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## Ungdata, Mental Health and Gender Differences

*A Study of Gendered Mental Health Re-enactments  
in Ungdata's dLTC Youth Surveys*

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*Marthe Schille-Rognmo, 15. May 2017*

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*'There are systematic gender differences in the health of adolescents(...)*

*Nearly 25 percent of girls from the age of 15-16 struggle with depressive symptoms, approximately 20 percent with daily physical health issues and as many as every third female is dissatisfied with herself'*

NOVA 2015

*'There is a lot of talk about mental health, and with that it seems like there are more who struggle. I think it is on the verge of becoming a trend among girls to have a mental illness because there is so much emphasis on it.'*

'Mia' (17)

# 1 Introduction

A vast cross-national data collection scheme reports that nearly 25 percent of adolescent females, one in every four girls, struggle with depressive symptoms. In contrast, the rates for boys of the same age are approximately one third of this number (NOVA, 2015, Bakken, 2016). Several aspects of this conclusion prompted my interest; the high numbers themselves, the considerable gender differences reported and the severity of the diagnostic term applied. As a nurse educator, I have been increasingly interested in the philosophy of science and the traditions of knowledge production. As such, my initial reaction was to explore how these results came to be and in doing so targeting my attention on the social processes involved in the data collection scheme.

This thesis explores the relationship between the reported gender differences in mental health among Norwegian adolescents and the cross-national survey scheme responsible for *unearthing* them. Rather than looking to the teenage girls themselves to find causal explanations for the high levels of depressive symptoms, this study aims to examine whether processes within the survey system itself produces a biased image of gender differences in mental health.

## 1.1 Aim of project/research question

The primary aim of this project is to gain insight into the influence of the Ungdata research on the subjects of their study. Based on a notion of recursivity, I seek to find out whether the Ungdata survey system and subsequent media coverage could have been a contributing factor to the reported gender differences among adolescents.

## 1.2 Rationale for undertaking the research project

This project is situated in the context of the tendency of medicalisation. There is a propensity in society towards an expanding interpretation of more and more human behaviours and conditions as something deviant, in need of mapping and early intervention. We redefine an increasing number of human qualities and characteristics as signs of disease with subsequent diagnostic labels (Conrad, 2008). Furthermore, an increased focus on health promotion and disease prevention throughout the last decades has been accompanied by ways in which to monitor populations for such mental health risk factors and early signs of disease (St.meld.19, 2014-2015, Folkehelseinstituttet, 2016:1). In the last five years, a new cross-national data collection scheme, initiated and supported by Norwegian governmental authorities, has emerged as just the kind of population health mapping tool needed by local and governmental agencies.

The data collection scheme, aptly named Ungdata<sup>1</sup>, is a collaboration between the Norwegian Social Research Institute (NOVA), the seven regional Drug and Alcohol Competence Centres (KoRus) and the municipal sector organisation (KS). Ungdata could be seen as a digitalized Low Transaction Costs (dLTC) Survey. It consists of youth surveys offered free of charge to all Norwegian municipalities with the primary aim of providing an ‘overview of the local youth environment’ and a basis for local policy development and implementation, while simultaneously generating data for the national public health governance effort to reduce the overall burden of disease (NOVA, 2015).

Out of the 21 themes included in the Ungdata reports two have attracted the most academic attention: adolescent substance abuse (Pedersen and Bakken, 2016, Øia, 2013, Abebe et al., 2015, Pedersen et al., 2015, Nordfjærn et al., 2013) and mental health problems

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<sup>1</sup> Ungdata consists of the two Norwegian words *ung* and *data* and literally translates to *young data*, or perhaps more accurately *data about the young*.

(von Soest and Wichstrøm, 2014, Sletten, 2015a, Nordfjærn et al., 2012, Sletten and Bakken, 2016, Sletten, 2015b, Abebe et al., 2016). With regards to media attention, the conclusion that ‘nearly 25 percent of girls from the age of 15-16 struggle with depressive symptoms, approximately 20 percent with daily physical health issues and as many as every third female is dissatisfied with herself’ (NOVA, 2015) has had by far the most coverage. A quick internet search on articles containing the word *ungdata* in the two biggest newspapers in Norway, yields 56 and 76 results respectively (vg.no; 03.03.17 and aftenposten.no; 03.03.17). The majority of hits are fraught with negative connotations. Headlines such as ‘10th grade girls struggle the most with self-image’ (Ertesvåg et al., 2015) and ‘Norwegian girls strain themselves to the point of illness’ (Amundsen, 2014) have reached readers nationwide. Other media outlets have followed suit and television viewers have been able to tune into a range of programmes from fictional dramas to documentaries and debates focused on the psychological problems of teenagers<sup>2</sup>.

Throughout the last decade, several studies have shown an increase in mental suffering among teenage girls and there is no shortage of causal models that ascribe a negative influence on mental health to social changes taking place in the 21<sup>st</sup> century (Bor et al., 2014). Examples of such social changes include greater income inequalities (Pickett and Wilkinson, 2007, Wilkinson and Pickett, 2009, Luthar and Barkin, 2012, Langton et al., 2011, Sletten, 2015b), increased exposure to internet and social media (O’Keeffe and Clarke-Pearson, 2011, Carli et al., 2014, Primack et al., 2009), changes in family environments (Twenge, 2011, Richter et al., 2011) and body objectification and the social pressure of attractiveness (Tolman et al., 2006, von Soest and Wichstrøm, 2014). Most of the scientific articles on and about Ungdata aligns with these causal models. The majority of Ungdata writings are set within the

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<sup>2</sup>‘Jeg mot meg’ (NRK), ‘Sykt Perfekt’ (TV2), ‘Debatten: Ungdom og psykisk helse’ (NRK), ‘Helene flytter inn’ (NRK), ‘Innafor’ (NRK) and ‘Skam’ (NRK) are relevant examples of TV series depicting the psychological issues of teenagers.

epistemological framework of the project itself; presenting self-proclaimed *quality assured images* of the youth environment in question. There seems to be little discussion in the literature about whether the survey method, the normative nature of the themes or the questions used to determine mental ill-health (an eight-item revised version of the Hopkins Symptom Checklist-10) are sufficient to draw definite conclusions about the psychological state of Norwegian teenagers and its many associated causalities.

