus: Yeah, like if you feel faint or anything and then you like take a play on your bike and then you fell off before you got to anybody...

Andrew: And you're not - and you're not wearing a helmet...

Angus: And then nobody could see and tell anybody.

Russell: The person might fall off or somebody might hit you and just run away.

(P6b8)

Katie: Like anything could happen to you if you felt...if you says "Oh, I feel dizzy". If you were on your own it would be quite dangerous...

(S4g14)

Thus, pupils generally highlighted the potential of both asthma or wheezy chest and dizzy or faint to become worse if ignored or not treated. In relation to these symptoms, the fact that pupils often referred to their potential end-points as acute events, such as having an asthma attack or fainting, suggests that it was the threat of these 'dangerous' consequences occurring, and perhaps the further damage which these 'events' could cause, which made the pupils think of these symptoms as more likely than others to worsen.

The 'serious – trivial' continuum

Closely related to pupils' conceptualisations of symptoms as either 'worsening' or 'passing', they also distinguished between them on the basis of whether they were 'serious' or 'trivial'. Again, girls were more likely to conceptualise symptoms as 'serious' and, as when conceptualising symptoms as 'worsening', they were very inclusive in respect of those they referred to as 'serious'. For example, the girls in P6g2 only excluded feeling irritable or bad tempered, claiming that the other nine symptoms are "kind of more like serious" (Anna). Similarly, the girls in S2g25 said that symptoms such as headache; stomach ache or feeling sick; dizzy or faint; asthma or wheezy chest; aching back, legs or arms; feeling irritable or bad tempered; and sad, unhappy or low are all "quite important" (Vicky). As a result of the girls' tendency to conceptualise a large number of symptoms as 'serious', they constructed very few as being 'trivial'. For instance, in S4g13 having difficulty getting to sleep and aching back, legs or arms were the only two symptoms referred to as "not that serious" (Sheena). Again, this might also suggest that the girls had quite a broad understanding of what it meant for symptoms to be 'serious'. It is also significant that

the symptoms which girls conceptualised as ‘serious’ or ‘trivial’ were often the same as those they had constructed as ‘worsening’ and ‘passing’, respectively.

One boys’ group, S2b23, firmly distinguished between symptoms on the basis of whether or not they perceived them to be ‘serious’. In this group, Gregor claimed that symptoms such as headache; cold or flu; asthma or wheezy chest; dizzy or faint; aching back, legs or arms; and difficulty getting to sleep, were “more, like, serious”. However, Josh highlighted a symptom which he thought was more ‘trivial’:

Josh: Because you... everybody gets sad sometime during the day or something. Most people do, anyway.

Yeah. So you’d maybe just put it down to....

Josh: Yeah. Something’s happened, and... nothing serious.

(S4b19)

This quote is interesting for a number of reasons. Firstly, Josh highlighted feeling sad, unhappy or low as a symptom that is ‘trivial’ and, in doing so, contradicted the majority of the girls who had conceptualised this as a potentially ‘serious’ symptom. Secondly, Josh’s claim that “everybody gets sad sometime during the day” and therefore this is “nothing serious”, suggests that he made a causal link between the symptom being ‘ubiquitous’ and it being ‘trivial’. Finally, however, this quote is also interesting because, in saying that “[s]omething’s happened”, Josh implied that knowing the cause of the sad, unhappy or low symptom also contributed to his conceptualisation of it as ‘trivial’. This is something which was suggested in other groups and which will be discussed now as the ‘cause unidentifiable – cause identifiable’ continuum.

The ‘cause unidentifiable – cause identifiable’ continuum

Although it was more likely for girls to conceptualise feeling sad, unhappy or low and ‘feeling like crying all the time’ as ‘serious’ symptoms, there were instances in which both boys and girls seemed unsure as to whether they should be viewed as ‘serious’ or ‘trivial’. However, some pupils spoke about knowledge of cause as being a way of distinguishing between ‘serious’ and ‘trivial’ symptoms. These examples are typical:

Amanda: Like, if you're crying, just at anything... and like you can't stop yourself, then you could speak to your parents. But if you were just, like... somebody upset you and you were crying, I don't think it – well, it would be serious, but it wouldn't be as serious as kind of -

Gemma: Unless, yeah -

Nadine: Yeah, cos you'd know what, why you were crying...

(S2g23)

Adam: But if he [Steven, male vignette character] doesn't know what's making him upset, then... he would probably tell some... his mum because it might be something a bit more serious.

Yeah.

Adam: Than if you were just, like, generally upset.

Yeah. So what difference do you think it makes if you know what's wrong with you than if you don't?

Adam: Well, if you know what's wrong with you then you can sort it out.

Kenny: But if you don't know what's wrong with you, you kind of feel that you could be doing something wrong.

Adam: You could get confused as well on what's making you upset.

(S2b20)

The implication, in both groups and indeed generally, was that if the cause of this symptom is known, it helps to explain the symptom and provides a means of addressing it and resolving the feelings. Thus, knowing the cause of the symptom means it is 'less serious'. However, pupils' accounts suggested that if someone feels like crying for no apparent reason, this is 'more serious', presumably because it cannot be explained and, therefore, might suggest that the feelings are more to do with their mental health than their personal circumstances. Therefore, although girls were more likely to construct feeling sad, unhappy or low and 'feeling like crying all the time' as 'serious', there was evidence across the groups that both boys and girls felt that the degree of seriousness of these symptoms would depend on whether or not the cause could be identified.

A minority of pupils also used this logic to make distinctions between some ‘physical’ symptoms. It was mainly S2 and S4 pupils who did this and the following quotes are typical:

So [symptoms] you’d be less likely [to report] are cold and flu maybe, and irritable or bad tempered. [Why don’t you think that you would tell anyone about them?]

Nadine: [Because] there’s probably a good reason that you can think of why you’ve got them.

(S2g23)

Pamela: Mmm, I’m not sure if I would [tell anyone about] aching back, legs or arms, because I’d just put that down to P.E. or something.

(S4g13)

Josh: Achin’ arms and back could be from liftin’ stuff or anything, then it goes away, so [I wouldn’t tell anyone].

(S4b19)

Evidently, ‘physical’ symptoms which pupils were able to “put down to” a specific cause or “think of why” they had them, can be seen as having been conceptualised as ‘trivial’ for this reason. This suggests that pupils would also conceptualise ‘physical’ symptoms as being ‘serious’ if they could not attribute them with a cause. Both of these ideas were evident in one S4 girls’ group when Collette speculated as to how she might react to a stomach ache:

Collette: I’d probably think why I’m feeling unwell, and then if I could think why, and then I’d either take a Paracetamol or drink more water or, em, not eat anything unhealthy or something. But if I didn’t know [what had caused the stomach ache], then I’d probably just tell someone.

(S4g21)

Collette’s ideas suggested that being able to work out the cause of her symptom might help her to treat and cure it. However, she said that being unable to explain a stomach

ache would lead her to seek help for it, perhaps because she viewed it as being more serious if she could not identify the cause. Therefore, a minority of pupils drew on the idea that if the cause of a 'physical' symptom is identifiable, the symptom is 'trivial' because its cause can be addressed. In contrast, they implied that 'physical' symptoms with unidentifiable causes are more 'serious', perhaps because they might not be as easily treated and cured. Significantly, none of the pupils explicitly raised the idea that symptoms can have identifiable causes, but can also be serious and difficult to treat.

The 'real illness – not illness' continuum

Also related to severity, some pupils conceptualised symptoms in terms of whether or not they viewed them as representing 'real illness'. P6 girls were the only sub-group not to conceptualise symptoms in terms of whether or not they represent 'real illness' and, although a few S2 and S4 girls did, this was most characteristic of S2 and S4 boys. Having said that, when boys and girls spoke about symptoms in this way, there were many similarities between what they each said. For example, headache; stomach ache or feeling sick; asthma or wheezy chest; dizzy or faint; aching back, legs or arms; and cold or flu were described by girls and boys as "actual illnesses" (Rose, S4g26), symptoms that mean there is "something wrong with you" (Matthew, S4b16), and that "you can get sick with" (Jack, P6b8). As some of these symptoms were also conceptualised by girls as 'worsening' and 'serious', but were constructed by boys as 'passing' and 'trivial', this might suggest that boys and girls had subtly different conceptualisations of what constitutes illness. For example, boys could view a symptom as meaning that there is "something wrong" but also conceptualise it as being 'passing' or 'trivial'. In contrast, girls tended to view symptoms that signify 'real illness' as also being 'worsening' or 'serious'. These tendencies link with boys' constructions of themselves as dismissive of symptoms and girls' attempts to portray themselves as responsible and cautious in their responses to illness (Chapter 5).

In contrast, pupils, and mainly boys, conceptualised 'feeling like crying all the time' as 'not illness'. Paula (S2g25) was the only girl to claim, or perhaps question, that 'feeling like crying all the time' was "maybe not an illness or anything". However, boys were more definite in how they conceptualised this symptom:

Craig: [If Steven felt like crying in class] I don't think he would want to go home, though, because then everyone would just say...

Robert: Yeah, cos there's nothing wrong with you.

Craig: There's nothing wrong with you. There's... just... like, sad.

(P6b5)

In terms of other 'malaise' symptoms, boys generally constructed feeling sad, unhappy or low; irritable or bad tempered; and nervous worried or anxious as "not feeling ill" (Joe, S4b11) and symptoms that "you can't really get [...] sick with" (Jack, P6b8). This links with their dismissal of these symptoms as also being 'passing' and 'trivial'. Thus, it is significant that more boys invoked the 'real illness – not illness' continuum but that they did so mainly as they conceptualised symptoms, especially 'malaise', as 'not illness'.

6.2.4 The controllability of symptoms

Pupils conceptualised symptoms according to their controllability in three ways. Most commonly they spoke about whether or not, and how effectively, symptoms could be treated with medicine and the 'treatable – untreatable' continuum is used to conceptualise these discussions. Pupils also spoke about symptoms in terms of how 'involuntary' or 'voluntary' they perceived them to be. In this sense their accounts suggested that some symptoms can be seen as 'involuntary' because they manifest themselves despite people's efforts to control or stop them. In contrast, pupils constructed other symptoms as 'voluntary' because they can be controlled and this means that they need not be experienced. Lastly, in relation to controllability, pupils also conceptualised symptoms as 'acceptable' or 'taboo', depending on the degree to which they believed them to signify a lack or loss of control.

The 'treatable – untreatable' continuum

One of the most common ways that pupils conceptualised symptoms was according to whether or not they perceived them to be medically treatable. In terms of gender patterns, boys and girls were equally likely to conceptualise symptoms in this way. Across age-groups, it was P6 pupils who were most likely to talk about symptoms in terms of whether or not they could be treated. Typically, P6 boys and girls named

headache; stomach ache or feeling sick; asthma or wheezy chest; aching back, legs or arms, and cold or flu as symptoms that “[you can] treat” (Craig, *P6b5*) and for which “you need someone to give you some medicine” (Eve, *P6b1*). In relation to these symptoms, it was common for P6 pupils to suggest that “your mum would give you some tablets” (Liam, *P6b3*) or “if it’s not better the next day, then they [parents] would take you down to the doctor’s” (Sandra, *P6g9*). However, P6 pupils also conceptualised certain symptoms as being ‘untreatable’ in the sense that they could not be cured with medicine. For example, Connor (*P6b7*) implied that difficulty getting to sleep could not be treated in the same way as other symptoms when he said “they couldn’t exactly help me try and get to sleep, could they?” Similarly, Sandra (*P6b4*) claimed that “if you told them about difficulty getting to sleep, then they could just say, ‘Just close your eyes and try a bit harder’”. Therefore, both Connor and Sandra conceptualised difficulty getting to sleep as less ‘treatable’ than other symptoms, such as headaches and cold or flu.

The ‘treatable – untreatable’ continuum is most applicable to S2 and S4 pupils’ comparisons of the two symptoms featured in the vignette task, stomach ache and ‘feeling like crying all the time’. For example:

James: [...] if it’s a stomach ache, you know, just...

Kevin: Take a Paracetamol.

James: Get to bed early.

Kevin: See what it’s like in the morning.

Mhmm.

James: Whereas depression [‘feeling like crying all the time’] is, it’s not like you can just take a... Paracetamol and it’ll go away.

(*S4b17*)

In *S2g23*, Amanda made a similar point as she claimed that in the case of ‘feeling like crying all the time’, “the only thing [people] can say is ‘Oh, are you alright?’” and the sense of futility she conveyed was compounded as Gemma added, “but it doesn’t always help”. Indeed, a few pupils claimed that “[i]t can make you worse” (Ruth, *S4g13*) when people try to help and find out the cause of the upset. Therefore, the

general feeling across the groups was that stomach ache, and ‘physical’ symptoms in general, are more ‘treatable’ than ‘malaise’ symptoms.

Nevertheless, in a few exceptional cases it was suggested that ‘malaise’ symptoms, and particularly ‘feeling like crying all the time’, could be treated with medicine. For example, whilst discussing the ‘malaise’ symptom vignette, George (P6b6) suggested that, as a way of addressing his feelings, Steven (male vignette character) could “get anti-depressants”. Similarly, Becky made the following comment as her group discussed this symptom:

Becky: [...] like, you can go to the doctor about having a headache, you can go to the doctor about having flu, if you went to your doctor and you’re like “Oh, I’m sad and unhappy quite a lot”, they’ll end up just putting you on anti-depressants or something, even if you aren’t depressed, cos that’s the only thing they can do.

(S4g14)

On one level, in suggesting that ‘feeling like crying all the time’ could be treated with anti-depressants, both George and Becky conceptualised it as a ‘treatable’ symptom, albeit Becky implied that there would be fewer options in treating ‘malaise’ as compared to ‘physical’ symptoms. However, in order for George and Becky to conceptualise ‘feeling like crying all the time’ as a ‘treatable’ symptom, they had also interpreted it as being indicative of depression. This is confusing given that many pupils had conceptualised this same symptom, in relation to the ‘real illness – not illness’ continuum, as “nothing wrong” (see Section 6.2.3). However, what is significant about George and Becky’s comments is the link that they established between symptoms that signify ‘real illness’ and those that are ‘treatable’. For example, it is only after they interpreted ‘feeling like crying all the time’ as depression that they also conceptualised it as a ‘treatable’ symptom. This suggests that in order for symptoms to be viewed as ‘treatable’ they also have to be conceptualised as ‘real illness’ and vice versa.

The ‘involuntary – voluntary’ continuum

In a small number of groups, pupils compared and contrasted symptoms in a way which implied that some are ‘involuntary’, because their effects cannot be controlled

or stopped, whereas others are 'voluntary' because their effects can be controlled and, therefore, people who experience them are, in a way, choosing to do so. The idea that some symptoms are 'voluntary' whilst others are not, was only implied in three groups, one P6 boys', one P6 girls' and one S4 girls' group. However, pupils in these groups made similar distinctions between symptoms. For example, Ellie (P6g2) distinguished between symptoms "that you have to [feel]", such as headache; stomach ache or feeling sick; asthma or wheezy chest; dizzy or faint; and cold or flu, and other symptoms, such as feeling irritable or bad tempered; sad, unhappy or low; and nervous, worried or anxious, that "you have the choice of feeling". Similar sentiments were echoed as Liam (P6b3) contrasted the two vignette symptoms, claiming that "you can't help" stomach aches but that "you can kind of help crying if you want to". Therefore, Ellie and Liam suggested that certain, and especially 'malaise', symptoms are 'voluntary' because they can be helped or "you have the choice of feeling" them. In turn, their ideas implied that, because they can be controlled, 'malaise' symptoms do not "have to" be experienced and if they are it is because people are choosing to let themselves be affected by them. In contrast, they conceptualised symptoms which tended to be more 'physical' in nature, as 'involuntary' and, in turn, implied that they affect people regardless of their efforts to control them and, consequently, that suffering from them is unavoidable.

Implicit in these suggestions was the idea that it is a failing or a sign of weakness to suffer from 'voluntary' symptoms, because, being controllable, they should be shrugged off and not 'allowed' to develop. A similar idea was implied in an S4 girls' group as Pamela (S4g13) claimed that boys would report symptoms such as cold or flu and aching back, legs or arms because they "[are] not anything [that's] their fault". It can be inferred from this idea that people are not to blame for experiencing 'involuntary' symptoms because they will be affected by them despite their own best efforts to control or ignore them. However, the implication with regards to 'voluntary' symptoms was that people are culpable for allowing themselves to experience symptoms that they have the choice of ignoring or at least controlling.

The 'acceptable – taboo' continuum

Both boys and girls also conceptualised symptoms as either 'acceptable' or 'taboo'. Specifically, symptoms which were most likely to be conceptualised as 'taboo' were

those associated with a lack or loss of control over emotions or bodily functions, such as vomiting, diarrhoea, difficulty getting to sleep, or crying. Pupils were less likely to explicitly construct symptoms as 'acceptable', but implied that certain 'taboo' symptoms may be viewed as 'more acceptable' if it was evident that a certain degree of control was being exerted over them.

P6 pupils were most likely to voice their concerns with regards to symptoms that could be seen as signifying a loss of control over bodily functions. In particular, they came across as being afraid of the prospect of being sick in class or having diarrhoea at school. The following examples are typical of the ways in which they voiced these concerns:

Andrew: [...] and if you're like gonna, if you're gonna be sick in the classroom and there's too many people at the toilets.

Angus: At the toilet.

Andrew: You just kinda, you're going to be scared to puke up on the floor.

Russell: I puked on my tray once.

Angus: I know!

[Laughter]

(P6b8)

Sandra: Or sometimes people are a bit scared to go to the toilet in school, so it might be better to go into the toilet at your own house.

Mhmm, and why - why don't they like going to toilet in school?

Sandra: Because if they have diarrhoea or something.

Oh right, something like that could be quite...

[Laughter]

(P6g9)

Both “puking up” in class or having diarrhoea in the school toilets were prospects dreaded by pupils and situations they would hope to avoid by being able to control their symptoms, even if this just meant getting to the toilets before being sick or, in the case of diarrhoea, trying to wait until getting home before going to the toilet. Thus, the majority of P6 pupils’ discussions of these symptoms were linked by the fear of being seen as unable to control them in public and, for this reason, many pupils highlighted contingency plans in the hope of preventing this from happening, such as “stand[ing] next to the toilet” (Simon, *P6b6*) when feeling sick. P6 pupils also portrayed these symptoms as embarrassing as they laughed at the prospect of them occurring in public contexts. Indeed, participants’ own laughter suggests that this would be the general reaction from peers who found out about or witnessed the manifestation of these symptoms.

To a lesser extent, some S2 and S4 pupils also conceptualised being sick in public or having diarrhoea as ‘taboo’. For example, Carrine (*S4g14*) expressed the concern that “if you feel sick, you might actually throw up and that’s not good”. In response, the other members of her group laughed in agreement and, in doing so, conveyed the existence of a tacit understanding between them that vomiting in public is ‘taboo’. Similarly, the boys in *S2b18* also mentioned having diarrhoea as something people would laugh at. Therefore, when older pupils mentioned these two symptoms, either being sick or having diarrhoea, they also expressed fear that they might happen in public contexts as they described them as “embarrassing”, and even laughed at the prospect of them occurring to other people. It is possible that all pupils viewed diarrhoea as ‘taboo’, not only because they saw it as “embarrassing” and “horrible”, but because they might also have associated it with young children’s inability to control their bladder or bowels. Thus, it is possible that pupils viewed diarrhoea as a loss of control that would infantilise those who experience it.

It is significant, however, that S2 and S4 pupils were less likely to raise the prospects of being sick or having diarrhoea at school. One possible explanation for this might be that bodily control is more salient for P6 pupils because they are younger and perhaps still developing abilities to exert control over their bodies, perhaps especially in times of illness. Similarly, in approaching their last year of primary school and the transition to secondary, P6 pupils may have been concerned about their abilities to

control their bodies so as to make them conform to changing age-related expectations. Alternatively, S2 and S4 pupils may have been equally concerned about the prospect of losing control of their bodily functions, but were less likely to voice these concerns in order to construct themselves as ‘in control’.

A few pupils also spoke about difficulty getting to sleep as an “embarrassing” (Scott, S2b12) symptom and their reasons for thinking this shed light, more generally, on pupils’ conceptualisations of certain symptoms as ‘taboo’. For example, Sandra (P6g9) claimed that “if you have difficulty getting to sleep and you tell your friends then they [...] might think you need your mum to get you to sleep”. Along similar lines, Gareth (S4b16) asserted that “things like difficulty getting to sleep are things younger children generally have problems with”. Therefore, in addition to symptoms being seen as signifying an inability to control bodily functions, Sandra and Gareth conceptualised having difficulty getting to sleep as a symptom which “younger children” get and which signifies a child-like dependence on parents for basic functions. Given pupils’ awareness of the importance of demonstrating behaviour which accords with age-related expectations, it follows that symptoms which were seen as ‘infantilising’, were also conceptualised as ‘taboo’.

The inability to exert control over emotions was also conceptualised, by the majority of the pupils, as ‘taboo’. In particular, crying in public was constructed by all pupils as “a totally embarrassing thing” (Hazel, S2g25) and a scenario which should be avoided. Across age and gender, pupils voiced their opinions on this in very similar ways:

Rhona: Cos you don’t really want to sort of burst into tears in class

(P6g2)

Kevin: It’d probably be more embarrassing if you burst out crying in class than if you told the teacher [that you felt like crying]

(S4b17)

In each quote, as in most cases when pupils spoke about the prospect of crying in class, it is significant that they used phrases like “burst out crying” or “burst into tears”. The main effect of this was to highlight, in a vivid way, the sudden loss of control which they perceived that crying in class would represent. What is more, this language conjures up images of babies and young children who often “burst out crying” with very little warning and perhaps for no obvious reason. In fact, as many pupils stated that crying in class would be seen as “babyish”, they were also more explicit in highlighting the reason for conceptualising this symptom as ‘taboo’.

Pupils conceptualised crying in public as especially ‘taboo’ when no identifiable causes or reasons could be given to explain it. Although pupils did so regardless of age and gender, there were some gender differences in the ways they expressed this idea. The following examples are typical of the ways that girls did this:

Kirsten: People would be like “Why are you crying?” and-

Rhona: And if people heard around you-

Kirsten: ...if she had a no, if she had no reason then they’d just think she was a bit stupid [...] It’s kinda like cos they think it’s more silly to cry about just nothing. So they try and cover it up more. And when you’re younger it’s like, you don’t really care as much.

(P6g2)

And, so [this vignette] says she’s been feeling like she’s going to cry all the time, so it’s the same kind of thing... she’s in class, so in that kind of situation, what kind of things would be making her want to tell and what things would be putting her off?

Emily: Well, em, putting her off...she would seem like a baby, and if it’s like not, she can’t really explain why she’s feeling like gonna cry, then they might all like pick on her or tease her.

(S4g14)

In general, girls conceptualised crying for no reason as ‘taboo’ by referring to how this would be seen as “stupid”, “silly” and something which would make you “seem like a baby”.

Boys also conceptualised crying for no reason as ‘taboo’, but, interestingly, instead of constructing this as behaviour which is simply age-inappropriate, they also constructed it as gender-inappropriate. For example, the boys in *P6b3* claimed that:

Liam: If you’re just crying then you can’t tell them why...