The NOVA conclusion that 1 out of 4 girls between the ages of 16-18 reports depressive symptoms (NOVA, 2015) may very well be accurate. From a sociological perspective on health and illness, it is nevertheless interesting that terminology from diagnostic manuals (DSM-4 and 5) is used as a means to uncover an ‘image of the local youth environment’ (NOVA, 2015). Furthermore, it raises questions on what the effects of these images on the population repetitively studied might be.

This line of reasoning invokes a series of questions. If one of the causes of teenage depression is the normative pressure of 21st century living, is it then wise to measure this effect by asking questions that are medical and highly normative in nature? How does the survey itself affect males and females respectively? May the way the questions are formulated and framed, the practical execution of the survey and the expectations created within the mapping system produce the image of gender differences in mental health as opposed to discovering real divergence?

If one assumes that a diagnosis is created, made visible and validated through social processes where scientific, political, cultural and financial factors play a part (Lian, 2012), is it not then relevant to question whether the Ungdata survey system and the municipalities that commission it are contributing to, rather than subtracting from, the potential problem? In our eagerness to get ahead of potential public health issues, might we be contributing to the medicalisation process: exposing an entire generation of teenage girls to a diagnosis of

depression in our eagerness to help them deal with what might just be the normal emotional make-up of their time? This is what Sissel Gran calls ‘a reaction to being overwhelmed faced with a thousand internalized demands<sup>3</sup>’ (2014) as opposed to a mental illness. Furthermore, what are the consequences of such a diagnostic characterisation?

A diagnosis might be understood as a label of deviance that affects our perception of self as well as influencing how others see and treat us (Lian, 2014). Our identity is not only constructed by the narratives regarding us, but this narrative and our perception-of-self, our social identity, recursively influence how we act (Nelson, 2001, Gee, 2014). If one accepts these notions, it would be relevant to find out in what way the Ungdata research and subsequent diagnostic labels have affected the perception-of-self. Moreover, and in extension of this, if and how these diagnostic narratives influence the “box-ticking behaviour” of teenage girls when they participate in the Ungdata survey.

### **1.3 Theoretical requirements and conceptual framework**

The theoretical framework and methodological approach chosen to explore the relationship between the survey system and the subjects of the study needed to enable me to move out of the epidemiological frame *embedded* in Ungdata. My theoretical requirements when embarking on this research were firstly that the theories chosen enabled me to understand the different styles of generating meaning, between Ungdata and their *strong calculations* on the one hand, and the teenagers’ reception and adaptation of the Ungdata results on the other. Secondly, I needed a theoretical framework that enabled me to contrast the linear logic and causal explanations seen in the Ungdata mapping system with an understanding of knowledge production as self-generating and self-transforming social processes. Thirdly, I needed

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<sup>3</sup> My translation. Original quote: “en overveldelsesreaksjon i møte med de tusen internaliserte krav” Morgenbladet 26.09.14.

theories that shed light on the relationship between knowledge production and public health governance. I will return to these theoretical issues later. Key concepts and theories and their implications for the analysis will be presented in a later chapter. It is however necessary to introduce some ontological, epistemological and conceptual perspectives already at this point.

Theories and scientific practices shape our assumptions about existence and definition of reality (ontology) as well as what counts as knowledge (epistemology) (Hatch, 2006). The representational notion that reality comes first and that scientific practices simply mirrors it may however very well be challenged. In accordance with the concept of an *inversed relation between epistemology and ontology* (Woolgar, 1988), it makes perfect sense to explore whether Ungdata's scientific practices, based on the epistemological understanding within the knowledge production process, generate realities. Callon (2007) recognises this as a 'performative turn' (pp.311-354), an account of how scientific practices *perform*, what they *do* as opposed to *show* and how they *enact* (Mol, 2002, p.44) as opposed to *depict* realities. Scientific practices do not just present something already there, but have 'powerful productive consequences' of their own (Law, 2004, p.56).

If one applies this understanding and examines the Ungdata knowledge production process as a *reality-producing machine* through which the world (ontology) is formed, as opposed to the prevailing image of an objective method dealing with *true* or *actual* welfare issues, the way to account for variables, factors and phenomena within the Ungdata universe also shifts. Rather than viewing gender and depressive symptoms as *stable categories* that correlate, my attention is focused on how teenage girls come to be *categorised* and *classified* as depressed and how connections between the screening system, the political processes that accredit it, and the media attention that enhance it, affect the adolescent subjects' collective identities and their "box-ticking behaviour". These are the *recursive processes* between knowledge and reality.