Gordon: They’ll think you’re a wee...

Liam: Just think you’re a wee wimp or something.

(*P6b3*)

Thus, Gordon and Liam’s use of the words “wee” and “wimp” suggest that crying, especially without being able to tell people why, may be seen as both age- and gender-inappropriate. For these reasons, then, pupils generally perceived this behaviour as ‘taboo’ and, consequently, felt that they would try their utmost to avoid being seen to cry, whatever the reason, but would hide their emotions even more so if they could not explain them.

Given that pupils also conceptualised crying as ‘serious’ when there were no identifiable causes for it (see ‘cause unidentifiable – cause identifiable’ continuum, p.161), when thinking about how these conceptualisations might have implications for reporting, it seems that a tension may exist between the need to report the symptom because it is ‘serious’ and efforts to suppress these emotions because crying for no reason is seen as ‘taboo’. Thus, deciding whether to tell someone about ‘feeling like crying all the time’, especially when there are no apparent reasons for this, may depend on whether the symptom is viewed by the person experiencing it as ‘serious’ or ‘taboo’ and, in turn, on their perceptions as to how others will conceptualise and react to this symptom. The links between conceptualisations of symptoms, implications for reporting and the consequences of reporting are discussed in detail in Chapter 7.

It was less common for pupils to construct symptoms as ‘acceptable’ in the same way as they had highlighted certain symptoms as ‘taboo’. However, pupils highlighted the idea that being seen to exert control over symptoms is a ‘more acceptable’ way of dealing with them, even in the case of symptoms that are otherwise seen as ‘taboo’.

For example, as George (*P6b6*) said that “if somebody cries at school, you’re sorta like...cry out the side of your mouth”, his idea implies that in order to be seen as dealing with this otherwise ‘taboo’ symptom in a ‘more acceptable’ way, it needs to be evident that a degree of control has been exerted over the symptom. Thus, it appears that crying “out of the side of your mouth” is marginally more acceptable because it does not signify the same loss of control that “bursting out crying” represents.

If crying without identifiable cause was conceptualised by pupils as ‘taboo’, we might assume that being able to identify a specific reason for crying would have been seen by pupils as ‘acceptable’, or at least ‘more acceptable’. Indeed, this seems to have been the case in relation to certain reasons for crying, but there were other identifiable reasons for crying which were constructed as ‘less acceptable’. Pupils’ ideas as to ‘more acceptable’ and ‘less acceptable’ reasons for crying changed subtly according to age and fewer reasons were perceived as ‘more acceptable’ by older pupils. For example, P6 pupils viewed it as ‘more acceptable’ to cry as a result of tripping or falling than it would be to cry for no reason:

Tom: [If Sarah felt like crying when she was out with friends] she would just cry.

Jonathon: I think she would probably like, fake something like trip over-

Cameron: Running and then like she falls and then she starts crying.

(*P6b7*)

Sandra: [If Sarah felt like crying at home] she might fake fall or something and then say, “Ah, mum, I really hurt myself” and burst out crying. [...] But really she never fell.

(*P6g9*)

Pupils’ accounts implied that crying needs to be justified with a believable and identifiable reason in order for it to be seen as ‘acceptable’ behaviour. S2 pupils, however, were less likely to conceptualise falling over as a ‘more acceptable’ reason for crying. For example, when the boys in two S2 groups were asked to talk about ‘less acceptable’ reasons for crying, they suggested:

Gary: If you fell down the stairs and started crying ...

(S2b24)

Robbie: Fallin' down and hurtin' their leg or something, just ...

Lewis: Yeah, something-

Robbie: ...trippin' over.

[...]

Lewis: Well, if you're, like, falling over and hurting yourself people might just tease you because ...eh, they might not think you're tough enough to take it...

(S2b18)

These examples show that S2 pupils, unlike those in P6, viewed falling over and hurting themselves as a 'less acceptable' reason for crying, perhaps because, as Lewis suggested, they saw this as a sign that "you're not tough enough" to deal with such knocks without crying. This subtle difference between P6 and S2 pupils' ideas may reflect the influence on them of age-related expectations and, in particular, suggests that S2 pupils are under more pressure than those in P6 to display stoicism and control in reaction to any accidents, falls or illnesses that they might experience. The fact that the possibility of being hurt and crying as a result of a fall was not even mentioned by any S4 pupils, as either a 'less acceptable' or 'more acceptable' reason for crying, may simply have been because, by their age, falling might have been something which they felt was less likely to happen to them.

In relation to their conceptualisations of reasons for crying as 'more acceptable', what pupils had in common, across gender and age groups, was that they all constructed crying in reaction to a family death as being a 'more acceptable', if not *the most* acceptable, reason for crying. In the following examples, Amy and James tried to explain why this might be the case:

Amy: ...cos people are quite sympathetic if you're crying cos, like, somebody in your family's dead cos they kind of can relate to how you feel, but em... if you're crying just because there's no reason, then they

think it's stupid, or cos you've... failed a test or something, they think you're just being silly.

(S4g26)

James: Well, I mean... if you'd come into class and you'd... like your gran or somebody had died the last time you came into the class and you started crying, I don't think anyone would take... like, take the mickey for that, cos... I think people have got too much respect for things like that to... take the mick, whereas... for instance if you came in and you... started crying because... your hamster had died, then I think people would be slightly less... tolerant with it.

(S4b17)

The impression given by Amy and James, and in general as pupils spoke about crying in response to a death in the family, was that crying for this reason would be seen as 'more acceptable' because it could not be viewed as something "stupid" or "silly", but instead was something others would have "respect for". Thus, their accounts implied that crying would be seen by others as an appropriate response to something as serious as the death of a family member, but they suggested that crying because of failing a test or the death of a pet would perhaps be seen as an 'over-the-top' or childish reaction to events that, after a certain age, society expects to be dealt with in more controlled ways.

There was also a sense that crying because of a death in the family was seen as 'more acceptable' because it cannot be perceived as an age-related or age-limited occurrence. More specifically, it is possible that pupils viewed this as a 'more acceptable' reason for crying because, unlike failing a test or having a hamster die, which could both be viewed as childhood- or youth-limited experiences, people can lose others that are close to them at any time in their lives. Perhaps, then, crying in response to a death was viewed as a 'more acceptable' reason for crying because, as compared to other reasons that pupils talked about, it does not signify an inability to conform to age-related expectations and, instead, can be perceived as a natural reaction to an inevitable life-experience.

6.3 Chapter summary

In an attempt to elucidate pupils' understandings of symptoms, and to build a foundation from which we might begin to understand their reactions to them, this chapter has addressed the ways in which pupils conceptualised the symptoms that they discussed during the focus groups.

Pupils conceptualised symptoms in relation to four over-arching themes: ways of experiencing; prevalence and frequency; severity, and controllability of symptoms. Conceptual continua can be drawn from pupils' discussions and used to illustrate their understandings of symptoms and the comparisons or distinctions which they made between them. Pupils' conceptualisations of symptoms ranged from being based around fairly concrete notions, such as the degree of pain that they cause or whether or not they can be treated with medicine, to representing more abstract ideas, such as whether or not symptoms signify 'real illness'.

Age differences were evident in the ways that pupils conceptualised symptoms. Specifically, P6 pupils were more likely to base their conceptualisations on concrete notions, whereas S2 and S4 pupils were most likely to conceptualise symptoms using abstract ideas. Perhaps this relates to pupils' differing stages of cognitive development and younger pupils having less developed abilities to think of symptoms in more abstract ways. Alternatively, the younger pupils may simply have been more likely to think that they would be affected by the physical and tangible effects of symptoms, especially if they felt under increasing pressure to show that they could control these aspects of their symptoms. By discussing identifiable reasons for crying which they viewed as 'more acceptable' or 'less acceptable', pupils' accounts also demonstrated subtle age differences which implied that pupils were affected to different degrees by age-related expectations and suggested that by age 15 there were fewer reasons for crying which are viewed as relatively 'acceptable'.

The main gender difference in how pupils conceptualised symptoms, and this was still a fairly subtle difference, was in terms of their severity. In particular, girls were more likely to conceptualise symptoms, and in some cases the majority of symptoms, as 'worsening' and 'serious', whereas boys were more likely to conceptualise them as 'passing' and 'trivial'. However, given the girls' tendency to construct themselves as

responsible in their reactions to symptoms and the boys' constructions of themselves as dismissive of and able to overcome symptoms (see Chapter 5), it perhaps makes sense that they would each conceptualise symptoms in these ways.

Chapter Seven: Deciding whether to report symptoms in different social contexts: age and gender patterns in assessing symptoms and thinking about the consequences of reporting

7.1 Introduction

This chapter presents data which were generated during the vignette task. Its purpose is to outline the factors highlighted by pupils in their decisions about whether or not to report a ‘physical’ and ‘malaise’ symptom, specifically examining any age or gender patterns. One of the main claims made in the chapter is that these decisions are influenced by two factors: the assessment of symptoms according to a number of conceptual bases and the prediction of positive and negative consequences of reporting. These factors are inter-linking and co-dependent in that the perceived consequences of reporting vary according to the ways in which symptoms are conceptualised, while at the same time, conceptualisations of symptoms are influenced by the consequences of reporting. Another of the claims made in the chapter is that the influence of both factors, on pupils’ decisions about whether or not to report symptoms, varies significantly according to social context and in particular whether peers are present or absent.

The chapter is structured around the two main factors which influence pupils in their decisions about whether or not to report symptoms. It begins by looking at how pupils assess symptoms according to various conceptual bases, highlighting the ways in which this is influenced according to whether or not they are in the presence of peers. The second half of the chapter looks at pupils’ perceptions of the consequences of reporting symptoms and emphasises the ways in which they felt that outcomes would vary significantly according to social context, the type of symptom disclosed and the gender of the person experiencing it.

Before proceeding, it is important to bear in mind some key findings already discussed. Chapter 5 outlined pupils’ opinions that boys and girls would have distinct reactions to symptoms and demonstrated their efforts to ‘do gender’ by portraying themselves as reacting to symptoms in gender-distinguishing ways. Indeed, when

pupils were shown histograms displaying boys' and girls' symptom reporting rates ('11-16 study' results), some expressed surprise that the gender gap was not wider.

However, the data which this chapter presents, specifically those where pupils discuss the ways in which their *same-sex peers* would decide whether or not to report a 'physical' and 'malaise' symptom, are perhaps the closest available to boys' and girls' own accounts of how they might respond to symptoms. In fact, pupils often spontaneously talked about how they, personally, would assess, and decide whether or not to report, each of the symptoms. What is important about these data is that comparisons of what boys and girls said about their same-sex peers showed that, regardless of age, there were more similarities than differences between their accounts. Therefore, this goes against pupils', as well as wider societal, expectations that boys and girls respond to illness in distinct ways and highlights a very important mis-match between pupils' stereotypical expectations and 'reality', as represented in their hypothetical discussions of how same-sex vignette characters would decide whether or not to report symptoms.

7.2 How do boys and girls assess symptoms in order to decide whether or not to report them?

In saying that pupils assessed symptoms according to conceptual bases, this refers to the ways in which various concepts can be drawn from their discussions about how they would decide whether, and when, to report symptoms. Thus, whereas pupils' conceptualisations of symptoms showed what they understood them to mean, their assessments of symptoms can be described as the way in which they used their understandings, or conceptualisations, to assess whether or not symptoms were "bad enough" to warrant help-seeking. This section looks first at how pupils spoke about assessing symptoms in two different peer contexts ('in class' and 'out with friends') and then deals with their thoughts on how they would assess symptoms when in a more private context ('at home'). In relation to each context, pupils' discussions about how Sarah and Steven, the vignette characters, might react to a stomach ache are examined first, followed by their discussions of the 'malaise' symptom, 'feeling like crying all the time'.

7.2.1 Assessing symptoms in the presence of peers: similarities and differences according to age and gender

The ‘worsening – passing’, ‘painful – painless’ and ‘acceptable – taboo’ continua can be applied to pupils’ discussions of the ways in which a stomach ache would be assessed when in the presence of peers and so used to better understand pupils’ reasons for deciding whether and when a stomach ache is “bad enough” to warrant disclosure or help-seeking.

In relation to both being in class and out with friends, pupils claimed that they would not seek help for a stomach ache “straight away”, but, before doing so, would wait to see how long it lasted and/or if it got “worse”. These examples are typical and show the degree of similarity between the ways that boys and girls from all age-groups voiced these ideas:

And what about if [Sarah] was out with friends [and she had a stomach ache]?

[...]

Debbie: If it’s so bad she’d have to tell her friends.

[...]

Angela: But if it wasn’t that bad she could maybe get over it.

(P6g10)

So do you think that [telling the teacher] would be the first thing [that Sarah] would do [about the stomach ache in class]? Would she do it straight away?

Hazel: No.

Vicky: Maybe not.

Hazel: She’d wait... she might wait until it gets worse.

(S2g25)

So when, how would [Steven] come to the decision, “Right, I need to tell the teacher [about my stomach ache]”?

Charles: Just if he hadn’t been feeling well for a while.

(S4b11)

As pupils spoke about waiting to see if a stomach ache “gets worse or it just calms down” (Angus, *P6b8*), the ‘worsening – passing’ continuum (Chapter 6) can be applied to their ideas and seen as integral to the way in which they would monitor, and then decide whether or not to report, it in both peer contexts. Pupils’ accounts suggest that they would report stomach aches that they perceived as ‘worsening’, but not those they considered to be ‘passing’.

The ‘painful – painless’ continuum can also be used to conceptualise pupils’ ideas about why and when they would decide to seek help for a stomach ache when in the presence of their peers. Although it was common for P6 pupils to say that stomach aches would be reported if they were “really, really sore and [Sarah or Steven] didn’t want to put up with the pain anymore” (Sandra, *P6g9*), this age-group were not asked in as much detail as older pupils about when they would know that a stomach ache was “bad enough” to warrant help-seeking. The following quotes are characteristic of how S2 and S4 pupils responded to more detailed questioning and show the extent to which boys’ and girls’ ideas were nearly identical:

[...] how do you know when a stomach ache is bad enough to tell someone?

Peter: When it starts really hurting.

Oliver: When it’s aching pain.

Peter: You can hardly talk or something.

Mhmm.

Nick: And you don’t feel well, like you feel, you start to get sick or...

(S2b12)

...how do you know when [a stomach ache is] bad enough to tell?

Emily: When it's really painful and you just can't stand it anymore, and you're just about to break down into tears cos it's that painful.

Katie: But if you can-

Emily: It's like when you should've told like a while before it got that bad.

Katie: And if you can't like concentrate on your work properly, because it's disturbing you and you're just really uncomfortable and stuff, then....

(S4g14)

The majority of the pupils claimed that the more 'painful' a stomach ache is, the more likely they would be to seek help for it. Further to this, pupils spoke about some stomach aches as causing so much pain that "[y]ou can hardly talk" (Peter, S2b12), "you can't concentrate" (Gemma, S2g23) or "you can't really walk" (Josh, S4b19). However, they described others as "[not] that bad" (Angela, P6g4) or "just a wee thing" (Eve, P6g1). Thus, it seems that pupils' conceptualisations of stomach aches as 'painful' can be broken down further if we look at how they constructed some as causing debilitating or 'limiting' pain, but suggested that others are 'less limiting' because they can be lived with, ignored, or gotten over relatively easily. Therefore, pupils were not suggesting that all stomach aches should be reported because they are painful. On the contrary, both boys and girls, especially those in S2 and S4, gave the impression that whilst in the presence of their peers they would only report a stomach ache when the pain became so debilitating that it had begun to affect bodily functions, such as walking and talking, and could no longer be coped with, except by asking others for help.

The extracts above are also interesting because Nick (S2b12) and Emily (S4g14) claimed, respectively, that a stomach ache would be reported when "you start to get sick" or "you're just about to break down into tears". Therefore, they both implied that a stomach ache should be reported (just) before it results in a loss of control over bodily functions or emotions. Thus, the 'acceptable – taboo' continuum is also helpful in conceptualising pupils' assessments of symptoms. However, it is mainly

applicable to boys' discussions and only those relating to their reactions to a stomach ache in class. This example is typical:

So, how would [Steven] decide, do you think, [that his stomach ache is] bad enough to tell the teacher?

Lewis: When it gets... when he feels like he's gonna be sick, or... get very ill.

(S2b18)

The implication is that, when they start "to feel physically sick" (James, S4b17), boys would report a stomach ache in order to avoid vomiting in front of other people.

Because most pupils felt that they would conceal rather than seek help for the 'malaise' symptom (Chapter 5), they were less likely to talk about how they would assess it in order to decide whether it was "bad enough" to warrant reporting. This only occurred in one group of S4 girls:

...what would make [Sarah] want to tell someone [that she felt like crying] and what would be putting her off [in class]?

Pamela: Well if she knows that if she's been doing it a lot, then she should probably talk to somebody.

Sheena: Yeah.

Ruth: If it's really that bad she might talk to, like, a close friend.

Mhmm.

Carla: She might even go to a guidance teacher.

(S4g13)

The girls in this group suggested that they might 'wait and see' whether the symptom persisted or 'worsened' and gave the impression that in both cases it "should" be reported. It is significant that this S4 discussion is the only one to which the 'worsening – passing' continuum applies to pupils' assessment of whether this symptom is "bad enough" to warrant help-seeking, perhaps this is because girls were

generally more likely to conceptualise 'malaise' symptoms as 'worsening' and 'serious' (Chapter 6).

7.2.2 Assessing symptoms in the absence of peers: similarities and differences according to age and gender

Pupils' speculations as to how Sarah and Steven would respond to a stomach ache when at home conveyed the general feeling that they would both report it without as much deliberation or waiting until the pain became unbearable when compared with being in the company of peers. The apparent simplicity of the decision to report a stomach ache when at home was conveyed by boys and girls in all age-groups and these examples are typical:

And what about if [Sarah] was at home [and she had a stomach ache]? What do you think she would do?

Caroline: Tell her mum.

Sharon: Tell her mum.

Alison: Or her dad or...

(P6g10)

Okay, what about [if Steven was] at home [and he had a stomach ache]?

Gareth: Go and speak to your mum, and then go down the pharmacy and get some medication for it, or just stay in bed.

Mhmm. So how does being in class and being at home compare?

Justin: Cos you're not with your peers.

Mhmm. What difference does that make?

Justin: It's easier to tell your mum and dad than your peers.

(S4b16)

Thus, when pupils were asked how Sarah or Steven might react to a stomach ache when at home, they responded quickly by suggesting that they would tell their

parents. Indeed, P6 and S2 pupils tended to portray themselves as likely to report the symptom *immediately* in this context, thus sharing the responsibility of it, with either their parents or “whoever was looking after [them]” (Amanda, S2g23), without assessing first whether it was ‘worsening’, ‘passing’ or “bad enough” to tell, as they would do in more ‘public’ contexts. In the following example, Calum gives the impression that, at home, there would be less need to assess the stomach ache before deciding to report it:

And what about if [Steven] was at home [and he had a stomach ache], what do you think?

Calum: He would just tell straight away.

Liam: I would just tell my mum.

Straight away at home?

Calum: Yeah, cos it’s not as big a deal as going home from school and missing work.

(P6b3)

Calum suggested that there would be no need in this context to assess a stomach ache and decide whether it was “bad enough” to warrant reporting. This suggests that younger pupils may have been more willing to depend on others’ help in the contexts of their own homes and, indeed, the simplicity with which Tara (S2g22) expressed her belief that Sarah would “just tell, cos it’s like her mum and dad”, suggests that the disclosure of illness to parents is seen as an automatic reaction and because of this there would be less of a need to assess the symptom before seeking help.

Further to this, as Calum suggested that reporting the symptom at home is “not as big a deal as going home from school”, he highlighted another reason for the importance of symptom assessment in contexts other than at home. This is simply that when in school, or indeed out with friends, symptoms are assessed in order to decide whether the person not feeling well should go home to recuperate or, if necessary, seek medicine or medical advice. Thus, if symptoms occur when children are already at home, there is obviously less need to assess them before seeking help. In addition to this, the idea that at home “[n]o-one’s gonna really know” (Liam, P6b3) about the

stomach ache suggests that reactions to illness are less actively policed, and admitting to illness seems to matter less, in contexts where peers are not present.

Indeed, the absence of peers from the home was explicitly highlighted by boys and girls in all age-groups as important in facilitating symptom reporting in this context. The extracts below represent typical examples:

And do you think [it's] easier [to decide what to do about the stomach ache] at home?

Alison: Yeah.

[...]

Caroline: Cos not everybody's going to find out.

(P6g10)

Age-based differences came to light, however, as some older pupils were less likely to say that they would report the stomach ache “straight away” when at home, but were more likely to portray themselves as making an effort to deal with it independently for as long as possible. For example:

Okay, so what if [Steven] was at home [and he had a stomach ache]?

Joe: Mmm, just... go to bed, that's what I would do.

Mhmm, would he say anything?

Joe: Em... if he was feeling really bad.

Charles: Yeah.

(S4b11)

And what about if [Sarah] was at home [and she had a stomach ache]?

Zoe: Eh... she'd probably... just, like... well, if I was her, I'd probably just, like, sort of like do the same as I would at school – just sort of think about it and, like... you know, just, like, get a drink of water or something, and then if it was getting really bad, I'd probably, like, tell my

mum, and she'd advise me to, like, take some sort of medicine or something.

(S4g21)

Significantly different in both S4 examples, as compared to the majority of the P6 and S2 groups, was that neither Joe nor Zoe suggested that at home they would “just tell” whoever was in the house about their stomach ache. On the contrary, they both portrayed themselves as adopting self-management strategies, such as going to bed or getting a drink of water, and only seeking help once they had assessed the symptom as being “really bad” and beyond their abilities to manage independently. Therefore, pupils in S4 were more likely to portray themselves as basing their decision, whether or not to report the symptom, on the same assessment criteria they would use when in the presence of peers. Zoe actually stated that when at home she would react to the stomach ache by doing “the same as [she] would at school”. This suggests that older pupils may have become, or, at least, wanted to portray themselves, as less dependent on others’ help even when at home and especially if they interpreted the symptom as ‘trivial’ or not “really bad”. It is possible that S4 pupils were more likely to react, or to construct themselves as reacting, to symptoms in these increasingly independent ways because they felt under pressure to do so as a result of age-related expectations. Alternatively, the reactions to the stomach ache at home may reflect their efforts to become more independent of their parents and manage their illnesses on their own.

As most pupils felt that they would initially try to conceal the ‘malaise’ symptom, even when at home, it was less common for them to talk about how they would assess it, in order to decide whether or not they should seek help for it. Nevertheless, a minority of boys and girls highlighted that, depending on “how serious it was” (Amanda, S2g23), there were special circumstances in which they thought that this symptom should be disclosed (Chapter 6, Section 6.2.3). Thus, the ‘serious – trivial’ continuum helps to conceptualise the ways in which a minority of pupils implied that they would assess the ‘malaise’ symptom when at home.

Having considered the ways in which pupils said that they would *assess* the stomach ache and ‘feeling like crying all the time’ when both in the presence and absence of

peers, it is now important to look at how the perceived *consequences* of reporting these symptoms in the same contexts might also impact upon their decisions about whether or not to report them.

7.3 How do boys' and girls' perceptions of the consequences of reporting symptoms influence their decisions about reporting?