The distinction between Ungdata as a *portrayer* of mental health and Ungdata as *producer* of mental health images, or between Ungdata's scientific claims as a *representation* of reality and being a *contributing cause* of reality, has further implications for how one *explains* and *explores* gender differences in mental health. In the former, one needs to look to the teenage girls themselves, their lives, societal and environmental risk factors, their relations and coping mechanisms to find the explanation for the increase in psychological problems among females (Sletten and Bakken, 2016). In other words, one stays *inside* the onto-epistemological frame to which Ungdata subscribes, relying on the distinction between dependent and independent variables underlying its causal models. In the latter, within the frame of performativity, one might instead explore accounts for the ways in which the public health image of depression among adolescent females is produced in the Ungdata survey system, in accordance with John Law's assertion that 'method works not simply by detecting but also by amplifying a reality' (2004 p.116).

#### **1.4 Methodological implications**

In the previous section, I have tried to describe how scientific claims can be understood as versions of the reality they profess to represent. The scientific practices, or performances, carried into effect are contingent on the onto-epistemological understanding within any scientific study (Law and Urry, 2004). My study relies heavily on the ability to retain a critical distance from the onto-epistemological presuppositions within the Ungdata knowledge production system. There might be a difference between what Ungdata does and what it aims and claims to do. It is only through the empirical investigation of *enactment* or *performance* that it becomes apparent how knowledge is *done* or what knowledge *does*' (Wackers and Markussen, 2015, p.303).

Furthermore, I need to be attentive to tensions between the epistemological understanding embedded in the Ungdata system on the one hand, and the perceptions of the recipients, that is what recipients do with Ungdata results, on the other. All the while, I had to remain conscious of the premises of my own perspective, the onto-epistemological assumptions within my theoretical framework and the methodological implications this would have on my research.

It was evident that there was a need for collection of different kinds of data related to the various aspects of the knowledge production system in order to present a coherent account of the recursive processes at play in the Ungdata survey scheme. This has resulted in the use of qualitative methods to explore perceptions and connections. This was done firstly through focus group discussions with a selection of teenagers and secondly, but no less importantly, through the analysis of NOVA documents. In addition, various political documents, newspaper articles and other media presentations relating to Ungdata and mental health have served as secondary sources. Details of which analytical methods have been applied to which types of data will be described further in Chapter 3. It is nevertheless essential to call attention to the fact that discussion throughout this thesis will largely be performative.

One of the central criteria for solid scientific research is the coherence between one's ontological understanding, theoretical framework, methodology and empirical data (Høyer, 2012). In relating to vastly different types of empirical data on various levels, I needed to be able to poke and prod at them and navigate between them in ways that permitted a certain level of flexibility. In the same way that one would use different tools to examine e.g. bacteria (microscope) and animal migration (GPS tracking), both methods would be highly appropriate to combine if your area of interest was fish migration due to oceanic toxicity. I too needed to use different analytical tools and methods in order to provide a plausible and coherent version of the recursive processes concerning Ungdata. The reflections of teenagers

are of a completely different nature from, for example, the wording in a diagnostic manual and therefore analytical *uniformity* would not only be impossible, but downright nonsensical.

Katie King uses the metaphor of google maps in the introduction to her book ‘Networked Reenactments’ (2011), *zooming in* for a detailed view of specific backyards or *panning out* for a wider perspective on the geographical area, to account for how she shifts orientation and scale in order to explore different domains at play in her area of interest<sup>4</sup>. This metaphor is highly adaptable to how I relate to the various domains present in the Ungdata production processes. Google maps allows you to change between first-person view and map views, to combine or move between different types of maps<sup>5</sup> and to zoom in and out based on your research needs and wants. In a similar fashion, I will change my perspective and vary the intensity of scrutiny depending on the material in question. Sometimes my analysis will be *intensive*: zooming in on details, e.g. the exact wording of a survey question or a statement from a teenage subject. At other times, the writing will be *extensive*: panning out to see the bigger picture, say how the Ungdata results correspond with other political or populist tendencies in society.

Throughout this thesis, I seek to scope and scale among three domains in order to explore Ungdata as a producer of knowledge and explain possible recursive effects:

- **knowledge production:** that is to say, how knowledge is defined, its scientific practices, materialities and technologies.
- **governance,** viewing public health images as both a consequence of political attention as well as a scientific base for political responses.

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<sup>4</sup> Katie King (2011) Networked Reenactments explores transmedia storytelling across different platforms.

<sup>5</sup> Google maps operates with the following map types: *roadmap* displays the default road map view, *satellite* displays Google Earth satellite images, *hybrid* displays a mixture of normal and satellite views, *terrain* displays a physical map based on terrain information. Google. Map Types [Internet]. 2017. [Accessed 11 May 2017] Available from: <https://developers.google.com/maps/documentation/javascript/maptypes>.

- **collective identity formation**, where shared and supra-individual perceptions of a generation's state of mind and the attribution and acceptance of these collective attributes are influenced by the narratives relating them.

## 1.5 Overview of following chapters

**Chapter 2** introduces key concepts and theories and concludes with implications for the analysis. **Chapter 3** accounts for the qualitative research design of the project. I report on the methodological choices made and discuss the challenges and implications related to these choices. In **Chapter 4**, the backdrop, epistemological framework and development of the Ungdata survey system as well as the structure, implementation and execution of the surveys themselves are presented in a descriptive manner to the extent they are relevant to the theme of this project. **Chapter 5** outline important elements that the further analysis rests on. Here I explore the epistemological basis, use of diagnostic terminology and transaction costs associated with Ungdata in regards to their recursive consequences. **Chapter 6** presents the findings from my focus groups and interprets how the mental health images generated by Ungdata relate to the “box-ticking behaviour of the teenage participants”. **Chapter 7** summarises my study and presents the implications derived from it.