The second factor which influences boys' and girls' decisions whether or not to report symptoms is their perceptions of positive and negative consequences of doing so. Pupils' discussions suggested that the outcomes of reporting symptoms could vary according to whether peers were absent or present, the type of symptom which had been disclosed and the gender of the person experiencing it. This section begins by looking at the perceived consequences of reporting symptoms in contexts where peers were likely to be present ('in class' and 'out with friends') and goes on to discuss these in relation to a less 'public' context ('at home').

7.3.1 Boys' and girls' perceptions of the consequences of reporting symptoms in the presence of their peers

As pupils speculated as to the consequences of reporting a 'physical' and 'malaise' symptom in the presence of their peers, they highlighted the potential for both positive and negative outcomes. Since pupils often highlighted the negative outcomes first and spent most time discussing these, they are examined first, followed by a consideration of the positive consequences which pupils outlined.

Negative consequences:

1) Being made fun of

The prospect of being made fun of for reporting symptoms in the presence of peers was discussed in every focus group and talked about at most length by boys and girls of all ages. They believed that those who reported symptoms could be made fun of in a variety of ways, including being called names, laughed at, gossiped about or bullied. They also suggested that the disclosure of 'malaise' symptoms would lead to worse forms of teasing and that these more severe forms would be more likely to be experienced by boys. Only in very few cases, all in relation to stomach ache, did pupils not suggest that some sort of teasing would follow symptom reporting.

Most commonly pupils suggested that seeking help for a stomach ache in the presence of peers would lead to name-calling. For example, it was suggested that Steven might be called “a wussy” (Gordon, P6b3) and Sarah labelled “really weak” (Kirsten, P6g2). Being called names similar to these was the only consequence which both boys and girls outlined in relation to Sarah. However, pupils felt that, for Steven, reporting the stomach ache may lead to more severe forms of teasing and this would be especially if he sought help for the symptom when in class. For example:

And what things do you think might be putting [Steven] off saying anything [about his stomach ache in class]?

Calum: Well, in some other schools they might, like, bully him but I don't think they'd do that in our... school.

(P6b3)

What about, then, other people in class, like say, people sitting beside you, or just other folk in the class... what would their reactions be [if Steven told the teacher that he had a stomach ache]?

Gareth: Just smack him in the stomach.

(S4b16)

The fact that these more severe forms of policing and victimisation were only highlighted as possible consequences of Steven's, and not Sarah's, symptom reporting suggests that boys are 'punished' more for reporting their symptoms. Possible reasons for this were alluded to in a number of girls' groups:

So [Steven's] got a stomach ache [...] so what do you think he would do if he was in class?

Angela: Keep it a secret.

Elaine: Em, boys can't explain to the teacher, cos other boys think they're...

Angela: Wussys.

(P6g4)

Paula: Em, I think he'd be more embarrassed in front of everyone else, like ... and everyone would, like, make fun of him and...

Yeah. And so do you have any ideas why... it's more embarrassing for boys?

Vicky: Because they feel like they might have a reputation to keep up, so that they don't make a fool of themselves.

(S2g25)

All pupils claimed that boys would face more, and worse forms of, teasing and the girls in these groups implied that this is because symptom reporting may be interpreted as breaking the 'rules' of masculinity. Pupils' narratives suggested that they believed that boys are expected to react to illness in independent, stoic and controlled ways (Chapter 5). Therefore, asking for help may be construed as a sign of weakness and as gender-inappropriate behaviour. As a result, the consequences of symptom reporting for boys, such as being teased, laughed at, or bullied, may be worse than for girls.

The type of symptom disclosed was also seen as important in determining the form of teasing which may take place. All pupils believed that, as compared to stomach ache, the consequences of reporting 'feeling like crying all the time' "would be worse" (Josh, S4b19) and would involve more intense forms of ridicule. The following quote demonstrates the ways in which pupils typically felt that teasing would differ for the two symptoms:

Keith: [The teasing for 'feeling like crying all the time'] would be... a lot more [...] worse. It would keep going on other than... one day.

Gary: They'd go on for, like [...] weeks on end.

(S2b24)

In addition to the general feeling that the disclosure of the 'malaise' symptom would inevitably incur "a lot more" teasing, pupils also felt that its disclosure would result in "different" and "worse" forms of ridicule, particularly for boys. For example, girls spoke about being called names in relation to reporting the stomach ache but seemed

more in fear of the prospect of being laughed at or gossiped about as a result of reporting the ‘malaise’ symptom. Although boys highlighted worse forms of teasing for both types of symptom, they were more likely to suggest that disclosure of the ‘malaise’ symptom may lead to threats of physical harm and social exclusion. Indeed, after being shown the ‘malaise’ symptom vignette there were groups who dismissed the consequences of reporting a stomach ache as compared to the potential consequences of seeking help for ‘feeling like crying all the time’. In many groups, pupils gave clues as to why the name-calling, mocking and gossiping would be worse in response to the ‘malaise’ symptom. These examples are typical:

Calum: Going home with a sore stomach’s not really a big deal, but crying in class would be pretty ...

Liam: That’s pretty embarrassing.

[...]

Calum: ... everyone would just talk behind your back about you and... if you cried. If you’re sick, people are sick every day in our class and they have to go home, practically [...] but no-one really gives a big deal about that.

(P6b3)

... what’s the big difference [between] not feeling well with a stomach ache and [feeling like crying all the time]?

Joe: It’s different feelings, it’s, em ... stomach ache’s like a ...

Charles: Physical.

Joe: Yeah, and ...

Charles: Everyone gets that.

Joe: But this [‘feeling like crying all the time’] is like emotional ...

(S4b11)

The ‘ubiquitous – rare’ and ‘normal – weird’ continua can be applied to these boys’ discussions. They implied that because stomach aches happen in class “every day”

and because “everyone” gets them, this symptom would be seen as relatively ‘normal’ and, as compared to ‘feeling like crying all the time’, there would be relatively little reaction to it being reported in class. By implication, they portrayed ‘feeling like crying all the time’ as ‘weird’ because it is assumed to be ‘rare’ and suggested that this is the crucial difference between the two symptoms which would lead to the different consequences of reporting them. Indeed, Gareth (S4b16) made a similar comparison between ‘physical’ and ‘malaise’ symptoms in general as he claimed that “it’s easier for people to empathise with physical factors [symptoms] rather than emotional factors [symptoms] [...] because they’re more likely to have experienced them themselves”.

The ‘normal – weird’ continuum is also helpful in conceptualising pupils’ thoughts around why the consequences of reporting the ‘malaise’ symptom would be more severe for boys. In fact, the ways that they spoke about this suggest not only that pupils’ conceptualisations of symptoms influence their perceptions of the consequences of reporting, but also that gender-related expectations may influence their conceptualisations of symptoms. Based on stereotypical expectations, that “boys aren’t meant to cry” (Gary, S2b24) and girls are “more emotional” (Josh, S4b19), pupils’ accounts implied that because crying is expected of girls it is ‘more normal’ for them than it is for boys. Indeed, they suggested that if Steven were to report the ‘malaise’ symptom or cry in the presence of peers he would be seen as a “wussy”, “sissy” or “girl”, and thus as betraying his masculinity. The more severe forms of teasing which boys may face can be seen as ways in which they would be ‘punished’ for gender-inappropriate behaviour and also as ways that their masculinity would be put to the test. If this is an accurate summation of how pupils came to the conclusion that the consequences of symptom reporting would be worse for boys, then it demonstrates the ways in which expectations, conceptualisations and consequences can perhaps be viewed as mechanisms which feed into and from one another and which play a critical part in influencing pupils’ decisions whether or not to report symptoms.

It is also important to note that although boys were seen as more likely to be the victims of teasing, they were also portrayed as more active than girls in policing each

others' gender identities as well as being more likely to mock girls for reporting symptoms. Even within the focus group setting, boys tended to make fun of each other, to accuse one another of reporting symptoms and to make examples of boys who were known for complaining about illness or generally going against masculine 'rules'. For example:

And what about, erm, teachers in class? What would their reactions be [if Steven reported a stomach ache]?

Gareth: Depends what sort of teacher it is. Might be really sympathetic and really go over the top. Also he might just tell you to stick around.

Matthew: Depends if he's done it before.

Mhmm.

Gareth: You do it all the time, Brown.

Matthew: I do not!

Gareth: "Got a sore tummy" [in a voice that sounds like he's crying]

[All laugh]

[...]

...so what would [Steven] do if he was in class [and he felt like crying]?

[Matthew and Gareth look at each other, stifle laughter and look embarrassed]

Gareth: He wouldn't say anything at all.

Matthew: Mmm, just hold it in and just not tell anyone....

Gareth: Unless he was Billy...

[All laugh]

(S4b16)

In this group, Gareth was the main instigator when it came to making fun of other boys. Initially he accused Matthew of reporting symptoms "all the time" and his imitation, using a feminine and immature voice, may be seen as an attempt to

emasculate Matthew or at least to call his masculinity into question because of his tendency to report symptoms. This demonstrates the ways in which boys used humour and teasing to highlight behaviour which is not deemed as meeting masculine ideals and to 'name and shame' those who participate in this. Indeed, boys' increased tendency to use humour and teasing as a way of questioning, and perhaps even testing, other boys' masculinity, suggests that certain consequences of symptom reporting might threaten boys' gender identities.

In the latter half of the above quote, Gareth and Matthew could be construed as 'doing gender' as they claimed that most boys "wouldn't say anything at all" and would "hold it in" if they felt like crying. However, Gareth made the others laugh as he suggested that "Billy", presumably another pupil in their year, would be the only boy who would not react in typically masculine ways. The fact that all other boys in the group immediately laughed at Gareth's quip suggests that Billy is perhaps renowned for behaving in less than stereotypically masculine ways. Coupled with this, the fact that Gareth was able to pin-point Billy as being one of the boys most likely to cry, highlights that boys crying within the school context is an unusual occurrence and that those who do this stand out from the crowd and are remembered for it by others around them. Therefore, another way in which boys may tease one another is by retelling past incidents where other boys have been humiliated because their behaviour has been construed as 'feminine' or not stereotypically masculine.

A final point to highlight here is the importance which pupils placed on popularity as another determinant of whether, and in what ways, boys and girls might be made fun of for reporting symptoms in class. P6 and S2 pupils, mainly, suggested that differences in popularity could affect both the ways in which people are teased and the degree to which they make fun of others. In particular, they referred to *less* popular people as those who *more* popular people would make fun of. Typical examples are given in the following extracts:

Owen: If they're like the popular kids and you're like a geek and that, like, they'll, like, laugh at you [for crying or saying that you felt like crying all the time]. [...] All the people that aren't as popular, they don't tease anyone much.

(P6b6)

... if [someone started] crying in class [...] can you think of [anything] actually happening to a person?

Nick: Yeah.

So what happened to them?

Oliver: They got teased, but they already get teased by like everyone else in the school as well.

(S2b12)

And what would be the reaction, say, if [a boy] was to cry in class?

Amanda: I don't think if he- eh, well, it depends if he was open or not. Like, if it was a really popular person-

Gemma: Yeah, but like, if he was popular nothing would happen to him, but if he wasn't popular he'd get picked on and everything. [...] cos if you're popular you're confident [...] and if you're not popular you're shy.

Amanda: And you know you're gonna get made fun of...

(S2g23)

In the majority of the discussions where popularity was discussed, pupils made this connection between popular, “confident” people and it being less likely that they would get teased. On the other hand, they felt that “geeks” or people “who don't fit in” (Amanda, S2g24) would certainly be made fun of if they were to report symptoms in class, and probably that the more popular pupils would be most likely to tease them. This suggests that pupils saw popularity as protective, in that those already established as ‘popular’ within the school are those with the power to tease others and who can perhaps behave in any way they choose without having to face the same consequences as unpopular pupils. However, it seems that the protective nature of popularity varies according to gender and is related to the different ways in which boys and girls achieve popularity.

Pupils highlighted that popularity, for girls, is achieved by being perceived as “fashionable” (Vicky, S2g25) and “pretty enough” (Nadine, S2g23) to fit in with the popular crowd. However, in order for boys to achieve popularity they were described as needing to be “confident”, “tough” and “a bit of a lad [who is] emotionally strong” (Gareth, S4b16). Therefore, pupils described quite distinct qualities as determining girls’ and boys’ levels of popularity and implied that demonstrating stereotypically feminine and masculine characteristics is critical if girls and boys are to achieve popularity. Perhaps it is because of these beliefs that pupils felt that symptom reporting, and especially seeking help for ‘malaise’ symptoms, is not particularly damaging to girls’ popularity but is, very much so, to boys’. These next quotes demonstrate how pupils generally perceived popularity as being protective for girls:

Oliver: It’s like [boys have got] a reputation you’ve got to keep up.

And what about girls, do they have to keep a reputation up, or...?

Oliver: Not really, not if they’re like... high up in, like, popularity and things like that.

[...]

So do you think girls get teased, like you were saying that, em, boys have, you know, that if they had certain things and want out of class for crying or whatever, they’d get teased, what about girls?

[...]

Peter: If they’re really popular, then all their friends would comfort them.

(S2b12)

...so do you think that if a popular person was to cry, they wouldn’t... nothing would happen to them?

Gemma: Everyone would be like “Oh, are you alright?”

Nadine: All their friends would go “Aaw!” and start hugging them and everything.

[...]

And would that affect their popularity?

Amanda: No, not at all. Not if they're, like, really popular.

(S2g23)

Generally, it was implied that girls who are already "really popular" and "high up in popularity" would be protected and that, instead of symptom reporting threatening their popularity, they would receive the support and understanding of their friends and peers.

However, the following extract is typical of pupils' opposing beliefs that boys' status as popular is highly precarious and easily threatened by symptom reporting:

... there'll be things making [Steven] want to tell the teacher [that he feels like crying all the time] and things putting him off. What kinds of things, do you think, will be making him want to tell about that?

Scott: His feelings but, but then he'd kind of, he'd want to, like, stay popular and not get teased, so...

[...]

And how does something like that affect your popularity? Like if you were crying in class, would that make you...?

Oliver: Get called a wimp.

Yeah. So are wimps popular, is what I'm trying to say?

Scott: No.

Nick: No.

And why not, do you think?

Scott: Because they don't come off as, like, tough.

(S2b12)

Reporting symptoms, particularly 'malaise', was seen as more of a threat to boys' popularity than girls' because the acts of seeking help, admitting to weakness, or even crying in class would all be seen as contradicting the basic foundations of what it

means to be masculine. For popular boys, therefore, one of the main consequences of symptom reporting would be the calling into question of their masculinity and, in turn, the destabilisation of their popularity, which is based on continually proving and maintaining a successfully and stereotypically masculine identity. Symptom reporting was thus seen as having the potential to jeopardise boys' popularity. Lewis' (S2b18) claim that symptom reporting is "not such a big thing" for "quieter and softer" boys, suggests that, although being low down in popularity means that there is more chance of being teased, there is less to lose, in terms of status, as a result of symptom reporting and any consequent victimisation.

2) Becoming "class history"

Pupils portrayed incidents where peers had been ill or upset in the presence of peers as 'events' which become public property, open to reinterpretation and retelling even years after they occurred. The prospect of this consequence was often conveyed implicitly as they told stories about peers who had been ill or upset. This is something which boys and girls in all age-groups did. However, it was incidents in which boys had been ill or upset which were most frequently recalled and retold.

In two P6 groups, for example, pupils referred to an incident where a boy in their class had once "puked up" (Rhona, P6g2) in his work tray. The boys in P6b6 also told the story of Ally (present in the group) having fainted in nursery and Simon claimed that it would "go down as class history". The retelling of these stories, and the fact that this continued years after the incidents had taken place, acts as evidence of the extent to which such illness episodes or 'events' can become public property which may be used to make the person in the story live through the humiliation again and also as a lesson to others of the kinds of behaviour not acceptable in public. This was especially the case in relation to symptoms which pupils conceptualised as 'taboo', such as vomiting or crying. For example, one group described how a boy in their class was renowned for crying in school and the fact that George (P6b6) revelled in telling that he could "actually see all his eyes puffed up" suggests that, at the same time as taking pleasure in retelling the story, the boys in this group were emphasising that it is not acceptable for boys to cry in school. Indeed, the S4 girls' retelling of how boys in their class had cried on a school trip proved that these 'events' do not

need to take place in school, but that if they occurred within the school peer group context they would still generate gossip and ridicule. In three out of the four S4 girls' groups they talked about this school trip which had generated a lot of gossip and teasing. Significantly, it was not mentioned in any of the boys' groups. Although Becky had not been present on the trip, she described what had happened:

Becky: Eh, well there was a school trip recently to... where was it you went?

Emily: Belgium.

Becky: Yeah, and all the guys were taking the piss out of some of the guys who went because eh they went... well where did you go? You went to graves sites on the battlefield, and quite a lot of them cried on the bus back, and everyone, like, knows about it, and everyone's jokin' about it...

(S4g14)

Examples of this type of retelling not only demonstrate the types of gossip which follow such 'events', but in themselves, the gossiping and joking serve to alert others to behaviour which is viewed as unacceptable or 'taboo' and to discourage them from participating in this. It is also important to reiterate that most of the stories which pupils told during the groups tended to feature incidents in which boys had embarrassed themselves by being ill or upset in school. Indeed, Rose (S4g26) stated that when boys cry in school others "always seem to remember it" and Amy (S4g26) agreed, saying that this is seen as a "big event". Perhaps this is because boys have more to lose or face worse consequences if they become known as weak or unable to control their bodies or emotions.

3) Being at the centre of a fuss

Drawing attention to themselves and, as a result, being at the centre of a "big fuss" (Andrew, P6b8) was seen by pupils, regardless of age or gender, as another negative consequence of reporting symptoms in the presence of peers, and especially in class. Pupils felt that it was highly unlikely that reporting symptoms in class or being sent home sick could be kept private, but they perceived being stared at, asked questions or unduly fussed over as likely and embarrassing outcomes. Pupils also felt that the degree to which a fuss would be caused would vary according to the symptom disclosed, with 'feeling like crying all the time' creating more of a commotion in class

than stomach ache. This example shows how pupils felt that a fuss might be made after reporting a stomach ache in class:

...why would you have to keep things [symptoms or going off sick] a secret in school, do you think?

[...]

Angus: Cos you don't want people making a fuss of it [...] Like saying "Where are you going? What's wrong? Why are you going home and why do you have your bag or why do you have your jacket?" [...] "What are you feeling like...?"

[...]

So how does, how do you think the person who's going home, how would they feel when all that was going on?

Angus: You're just like nervous, like everybody's going "Where you going? ...wha, wha..."

(P6b8)

More often than not, pupils' descriptions of reactions to symptom reporting in class, such as pupils going silent, staring or asking questions, were not as vivid as this example, yet pupils always gave the impression that they would prefer to avoid being the centre of attention as a result of feeling unwell.

James' ideas are representative of the majority voiced around how others' reactions, and particularly teachers', would vary according to whether it was the stomach ache or 'feeling like crying all the time' which had been reported:

James: I mean...I just... don't really trust [teachers] enough [to tell them if I felt like crying] sort of feel they'd want to get someone else involved and just "Do you want helpline [numbers]?", "Do you want me to tell this person?" and so on and so on.

(S4b17)

In comparison to the stomach ache, James portrayed the repercussions of reporting the 'malaise' symptom as of greater magnitude and implied that others would feel increased concern about 'malaise' symptoms and would therefore make more of a

'fuss' in response to their disclosure. Nevertheless, pupils rarely seemed to view this type of reaction as a reassuring consequence of reporting. On the contrary, they often claimed that they would keep quiet about the 'malaise' symptom so as to avoid this type of fuss:

Grace: Em, [if you said that you felt like crying in class] they'd probably send you down to like guidance and make you... you'd probably have to tell them things and, that you didn't really want to.

Isla: Answer questions.

(S2g22)

And so what would be the consequence, do you think, if [Sarah] did start crying in class?

[...]

Amanda: And the teacher would make a fuss about it.

Gemma: The teacher would... yeah, "Do you want to go and see someone in guidance?" or something. "What's wrong?" and...

Nadine: Yeah.

Amanda: "What's happened?"

Gemma: Until they found out.

(S2g23)

As pupils spoke about the prospect of reporting the 'malaise' symptom in class, their discussions entailed a sense that this would lead to immediate repercussions, such as being sent to speak to a guidance teacher, and, as a result, that the symptom would be taken out of their control without their say so. In the above examples, this sense of a loss of control and even claustrophobia comes across as the girls and James speculated about reporting the 'malaise' symptom and highlighted persistent questions and the involvement of more and more people, as being inevitable consequences. Indeed, their depictions of teachers' possible reactions convey a sense of panic and suggest that pupils believed that adults would also view this symptom as 'different' in

some way. On this basis, it is possible that pupils' conceptualisations of 'malaise' symptoms as 'rare' and 'weird' are informed by their observations of teachers' reactions to them. Alternatively, their speculations as to the ways in which teachers might react may be informed by their own conceptualisations of 'malaise' symptoms as 'rare'. There is also a sense in the above quotes that as they were getting older the pupils simply wanted to guard their privacy and lay claim to similar rights of this as adults are entitled to.

Although many girls and P6 boys talked about how they might be unduly fussed over for reporting symptoms in class, it is significant that this consequence was rarely mentioned by boys in S2 or S4. Perhaps this is because they were less likely to view the reporting of symptoms, particularly 'malaise' symptoms which pupils felt were especially likely to create a fuss, as a possibility and therefore were less likely to think about the consequences of doing so. Alternatively, these boys may have been less likely to discuss the possibility of being fussed over because they felt that the consequences of symptom reporting which they were more likely to face were being made fun of or bullied.

4) Getting a row from the teacher

Pupils felt ambiguous about the prospect of reporting symptoms to their teachers in case this would result in further negative consequences, such as being shouted at or not believed. In terms of age-based differences, P6 pupils' thoughts on whether they would report symptoms seemed to be most influenced by the possibility that their teachers would react negatively.

Across the groups, pupils described a variety of different ways in which teachers might react to pupils reporting a stomach ache, ranging from telling them to "put your head down" or "sit down", to taking no notice or giving them a row if they thought pupils were "faking it". Although it was common for boys and girls to feel ambiguous about their teachers' reactions to symptom reporting, they felt that boys would receive more negative reactions. P6 pupils spent most time talking about this and why it might be so:

So does the teacher, em, react in a same, in the same way to the girls and to the boys [when they tell her that they don't feel well]?

Jane: Yeah.

Angela: Sometimes she does things for the girls.

Debbie: Sometimes she acts like the girls are more better than the boys.

Mhmm.

[...]

Elaine: Boys just... play up, saying they're not feeling well so they can go home.

Debbie: That's happened before in the class.

Nina: Boys fake it. That's why teachers think that they're faking it all the time.

(P6g4)

The girls, both in this group and generally, suggested that teachers tend to do more to help girls and implied that this is because they expect boys to “play up” and “fake it” so that they can get out of class. Boys also believed this to be the case:

Angus: And if it was a girl, they'll be like, “Go to the toilets and then if you're not feeling good, go outside and -

Jack: “Get some fresh air and go and have a drink of water and if you're not feeling better after that, go... to Mrs Scott [school nurse?]”, and like [...] With the boys she just like “I'm fed up, go and sit down, you're always being annoying me, just sit down”.

(P6g8)

As an explanation for teachers' often very different reactions to boys' and girls' complaints of illness, pupils highlighted the idea that it is “mostly boys” (Joe, S4b11) who fake illness in order to “skive” out of class, thus implying that boys partly have themselves to blame for their teachers' stern or disbelieving reactions. Pupils also suggested that teachers would be influenced by stereotypical ideas that “girls never lie” (Jonathon, P6b7), whereas boys are “cheeky” and “lie more often” (Connor,

P6b7). This implies that gender-related expectations may inform teachers' reactions to pupils' complaints of illness.

5) Missing out

Pupils highlighted the prospect of missing out on enjoyable activities or falling behind with schoolwork as another negative consequence of reporting symptoms when out with friends or in class, with the result being having to go home. For example, it was common for pupils to suggest that Sarah or Steven would ignore a stomach ache when out with friends because they “would be having the most fun” (Amy, *S4g26*) in this context. Similarly, many pupils felt that being off school may lead to them missing out on “good work” (Craig, *P6b3*), fun activities or having to catch up with work that was done in their absence. These ideas highlight the trivial nature of (some) symptoms imagined by (some) boys and girls.

Significantly, *S4* girls were more likely than the boys to express their reluctance to be off sick from school because of their need to study for their impending (prelim) exams. The girls in *S4g14* spoke at length about the pressure they felt under to study:

Emily: Well, if [Sarah was in *S4*] she would be wanting to still stay on and study for like prelims and things but she'd want to go home because she's not been able to keep working.

[...]

Katie: Your teachers are puttin' a lot more pressure on you as well...

(*S4g14*)

Evidently, it was not 'fun' activities at school that *S4* girls were concerned about missing. Indeed, they went on to describe the ways in which doing nothing but studying or working “late at night” could be detrimental to their health, making them “tired all the time” and causing headaches. Significantly, none of the *S4* boys voiced similar concerns despite the fact that they were also about to sit their prelim exams when they took part in the research. This suggests that girls may feel under more pressure to work hard for, and do well in, their exams. Alternatively, boys may have felt the same pressure but, as part of their constructions of themselves as 'successfully

masculine', were reluctant to voice these concerns in the focus group setting.

However, in the following examples, P6 and S2 boys highlighted other, perhaps more 'masculine', reasons for their reluctance to be off school sick:

Hamish: [...] things that happen after school put me off [telling that I didn't feel well]. If we've got football training and things. I want to go to school, so I can go to football... (P6b5)

... some things might be making [Steven] want to tell the teacher [that he has a stomach ache] and some things might be putting him off telling the teacher, what do you think those kind of things are?

Derek: Being in P.E. [...] Or unless you're at your lunch break.

(S2b20)

Although Kenny and Derek claimed that the reason Steven would not want to report the stomach ache during a P.E. lesson or lunch break is because the activity involved in both settings would distract him from the pain, it is also possible that boys are reluctant to report symptoms in contexts where their social identities are based heavily on masculine characteristics and where there is a heightened need to meet masculine standards. This may also have been the reasoning behind Hamish's apparent reluctance to miss football training, as perhaps his absence due to illness would be construed as a sign of weakness. Alternatively, it is possible that the boys in these groups simply enjoyed P.E, football training and spending lunch breaks with their friends and, as a result, would not want to miss out by reporting illness during these particular times.

6) Being pressurised to stay 'out with friends'

A number of P6 and S2 pupils felt that they would be reluctant to report symptoms when out with friends for fear that they would be pressurised to stay out or made to feel responsible for spoiling everyone's fun. For example, Debbie (P6g4) felt that Sarah might be wary of telling her friends that she felt ill and was going home in case they "fell out with her for it". Similarly, Connor (P6b7) expressed concern that if he

was to go home ill, his friends “might be a bit annoyed because we might have been having fun”. Both examples show the ways in which the decision to report symptoms when out with friends involves gauging those friends’ responses and weighing up the risks of disappointing or annoying them against the benefits of going home.

Significantly, P6 and S2 boys were more likely to talk at length about the ways in which their friends might pressurise them to stay out. The following examples portray how, and give clues as to why, they might do this:

And what kind of things would [friends] say if you did say, “Oh, I’m not feeling well, got a sore stomach [and I’m going home]”?

Craig: They’d sorta say “Oh, come on, just stay out for a wee bit longer, just till we finish this football game” or...

Hamish: That you’re a wee, you’re a baby.

Robert: And then it [the football game] lasts for about another hour or something.

Mhmm.

Craig: ...and “Just stay for, like, five more minutes and finish off this, then you can go”.

Robert: And then it turns into, like, an hour.

Hamish: I’ve done that once and I’ve been out until ten o’clock playing football.

Robert: And you don’t feel well

(P6b5)

Keith: [If I was out with friends and had a stomach ache] I would just say “Oh, I’m not feeling well, I think I’ll go home.” That’s probably what I would do.

Mhmm.

Gregor: But most people would go “Oh, dinnae go in...”

Keith: But if... yeah.

Gregor: ... it doesn't matter, just forget about it."

Keith: Yeah, if you really want, they really want to stay out you might be... like, pressurised to staying out and then you could just get worse and worse... (S2b24)

Both Hamish and Keith implied that they would succumb to this pressure. Significantly, they also highlighted the possibilities of being called "babies" and urged to "just forget about" their symptoms. Thus, it is possible to see this type of peer pressure as another way in which boys question and test one another's masculinity; they make it harder for one another to admit that they cannot cope with illness by suggesting that giving in to it is a sign of weakness and implying that they should be able to shrug it off easily.

Positive consequences:

1) Feeling better

Because all pupils tended to conceptualise stomach ache as a 'painful' but 'treatable' symptom (Chapter 6), they believed that reporting it would result in being given medicine or being advised to partake in illness behaviours, both of which they thought would cure a stomach ache or at least ease the discomfort caused by it. Boys and girls in all age-groups suggested that if they had a stomach ache, these potential positive outcomes would motivate them to report it:

So what do you think in class, what kind of things do you think might make [Steven] want to tell the teacher that he [has a stomach ache]?

Liam: Cos like, if it's really sore.

Calum: Like medicine.

Neil: To be on his own-

Gordon: To lie down and stuff.

[...]

Calum: If he stayed at school he'd just get shouted at, do work and stuff, not gonna help it much.

(P6b3)

What do you think would be making [Sarah] want to tell the teacher [that she has a stomach ache]?

Angela: Cos it hurts.

Mhmm. Anything else?

Debbie: Em... she might want some fresh air or something.

[...]

Angela: But I think if she wants to [tell the teacher] then it'll probably be so she can get something to make it stop.

(P6g4)

At the same time as suggesting that there would be positive outcomes of reporting a stomach ache because it is a 'treatable' symptom, the majority of pupils portrayed the classroom environment as being uncondusive to recovery from illness in general. Indeed, some pupils specifically highlighted that "they can't help you [at school] cos they don't have any medicine" (George, *P6b6*) and also that "[y]ou've got nowhere to go and lie down [at school]" (Tess, *P6g1*). As a result, pupils suggested that both Sarah and Steven would be motivated to report the stomach ache in class, especially if it was extremely painful or 'worsening', so that they would be sent home, where they would be able to get medicine or lie down.

However, perhaps because most pupils had conceptualised 'malaise' symptoms as 'untreatable' (Chapter 6), they were less likely to suggest that they would report 'feeling like crying all the time' in class. Regardless of age or gender, pupils implied that reporting the stomach ache would lead to less negative outcomes than would reporting the 'malaise' symptom. Boys in one S2 group alluded to the differences between the perceived consequences of reporting each symptom:

And what about how other people might react to that one ['feeling like crying all the time]?

Lewis: Might treat you differently.

Mhmm. And what... how would people react to it if you were ill with a stomach ache?

Lewis: Just give you some tablets or send you to bed or somethin' ... until it goes away.

(S2b18)

Lewis suggested that a stomach ache can be treated directly and in isolation. In the case of 'feeling like crying all the time', on the other hand, he conveyed less of a sense of separation between the symptom and the person experiencing it. Indeed, he stated that it would be "you" and not the symptom which would be treated differently. Thus, not only did he reinforce the conceptualisation of 'malaise' symptoms as 'untreatable', but by suggesting that others might "treat you differently" because of it, he also implied that, because 'malaise' symptoms can be seen as 'weird', people known to suffer from them would be also viewed as "different". This demonstrates the ways in which pupils' conceptualisations of symptoms informed their perceptions of the consequences of reporting them and also shows how perceived negative consequences may act as barriers to reporting. This also links to the ways in which pupils were more likely to assess the stomach ache according to its potential effects on their bodies but seemed to assess 'feeling like crying all the time' in terms of the consequences which its disclosure could have for their social identities.

The girls in *P6g1* were the only pupils to imply that reporting the 'malaise' symptom in class might lead to the positive consequence of 'feeling better'. They suggested that Sarah could "tell her friends" (Anna, *P6g1*) how she felt and "one of the friends [could] go with her into the toilet so she could...tell them and have a wee cry to herself, so it could get it out of her head" (Eve, *P6g1*). They implied that Sarah would unburden herself of the cause of the 'malaise' symptom and feel better as a result. The girls in this group may have been more likely to suggest that they would feel better after reporting the 'malaise' symptom because girls were generally more likely to conceptualise this as a symptom which could 'worsen' or have a 'serious' effect, as were these particular girls. Therefore, they perhaps assumed that reporting the symptom would prevent it from worsening or becoming serious. Thus, the differences between the ways that boys and girls conceptualised 'malaise' symptoms (Chapter 6) may have led them to perceive different consequences of reporting them. The fact that boys were less likely to conceptualise 'malaise' symptoms as having the

potential to worsen or become 'serious' suggests that they would not perceive a need to seek help for them.

2) "Skiving" school

The prospect of reporting the stomach ache was described by many pupils as "a good way of getting out [of class]" (Rose, S4g26) and avoiding "really hard work" (Craig, P6b5). Thus, some boys and girls from all age-groups suggested that symptom experiences, even if they were not causing great discomfort, could be used as excuses to "skive" (play truant from) school. However, there were age and gender differences in how much and in what ways the pupils spoke about the possibility of "skiving". Firstly, it was more characteristic of boys to talk about reporting the stomach ache in order to skive and girls were also more likely to accuse them of this. Secondly, P6 and S2 boys alluded to "skiving" in a positive way, giving the impression that they saw it as a chance for boys to boost their masculine status, but S4 boys appeared to think that "skiving" was not impressive masculine behaviour.

More often than not, P6 and S2 boys' suggestions that they would report the stomach ache in order to "get off school" (Andrew, P6b8) or "get home from school quicker" (Gary, S2b24) were met with laughter from, and found favour with, others in their groups. They gave the impression that skipping school is something which boys are more likely to do, and which gains admiration for those who manage to do it, implying that if symptom reporting is seen as facilitating "skiving", it can boost boys' masculine status.

Nevertheless, not all boys viewed skipping school as a sign of masculinity. The boys in these S4 groups viewed it less favourably:

Right, so [Steven's] not feeling well, he's got a stomach ache, and he's in class. So what would he do in class?

Matthew: Really act up so you get sent home.

Gareth: I wouldn't. I'd stick at school. I dinnae like goin' home.

... how do you think other people would react [if he acted up to get sent home]?

Gareth: Just eh... other people might think he's bein' a bit of a wuss.

Mhmm. What about... is skiving ever seen in a good way?

Gareth: Yeah, but it's not particularly daring when you're skiving, is it?

Matthew: Mmm.

(S4b16)

What do people think about that, like skiving? What's the general [opinion of it]?

James: Em... well... I'd say, if you did it every now and again, that people wouldn't say anything about it. [...] I mean, but then if you've got someone who's never in school and he's always skiving, you... you just don't care any more. Just... it's not cool or big. It's... pointless.

(S4b17)

Gareth gave the impression that, by S4, skiving school is no longer seen as something for which boys would be admired. The second quote also shows how James referred to skiving in derogatory terms. The general feeling conveyed in both extracts suggests that skiving school went from being seen by P6 pupils as a valid way for boys to enhance their masculinity, to being viewed by S4 pupils as a pathetic and failed attempt to boost a masculine reputation. The apparent contrast between the two age groups suggests that ways to construct masculine identities change with age.

The prospect of being accused of "skiving" by classmates was mentioned in the majority of the groups. This example is typical:

And what about the reactions of people in class [if Sarah reported her stomach ache]?

Amy: They would probably say that she was just gonna go for a skive but...

Rose: Yeah. Everyone kind of says that when people ask to get out of class.

[...]

...how does that make people feel when they genuinely are ill, but then everybody starts...?

Rose: Don't really mind, I don't think [...] Just think it's funny... (S4b26)

Boys and girls in all age-groups portrayed being called a "skiver" as an inevitable outcome of complaining of illness in class. However, none portrayed this as a threatening experience but often added that "you know [when someone calls you a skiver] they don't mean it" (Adam, S2b20). Thus, pupils gave the impression that this would not represent a barrier to them seeking help for illness whilst in class.

Significantly, no pupil suggested reporting the 'malaise' symptom in order to "skive". Perhaps this is because, regardless of age or gender, they may have felt that the benefits of doing so would be outweighed by the negative consequences of reporting 'malaise' symptoms.

7.3.2 Boys' and girls' perceptions of the consequences of reporting symptoms in the absence of their peers

Regardless of age or gender, pupils suggested that the consequences of reporting symptoms at home would be less negative and more helpful than when in contexts where peers would be present. Nevertheless, pupils also highlighted a couple of negative consequences of reporting symptoms at home. The remainder of this section discusses both types of consequences, looking first at the positive because they were highlighted first by pupils in relation to this context.

Positive consequences:

1) Feeling better

Pupils felt that the home environment is more conducive to recovery from illness. This was because they saw it as enabling more freedom to react to symptoms in a variety of ways and because they believed that the absence of peers would increase confidentiality and, as a result, facilitate symptom reporting. Most pupils felt that telling parents about the stomach ache would go hand in hand with receiving treatment for it. The ideas expressed in the extract below are representative of this general view:

Cameron: And if [Steven] was at home he could tell his mum or dad [about his stomach ache].

Jonathon: So they could like, go to the shops and get medicine or something.

[...]

Cameron: Take him to the doctor's... (P6b7)

Clearly, pupils felt that telling their parents about a stomach ache would result in a positive change to their physical state as they presumed that the advice or medicine, which either their parents or the doctor may give, would make them feel better.

As well as the availability of medicine, pupils commonly alluded to the 'freedom' of the home environment and their autonomy in this context to self-care. For example, Vicky's (S2g25) statement, that "...you kind of have the freedom to do what you need to do and what you want to do at home", sums up the general feeling around the advantages of being at home when feeling unwell. Indeed, pupils highlighted that at home it would be easier to tell their parents about the stomach ache, go for a lie down, help themselves to food or get fresh air whenever they wanted. Frequently they compared this freedom to the more controlled school environment where they felt it is dictated that "you have to do this, you have to do that" (Zoe, S4g21) and, consequently, where they believed there to be fewer opportunities to ease symptoms by partaking in illness behaviours or taking medicine.

2) Receiving comfort and understanding

Across the groups, many pupils felt that they would tell their parents about the stomach ache and some would confide about the 'malaise' symptom. Generally, those who said they would confide in their parents, about either symptom, believed that they would react in comforting and understanding ways. The following quotes show how some pupils felt that their parents would react if they were to tell them about the 'malaise' symptom:

Okay, what about if [Steven] was at home [and he felt like he was going to cry]?

Connor: He would just start crying. Cos if you feel like crying then you just cry and then maybe he could tell his dad and his dad could do something or try and cheer him up... (P6b7)

So how do you think parents might react to something like that [being told that their child feels like crying all the time]?

Collette: Well, I know my mum would be very... very supportive about it. I always tell my mum if I'm feeling very down or something, even if it's the slightest thing she'll always help me.

(S4g21)

Significantly, it was mainly girls, and especially those in P6, who seemed most assured that they would receive understanding and comfort if they were to report the 'malaise' symptom. Significantly, girls thought that it would be easier to talk to their mothers rather than fathers because they assumed that their mothers would be more able to empathise with their problems. For example:

So why is it easier to say to your mum [that you feel like crying all the time]?

Jennifer: Probably because she's like, may have been there before and she may have felt the same. So she'll know what you're talking about. [...] If you just say that you're gonna cry all the time. And she'll know what it is and she can sort of reassure you.

Mhmm.

Ellie: Mums seem more understanding.

(P6g2)

Girls portrayed their mothers as more approachable and understanding than their fathers and they based this on the assumption that, having also grown up as girls, they will have "been there before", the experiences that they may share with their daughters enabling them to be more empathic towards their problems. Underlying this idea is the concept that people of the same gender are more likely to have had

similar experiences and, as a result, to empathise with one another. This would imply that the boys would not have talked about confiding in their mothers because they believed that they could not be empathic or understanding towards their problems. However, this was not the case as boys were also more likely to say that they would confide in their mothers about their symptoms or problems and to claim that this was because they also felt that their mothers would be more understanding. This suggests that it may not only be shared gender and experiences which lead to the ability to empathise with others, but also that mothers are expected to be more understanding simply because they are women and this is perceived to be a feminine characteristic. As opposed to this, some boys felt that their fathers would not react in understanding ways to symptom reporting. Their perceived reactions are discussed next.

Negative consequences:

1) Being called "a wimp"

Some of the boys, from all age-groups, felt that they could tell their parents about the 'malaise' symptom, even if they portrayed this as a last resort. However, some said that they would be unlikely to tell either parent or that they would only tell their mothers. This is the case in the following examples:

And do you think [Steven] would say anything to his mum and dad [if he felt like he was going to cry]?

Gordon: No, I wouldn't.

Calum: No. My dad would call me a...

Gordon: A wussy.

Calum: ...a wimp. But I'd probably go up to my room... and cry.

(P6b3)

What about if [Steven] was at home [and he felt like he was going to cry]?

Gareth: He probably wouldn't say anything either.

What kind of... why wouldn't he?

Matthew: If he was with his mum he might, but not with his dad.

[Gareth laughs.]

[...]

So, you were saying if he was at home he might tell his mum, but not his dad that he was feeling like that. So, why do you think...?

Matthew: Cos you never see your dad cry.

Uh huh... but how would he react do you think?

Alistair: Not very happy.

Gareth: “Och, you wee jessie” [impersonating Scottish accent]

Matthew: Aye [laughing]

Mmm.

Alistair: Toughen up.

Mhmm.

Alistair: Maybe take the mick’ out of him.

(S4b16)

These boys implied that reporting the ‘malaise’ symptom would result in their fathers calling them “wussies”, “wimps” and “jessies”, thus accusing them of betraying their masculinity in the same ways as they thought their peers would do. None of the boys went into detail about why they thought that some fathers might react in these ways, but Matthew’s statement, “you never see your dad cry”, is perhaps important. This suggests that fathers who construct stereotypically masculine identities for themselves, perhaps see their sons’ masculinity as an extension of their own or as proof to others that they have been brought up by a ‘real man’. Gareth’s impersonation of a Scottish accent is significant as it may suggest that unsympathetic reactions are typical of Scottish fathers and thus are culturally specific.

2) *Being at the centre of a fuss*

Although many pupils felt that it would be easier to report symptoms at home, a few expressed concern that telling their parents that they felt like crying all the time would result in panicked and over the top reactions. These quotes portray the fuss which they thought might result from reporting the 'malaise' symptom at home:

Mmm, and what about, how do you think your parents would react if you did tell them [that you felt like crying all the time]?

Andrew: They'd be like, "Ooh no, what's wrong, what's wrong, what's wrong? Are you getting bullied at school?" and stuff.

Jack: Making a lot of fuss and you don't want a lot of fuss when you're not feeling like ... you're going to cry and all that.

[...]

Angus: Saying everything that gets your head really [makes whirring noise]

Andrew: They might think, they might like make you go to the doctor cos they might think you're depressed.

(P6b8)

And what about if she was at home [and she felt like crying]?

Sharon: Er, she would maybe tell her mum or her dad and...

Caroline: Maybe.

Mhmm.

Caroline: If she didn't want to like, tell her mum cos they might tell her teacher and they'll get all ...

Mhmm.

Alison: Like if at home and they saw her crying they would ask what's wrong and it might... get to the teacher-

Caroline: And they all get involved in it and... she'll just get more worried.

(P6g10)

Similar to the reactions that they thought their teachers might have, these pupils gave the impression that in response to the 'malaise' symptom parents might also panic and take immediate action, such as speaking to teachers or the doctor, whilst assuming that the symptom could be caused by bullying or depression. Indeed, when asked how he thought parents might react to being told about this symptom, Josh (S4b19) said he thought they might be "shocked". Although it is possible that parents' reactions inform pupils' conceptualisations of 'malaise' symptoms as 'rare' and 'weird', it seems more likely that pupils' own conceptualisations of the 'malaise' symptom led them to depict the potential reactions of their parents in these ways.

7.4 Chapter summary

This chapter has highlighted the factors which influence boys' and girls' decisions about whether or not to report symptoms in different social contexts. Pupils' accounts suggested that these decisions are influenced by two inter-dependent factors; the assessment of symptoms according to various conceptual bases and the prediction of positive and negative consequences of reporting. Significantly, pupils' descriptions of the ways in which they would assess symptoms and their perceptions of the consequences of reporting showed little variation across gender or age. However, both boys' and girls' ideas varied according to the social context of symptom reporting, the type of symptom which is disclosed and the gender of those experiencing it.

In contexts where peers are likely to be present ('in class' and 'out with friends') pupils suggested that both Sarah and Steven would assess a stomach ache and only report it if they perceived it to be 'worsening' or 'painful', especially if debilitating. Nevertheless, when discussing less 'public' contexts where it was less likely that peers would be present ('at home'), the majority of the pupils implied that they would spend less or no time assessing the stomach ache and, instead, they gave the impression that they would report it to their parents without having to judge it as 'worsening', 'painful' or "bad enough" before doing so. This suggests that boys and girls are more conscious of the ways that they present themselves in the presence of peers and implies that their reactions to illness can play a part in discrediting their efforts to construct themselves as behaving in gender- and age-appropriate ways.

Only some S4 pupils suggested that they would assess the stomach ache in the same rigorous way whether in 'private' or 'public' contexts. This may reflect their increasing independence or their increasing adherence to age-related expectations. Overall, however, there was a surprising degree of similarity between boys' and girls' accounts of how they would assess a stomach ache. Few pupils spoke about how they would assess the 'malaise' symptom before deciding to report it. This was because the majority said that they would prefer to conceal this symptom for as long as possible.

Pupils also portrayed the consequences of reporting symptoms as varying significantly according to whether or not they were in the presence of their peers. Boys and girls believed that consequences in 'public' contexts would be more negative because their reactions to symptoms, and especially boys', would be more actively policed by their peers. With the exception of some fathers' negative reactions to their sons' emotional symptoms, pupils conceptualised the home as a safer environment in which to adopt the sick role and where their performances of gender and age were not as highly dependent on performances of health.