## 2 Key concepts and theories

### 2.1 Introduction

In light of my theoretical requirements, my choice of conceptual framework falls within the traditions of Science and Technology Studies (STS), an interdisciplinary field where the primary area of interest has been the study of knowledge production and scientific practices. Within the traditions of STS the production of knowledge is understood as socially ingrained practices where cultural, social, historical and political factors affect scientific questions, research and results. Research within this tradition is concerned with understanding and explaining how scientific facts come about and which processes help shape them. This contrasts with a traditional epistemological understanding of science as autonomous and independent of society and social aspects (Skjølsvold, 2015).

Scholars within the field of STS has concerned themselves not only with the relations, interactions and influence between different actors involved in a knowledge production process, but expands to include objects, instruments and embodiments as equal participants in social networks (Latour, 2005). This approach known as Actor Network Theory (ANT) is applicable when studying the role of survey questions, computer systems, documents, media outlets and humans alike within the knowledge production processes of Ungdata. This way of thinking and speaking of materialities as entities of equal agency to humans will inform my writing throughout this thesis. In this chapter, I will present three key concepts that underline my further analysis.

## 2.2 Recursivity: derived from Latin; recurrere, meaning to run back<sup>6</sup>

One can hardly open a book about methodology, quantitative or qualitative, without finding a chapter on various forms of research bias: the multiple ways in which design, researchers, research questions or research technologies might influence the subject of study and consequently the outcomes of the study. No research is completely without bias. Bias, in some form or another, or to a smaller or a greater extent, is largely unavoidable. Any research process aims to understand these inherent biases in order to minimise the effect of influences, or at the very least acknowledge them. This accentuation of biases as intrinsic to any research might seem obvious and perhaps even superfluous; it is however an excellent introduction to the notion of recursivity as it will be used in the context of this thesis.

A recursive process is a process that refers back, returns to itself, a process that repeats an operation on a different set of materials, on products of itself or in the execution of a task (Wackers, 2009 p.94). We can expect to find recursive processes everywhere where we tend to say that a pattern is being produced and reproduced, and the term is used in various disciplines from mathematics to art.

Its use in the social sciences and in relating to research processes however is somewhat difficult to comprehend intuitively. This is maybe because it involves a substantial shift away from the linear logic more commonly associated with the causal modelling in quantitative research. In relations to the Ungdata knowledge production, we can find patterns of recursion when inquiring into such diverse connections as:

- How the use of a diagnostic checklist influences the data input.
- How the use of already existing infrastructures (schools, municipalities, digital technologies) influences response rates and municipal coverage.

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<sup>6</sup> OXFORD ENGLISH DICTIONARIES. 2017. *Recursivity* [Online]. Available: <https://en.oxforddictionaries.com/definition/recursivity> [Accessed 05.05.17].

- How the digital setting and limited time spent on answering each question influences the answers given.
- How the presentation of mental ill-health (through NOVA reports and media attention) influences teenage perception of self.
- How the mutual relationship between public health policies and statistics generated by Ungdata influences policies and the screening system respectively.

Not all of these relationships will be addressed in detail, neither is the list exhaustive, but these sorts of questions illustrate the applicability of recursivity as a perspective when viewing Ungdata as a social process of knowledge production.

When I explore what I identify as *recursive processes* within the Ungdata survey system, I do so in order to understand biases within the system and the effects of these influences. I explore how the knowledge production processes *act* and *interact*. To do this, one needs to look at not only how the outcomes are shaped by the methodologies, technologies and contexts they are produced in, but also how these outcomes in turn, through the narratives of a generation, *run back* to influence the teenage population. This population in the next instance provides the subjects of the subsequent round of surveys, creating what John Law describes as self-generating and self-transforming social processes, in which the social is both medium and outcome (Law, 1994, p.14-16).

### **2.3 Medicalisation and the processes that drive it.**

Medicalisation literally means *to make medical*. It has been defined as a ‘a process where non-medical problems become defined and treated as medical, usually in terms of illness or disorders’ which transforms aspects of everyday life into pathologies (Conrad, 2008, p.4). The concept of medicalisation is closely associated with the definition of health and illness, and

critics have expressed concern with the continuing shift of the boundaries between what is normal, and what is defined in terms of deficiencies and disease.

A discursive transformation has occurred where normal body functions become risk factors, subsequently becoming disease, which in turn demands medical attention or intervention. Rather than a pattern where people experiencing symptoms seek out health care professionals, we are witnessing a process where research findings indicate that people without symptoms are in need of health care professionals; a shift from early diagnostics toward presymptomatic diagnosis. There has been a shift in attention from treating those who *seek help* into actively targeting people who *normally feel healthy* (Skolbekken, 2008). Medicalisation is as such also a question of classification and the power that lies within such classifications in the way that health and illness are not objective variables (Bowker and Star, 2000). Where good health ends and illness starts has to be defined and is as much a pragmatic question as anything else (Svendsen, 2006).

Psychological illnesses possess an important social component and therefore cannot be seen as disconnected from their social and political context (Svendsen, 2006). Historically, medicalisation has been concerned with overdiagnosis and overmedication. Thus the medical profession and the pharmaceutical industry have been important drivers behind the medicalisation processes, but also social movements and patient organisations are seen as promoters for medicalisation (Conrad, 2008). Increasing political focus on early disease detection and risk prevention<sup>7</sup> has led to an explosion in the amount and type of risk factors and diseases we consider appropriate for monitoring (St.meld.47, 2008-2009, p.83-84). Mapping systems and screening tools have reached a considerable political status and

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<sup>7</sup> Examples on the increased national political attention on public health can for instance be seen in the extended public responsibilities and increased sphere of interest in St. melding nr. 47 (2009) and Lov om Folkehelsearbeid (Folkehelseloven) that became operational in 2012.

popularity, within society in general and public health efforts in particular, that is fashionable, a sign of proactivity, modernity and progress.