There was also evidence that pupils' perceptions of the consequences of reporting symptoms were informed by their conceptualisations of symptoms which, in turn, could be informed by gender-related expectations. Thus, it is possible to see gender-related expectations, conceptualisations of symptoms and the consequences of reporting as factors which are all part of the same 'process' and which work in subtly different ways as they influence boys' compared with girls' decisions about whether or not to report symptoms. It is possible that pupils' perceptions of the negative consequences of reporting 'malaise' symptoms, such as being treated as "different" or made fun of, may well have stemmed from their conceptualisations of 'malaise' symptoms as 'untreatable', 'rare' and 'weird'. Similarly, as pupils also suggested that the consequences of reporting symptoms, especially 'malaise' which were viewed as more 'feminine', are more severe for boys, their accounts implied that because symptom reporting goes against stereotypically masculine expectations, it is seen as out of the ordinary for boys to do so. As punishment for this, the consequences of symptom reporting serve to question and test boys' masculine identities. This

highlights the way that gender-related expectations might also inform pupils' conceptualisations of symptoms and perceptions of the consequences of reporting.

As pupils discussed both the ways in which they would assess symptoms and their perceptions of the consequences of reporting them, there was a high degree of overlap between boys' and girls' accounts. This is significant as it contradicts societal expectations and gender stereotypes that girls find it easier to report symptoms and will do so quicker than boys. It also brings to light the mis-match between pupils' own expectations, that boys and girls react to symptoms in very different ways, and 'reality' as represented by the accounts they gave in the focus groups.

Chapter Eight: Discussion

8.1 Introduction

This thesis represents the first piece of research which has investigated the ‘gender reversal’ in child and adolescent health by exploring and comparing the perspectives of boys and girls at different stages of the child-adolescent transition. It therefore represents original thought in this area of research and enables understanding of the factors which influence boys’ and girls’ illness behaviours and symptom reporting.

This chapter summarises and discusses the main findings of the study, specifically highlighting the ways in which they address the research questions, as well as looking at whether they support, contradict or extend previous research and existing social theory. Also included is an outline of the study’s limitations and strengths as well as a discussion of its main conclusions. The chapter closes by highlighting the implications of this study for health and education policy as well as for future research.

8.2 Addressing the study’s aim and research questions

Chapter 2 highlighted evidence of a ‘gender reversal’ in the health of children and adolescents, characterised by male excess morbidity in childhood which reverses to a female excess by early-mid adolescence (Cohen, Brownell et al. 1990; Cohen, Cohen et al. 1993; Eiser, Havermans et al. 1995; Sweeting 1995; Allard 1996; Eminson, Benjamin et al. 1996; Klepp, Aas et al. 1996; Haugland, Wold et al. 2001a; Hetland, Torsheim et al. 2002; Sweeting and West 2003a; Torsheim, Ravens-Sieberer et al. 2006). Research to date has concentrated on investigating these patterns only in relation to psychological conditions (e.g. Kandel and Davies 1982; e.g. Allgood-Merten, Lewinsohn et al. 1990; Petersen, Sarigiani et al. 1991; Cohen, Cohen et al. 1993; Nolen-Hoeksema and Girgus 1994; Schraedley, Gotlib et al. 1999; Cyranowski, Frank et al. 2000; Marcotte, Fortin et al. 2002; Bennett, Ambrosini et al. 2005) and has mainly used quantitative methods in doing so. The current study aimed to improve understanding of the ‘gender reversal’, in respect of both physical and psychological symptoms, through the exploration of boys’ and girls’ experiences and understandings of symptoms. Qualitative methods were used to explore 10-, 13- and 15-year-old boys’ and girls’ perspectives on gender- and age-related expectations,

their understandings of a range of symptoms, and the factors considered in their decisions about whether or not to report 'physical' and 'malaise' symptoms in different social contexts. Comparative analyses of the data were conducted in order to assess whether gender and/or age differences were evident and specifically whether any differences or similarities might help to explain or improve our understanding of changing gender patterns in symptom reporting. The findings are now summarised as they relate to each of the research questions.

8.2.1 Do gender- and/or age-related expectations influence boys' and girls' illness behaviours and symptom reporting?

In line with previous research (Prout 1986; Moynihan 1998; Williams 1999; Williams 2000; Swain 2003; Swain 2004), all pupils demonstrated a clear awareness that societal gender-related expectations dictate that boys should react to illness with displays of stoicism, strength, control and independence. Pupils' narratives suggest that these expectations take the form of 'rules' which outline acceptable behaviour for boys and discourage any behaviour which may be interpreted as signifying weakness, such as asking for help or displaying emotion. A wider range of ideas was outlined as pupils spoke about societal gender-related expectations in relation to girls and their accounts suggested that expectations do not represent 'rules' for girls in the way that they do for boys. Instead, for girls, expectations seemed to represent 'guidelines' for behaviour. In many respects, however, the 'rules' for boys and 'guidelines' for girls were very similar; both felt under pressure to react to symptoms in stoic, controlled and independent ways. Although gender stereotypes might lead us to believe that girls find it easy to seek help for illness, the findings suggest that this was not the case. The main differences seemed to be that girls could contemplate and talk about breaking the 'guidelines' but boys rarely indicated that they would or could break the 'rules' governing their behaviour.

In relation to whether and how gender-related expectations impact upon boys' and girls' reactions to symptoms, pupils' accounts suggested that illness behaviours can be used as important practices' in the 'performance' of gender identities. Many researchers have outlined the importance for boys, if they are to become popular or viewed as acceptably masculine, of projecting identities which centre around physical strength or 'toughness' and being athletic or sporty (Mac an Ghail 1994; Connell

2000; Frosh, Phoenix et al. 2002; Swain 2003; Swain 2004). Thus, admitting to illness or talking about how they might adopt the sick role would jeopardise boys' efforts to conform to masculine ideals by acting as proof that they are not strong enough to overcome illness or, even, independent enough to deal with it on their own (Prout 1989; Moynihan 1998). In the current study, boys' accounts suggested that boys would conceal, disguise or attempt to ignore and overcome symptoms as ways of dealing with them whilst conforming to masculine ideals. This is consistent with research by O'Brien and colleagues (2005) who report that the younger participants in their study of men's help-seeking were those especially likely to emphasise the need to be badly injured or seriously ill before considering seeking medical attention. There are also parallels between the current study and findings reported by Williams (1999; 2000) who used Goffman's notion of 'passing' to conceptualise the ways in which boys in her study described themselves as reacting to their medical conditions (asthma and diabetes). In order to 'pass', or present themselves as normal so as to avoid the stigma of illness, Williams highlights the ways that boys refused to incorporate illness into their identities and did not take their medication in public so as to keep their conditions as 'invisible' as possible. In the current study, 'passing' can be seen as an especially important strategy in dealing with 'malaise' symptoms whilst preserving masculine gender identities. In addition to this, the strategy of 'covering' (Goffman 1963), whereby 'malaise' symptoms were disguised as more acceptable 'physical' symptoms, was also evident in boys' accounts.

Similarly, girls' accounts also implied that certain illness behaviours can be used as practices in the 'performance' of feminine identities. For example, they referred to girls' increased tendencies to report symptoms as being a result of stereotypically feminine traits such as 'honesty' and 'openness'. More significantly, in portraying themselves as willing to confide in and comfort friends, they laid claim to another key feminine characteristic; the ability to establish and maintain close, trusting and supportive relationships (Hudson 1984; Griffiths 1995; Hey 1997; Frosh, Phoenix et al. 2002; Rose 2002). It is perhaps because these ways of 'doing girl' allow, if not require, girls to confide in others that it may be easier for them to report symptoms and incorporate the sick role into their feminine identities. There are also parallels between girls in the current study and those with asthma and diabetes who took part in Williams' (2000) study. As compared to boys, girls in both studies were less likely to

adopt 'passing' strategies in their reactions to illness. Thus, in the case of relatively minor illness at least, symptom reporting and the adoption of the sick role seem to be less threatening to feminine than masculine identities.

Nevertheless, there was also evidence of girls adopting certain illness behaviours as ways of 'passing' and 'covering' in order to conceal and avoid the stigma of 'malaise' symptoms especially. For example, many girls said that they would conceal, disguise or try to overcome feelings or sadness or irritability. Their fears that the disclosure of feeling sad, unhappy or low would lead to them being viewed as "babyish" or "weak" suggest that girls did not feel that they are "expected to cry" but either that expectations of girls have changed in tandem with changes that have taken place in the societal gender order, or, indeed, that girls have never felt that it is acceptable to cry in public. However, some of the girls' accounts suggested that they viewed irritability and aggression as 'unfeminine' behaviours and that they were aware of, and keen to conform to, certain 'traditional' expectations of femininity. These ideas suggest that there may be truth in proposals that adolescence is an especially contradictory and confusing time for girls and has become more so as a result of societal changes, perhaps resulting in a clash of 'old' and 'new' expectations (Mac an Ghail 1994; Frosh, Phoenix et al. 2002). However, in the current study, it is perhaps because of this broadening of expectations for girls that their narratives were less likely to highlight strict 'rules' or 'prohibitions' as governing girls' behaviour. Thus, it is possible that the increasing need for girls to ask themselves "who they are and what they want to become" (Bjerrum Nielsen 2004) and to face "difficult choices and conflicts" (Holstein-Beck 1995) can be seen as a creative process which may have led to girls' realisation that many more scripts are now available to them in their constructions of feminine identities.

In terms of age-related expectations, all pupils believed that boys are supposed to react to illness in increasingly masculine ways as they get older. In relation to age-related expectations of girls, all girls, but not boys, suggested that girls are also expected to react to illness in more stoic and independent ways as they get older. Thus, pupils portrayed themselves as practising certain illness behaviours, such as concealing or disguising symptoms, in order to be seen as 'acting their age'. P6 and S2 pupils were most likely to express these ideas and often they referred to 'social

thresholds', such as becoming a senior pupil in primary school or the transition to secondary school, as being times when their awareness of age-related expectations was sharpened, both through their own realisation or as they were told by others to "buck up" or "toughen up". This is consistent with previous research (e.g. Prout 1986; 1989; 1992) which has reported that children's claims of sickness take on special significance during the transition to secondary school. There are also parallels with Simpson's (2000) work which found that children's bodies are subject to increased surveillance during this period of transition and that extra significance is placed on the exertion of control over bodies as a prerequisite of 'acting their age' in secondary school. In the current study, being seen to be in control of emotions was also portrayed by pupils as an essential way of conforming to age-related expectations and especially so after their move to secondary school. The idea that "you can't really [cry] in high school" reflects the impression of secondary school as the "unemotional world" described by Prout (1992). The overall impression given by pupils was that, after their move to secondary school especially, signs of them not being able to control their bodies or react to symptoms in age-appropriate ways would result in them being dangerously visible (Simpson 2000) in a more threatening environment.

Pupils' awareness of age-related expectations was mediated by gender, a finding consistent with Prout (1986; 1989). Boys referred to the 'social thresholds' noted above as markers for when they also became more aware of gender-related expectations. Indeed, they implied that it was around times of transition that masculine hierarchies began to form and that boys' behaviour could impact upon whether they were seen as "cool" or "geeks". Pupils' narratives also implied that around times of transition, others', and especially parents', reactions to accidents and symptom reporting are crucial in distinguishing gender, and teaching gender- and age-related expectations. Given that symptom reporting and minor accidents are relatively everyday events during childhood, the extent to which parents' reactions to these are gender-distinguishing could prove to be a key influence on their children's subsequent illness behaviours.

In addition to suggestions that gender differences in behaviour are socially constructed, pupils also drew on discourses around the effect of puberty and hormonal changes on girls' and boys' bodies. As they discussed histograms displaying the

increasing gender gap in symptom reporting, they attributed these patterns to the differential effects which puberty has on boys and girls. Specifically, they claimed that girls' bodies change more than boys', that girls experience an increased number of 'physical' symptoms due to menarche, and that girls' emotions are detrimentally affected by these changes. These suggestions parallel links which have been made between pubertal status and the emergence of girls' increased rates of depressive symptoms during early-mid adolescence (e.g. Allgood-Merten, Lewinsohn et al. 1990; Siegel, Yancey et al. 1999; Ge, Conger et al. 2001; Marcotte, Fortin et al. 2002). Similarly, pupils' suggestions that menarche causes an increase in girls' experiences of 'physical' symptoms is also supported by research (Haugland, Wold et al. 2001a). Pupils also suggested that the academic pressures experienced by girls have a negative impact on their health and could potentially lead to an increase of 'physical' and 'malaise' symptoms. Recent research (e.g. Cyranowski, Frank et al. 2000; Ge, Conger et al. 2001; Marcotte, Fortin et al. 2002; West and Sweeting 2003) has also suggested a link between increasing academic pressures, or stressful life events generally, and girls' higher levels of psychological distress. Boys' experiences of puberty and its affect on their health were rarely mentioned by pupils. Similarly, it was never suggested that boys experience academic pressures to the extent that they affect their health.

These findings contribute significantly to the aim of developing a deeper understanding of changing gender patterns in boys' and girls' symptom reporting rates. They highlight the degree to which boys' illness behaviours are restricted by stereotypically masculine expectations which act as 'rules' in dictating that boys should react to illness by displaying stoicism, independence, strength and control. Thus, it is possible that the increasing gender gap in symptom reporting is brought about, or at least influenced, by boys' attempts to conform to increasingly strict masculine expectations as they get older. Although girls' accounts suggested that similar expectations affect their behaviour as they do boys' (e.g. ideals of strength and control), their reactions to illness did not seem to be dictated by these expectations to the same extent as boys'. It is possible, therefore, that the more lenient 'guidelines' surrounding girls' reactions to illness contribute in some way to their (predominantly) higher rates of symptom reporting. In addition, pupils drew on biological frameworks to construct the argument that girls are 'sicker' than boys during this stage of their

lives as a result of age-related changes (advent of puberty and menarche) which lead to increases in girls' experiences of 'physical' and 'malaise' symptoms. However, both boys' and girls' suggestions that they are expected to become more stoic and independent with age, do not help to explain the fact that symptom reporting rates often increase with age, especially for girls.

8.2.2 Are there gender and/or age differences in the ways that boys and girls conceptualise symptoms?

There were few gender differences in the ways that pupils conceptualised symptoms, indeed these were only evident in terms of symptom severity. Girls tended to conceptualise a large number of both 'physical' and 'malaise' symptoms as potentially 'worsening' and 'serious', whereas boys were more likely to conceptualise them, and especially 'malaise' symptoms, as 'passing' and 'trivial'. There are parallels here with previous research which reports that boys are more likely to base their assessments of their health on measures of physical health, whereas girls also take emotional and social concerns into account (Alexander 1989). Williams (1999; 2000) also found that girls portrayed themselves as taking their medical conditions (asthma and diabetes) seriously and worrying about them, whereas boys were more likely to dismiss them as a trivial and minor part of their lives. There was also evidence in the current study that girls were generally more mindful of, and thoughtful in relation to, their physical and mental well-being. As others have suggested (Pennebaker 1982; Gijsbers Van Wijk and Kolk 1997), this increased awareness of their health might mean that they are more likely to conceptualise bodily sensations or emotions which are out of the ordinary as being symptoms of illness.

In terms of age-based differences in the ways that pupils conceptualised symptoms, P6 pupils were most likely to refer to more concrete ideas, such as how painful or treatable they believed them to be. Older pupils, however, were more likely to construct symptoms by reference to abstract notions, such as whether they signified 'real illness' or what it meant if they had an identifiable cause. These findings are consistent with previous research which has found that children's conceptualisations of illness move from concrete to more abstract understandings and which has aligned these changes with different stages of cognitive development (Perrin and Gerrity 1981).

In relation to how these findings enable further understanding of gender differences in symptom reporting rates, it is possible that girls' tendencies to conceptualise a larger number of symptoms as having the potential to seriously affect their health, along with boys' increased likelihood to dismiss symptoms as 'passing' or 'trivial', may help to explain girls' tendencies to report more symptoms than boys in most cases. However, it is important to note that gender differences were only evident in pupils' conceptualisations of symptoms according to their severity. The fact that there were far more gender similarities than differences in the ways that pupils conceptualised symptoms suggests that overall gender differences in symptom reporting rates cannot be attributed to differences in the ways that boys and girls understand or conceptualise symptoms. Nonetheless, the age-based differences in the ways that pupils conceptualised symptoms may be especially significant in deepening our understanding of the ways that symptom reporting rates often increase with age. They suggest that if understandings and conceptualisations of symptoms become wider and more abstract with age, it is possible that this could contribute to increasing symptom reporting rates as both concrete and abstract notions and feelings come to be included in conceptualisations of illness.

One of the most significant findings with regards to pupils' conceptualisations of symptoms was not related to gender- or age-based differences but was, rather, how distinctly all pupils tended to conceptualise 'physical' and 'malaise' symptoms, a finding consistent with Roose and John (2003). Regardless of age or gender, pupils in the current study conceptualised (most) 'physical' symptoms as 'painful', 'ubiquitous', 'normal', 'treatable' and 'involuntary'. In opposition, 'malaise' symptoms were constructed as being 'painless', 'rare', 'weird', 'untreatable' and 'voluntary'. Boys and girls in all age-groups portrayed themselves as being more reluctant to report 'malaise' symptoms as compared to 'physical', with the exception of feeling irritable or bad tempered which boys were keen to identify themselves with. These findings are consistent with previous research (e.g. See Me Scotland 2005; Williams and Pow in press), which reports young people's reluctance to seek help for mental health symptoms because of their beliefs that this would lead to stigmatisation through social exclusion and peer alienation. Indeed, pupils often claimed that they would either completely conceal 'malaise' symptoms, thus attempting to 'pass', or they would 'cover' (Goffman 1963) by disguising them as more acceptable 'physical'

symptoms. Both strategies were highlighted by pupils as ways of avoiding the stigma which they believed would be attached to the disclosure of 'malaise' symptoms.

The findings of this study not only allow us to back up previous research which has reported that young people, and especially young men, are more reluctant to report symptoms indicative of mental distress, but, because respondents talked in detail about their understandings of both 'physical' and 'malaise' symptoms, we are able to add to existing knowledge by exploring why this might be so. One of the most important factors underlying pupils' reluctance to report 'malaise' symptoms, especially 'feeling like crying all the time', was their beliefs that they are 'rare' and therefore that such symptoms and especially those suffering from them would be seen as 'weird'. There are parallels here with research conducted by Secker and colleagues (1999) which reported that young people conceptualise behaviour indicative of mental illness as being that which deviates from social norms and which they cannot identify with nor explain. In the current study, a fear of the stigma attached to having an "undesired differentness" (Goffman 1963, p.15) was central to pupils' discussions of 'malaise' symptoms and contributed heavily to the clear distinctions they made between them and most 'physical' symptoms, which they perceived to be more 'normal'. What seemed to be most important to all pupils was the concealment of any symptoms which would lead to them being perceived as 'weird' or anything less than 'normal'; thus conformity, or at least being able to 'blend in' with the crowd, was imperative.

Pupils' perceptions that 'malaise' symptoms are medically 'untreatable' and that 'person-centred' attempts to solve them are often ineffective or can even make them worse, may explain the low help-seeking rates of young people with mental health problems (see Williams and Pow (in press) for similar findings). Related to this, when pupils in the current study compared 'physical' and 'malaise' symptoms there was a sense that they viewed the effects and treatment of (most) 'physical' symptoms as being bounded by and limited to their bodies and, in turn, implied that they were largely separate from and had little impact on their personal or social identities. In comparison, however, 'malaise' symptoms were viewed as being inextricable from the personal and social identities of those experiencing them. This came across most clearly in the idea that it is "you", as a person, who is treated and judged when

experiencing 'malaise' symptoms, but that it is the symptom, in isolation from "you", which is treated when experiencing 'physical' symptoms. These ideas imply a moral aspect to the experience of symptoms and convey a sense that 'malaise' symptoms signify weakness or other moral deficiencies in those who experience them. An idea voiced by a minority of pupils, that 'malaise' symptoms are 'voluntary', conveys the impression that people should be able to prevent themselves from being affected by them, thus it is a sign of weakness if they cannot do so. In addition to this, the idea that crying is 'taboo' because it signifies a child-like lack of control also shows how pupils conceptualised emotional expression, especially if there were no circumstantial explanations for it, as a sign of character deficiencies. There are parallels here with Goffman's (1963) concept of 'discreditable attributes' and consistencies with Williams and Healy (2001) who reported adult respondents' fears that the disclosure of mental health problems would lead to others perceiving them as weak, not in sufficient control of emotions and unable to cope with 'life problems'.

8.2.3 Are there gender and/or age differences in how boys and girls decide whether or not to report symptoms in different social contexts?

Both boys' and girls' decisions about whether or not to report symptoms were influenced by their use of conceptual continua to assess whether symptoms were "bad enough" to report along with the prediction of potential positive and negative consequences of reporting. Although boys' and girls' accounts suggested that they would assess symptoms in very similar ways (or would tend not to assess 'malaise' symptoms), they perceived the consequences of reporting most symptoms in any context as being worse for boys.

The findings of the current study support Levine's (1999) claims that social context plays a more central role than physiological changes in the ways that people respond to, and make sense of, their symptoms. Certainly, the contrast between being in the presence of peers ('in class' and 'out with friends') or in their absence ('at home') was central in distinguishing the ways in which boys and girls described their assessments of, and reactions to, symptoms. For example, their accounts suggested that 'physical' symptoms would be assessed more rigorously in 'public' contexts, especially where peers would be present, thus implying the importance of not being seen to 'give in' to illness too readily in such situations. Therefore, being in the presence of peers

enhanced the importance of reacting to symptoms whilst 'doing gender' and also conforming to age-related expectations; both boys and girls claimed that they would wait until they could no longer cope with symptoms on their own before reporting them in public contexts. A minority of pupils suggested that they would assess the 'malaise' symptom according to its severity and only tell someone about it if it persisted or they thought it was "really bad". However, most pupils spoke about how they would try to conceal the 'malaise' symptom, thus their accounts implied that they would not assess whether it was "bad enough" to warrant help-seeking in the same ways as they would a 'physical' symptom.

In terms of the consequences of reporting symptoms and others' reactions to this, pupils' accounts suggested that 'public' and peer contexts are the most punitive in which to disclose symptoms, especially 'malaise'. Boys and girls in all age-groups expressed most concern over their peers' reactions to the disclosure of symptoms and described how these could range from harmless teasing, such as being called a "skiver", to more serious forms of policing, such as being alienated or bullied. Girls were more likely to suggest the possibility of being comforted by their "close friends". However, all pupils suggested that boys would face the more severe consequences for reporting symptoms in front of their peers, their accounts implying that boys' masculine identities would be tested, through being laughed at or bullied, and publicly called into question, by being labelled "wimps", "sissies" or "girls". These findings support others' claims (e.g. Mac an Ghail 1994; Kehily and Nayak 1997; Epstein and Johnson 1998; e.g. Duncan 1999; Frosh, Phoenix et al. 2002; Swain 2003; Swain 2004; Plummer 2005) that boys actively police the boundaries of masculine behaviour and punish those who transgress these or whose behaviour is seen as signifying a failure of masculinity.

In line with Prout (1986), pupils' accounts suggested that teachers would initially rebuff their claims to the sick role and it is possible that teachers might do so to encourage stoicism and instil the idea that symptoms should not be reported unless they have become debilitating or pupils can no longer manage them on their own. Boys and girls were agreed in suggesting that teachers are more sympathetic and give preferential treatment to girls when they complain of feeling ill in school, a finding which is consistent with Wilkinson (1988) and Prendergast and Forrest (1997). If

they are more likely to dismiss boys' symptom reporting, teachers may also play a part in reinforcing stereotypical expectations that boys are less likely than girls to suffer from illness and, that when they do, they should not complain. This demonstrates the ways in which expectations, conceptualisations, and consequences can be viewed as factors in the 'process' of reporting symptoms which are intricately linked and dependent on one another. However, it is important to note that these findings are pupils' reports of teachers' reactions to complaints of illness and are not based on teachers' accounts or observations of their reactions. It is also worth noting the difficulty which teachers face in judging the difference between pupils using illness as a way of "skiving" and when they really are ill.

The majority of the pupils were more likely to suggest that they would seek help for 'physical' symptoms and participate in illness behaviours when in the more 'private' contexts of their own homes. This is consistent with Williams (1999; 2000), who found that boys were more likely to participate in illness behaviours when at home and suggests that boys' and girls' social identities at home, as 'sons' and 'daughters', are not put at risk by asking for help but instead allow them to adopt the sick role regardless of gender (Williams 2000). Most pupils, especially those in P6, gave the impression that there would be less need to assess 'physical' symptoms in 'private' contexts before seeking help. However, a minority of S4 pupils showed increasing independence in the management of their symptoms as they suggested that when at home they would assess them in the same ways as they would in school. Generally, pupils gave the impression that they would not be judged for reporting illness at home and that the consequences of doing so (e.g. being given medicine and/or comfort) would be less negative than in public contexts. In terms of the 'malaise' symptom, most pupils suggested that they would initially conceal this at home, but they also considered confiding in their parents as an option which would be dependent on their relationship with them. However, consistent with Duncan (1999) and Frosh and colleagues (2002), in the current study a number of boys' accounts suggested that their relationships with their fathers lacked emotion and indeed that expressions of emotion would be actively policed by their fathers. It is possible that some fathers may be keen for their sons to project a stereotypically masculine identity in order to boost, or at least preserve, their own. More simply, it may be that these reactions to their sons' expressions of emotion exemplify the way in which some fathers may

(subconsciously) teach their sons how to 'be a man'. Alternatively, it may be that some fathers would react in these unsympathetic ways in order to prepare their sons for the teasing and mocking that they may receive from their male peer groups. Thus, some fathers perhaps try to 'toughen up' their sons so that they will be less likely to fall victim to peer group taunts, or at least so that they will be prepared for, and perhaps better able to cope with, them. Like their teachers' and peers' reactions, however, their fathers' responses might also serve to reinforce masculine stereotypes which discourage boys from expressing their emotions or seeking help for mental health problems.

The fact that boys constructed themselves as being especially reluctant to seek help for 'malaise' symptoms, in any context, supports research which has found that young men are more likely than girls and women to conceal symptoms of mental ill-health (Armstrong, Hill et al. 2000) and only seek help when they have reached high levels of distress and can no longer cope on their own (Biddle, Gunnell et al. 2004). Pupils' ideas around gender differences in help-seeking confirmed those of the children who took part in Roose and John's study (2003, p.548), who acknowledged that the pressures placed on boys "to live up to a certain image" make it difficult for them to seek help for mental health problems. Some girls in the current study suggested that delaying help-seeking could result in future mental health problems for boys. However, boys came across as being more concerned about the social consequences of disclosing 'malaise' symptoms, particularly being labelled a "wimp" or "girl". A worrying finding is that the 10-year-old boys who took part in this study were already aware of, and keen to be seen as conforming to, stereotypically masculine expectations in relation to the expression of emotion. The fact that 15-year-old boys never acknowledged the possibility of them crying in any circumstance, and were even reluctant to talk about most 'malaise' symptoms, demonstrates the extent to which efforts to conform to masculine expectations had become entrenched in their performances of gender and how succeeding at this took precedence (at least within the focus groups) over any thoughts about how their mental well-being might suffer.

In terms of how these findings aid a deeper understanding of the changing gender differences in symptom reporting, it is unlikely that the ways in which boys and girls assess whether symptoms are "bad enough" to warrant reporting influence these

patterns considering there were very few differences between boys' and girls' accounts of how they would do this. However, because boys were portrayed as facing worse consequences for reporting both 'physical' and 'malaise' symptoms, this finding does contribute to our understanding of gender differences in levels of symptom reporting and help-seeking. Even when talking about seeking help for symptoms when at home, the least punitive social context, some boys were wary of their fathers' unsympathetic reactions. Therefore, it is possible that boys are deterred from reporting symptoms because they face worse consequences for doing so. The main difference for girls and boys, in terms of consequences, seems to be the extent to which their social and gender identities are threatened by the act of seeking help. Although girls feared being seen as weak or 'different' by their peers, there was less of a sense for them that their entire identities would be questioned as a result of reporting symptoms. The opposite was the case for boys who feared that symptom reporting would directly challenge the most important aspect of their identities; their masculinity.

8.3 Discussion of main findings

In order to address the central aim of this study, it is essential to evaluate the extent to which the qualitative findings presented here confirm, or 'map onto', quantitative evidence of a 'gender reversal' in the distribution of ill-health across the child-adolescent transition and the emergence of an increasing female excess in symptom reporting. Findings which support evidence of these patterns relate to the perceived need for boys to react to symptoms in increasingly masculine ways as they get older. Thus, it follows that if boys become increasingly more likely to conceal, disguise or try to overcome their symptoms, a gender gap will emerge between boys' and girls' symptom reporting rates. Similarly, ideas that girls' illness behaviours are less restricted by societal expectations, along with suggestions that the effects of puberty and academic pressures result in girls being 'sicker' than boys, also 'map onto' evidence of an increasing female excess in symptom reporting. However, findings which suggest that with increasing age both boys and girls would become more independent and stoic in response to their symptoms, do not support the quantitative data as they suggest decreasing, instead of increasing, symptom reporting rates for boys and girls with age. Indeed, analyses of the qualitative data revealed very few and relatively subtle differences between boys' and girls' accounts, especially in

relation to the oldest pupils. Thus, it is important to consider why this may have been the case, especially considering that quantitative data show age-related increases in the differences between boys' and girls' symptom reporting rates.

It has been suggested that 'accounts' generated in research settings can be 'public' or 'private' depending on a number of factors, including the contexts in which interactions take place and the nature of the interviewer-interviewee relationship (West 1990; Radley and Billig 1996). Cornwell (1984) described 'public' accounts as those which are given in an attempt to conform to and reinforce dominant discourses and ideologies. 'Private' accounts, on the other hand, have been described as revealing "a deviant or 'darker' side of things" (West 1990, p.1229) and less dominated by the need to be interpreted as 'acceptable' by others (Radley and Billig 1996). Therefore, it is probable that in the focus groups, pupils were concerned with producing 'public' accounts of their illness behaviours which would be viewed as 'acceptable' by their peers. This is especially likely given that focus groups took place in the school context, which pupils highlighted as the most punitive in which to report symptoms or engage in any sort of behaviour which might be perceived as 'taboo' or against the norms of that particular context. In contrast, the '11-16 study' surveys were administered under exam conditions and could therefore be described as 'private' accounts. Thus, as performances of gender vary depending on whether they are given in 'private' or 'public' contexts, there are bound to be differences between the resulting types of accounts and this may help to explain why the gender differences evident across the focus group data do not seem to reflect the levels of differences demonstrated by the survey data.

This interpretation suggests that boys are more self-censoring than girls regardless of the context. Therefore, they report lower levels of symptoms than girls in survey situations and, in the focus group setting, they were also more likely than girls to claim not to suffer from, or to be able to overcome, illness. However, girls might be less self-censoring when giving 'private' accounts, which is one way of accounting for their predominantly higher symptom reporting rates in survey situations, but in the focus groups they appeared to feel under similar pressures to boys to present themselves as strong and independent individuals. This would suggest that differences in the degree to which boys and girls self-censor in 'private' and 'public'

contexts may lead to 'private' accounts being characterised by greater gender differences and 'public' accounts exemplifying less obvious differences because both boys and girls are more aware of how they are presenting themselves. Alternatively, it is possible that girls' predominantly higher rates of symptom reporting in survey situations reflect that they are 'sicker' than boys, but that these differences are made less obvious in 'public' settings where girls may be more wary of the information that they reveal and more conscious, perhaps particularly as they get older, of presenting themselves as strong and independent. Indeed, given evidence of changes in the societal gender order and reports of a gender convergence in terms of expectations, values, and activities (Holstein-Beck 1995; Wilkinson and Mulgan 1995; McRobbie 2000; Sweeting and West 2003c; Bjerrum Nielsen 2004), it is possible that girls' 'public' performances of gender are becoming less distinct from boys' as they may have become more conscious of not conforming to certain stereotypes of femininity.

Nevertheless, arguing that different research settings lead to the production of different types of accounts, is not to say that the 'public' accounts which pupils gave should be considered untrue or less true than 'private' accounts which they may have produced in different circumstances (West 1990; Frosh, Phoenix et al. 2002). Indeed, neither is it possible to say that the less distinct gender differences evident in the qualitative findings prove that quantitative data, which display stronger gender differences, are inaccurate or 'wrong'. On generating different types of accounts in focus groups and interviews with boys and young men, Frosh and colleagues (2002, p.32) argue that:

...the interviews themselves were sites for 'acting' or 'performing' [...] the boys' behaviour in different kinds of interview or at different times might reveal different facets of their masculinities [...] we do not see their performances in individual interviews as somehow having been more 'authentic' than those in the groups (or vice versa), but rather see each setting as drawing out different manifestations of masculine identity construction – different ways of 'doing boy'.

The accounts pupils constructed in the current study should not be dismissed because of their 'public' nature, but instead taken as one example of the many ways that boys and girls construct their identities according to the 'rules' and 'norms' of different contexts. Indeed, Hyde and colleagues (2005) have argued that the social interaction

and associated 'performances' which take place in focus groups can mimic and shed light on the everyday practices and norms of 'naturally occurring' groups. In fact, it could even be argued that the focus groups conducted with primary school pupils, which were composed of friendship groups, represented 'private' settings. Thus, far from being 'untrue', the accounts pupils constructed in the focus groups provide rich insights into the rules by which boys and girls shape their behaviour and the practices they employ whilst presenting themselves to others in their everyday lives. Therefore, a plausible way of explaining the less obvious gender differences evident in the qualitative as compared to quantitative data is by arguing that the diverse ways in which boys and girls 'do gender' in different contexts leads to 'public' and 'private' accounts being characterised by gender differences of varying degrees. Nevertheless, along with debating whether and to what extent the qualitative findings of this study 'map onto' existing quantitative data, it is also important to consider the ways in which they help to improve our understandings of quantitative evidence by facilitating an in-depth appreciation of the factors which influence boys' and girls' illness behaviours and symptom reporting.

One of the main findings of this study is that performances of gender (and, to a lesser extent, being seen to behave in age-appropriate ways) were key aspects in pupils' presentations of themselves. Pupils' accounts of their reactions to symptoms can be interpreted as 'doing gender' and constructing identities which would be viewed by others as gender-distinguishing and gender-appropriate. Indeed, the majority of the pupils' concerns about symptom experiences and reporting were related to how the disclosure of symptoms would reflect on their social identities or impact others', and particularly their peers', perceptions of them in terms of their abilities to behave in gender- and age- appropriate ways. Pierret's (2003) review of the illness experience highlights the way in which illness has been said to represent the body as being without bounds or control and that this can have detrimental effects on people's sense of identity. This may be a particularly salient prospect during adolescence given that social identities are still being formed and subject to strict scrutiny. Therefore, it is likely that boys and girls will try to limit the extent to which illness draws attention to them, thus rendering them subject to greater scrutiny. Indeed, pupils' accounts suggested that illness behaviours are practices which can be manipulated in order to conform to the gender- and age-related expectations of a particular context.

Performances of health can therefore be seen as integral to the performance of gender and age. In turn, getting these performances 'right' was seen as more important in 'public' contexts and in the presence of peers, where pupils believed that their behaviour would be more actively policed and where failures to conform to expectations could jeopardise their presentations of themselves as competent individuals. Some boys' accounts suggested an exception to this as they highlighted the need to maintain performances of gender in more 'private' contexts when in the presence of their fathers. Indeed, these findings suggest that there may be less of a distinction for boys between 'public' and 'private' performances of gender as their reactions to symptoms in both types of context seem to be more restricted by expectations than are girls'. On the whole, girls seemed marginally more concerned than boys about the potential impact of symptoms on their health, whereas boys portrayed themselves as more concerned about the effects of the disclosure of symptoms on others' perceptions of them (as masculine).

The findings of this study also suggest that a reciprocal relationship exists between the social construction of gender identities and that of symptoms, and illness in general. Not only did pupils' accounts suggest that illness behaviours are practices which would allow them to perform gender, but their presentations of themselves and their performances of gender can also be seen as playing a part in the ways that they constructed symptoms. For example, boys' attempts to present themselves as stoic and controlled, or generally 'successfully masculine', may have informed their tendencies to conceptualise symptoms as trivial and surmountable. What is more, pupils' understandings of symptoms can also be viewed as socially constructed due to the extent to which they were informed by their perceptions of the social consequences of reporting them. For example, it was pupils' speculations as to others' reactions to symptoms which often informed their conceptualisations and, in turn, shaped their ideas as to how they would deal with symptom experiences. Also important is the extent to which pupils' perceptions of others' reactions to symptoms were based around the enforcement of gender- and age-related expectations. In this sense, pupils believed that others would react negatively to illness behaviours which they viewed as being gender- or age-inappropriate. Thus, the findings of this study suggest that pupils' performances of gender, their understandings of symptoms and their reactions to illness can be viewed as factors which are intricately related to one

another and are socially constructed in the way that they are each informed and shaped by societal expectations and perceived social consequences.

8.4 Study limitations and strengths

One of the main limitations of this study was that the amount of time granted to conduct the focus groups was at the discretion of school gatekeepers. Ideally, the secondary school focus groups would have benefited from taking place over two school periods (80 minutes) because it transpired that the 40-minute time-slots which I had been allocated were often too short to discuss all of the focusing exercises with these pupils. In contrast, the more relaxed primary school timetable meant that the data generated with P6 pupils were more in-depth in many cases. Thus, when analysing and comparing the accounts generated with pupils in different age-groups, it was often hard to judge whether P6 pupils subscribed to stereotypical ideas and expected there to be distinct differences between boys and girls because their stage of cognitive development meant that their understandings of gender were still fairly rigid (Martin and Ruble 2004), or whether it was because their discussions had more time to develop and pupils had greater opportunity to voice their opinions. Indeed, it is important to note that because of age-based changes in cognitive abilities, the opinions expressed by each age-group could not be interpreted on the same bases, but comparisons across age had to take account of pupils' differing stages of cognitive development.

Although recruiting respondents through schools provides access to a large and relatively representative sample (Testa and Coleman 2006), there are also limitations involved in taking this approach. In addition to the difficulties experienced in gaining access to conduct research in schools (see Chapter 4), once access has been granted and teachers take on the task of recruiting pupil volunteers, it is hard to ensure that respondents self-select rather than 'volunteering' (or not) as a result of pressure from either teachers or peers. As Hyde and colleagues (2005) note, once a researcher has navigated the "delicate process" of gaining access to a school they are in fear of being perceived as "too directive" by teachers or making too many extra demands. Thus, beyond asking teachers at both schools to aim to recruit sufficient boys and girls from a range of social backgrounds, I felt that telling them how to go about this may have been perceived as "too directive" and inconsiderate of their efforts to help with the

research whilst simultaneously coping with their own workloads. The fact that the focus groups conducted in the primary school, but not the secondary, were composed of friendship groups may have led to biases within the sample and demonstrates the ways in which elements of schools' structures (both physical and temporal) can place limitations on the types of research that they can facilitate. If I were to start this study again, I would still contact mainstream schools and hope to recruit the majority of the respondents from them. However, I feel that I might also widen my options by contacting youth groups or clubs, where access negotiations might not have been as lengthy and where there may have been fewer restrictions placed on the amount of time spent with each group. Nevertheless, it is likely that other options would have had other associated constraints.

Another limitation of the current study may have stemmed from the methods employed in the focus groups and the possibility that the focussing exercises led pupils to expect that there are distinct differences between the ways that boys and girls behave. For example, because pupils were continually asked to talk about their own thoughts and actions but were then asked to compare these to what their opposite-sex peers might think and do, it is perhaps not surprising that many pupils claimed that boys and girls would behave in distinct ways. Also, as pupils were aware that focus groups were being conducted separately with boys and girls, some may have assumed that their ideas would be compared to those of their opposite-sex peers and this could have resulted in them being more conscious that they were answering as 'boys' being compared to 'girls', and vice versa. Levine (1999, p.66) writes that "the beliefs and values of a group are dependent on whom the group is comparing itself to". Thus it is possible that boys' and girls' already strict performances of gender were heightened by the prospect of having their values and behaviour compared against one another. It could be argued that the single-sex composition of the focus groups represents a further methodological limitation as mixed-sex groups could have provided further insight into the ways that gender is performed in social interactions between boys and girls.

A further key shortcoming of this study is the fact that the interview data were not systematically analysed and incorporated into the findings chapters, resulting in the thesis lacking pupils' experiential accounts of illness and detailed personal narratives

of boys' and girls' decisions about whether or not to report symptoms. Also, as noted in Chapter 4, it is impossible to ignore the impact of conducting the interviews and generating this type of data on the research process as a whole. It seems inevitable, although not directly referred to in the findings chapters, that the interview data informed the analysis of the focus groups. However, it is difficult to say in what ways and to what extent this may have occurred.

It may also have been advantageous to determine the socioeconomic backgrounds of the participants as this would have helped to ascertain whether the findings of this study are class specific. In addition, it is important to note that the cultural context of the study may have influenced some of the findings. In particular, a sense of the Scottish 'macho male' culture was conveyed as boys spoke about fathers making fun of their sons for showing their emotions. However, this might not have been found had this study been conducted in a different geographic or cultural setting. Indeed, the cultural context of the research may have made it less acceptable for boys, perhaps older boys especially, to participate in the study, thus resulting in boys who took part being even more self-selected than girls. This possibility also helps contribute to our understanding of the different degrees of gender differences evident in the qualitative and quantitative data; if the boys who took part in the study were more willing to talk about their health and their reactions to symptoms, this could have served to mask gender differences between the oldest boys and girls.

A final limitation of the study lies in the fact that it took place between June 2004 and January 2005, whereas all waves of the '11-16 study' took place in the winter and spring months. This difference in the timing of the two studies limits the capacity to compare the two sets of data.

The main strength of this study is that it represents the first piece of research to explore the 'gender reversal' in child and adolescent health by drawing directly on the views and experiences of boys and girls at different stages of this transition. The use of qualitative methods enables a unique and in-depth exploration of children's and adolescents' understandings of symptoms, their opinions on how they would decide whether or not to report them and their perceptions of what might be the outcomes of doing so in different social contexts. Our understandings of boys' and girls' views on

symptom reporting, or seeking help for illness, are also enriched by the fact that they were discussed against a backdrop of the gender- and age-related expectations which pupils felt would influence their responses to illness and how these might shape their behaviour differently according to contextual norms.

Some might suggest that the ideas which pupils expressed in the groups cannot be interpreted as 'accurate' reports of how they would react to symptoms and that the presence of their peers may have inhibited them from expressing alternative or dissenting opinions. Although valid points, one of the strengths of using focus groups is that the performances of the group and participants' impression-management strategies allow the researcher to 'tap in' to, and witness some of the group processes and norms which may be at work in 'naturalistic' settings. Some have suggested that focus groups have "ethnographic potential" in the ways that they can lead to the enactment or mimicking of the cultural processes which participants claim to be normative group practices (Hyde, Howlett et al. 2005). This occurred in the current study as pupils alluded to the ways in which they would be teased for reporting symptoms in public and also provided evidence of this by actually making fun of others in their groups or in school who were well known for certain behaviours. Although we need to both remain aware that focus group participants are extremely conscious of how they are presenting themselves and be cautious of claiming that all of what is said in focus groups is a valid reflection of 'reality', the ideas expressed in this context can be valuable in improving our understandings of the cultural norms which influence participants' behaviour, both in the research setting and their everyday lives. Therefore, the use of focus groups in the current study facilitated a deeper understanding of the cultural norms which surround boys' and girls' illness behaviours and also provided a unique insight into the ways that they manage their symptoms as well as others' impressions of them.

8.5 Main conclusions

This study has found that pupils drew on both sociological and biological frameworks when constructing possible explanations for changing gender differences in symptom reporting.

In terms of sociological explanations, analyses of pupils' accounts suggest that boys' and girls' performances of gender and age heavily influence their illness behaviours in different social contexts and they even inform their conceptualisations of symptoms. However, because societal expectations represent 'rules' for boys and 'guidelines' for girls, it is boys' reactions to illness, and particularly to 'malaise' symptoms, which are more prohibited and restricted by pressures to conform to masculine ideals. Nevertheless, the data also suggest that the differences between the 'rules' and 'guidelines' which influence boys' and girls' behaviour are not as rigid as gender stereotypes would lead us to expect. Although boys came across as feeling compelled to try and fulfil conventionally masculine expectations, girls also claimed to feel pressure to react to symptoms in stoic, independent and controlled ways lest others would view them as "babyish" or weak. Thus, instead of stark differences, similar patterns were found across boys' and girls' accounts but there was a difference in degree as boys portrayed themselves as being more reluctant to report any symptoms and perceived that they would face worse social consequences than girls as a result of doing so, regardless of social context. Overall this suggests that the performance of health is more central to boys' performances of masculinity and that girls are perhaps marginally more able to incorporate minor illness in their constructions of themselves.

Pupils also accounted for the increasing gender differences in symptom reporting rates in terms of differences in biological developments experienced by boys and girls at this time in their lives. In particular, they argued that the advent of puberty leads to an increase in girls' experiences of symptoms as their bodies change and menarche is accompanied by headaches, stomach aches and emotional distress. In addition to this, it was only ever girls who highlighted that the stress of exam pressure could take its toll on their health. Thus, both ideas imply that the increase in female excess morbidity occurs because girls experience an increasing number of stressors at this time in their lives and, as a result, they are 'sicker' than boys. Pupils' expectations that girls will experience increased 'physical' and 'malaise' symptoms as they mature, and indeed that this is 'natural' for girls, are also significant, and perhaps contribute to the extent to which girls, but not boys, feel that they are 'allowed' to incorporate illness into their identities. Although pupils' accounts referring to biology suggest that gender differences in symptom reporting might be caused by real biological

effects, these accounts are, of course, also social constructions and seem to be drawn from frameworks with which pupils had been presented in school.