## 2.4 The power of numbers

In his book 'Powers of freedom: Reframing political thought' Nikolas Rose (1999) distinguishes between four sorts of political numbers (pp.197-232):

- *Numbers as determinative* to who holds power and whose claim to power is justified. Numbers, in this respect, confer legitimacy to politicians, authorities and institutions.
- *Numbers as diagnostic instruments* within liberal political reasoning where numbers have the ability to calibrate and quantify feelings, transforming lives and opinions into numeric scales and percentages.
- *Numbers make modern forms of government both possible and judgeable.* Possible because they make internal characteristics of population and society determinate, intelligible and calculable through, at least in part, numerical representations. Judgeable because they have become essential to the critical examination of authority.
- *Numbers as crucial techniques for modern government*, indispensable to the complex technologies through which government is exercised. Demographics, mortality and morbidity 'have become intrinsic to the formulation and justification of government' (p. 198).

I will not present a systematic exploration of the various Ungdata numbers in relation to these four dimensions of political power, although one could. There are however a couple of aspects which are important to involve as we move forward. The relations between numbers and politics Rose argues, are 'reciprocal and mutually constitutive'(1999 p.198). Numbers constitute what policies should concern themselves with, but also political judgement constitutes what to measure, how to measure it and how to present and interpret the results.

This is a recursive process with numbers influencing policies and policies influencing numbers in a continuous exchange. The relations between the statistics generated by Ungdata and local and national public health policies could easily be identified as such.

On the one hand, statistics on morbidity and identification of risk factors among adolescents influence policies on health promotion and disease prevention and have even come to dominate the political debate on mental health. On the other, the continued political emphasis on early detection of risk factors and the need for comparable data between groups determine how and what Ungdata measures, how these measurements are presented and to a large extent the afterlife of these numerical presentations. This recursive process also validates the already significant value put on statistical truth.

In her critique of the power and position of evidence-based public health, Vincanne Adams (2013, 2016) raises several critical questions regarding statistical truths in general. In order to challenge these numerical truths, Adams claims, one has to question the reliability of statistics and the objective knowledge they portray:

(...) outcomes of such studies are in some sense prefigured through the anticipatory logic of the statistical method (that is, their outcomes are produced by the very structure of the research design as opposed to being discovered by it) (2013 p.57).

Despite this, statistical methods are still advocated as the most impartial road to truth despite frequent criticisms of their claim on certainty from social scientists. This is done based on the notion that sufficient numbers in themselves will ensure reliability without question as to how those numbers came to be and what they actually stand for. Ungdata's numeric representation of the psychological wellbeing (or lack thereof) of teenagers could quite easily be conceived as both political numbers and entities of power, sacrificing complexity on the altar of p-values. The attention put on the municipal coverage and emphasis on the high response rate could easily be perceived to be signs of such high truth-values.

## 2.5 Implications for the analysis

As this presentation of key concepts suggests, I wish to employ a performative perspective on processes relating to Ungdata. The notions of recursivity, medicalisation and the power of numerical representations and statistical truths are central to my analysis. These concepts will form the underlying structure on which I build my arguments. I have chosen to operationalise these concepts by looking at 1) the transaction costs involved in the execution of the Ungdata surveys, 2) the process of medicalisation in the framing and phrasing of the survey questions, 3) Ungdata's constitutional power as a mapping system and 4) the perception, adaptation and employment of the Ungdata reported gender differences by teenage recipients.

I will divide my analysis into two parts. The first part, Chapter 5, provides an account of central elements within the survey system, how data become results, how input becomes outcome and *how psychological lives become numbers*. In chapter 6, I follow the data in the opposite direction, looking at what the results *do* in a wider context after they are presented. I do so in order to examine how results are manifested and embodied in teenagers to explore if and how outcomes become input and *numbers become lives*.

### 3 Methodology

In this chapter, I describe the methodological approach undertaken to explore the recursive relationship between the Ungdata survey system, the population health images portrayed and Norwegian teenagers. I will present my overall research design and my use of multiple methods as well as a multimodal form of analysis, where I utilise different kinds of materials and draw upon more than one analytical approach. The chapter will also discuss ethical issues and acknowledge limitations and potentialities of this study.

#### 3.1 Research site: Multiple methods

If there are multiple '*modes of ordering*' the world, with various logics, frames, styles, repertoires and discourses representing different ontologies that exist simultaneously, peacefully coexisting, in conflict, or both (Law and Mol, 2002, p.7), then I needed to choose my research site based on where these differences are in play. This is what Latour (1987) refers to as the places where 'science is in action' and Bijker et al identify as 'strategic research sites' where key aspects can be captured while complexities remain manageable (2012, p.185). In my study, this site is located at the intersection of a politically promoted, academically advanced survey scheme and the perception and apprehension of the teenagers being surveyed on the other. To be more specific, it is where the images of gender differences in mental health and how they are scientifically generated meets the understandings of the teenagers they are generated from.