It is also important to consider the significance of this study's findings in helping us to account for and further understand the gender differences which are characteristic of adult health. This study has found that boys and girls are intensely aware of societal gender- and age-related expectations from at least as young as 10 years of age and that their efforts to conform to these expectations have a significant impact upon their presentations of themselves and, in turn, their reactions to illness. This suggests that, from an early age, people's concerns about how others will perceive them, and the extent to which their character will be discredited by failures of the body or mind, often take precedence over their concerns about their health. As a result, people who feel under most pressure to conform to societal expectations, and this is especially likely to be boys and men, only seek help for illness when they can no longer cope on their own. Considering that these ways of thinking about illness begin at such an early age it is likely that the beliefs and habits which are established at this time will be carried on, both consciously and sub-consciously, into adult life. Indeed, perhaps the deeper entrenched that these expectations are in people's presentations of themselves, the more likely this is to occur. Thus, it may be that the stricter 'rules' which serve to dictate boys' illness behaviours from an early age result in adherence to these continuing well into adulthood and help to explain the origins of men's lower levels of symptom reporting particularly in relation to mental health (see O'Brien, Hunt et al. 2005). Conversely, the more lenient 'guidelines' which surround girls' behaviour, and the wider range of options which are available for them to draw on whilst constructing their identities, may mean that it is less risky for them to seek help for illness, but also more essential if the advent of puberty and increasing academic pressures result in girls experiencing an increasing number of symptoms.

8.6 Implications for policy and future research

8.6.1 Important findings for health policy-makers

Shibley Hyde (2005, p.589) claims that there are "serious costs of overinflated claims of gender differences". This study supports this claim and provides evidence that both boys and, to a lesser extent, girls, restrict their reactions to illness so as to be seen as conforming to societal gender- and age-related expectations. The extent to which

boys prioritise conforming to expectations and living up to stereotypes before concerns about their physical and, even more so, their psychological well-being represents a detrimental consequence of gender stereotypes. What is more, gender stereotypes reinforce the misconception that girls find it easy to adopt the sick role. This study also found that pupils' understandings of symptoms and their perceptions of the consequences of reporting them are heavily informed by gender- and age-related expectations. Thus, it seems that in order to lower help-seeking barriers and to improve boys' and girls' perceptions of the consequences of reporting symptoms, there needs to be considerable erosion of the idea that illness, particularly 'malaise' symptoms or psychological distress, signifies weakness.

The implications of these findings for health policy-makers point to the need for health education campaigns which would inform the general population, and especially young people, of the potential for gender- and age-related expectations to restrict behaviour and of the dangers of this when it restricts reactions to potentially serious physical or psychological illness. It also seems important to convey the impact which parents' or teachers' gender-distinguishing reactions to complaints of illness or injury could have in setting up health beliefs and illness behaviours as well as reinforcing potentially harmful gender stereotypes. However, considering the extent to which stereotypes and gender-related expectations are a pervasive and even unconscious element in our everyday lives, and perhaps more so in those of children and adolescents, the de-stabilising of stereotypes represents a huge challenge for health policy-makers. Perhaps a more achievable, but still challenging, aim would be to target boys' and girls' views that seeking help for illness represents weakness or serves to discredit their presentations of themselves as competent and independent.

The findings of this study not only suggest that the 'gender reversal' represents a need to tackle restrictions placed upon children's and adolescents' willingness to seek help for illness, but also that the transition from childhood to adolescence is a (more) stressful time for girls when biological changes and increasing school-related pressures cause their experiences of 'physical' and 'malaise' symptoms to increase. This suggests a need for an increase in services which concentrate on how this time of life can be made less stressful for girls and how they might be given more support to cope with the changes and increasing number of stressors with which they are faced

(Petersen, Sarigiani et al. 1991; Marcotte, Fortin et al. 2002; West and Sweeting 2003).

Pupils' understandings of 'malaise' symptoms, as well as their beliefs that others would react to them in stigmatising ways, can be seen as major barriers to boys' and, to a lesser extent, girls' help-seeking. The implications of this for health policy-makers is that campaigns to prevent the stigma of mental ill-health (e.g. 'See Me' Scotland) would benefit from taking boys' and girls' conceptualisations of mental health symptoms into account. Specifically, this study highlights a need to address children's and young people's misconceptions that 'malaise' symptoms are 'rare', and implies that educating them as to the prevalence, causes, effects and treatments of mental illnesses might help to change their understandings. The findings suggest that barriers to help-seeking for 'malaise' symptoms may be lowered if boys and girls conceptualised them as 'ubiquitous' or 'normal', in the same way that they do 'physical' symptoms. Indeed, boys' help-seeking for 'malaise' symptoms could be improved if their misconceptions that they are 'feminine' symptoms were also addressed. Thus, health education campaigns which strive to incorporate and change boys' and girls' conceptualisations of 'malaise' symptoms would represent a significant step forward in improving help-seeking rates for psychological complaints in general. In line with previous research (Williams and Pow in press), findings which suggest that boys and girls differ in their understandings of 'malaise' symptoms and tendencies to seek help for them suggest that campaigns to educate boys and girls about mental health may be more effective if gender-specific.

There is also a need for peer, teacher and parent training in how to deal with friends, pupils and children who seek help for mental health symptoms. This study highlights the importance for boys and girls of assurances that help-seeking will be confidential and will not lead to immediate repercussions, but that control of how to deal with their 'problems' will remain with those experiencing, and seeking help for, them. Again, given evidence that girls and boys tend to approach and resolve their emotional problems in different ways, training schemes may be more effective if they taught peers, teachers and parents gender-specific approaches to helping boys and girls cope with and overcome their difficulties. However, it is important that such gender-

specific approaches do not serve to reinforce ideas of masculinity and femininity as oppositional.

8.6.2 Important findings for teachers and education policy-makers

There are suggestions in the current study that aspects of school life, including sex education which teaches gender dimorphism, and teachers' differential reactions to boys' and girls' complaints of illness, serve to reinforce stereotypical ideas that masculinity and femininity are polarised, and that boys are not supposed to be ill or to complain about it when they are. Given that boys and girls are exposed to these ideas from an early age they are bound to play a large part in their conceptualisations of gender and in reinforcing the ideology that it is 'natural' to behave in gender-distinguishing ways. Thus, it is also important that teachers and all those involved in the education of children and young people are made more aware of the knock-on effects to boys' and girls' help-seeking and illness behaviours, of encouraging them to subscribe to strict gender- and age-related expectations. Health education policies which highlight the potentially damaging effects of stereotypes and societal expectations should also aim to target all those who work closely with children and young people. Perhaps the most worrying aspect of this research is the extent to which pressures placed on boys to conform to masculine ideals leads to age-related increases in the extent to which they internalise their emotions and have the potential to prevent their help-seeking for psychological problems until they reach high, and possibly life-threatening, levels of distress.

Pupils' reluctance to seek help for illness whilst in school was mainly influenced by the lack of privacy and their beliefs that reporting symptoms in this context would inevitably lead to being gossiped about or made fun of in various ways. These findings suggest the need for improvements in school policies around the reporting of illness and that these should aim to maximise opportunities for pupils to do this as confidentially as possible. Indeed, in line with Roose and John (2003), the findings of this study suggest that there may be a need for the provision of confidential health services specifically for children and young people which are located outwith the school environment. This may improve help-seeking rates for illness in general, but perhaps especially for symptoms which were perceived by pupils as 'taboo' and which they would be especially reluctant to disclose in school, where they believed it

to be inevitable that 'everybody' would find out about them. Nevertheless, it may still prove challenging to ensure such services are perceived as 'boy-friendly'.

8.6.3 Ideas for future research

This study has explored experiences of illness in school only from pupils' perspectives. It is important that future research considers teachers' and school health promotion officers' opinions on how best to incorporate pupils' concerns into practical arrangements that can improve their help-seeking opportunities and decrease the negative consequences of reporting symptoms in this context.

This study also highlights the need for future research to investigate in more detail the specific aspects of pupils' lives which may lead them to expect more differences than similarities between boys and girls, and which serve to reinforce the ideology that boys and girls are 'supposed to' behave in opposing ways. Specifically, there is a need to look at whether, to what extent, and in what ways these ideas restrict boys' and girls' presentations of themselves, especially with regards to illness. In relation to this, the findings of this study suggest that gender-related expectations may have changed for girls and that their behaviour is changing accordingly. However, given that there are no similar data to compare back to, further research is warranted which allows for such comparisons and monitors the extent to which girls' behaviour, and especially their reactions to illness, might change in tandem with women's changing position in society. Indeed, considering that masculinities have recently been challenged at a cultural level, it is also important that future research considers whether and the extent to which this enables boys and young men to construct gender identities which are not based on models of masculinity and femininity as dichotomous. In turn, it would be interesting to consider the ways in which such changes might impact upon boys' and men's performances of health as an integral practice in their performances of gender. In relation to this, further research is required to investigate boys' and girls' agency in developing renegotiated or 'alternative' gender identities in response to experiences of illness which cannot be concealed. Considering the importance of performances of health for successful performances of gender, it is important to investigate whether and how boys and girls manage to deal with, and seek help for, illness whilst retaining a positive sense of themselves as masculine or feminine.

Finally, this study demonstrates the rich insights which can be gained by exploring health from boys' and girls' perspectives and it highlights the need for further qualitative studies which explore children's experiences of health and illness, especially in the context of their presentations of themselves as gendered. It is hoped that this study represents an important step in meeting the need to "understand the place and meaning of sickness in children's everyday lives" (Prout 1986) and, furthermore, that it has contributed significantly to deepening our understandings of the integral nature and complex meanings of health and illness in boys' and girls' constructions of themselves as gendered beings as they progress from child to adult.

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Youth, Health and Growing Up.

Information for pupils

What is this project about?

This project is about the health of people your age. It will look at the kinds of symptoms that boys and girls your age might get and what they do when they feel unwell. I would like to talk to P6/S2/S4 pupils as I am interested in finding out their thoughts on this.

What will taking part involve?

If you would like to take part you will be involved in a group discussion and you could also take part in an interview. These will take place in school and will last about 45 minutes. In the group discussion, I will talk to you and a couple of friends about the symptoms that people your age get and how they deal with them. In the interviews you and I will talk about your own health and your experiences of not feeling well. You do not have to take part in the project if you don't want to, but it would be great if you could help and you might enjoy it!

Why take part?

This is a chance for you to talk about your health, either with your friends or on your own, and to give your own views on the ways that boys and girls react to feeling unwell.

Who knows about this project?

This project has received the support of your Head Teacher, the local authority education department and Glasgow University. Information will only be collected from those who want to take part and whose parents have agreed to this. If your parents have agreed to let you take part and you are not sure if you want to, the final decision is up to you.

What will happen to my answers?

Provided you agree, the discussions and interviews will be tape-recorded and some of what you say may be quoted when the results of this project are reported. But everything that you say will be anonymous and confidential. For example, everyone who takes part will be given a false name, so that no-one except the members of the research team will know who said what. Only if you reveal that something or someone is causing you serious harm, or that you are causing serious harm to others will I need to speak to you in private about this and then contact someone for help and advice on what should be done.

How do I get involved?

If you decide that you would like take part in the project please:

- Give your parent/guardian the information for parents and ask their permission to take part.
- Think about whether you would like to take part in a group discussion only, or in both a discussion and an interview. (You will be allowed to change your mind about this, if you wish. For example, if after taking part in the group discussion you decide that you might enjoy the interview, or that you no longer want to take part in the interview, you will be able to volunteer or withdraw).
- If your parents do/do not give you permission, return the completed consent form to school.

How do I find out more?

If you have any questions about the project, you can contact me by post, phone or email:

Write to: Alice MacLean, MRC Social and Public Health Sciences Unit,
University of Glasgow, 4 Lilybank Gardens, Glasgow G12 8RZ.

Telephone: 0141 357 3949

E-mail: alice@msoc.mrc.gla.ac.uk

Thank you for reading this leaflet.



Youth, Health and Growing Up.

Information for parents.

What is this project about?

This project is part of a study which is looking at the health of young people. The project builds on previous research which has found that there are differences in the symptoms most commonly reported by boys compared with girls, and that these differences change with age.

Who is conducting the project?

This project is funded by the Medical Research Council and is being carried out by Alice MacLean. Alice is based at the MRC Social and Public Health Sciences Unit, University of Glasgow.

What is involved?

The participation of your child in this study is voluntary and dependent on your permission being granted. If you agree, your child will take part in a group discussion and could also take part in an interview if they are happy to do so. These will take place in school and will last up to 40 minutes. In the group discussions your child, along with a few of his/her friends will be asked to talk to the researcher in a general way about the symptoms that young people experience and how they react to these. In the interviews your child will be asked to talk to the researcher about his/her thoughts on their own health and experiences of not feeling well.

Consent.

This project has received the support of the Head Teacher of your child's school, the local authority education department and from Glasgow

University's Ethics Committee. If you do/do not permit your child to participate in the project please complete the attached parental consent form and return this to the school as soon as possible.

What will happen to information given?

With the permission of those involved, discussions and interviews will be tape-recorded. However, all information gathered during this project will remain anonymous and confidential, unless young people reveal details of serious harm caused to them or that they are causing serious harm to others. If this occurs relevant bodies will be contacted to enable help and advice to be given. No names of participants or schools will appear in any reports or academic papers arising from the project and findings will not be reported in a way in which any individual or school can be identified.

Use of results.

It is hoped that the results of this study might be of interest and value to young people, parents, teachers, doctors and all those in contact with children and teenagers. Findings may well inform health and education policy in relation to children and young people.

Need more information?

If you have any questions about the project, you can contact the researcher by post, phone or email:

Write to: Alice MacLean, MRC Social and Public Health Sciences Unit,
University of Glasgow, 4 Lilybank Gardens, Glasgow G12 8RZ.

Telephone: 0141 357 3949

E-mail: alice@msoc.mrc.gla.ac.uk

Thank you for reading this leaflet.



Youth, Health and Growing Up.

PUPIL CONSENT FORM

To be completed by pupils who wish to take part in the Youth, Health and Growing Up project.

- I agree to take part in the Youth, Health and Growing Up project, as described in the pupil information sheet which I have read.
- I understand that I do not need to answer any questions if I do not want to and that I can withdraw from the project at any time.
- I realise that information I give may be quoted in the publications and presentations resulting from this study and I understand that my name will be changed so that no comments can be traced back to me.
- I am willing to take part in a (please tick preferred choice)
group discussion only
group discussion and interview and I understand that this/both will be recorded.

Name _____

Male/Female (Please circle) _____ Age _____

Date _____



Youth, Health and Growing Up.

CONSENT FORM FOR PARENT(S) OR GUARDIAN(S) (OPT-IN)

To be completed by a parent or guardian who wishes their child to take part in the Youth, Health and Growing Up project.

PLEASE USE BLOCK CAPITALS

I, (insert your name) _____

BEING THE (insert relationship) _____

OF (child's full name) _____

A PUPIL IN (year) _____

OF (school name) _____

WISH TO GIVE CONSENT FOR MY CHILD TO TAKE PART IN THE PROJECT,
AS DESCRIBED IN THE LETTER AND INFORMATION SHEET WHICH I
HAVE READ.

SIGNATURE:

DATE:

Youth, Health and Growing Up.

CONSENT FORM FOR PARENT(S) OR GUARDIAN(S)

To be completed by a parent or guardian who **wishes to withdraw** their child from the Youth, Health and Growing Up project.

If you do not complete and return this form by **(date)**, this will be taken to mean that you are willing for your child to take part.

PLEASE USE BLOCK CAPITALS

I, (insert your name) _____

BEING THE (insert relationship) _____

OF (child's full name) _____

A PUPIL IN (year) _____

OF (school name) _____

WISH TO WITHDRAW MY CHILD FROM THE PROJECT, AS DESCRIBED IN THE LETTER AND INFORMATION SHEET WHICH I HAVE READ.

SIGNATURE:

DATE:



Social and Public Health Sciences Unit
University of Glasgow
4 Lilybank Gardens
Glasgow
G12 8RZ
Tel 0141 3573949
Fax 0141 3572389
E-mail alice@msoc.mrc.gla.ac.uk
Date

School address

Dear Secondary Head Teacher,

Research project: Changing Gender Differences in Health in Childhood and Adolescence

I am writing to request your assistance with a research project that I am conducting to investigate gender differences in the health of children and adolescents.

Previous research suggests that the distribution of ill-health reverses in early-mid adolescence from an excess of conditions such as asthma, migraine and psychological problems amongst young boys, to an excess of such conditions amongst mid adolescent girls. My aim is to talk to children, who are in P7, S2 and S4, about their symptoms, their experiences of illness and how they usually deal with these. I would also like to talk to school nurses and PSE/Guidance teachers about their observations of how boys and girls react when they do not feel well within the context of the school.

This research project is funded by the Medical Research Council and is being supervised by two experienced researchers from the University of Glasgow. It has received the support of Glasgow University's Ethics Committee and I have enclosed a letter from Glasgow City Council Education Department which indicates their approval. I have also undergone a Police check and have been granted enhanced disclosure by Disclosure Scotland. In addition to parental consent, written consent will be sought from pupils before involvement in the project. Discussions and interviews will be tape-recorded with the consent of participants, and all information collected will be treated in the strictest confidence. The anonymity of those taking part will be maintained and findings will not be reported in a way which any individual or school can be identified.

I have attached details of what participation in the study would involve for both the school and individual participants. Copies of the materials produced to inform pupils, parents, school nurses and teachers about the study, are also enclosed. I am willing

to follow the school's usual protocol for gaining parental consent, whether this is opt-in/opt-out consent forms or an alternative procedure.

I would really appreciate it if you could consider helping me with this project which I would endeavour to carry out with the minimum amount of disruption to both pupils and staff. In return for your help I would be more than willing to distribute feedback leaflets to the school or to provide information about the health of young people, around which an information session or some class work could be based. I appreciate that you may have further questions and I would be more than happy to meet with you to discuss these. I will contact you in a week to enquire as to whether you would be willing to assist in this project and to answer any questions that you have about the proposed research

Thank you for taking the time to read and consider this.

Yours sincerely,

Alice MacLean MA

Youth, Health and Growing Up.

School Involvement

I would like your help in contacting about eight girls and eight boys, from both S2 and S4. This would involve me meeting with one S2 and one S4 class initially. It is hoped that enough pupils will be recruited from these classes. However, if this is not the case, it may necessary to speak to further S2 or S4 classes. I would also like to interview a Guidance/PSE teacher and a school-nurse/first-aider.

A summary of the involvement requested from the school is as follows:

- a quiet part of the school to conduct group discussions and interviews
- time during one S2 period and one S4 period for the researcher to introduce the study and distribute information packs
- arranging collection of consent forms from pupils and return of these to the researcher
- four S2 and four S4 periods for the researcher to conduct group discussions with four pupils. (Two groups of girls and two groups of boys from each age group.)
- two S2 and two S4 periods for the researcher to conduct individual interviews with two boys and two girls in each age group (Interviews should last between 20 and 30 minutes.)
- an opportunity for the researcher to distribute information packs to guidance teachers and school nurses.

Pupil/Staff Involvement

Participation in the study is voluntary. If pupil participants agree to be involved, and have parental permission, they will take part in two activities. These are:

- A single-sex group discussion with about four young people and the researcher. Group discussions will involve pupils talking about the factors that they think might influence them to report a symptom and why the illness behaviours of boys and girls might be different. This will be done in the context of simple exercises. The group discussions have been designed to last around 45 minutes.
- An individual interview with the young person and the researcher. These will involve pupils talking about their own symptoms and experiences of not feeling well. Interviews have been designed to last between 20 and 30 minutes.

If staff participants agree to be involved they will take part in an individual interview. This should also last up to 30 minutes and will focus on the symptom reporting of young people as observed within the school on a daily basis. Staff interviews will be conducted at a time which is most convenient to the participant.

Appendix D: Focus groups and participant pseudonyms

Group identifier	Pseudonyms
P6g1	Myra Anna Eve Tess
P6g2	Ellie Rhona Kirsten Jennifer
P6b3	Liam Calum Gordon Neil
P6g4	Nina Jane Angela Elaine Debbie
P6b5	Hamish Mark Robert Craig
P6b6	Ally Simon Jason George Owen
P6b7	Jonathon Connor Cameron Tom
P6b8	Russell Angus Jack Andrew
P6g9	Kerry Beth Sandra Lisa
P6g10	Sharon Caroline Leigha Alison

S2b12	Oliver Nick Scott Peter
S2b18	Robbie Hugh Lewis
S2b20	Kenny Adam Derek
S2g22	Grace Isla Jill Tara
S2g23	Amanda Gemma Nadine
S2b24	Gregor Gary Keith
S2b25	Hazel Vicky Paula
S4b11	Douglas Joe Charles
S4g13	Carla Pamela Sheena Lynne Ruth
S4g14	Becky Emily Carrine Katie
S4b16	Justin Alistair Matthew Gareth
S4b17	James Kevin Declan
S4b19	Josh Christian
S4g21	Zoe Collette

S4g26	Rose Amy
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Appendix D: Focus group topic guide

Symptoms cards

- **Introductions**
- Ask group if they know what is meant by symptoms and to describe this in their own words.
- Ask group to look at symptom cards - which ones would you be **most likely** to tell someone about?
- **Why?** (Try to get at specific symptom related considerations **and what they understand the symptoms to mean.**)
- Which symptoms would you be **least likely** to tell anyone about?
- **Why?**
- Arrange most and least symptoms into 2 groups and ask them to compare the 2 groups:
- **Try to get at what it is specifically about the symptoms in each group that makes them more/less likely to report them.**
- Look at symptoms that haven't been talked about at all (if any) and ask them why these seem to be less important to them.
- Which symptoms do you think girls/boys would be most/least likely or very reluctant to report?
- **Again try to get at what it is specifically about the symptoms in each group that makes them think that boys/girls would be more/less likely to report them.**
- Are there symptoms that girls might be more likely to get or that boys might be more likely to get?
- Separate into two groups and talk about why.
- Are there symptoms that are seen as more 'girly' or as more 'manly'?

Vignette (stomach ache)

- Explain to the group that you are going to show them some cards which talk about people in certain situations and you want them to talk about what they think this person would do in each situation. So, I'm not looking for what you think that they should do, but what you think they actually would.
- Ensure they consider each context separately and in turn.
- Would they tell someone straight away?
- What about other people's reactions? (teachers, peers in class, friends they are out with, parents.)
- **Talk about push/pull factors for each symptom in each situation.**
- What kinds of things do you think might push the person towards telling someone?
- What kinds of things do you think might be putting them off?
- Is it easier to tell in one situation than another? Which? Why?

Vignette ('feeling like crying all the time')

- Go through same questions as stomach ache vignette
- Try and pick up on any differences in how they would deal with the 'malaise' symptom.

- How do you think the way that he/she would deal with this symptom would compare to how he/she would deal with the stomach ache?
- What kinds of things might push him/her to tell someone about this symptom in class/at home/when out with friends?
- What kinds of things might put him/her off telling someone about this symptom in class/at home/when out with friends?
- Do you think this symptom is easier or harder to deal with than the first?
- Why? What are the main differences between them that makes one harder and one easier to deal with?
- In which situation would it be easier/harder to cope with? Why?

Vignettes (opposite-gender)

- Try and pick up on gender differences in how each symptom might be dealt with.
- Out of Sarah and Steven, would one find it easier than the other to deal with these symptoms? Who? Why?
- Some groups have said that people might get teased for crying but it depends on whether they have a good reason for crying. What do you think about this?
- What do you think counts as a good or acceptable reason for crying?
- What reasons are less acceptable, would people get teased about?
- What about the idea that boys show emotion more through getting angry and being aggressive than getting upset or crying? Why might they do this? Why might they prefer to show anger rather than sadness?
- Some other groups have also said that what Sarah and Steven would do would depend on the type of people they were. What do you all think about this?
- Can you give me examples of the different types of boys and girls? How would they each behave? Why do the different types behave differently?
- Another common idea is that girls are just more open than boys and that's why boys hide their emotions. Do you think this difference is something that is natural to boys and girls and that they are born with, or do they learn this?

Histograms

- Explain to the group that past research has found gender differences in the symptom reporting of children get wider as children get older.

For younger groups especially

If we look at these graphs we can see that at age 11 the differences between boys and girls are so small that they don't really count. But look at what happens as boys and girls get older; the gap between them gets bigger and bigger. So at age 15 there is quite a difference between the girls and the boys. This seems to be because the amount of boys who say they have these symptoms doesn't change much as they get older, but as girls get older more of them say they suffer from these symptoms.

- ***S4 groups -** Let the group look at the 4 histograms and ask them to look firstly at the gender differences for each. Can you describe the main patterns or trends that each graph shows?

- For each symptom –why might there be differences between the amount of girls and boys who say they have this?
- **Do these results surprise you or are they what you expected?**
- Do you think they reflect your experiences as you've got older? In what ways?
- **Do you think that there might be differences between what people experience and what they say they get?**
- Can you think of any reasons why this might be?
- What other explanations could there be for these gender differences?
- **Changes with age.**
- We talked about age earlier, these show that girls report more as they get older but nothing much changes for boys, what do you think about this?
- Can you think of any explanations for this?
- What kinds of things do you think might cause the gender gap to get bigger as boys and girls get older? What things change for girls as they get older that don't change for boys?

- **Conclusions, summing up, thanking participants and names for interview.**

Appendix E: Example of Vignettes

Steven is 10. He is not feeling well as he has a stomach ache. He is not sure what to do. What do you think Stephen would do if...

- a)...he was in class?
- b)...he was at home?
- c)...he was out with friends?

Steven is 10. Recently he has been feeling like he is going to cry all the time. He is not sure what to do. What do you think Stephen would do if...

- a)...he was in class?
- b)...he was at home?
- c)...he was out with friends?

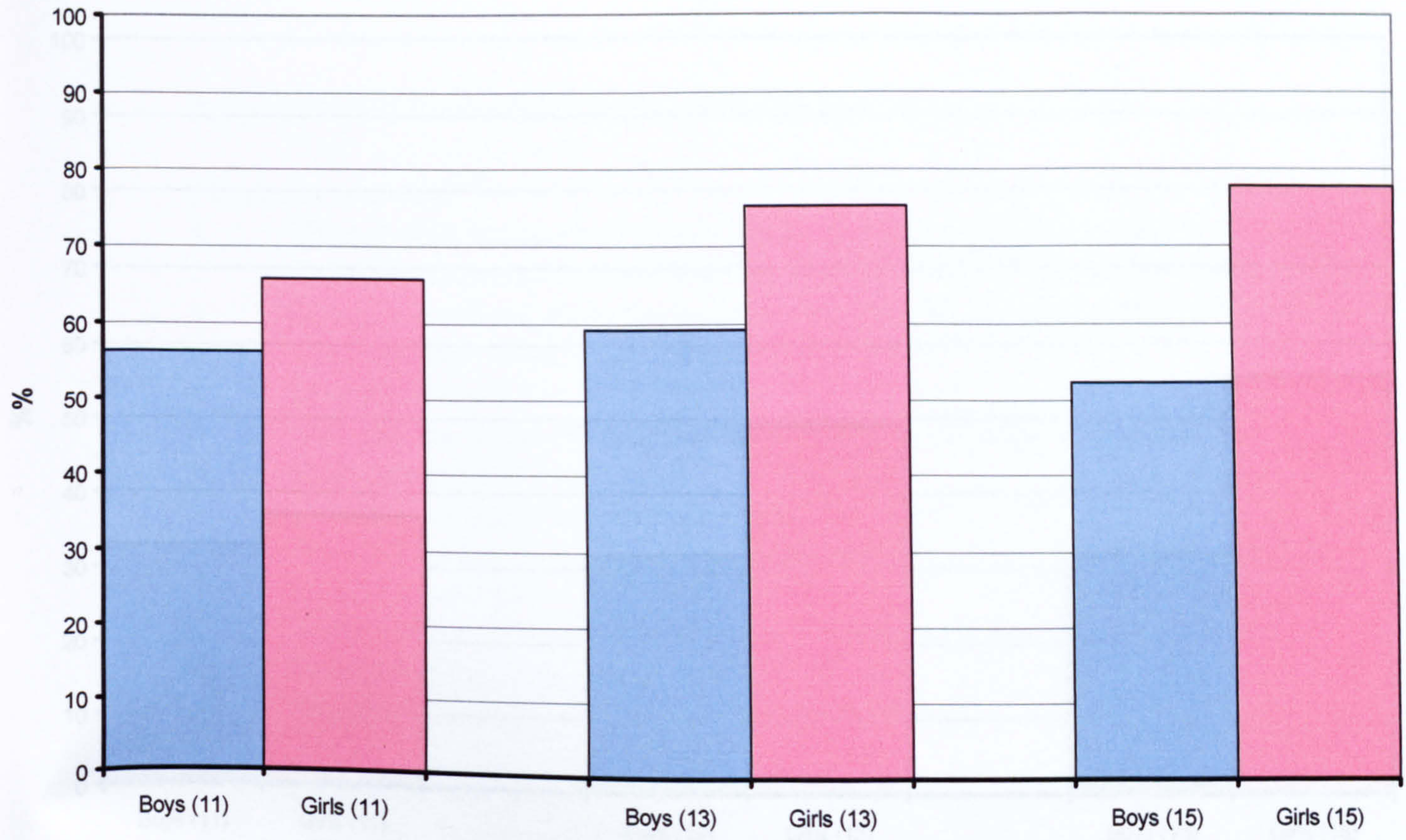
Sarah is 10. She is not feeling well as she has a stomach ache. She is not sure what to do. What do you think Sarah would do if...

- a)...she was in class?
- b)...she was at home?
- c)...she was out with friends?

Sarah is 10. Recently she has been feeling like she is going to cry all the time. She is not sure what to do. What do you think Sarah would do if...

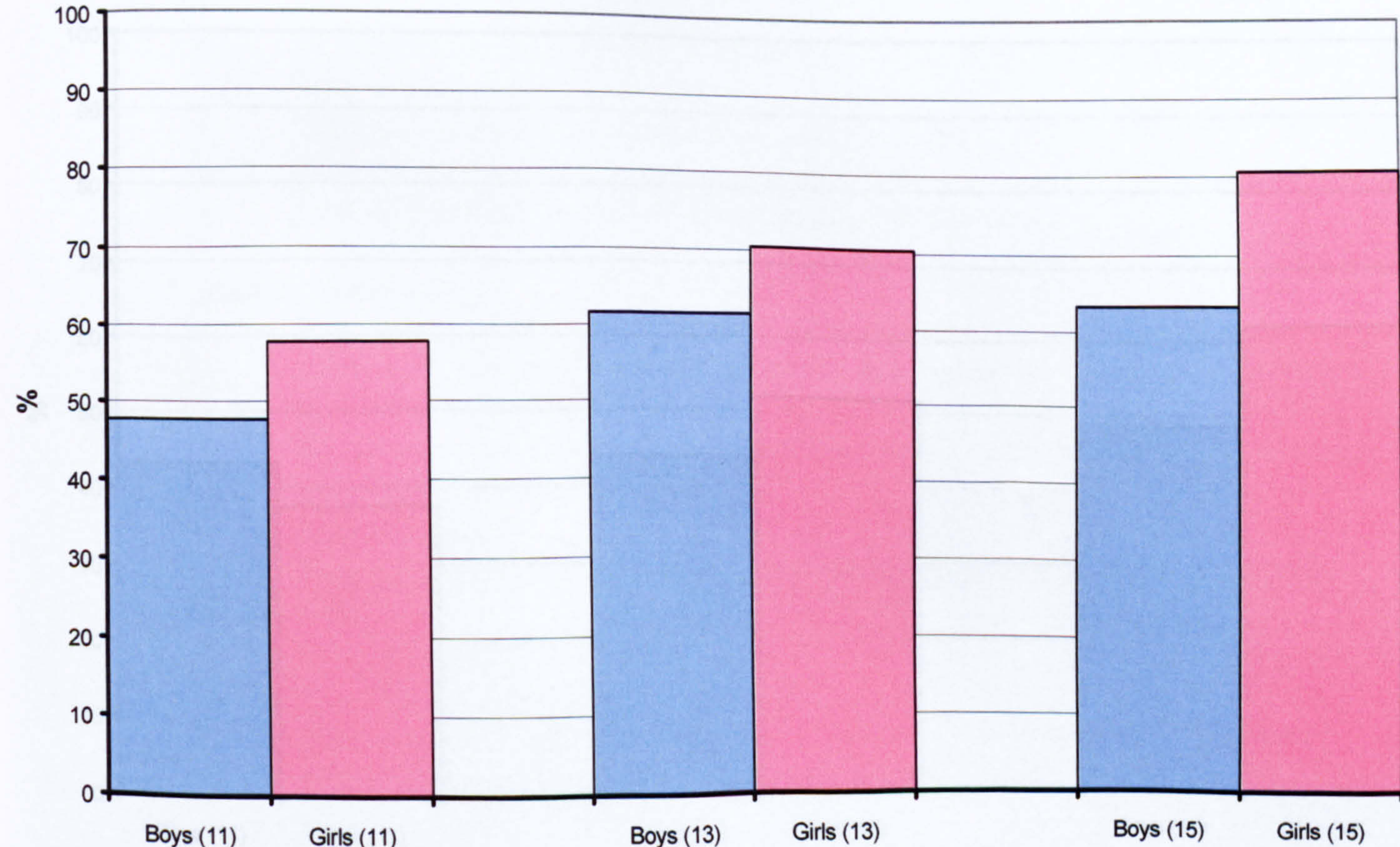
- a)...she was in class?
- b)...she was at home?
- c)...she was out with friends?

Stomach Ache



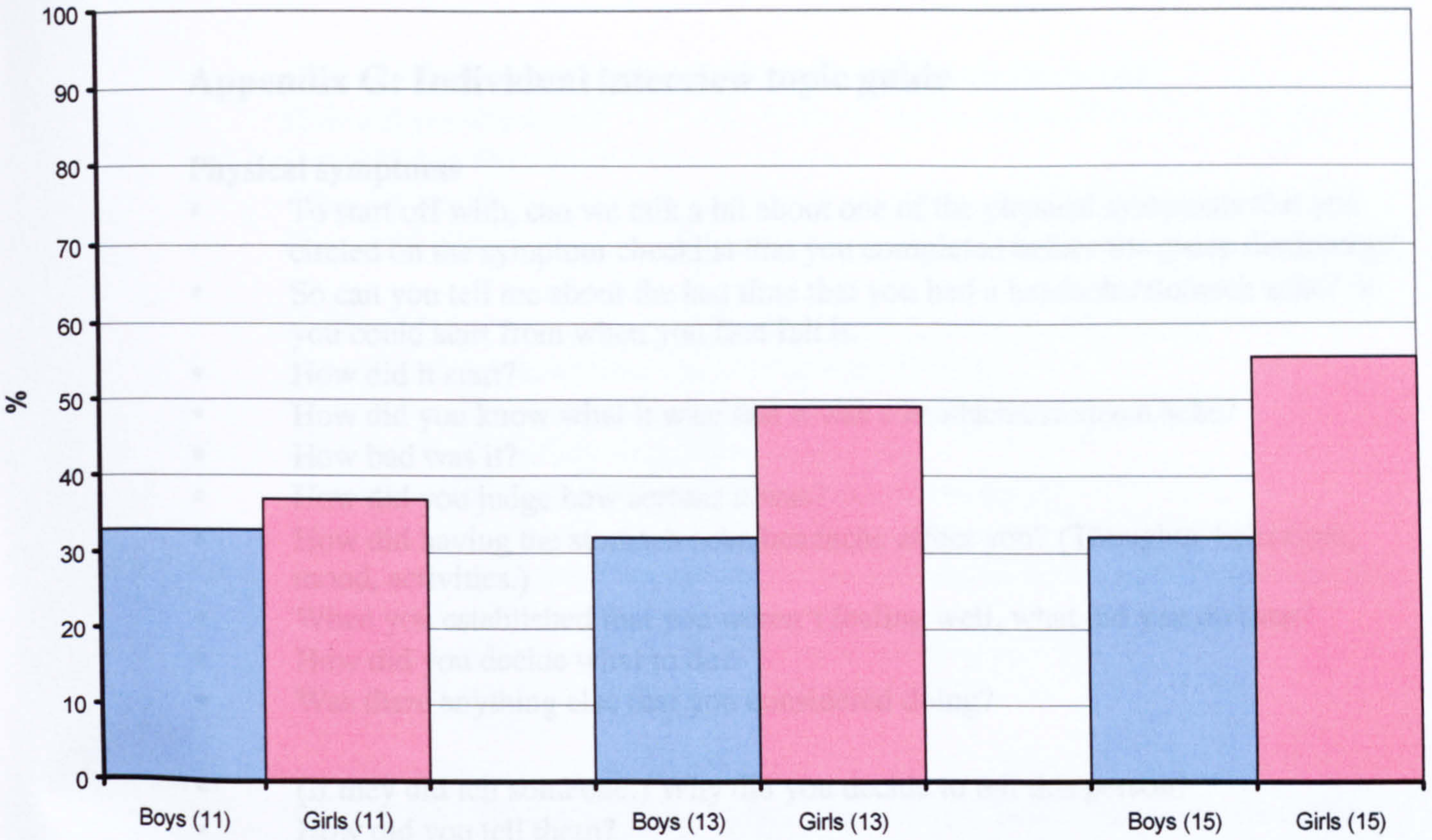
% of boys and girls who reported having stomach aches at ages 11, 13 and 15.

Headache



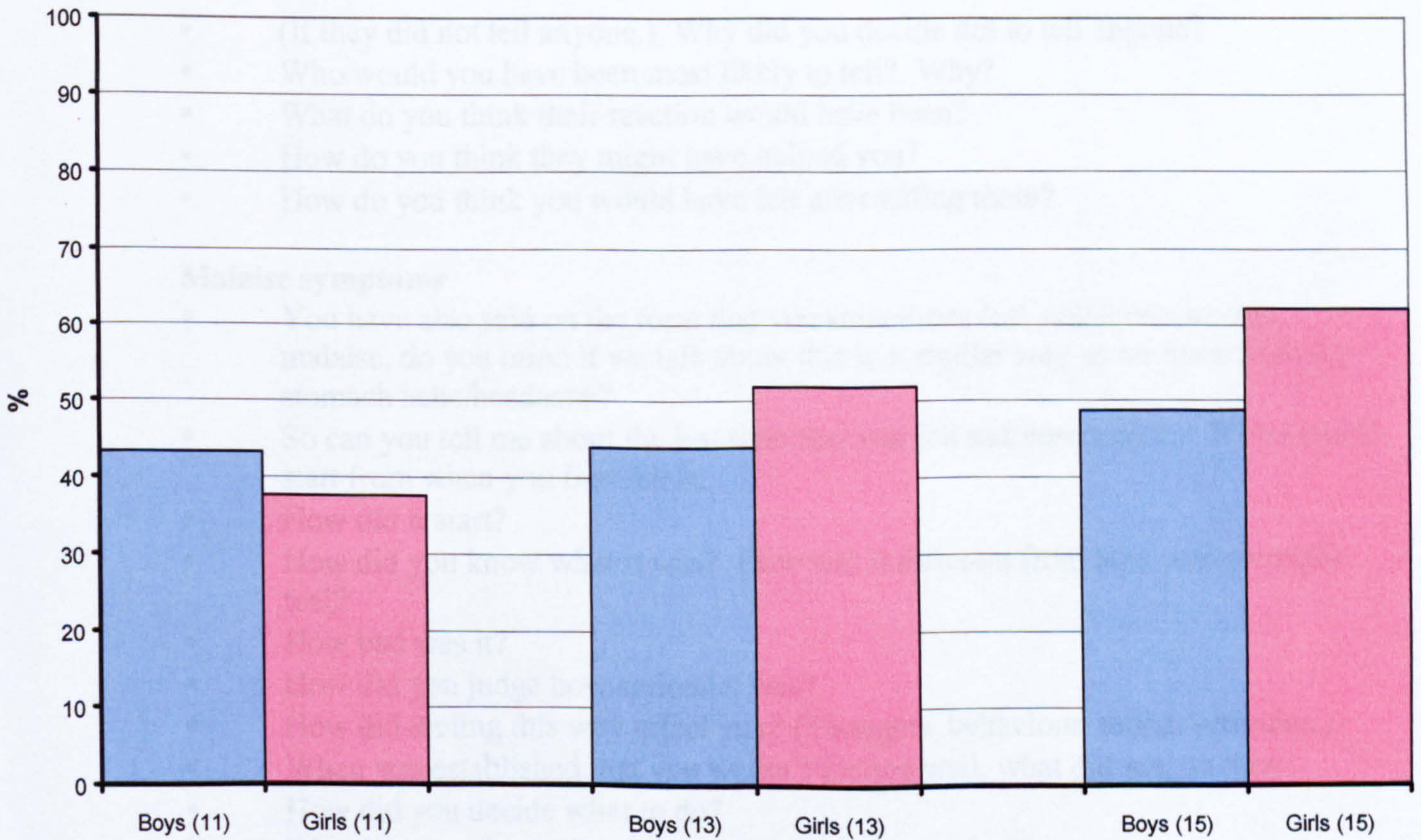
% of boys and girls who reported having headaches at ages 11, 13 and 15.

Sad, unhappy or low



% of boys and girls who reported feeling sad, unhappy or low at ages 11, 13 and 15.

Irritable/bad tempered



% of boys and girls who reported feeling irritable and bad tempered at ages 11, 13 and 15.

Appendix G: Individual interview topic guide

Physical symptoms

- To start off with, can we talk a bit about one of the physical symptoms that you circled on the symptom checklist that you completed before the group discussion?
- So can you tell me about the last time that you had a headache/stomach ache? If you could start from when you first felt it.
- How did it start?
- How did you know what it was/ that it was a headache/stomach ache?
- How bad was it?
- How did you judge how serious it was?
- How did having the stomach ache/headache affect you? (Thoughts, behaviour, mood, activities.)
- When you established that you weren't feeling well, what did you do then?
- How did you decide what to do?
- Was there anything else that you considered doing?

- (If they did tell someone.) Why did you decide to tell this person?
- How did you tell them?
- How did they react?
- What happened then?
- How did you feel after telling them? Did you feel that they helped you?

- (If they did not tell anyone.) Why did you decide not to tell anyone?
- Who would you have been most likely to tell? Why?
- What do you think their reaction would have been?
- How do you think they might have helped you?
- How do you think you would have felt after telling them?

Malaise symptoms

- You have also said on the form that you sometimes feel sad/nervous/other malaise, do you mind if we talk about this in a similar way as we have done for stomach ache/headache?
- So can you tell me about the last time that you felt sad/nervous/etc? If you could start from when you first felt it.
- How did it start?
- How did you know what it was? How was it different from how you normally feel?
- How bad was it?
- How did you judge how serious it was?
- How did feeling this way affect you? (Thoughts, behaviour, mood, activities.)
- When you established that you weren't feeling well, what did you do then?
- How did you decide what to do?
- Was there anything else that you considered doing?

- (If they did tell someone.) Why did you decide to tell this person?
- How did you tell them?
- How did they react?
- What happened then?
- How did you feel after telling them? Did you feel they helped you?

- (If they did not tell anyone.) Why did you decide not to tell anyone?
- Who would you have been most likely to tell? Why?
- What do you think their reaction would have been?
- How do you think they might have helped you?
- How do you think you would have felt after telling them?

- (If sad/nervous/worried not circled.) What would you do if you were feeling a bit sad or low?
- Would you tell anyone? Who is that most likely to be? Why?
- Who would you be least likely to tell? Why?

Symptom Checklist

- Did you find the checklist that I gave you to fill out before the group discussion easy or difficult to complete?
- What in particular made it easy/difficult to do?
- Were some symptoms easier to remember than others?
- Which ones? Why do you think this is?
- Which ones were hardest to remember?
- Why?
- When you were filling the form, how did you decide what symptoms you would circle?
- Did anything else influence you when doing this?
- In other research projects, when these forms have been handed out to boys and girls your age and a bit older, as they get older more girls circle certain symptoms than boys, can you think of any explanations as to why this might be? (*Show graphs to explain, if necessary.)
- Do you think it's the case that girls really do get more symptoms and boys get less?
- What other explanations can you think of?

Age

- These graphs also show changes with age.
- (Older) How would you describe the way you react to feeling unwell now compared to a couple of years ago?
- What has changed/stayed the same? (Thoughts, behaviour etc.)
- Why do you think this has changed/stayed the same?
- (Younger) Do you think the way you react to not feeling well will stay the same as it is now or will it change as you get older?
- What will change? In what ways? Why?

- Go back to talk about changes with age in graphs.
- What kinds of things do you think might cause the gap between girls and boys to get bigger as they get older?
- What things change for boys and girls as they get older that make their experiences different?

Peer relationships

- How would you describe your friends or the group of people you hang around with?
- Would you say they are quite a popular group in the school?
- If you started to feel unwell when with your friends, what would you do?
- Can you give me any examples of something like this happening to you?
- Would you be able to tell your friends about any kind of symptom- say a headache or feeling sad?
- How do you think they would react to each of these?
- Would there be any symptoms or health worries that you wouldn't feel comfortable telling them? Why?
- How do you know what friends you could talk to? What would a friend that you could talk to about these things be like?
- What about if a friend told you that they were feeling depressed, how would you react?
- In some group discussions people have talked about how it is brave to cope with your feelings on your own and in others people have said it is more courageous to tell, what do you think?
- Do you think these kind of ideas about what it means to complain of feeling ill or sad influence what people your age do when they don't feel well?
- How does it affect them? (Thoughts, behaviour etc.)
- Do they influence you? How? In what ways?
- Does it influence boys or girls more? Examples?
- Are there certain symptoms that boys would be less willing to tell about? Which ones? Why?
- What about girls, is it the same for them? Which symptoms? Why/why not?
- In some groups people have said that people who are seen as wimps are unpopular, what do you think? Why might they be less popular?
- How would you feel if people thought you were weak or called you weak?

Stereotypes

- Do you know what gender stereotypes are? (Younger – explain if don't know.) (Fixed ideas that say that boys should behave in certain ways and that girls should behave in certain ways, but that boys and girls should be quite different from each other.)
- What kinds of gender stereotypes are there about the ways that girls should behave?
- What about boys?

- How do you learn about and become aware of these? When? From which sources?
- How do gender stereotypes relate to what boys and girls are expected to do when they don't feel well?
- Do you think that your behaviour when you don't feel well is affected by stereotypical ideas and expectations? (why? in what ways? any examples?)
- Do you think that the behaviour of boys/girls is affected by stereotypical ideas and expectations? (why? in what ways? any examples?)
- Who is affected more by these ideas? In what ways are they affected? Why are they affected more?

Appendix G