In my attempt to explain and explore the quantitative research executed by Ungdata, a qualitative approach enabled me to illustrate how a multitude of comprehensions are possible (Riessman, 2008). To gain insight into the recursive effect of the mental health image presented based on the Ungdata surveys, I found that there was a need for a combination of

methods and the collection of different kinds of materials linked to the various aspects of the survey system to study different aspects of the same phenomenon. The purpose of this combination was not to cross-validate data, but to gain a more comprehensive perspective. This has resulted in the analysis of materials from focus group discussions and secondly, but no less importantly, the close reading of NOVA documents, including, but not limited to, the survey questions regarding mental health. Both types of materials were utilised and integrated throughout the study without any relative hierarchical value attributed to them.

### **3.2 Focus groups**

One series of data production took place through multi-stage, semi-structured focus group discussions. Focus group discussions are a process where the data forms through group interaction, but with a clear research driven agenda (Halkier, 2010). The reason for this methodological choice was to capture patterns of meaning that might occur due to the interactions between the participants and because of the group dynamics, and which might otherwise be lost in an individual depth interview (Halkier and Gjerpe, 2010).

Furthermore, focus groups are suited to highlight normative interpretations and constructions which might be of particular interest within a segment of the population where peer perceptions and peer constructions are paramount (Bloor, 2001). As I sought to gain knowledge of the influence of the Ungdata mental health images on teenagers as a group, it seemed prudent to seek this knowledge in a group setting. The potential disadvantage of this approach is of course that the experience of the individual may be overshadowed by the interpretations of the group as a whole (Bloor, 2001), in regards to my research question however, I considered this the most apt method.

The multi stage focus group discussions, three in all, took place in May and June of 2016. Participants were purposely sampled and recruited from one general studies form in a

local upper secondary school. I gained access to the participants through a contact in the school administration who then forwarded my request to all form teachers asking them for permission to visit their class, as to give information about my study. I wanted to recruit all participants from one form so that they would already know each other, this due to the interactional nature of focus groups. I was invited in and recruited a sufficient number of participants from the first form I visited, in fact, all the female pupils volunteered to take part in the study (n=12). The first focus group took place a week later during school hours and on school premises. I utilised an empty classroom where I placed the participants and myself in a circle. Audio was recorded in full and transcribed verbatim.

Since the issue of interest for the focus groups was based on the Ungdata conclusion that one out of four girls between the ages of 16-18 reported high levels of depressive symptoms (NOVA, 2015), it was only natural that the subjects of study would be teenagers in the same age bracket. The inclusion criteria were therefore informed by the mental health images themselves. Recruiting females between the ages of 17-18 would place them within the age bracket previously mentioned while simultaneously ensuring that they were old enough to have participated in the previous round of local Ungdata surveys which took place in 2013 (NOVA, 2013).

I revised the decision to exclusively include females ensuing the first focus group (FGf), due to the early identification of gender roles as a major theme. In light of assertions related to both male and female gender stereotypes, I considered it to be important to expand the sample to also encompass males and the focus-group design was revised. The remaining criteria were upheld, and the male participants (n=5) were recruited from the same form as the female participants. A second focus group including males only (FGm) took place two weeks later, immediately followed by a second stage focus group (FGm/f) where a selection of participants from the female focus group and the male focus group were combined (Figure1).

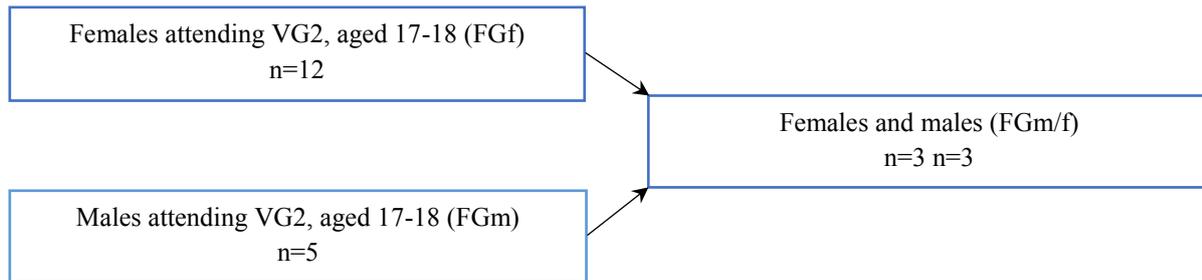


Figure 1 Focus groups

I developed a semi-structured focus group guide, identifying four main topics as a point of departure for both first-stage focus groups (FGf and FGm): ‘life as a teenager’, ‘the execution of the Ungdata survey’, ‘meetings with the Ungdata results’ and ‘gender differences in mental health’. The participants were given verbal and written information about the project a week prior to the first focus group discussion during my recruitment of informants. After an initial round of information and presentations, the first theme was introduced and the discussion started with a broad, open-ended question on that theme. The semi-structured guide included several sub-questions formulated with the intent of serving as aids to the discussion if deemed necessary by the moderator. My use of these question aids varied between the four themes and between the focus groups, with a particular note that decidedly more sub-questions and prodding comments were utilised during the all-male focus group. I developed no focus group guide for the second-stage focus group; instead, a short list of topics identified during the first-stage focus groups were used as basis for discussion. The duration of the focus groups were 55 minutes (FGf), 30 minutes (FGm) and 27 minutes (FGm/f) respectively.

### 3.3 Documents

Freeman and Sturdy (2015) identifies ‘the knowledge and meaning inscribed in (...) documents’ as entailing ‘particular ways of seeing, thinking and knowing’ (p.9). In line with

this reasoning the close reading of document served as much as a basis for my analysis as the materials from the focus groups. Considering my theoretical approach, I examined the NOVA documents as performative in the knowledge production processes, *enactors* in their own right, as opposed to an understanding of documents as merely mediators of human agenda.

The selection of documents was purposeful, and consisted of four of the seven published knowledge summaries (NOVA-reports) and three methodological/procedural documents (Table 1). The knowledge summaries I selected consisted of the three most recent national reports (NR 14-16), covering Ungdata results between 2012 and 2016, as well as one NOVA-paper specifically addressing trends in mental health (NRMH). The selected methodological/procedural documents included the two papers (M1-M2) made accessible under the heading of 'Methods and Documentation' at Ungdata.no as well as a NOVA-paper (M3) about the implementation and execution of the survey scheme in the municipalities. These three documents offer as extensive and comprehensive accounts of the implementation, execution and methodologies of the Ungdata survey scheme as I could find. All of the documents are accessible online at Ungdata.no.

My analysis of the documents was confined to sections relating specifically to mental health and the procurement of data on this theme, contextual information about the implementation and execution of the survey in general, and those sections that addressed, explicitly or implicitly, the onto-epistemological framing of the survey system. In addition, the Ungdata website, scientific articles on and about Ungdata, newspaper articles and other media communications served as secondary sources, providing contextual material from which the knowledge production processes and recursive influences could be understood.

Label	Documents selected	Data analysed
	<b>Knowledge summaries:</b>	
NR14	NOVA (2014). Ungdata. Nasjonale resultater 2013. Nova Rapport 10/14.	Public health images presented relating to mental health.
NR15	NOVA (2015). Ungdata. Nasjonale resultater 2014. Nova Rapport 7/15.	Language used Visual expressions
NR16	Bakken (2016). Ungdata. Nasjonale resultater 2016. Nova Rapport 8/16.	Epistemological framing Causal explanations for gender differences in mental health
NRPH	Sletten and Bakken (2016). Psykiske helseplager blant ungdom - tidstrender og samfunnsmessige forklaringer. NOVA Notat 4/16.	Societal explanations of gender differences in mental health
	<b>Methodological and procedural documents</b>	
M1	Frøyland (2015). Ungdata - Lokale ungdomsundersøkelser. Dokumentasjon av variablene i spørreskjemaet. NOVA 2015	Contextual data on the implementation and execution of the Ungdata digital surveys. Participant time spent on various aspects of the survey,
M2	NOVA (2013). Ungdata 2010-2013. Metode og dokumentasjon. NOVA 2013.	Demographic statistics.
M3	Sletten and Hartberg (2015). Ungdata. Erfaringer fra Ungdataundersøkelser i norske kommuner. NOVA Notat 11/15	Onto-Epistemological framing

Table 1 Documents selected and data analysed

### 3.4 Narrative methods

The method, or should I say methods, of narrative analysis in this thesis are not to be seen as a prescriptive methodology, which, if followed conscientiously, guarantees valid results. Within dialogical narrative analysis as presented by Arthur Frank (2010) and Catherine K. Riessman (2008) methods are not to be understood as prescriptions. There are no *absolute rules, steps* or *directions*. Rather they are to be seen as a practice of criticism which at least partly break with what Kuhn calls ‘normal science’ (1963). They represent a process of analytic and interpretive craftsmanship, a ‘movement of thought’ (Rabinow and Rose [1994] quoted in Frank 2010, p.74.) which implies motion, reciprocity and constant change. In such a method, the conceptual tools are chosen by the researcher because they correspond to and interact with the practices and problems being analysed. ‘If dialogical narrative analysis is a practice of

criticism that seeks movement of thought, its work is to pose questions and then let those who do analyses decide which of these questions are the most useful to emphasize' (Frank, 2010, p.74).

In dialogical narrative analysis, the basis for all the posed questions according to Frank is that of *what is at stake and for whom*. This includes the narrator of the story, the central figures (or objects) of the narrative and listeners to the story. The analysis of narratives revolves around how the various stories and the particular way they are expressed define and redefine this underlying concept of what is at stake and for whom, as such stories are *inherently performative*. By setting terms in which lives are narratable, they create conditions for improvement or diminution. '*How our lives become stories*' turns to '*how our stories become lives*' (p. 75). Frank's perspectives on narrative methods have greatly informed the analytical approach, in particular in relation to the material from focus group discussions.

I have supplemented Frank's ideas and general philosophies with the methodology of critical discourse analysis as presented by John Paul Gee (2014). This was important to me, especially in the close reading of NOVA documents and in the interrelation of the documents with themes identified in the focus group discussions. Although Gee in no way presents a "how to manual" for doing discourse analysis, he offers more of a toolkit than Frank and Riessman, which is an aspect much appreciated by the novice researcher in me. In critical discourse analysis the emphasis is placed not only on the description or explanation of how language works, but also on speaking to 'institutional, social or political issues, problems or controversies in the world' (2014 p.9). Gee's discourse analysis has enabled me to analyse how language *enacts*, language as *doing* and *being* in addition to *saying*. It has enabled me to look at and for *significance, practices, identities, relationships, politics, connections, sign systems* and *knowledge*, what Gee terms the seven 'building tasks of language' (pp. 32-43), in the documents enrolled in Ungdata.

To describe the analytical process in a qualitative study is rarely an easy task. My study started out with the extensive reading of NOVA documents, associated articles and various media presentations about mental health. I also watched TV-series and listened to debates on the radio as part of the planning process. This approach was not a conscious part of the analytical process, but rather a way of gaining an impression of the topic I was planning to study. This superficial reading was important because it informed not only my choices of which materials to include and what type of information I could expect to find in the various documents, but it also informed the topics of the focus group guide and as such the direction of my research.

My analysis of the NOVA documents and the material from the focus groups took place simultaneously and in constant relation to each other. While the early reading of NOVA documents informed the direction of the focus groups, the analysis of the materials from the focus groups also informed the analytical approach toward the documents and vice versa. Furthermore, some themes were identified through the intensive focus on concrete textual formulations and observations, moving from codes via categories to themes and theories, while others were evident instantaneously. In addition, the analytical process I endeavoured upon when exploring evidence of recursivity in a knowledge production system is in large a question of choices and the opportunities perceived in the material. As such, the analytical approach is defined by subjective interpretation.

### **3.5 Ethical considerations**

This project was registered with the Norwegian Centre for Research Data (NSD) and followed national privacy requirements and ethical guidelines for the gathering, storing and processing of personal data. I informed the participants about the study and its intent, both verbally and in writing. Written consent was obtained from all participants and they were informed that

they could withdraw their consent at any time during the study. The participants have been anonymized by either referring only to the focus group or by giving them gender-appropriate pseudonyms.

### **3.6 Methodological reflections**

My aim with this study has not been to generalise knowledge I have obtained through focus group discussions or close reading of NOVA documents. Rather my objective has been to explore how processes associated with Ungdata could be interpreted. Generalisation is but one way of creating and accumulating scientific knowledge. That a qualitative method cannot formally be generalized, that does not mean that it cannot contribute to the collective processes of generating knowledge within any given scientific field or society.

This thesis says *something* about recursive consequences of a specific mapping system. This is not *the truth*, the *whole truth* and *nothing but the truth*. Neither is God present in any way, shape or form. This is *a truth*, or preferably, a *version* of reality. This version could have been different. Our scientific claims are as much reliant on what was left out as what was included. I have sought to tune in on certain areas of controversy in an attempt to identify elements in those places that speak of the recursive relationship between a survey system and the subjects of their study. My ambition is not to present an exhaustive and comprehensive display of every relevant and influential aspect of the knowledge production system that is Ungdata.

## 4 Ungdata

In this chapter, I present the backdrop, epistemological framework and development of the Ungdata survey system as well as the structure, implementation and execution of the surveys in a descriptive manner to the extent that they are relevant to the theme of my project. In doing so, I will to the best of my ability present the Ungdata survey scheme as it presents itself. Throughout this chapter I will highlight what is terminology used to portray the survey system in NOVA's own documentation. Note that if not otherwise specified any translations are my own.<sup>8</sup>

### 4.1 Ungdata

'Ungdata is a *quality assured* system designed to conduct youth surveys at the municipal level' (M1, p.8). The project is a collaboration between the Norwegian Social Research Institute (NOVA), the seven regional Drug and Alcohol Competence Centres (KoRus) and the municipal sector organisation (KS). Both NOVA and KoRus have a substantial history of conducting youth surveys as far back as the 1980s. A primary component in all of these early surveys was young people's relation to drugs, alcohol and tobacco, but other aspects of the youth environment were included in various forms and degrees.

As a consequence of complying with increasing requests for the possibility to compare data across different individual studies and populations, Ungdata was born as a coordinated and standardised survey system directed at various aspects of adolescent life. The development of Ungdata has been supported through grants from the Norwegian Directorate

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<sup>8</sup> Most, but not all, of NOVA documentation is in Norwegian. There are some texts in English, such as the survey questions, fact sheets and English versions of online documentation. Whenever I have used terms or wordings that are not NOVA's own translations, I have tried to find support for my renditions in articles on and about Ungdata, preferably articles written by NOVA's own researchers who have also written the official NOVA reports. There are however some instances where I have had to resort to translations which are exclusively my own.

of Health, the Ministry of Education and Research, the Ministry of Children, Equality and Social Inclusion and the Ministry of Justice and Public Security, and from 2015 onwards the Ungdata project has been financed through the National Budget (M1). NOVA is responsible for the national coordination of the project, while KoRus in collaboration with local actors is responsible for conducting the municipal surveys. The engineering firm Rambøll provides technical support and the digital solutions for the processing and adaptation of the data.

## 4.2 Objectives

Ungdata consists of local youth surveys offered free of charge to all Norwegian municipalities with the primary aim of giving an ‘overview of the local youth environment’ (NR15, p. 1) and a basis for local policy implementation, while simultaneously generating data for the national public health governance effort to reduce the overall disease burden (Robertson, 2011). The national data deriving from the Ungdata survey system is used both as grounds for comparison between municipalities as well as to produce a national report on the state of youth across the nation (M3). As of 2016, Ungdata results are integrated in the municipal public health profiles published by the Norwegian Institute of Public Health in addition to the national database administered by NOVA, which contains all conducted surveys.

It is however, an expressed objective that Ungdata should provide more than just knowledge accumulation; the survey system should be a ‘tool’ for the development and planning of municipal measures (M3, p.4). ‘Through the mapping of the local youth environment Ungdata is well suited as a basis for municipal planning and developmental work related to public health’ (M1, p.8). The primary areas of application of the surveys are presented as being ‘*local policy-making*’, ‘*strategic planning*’ and the ‘*development of preventive and promotive measures*’ in addition to acting as the ‘base in which to enter into dialogue with youth, parents and various municipal services’ (M3, pp 3-6). The power of the

Ungdata project derives to some degree from its applicability as reasoning for the implementation of new efforts and the further development of existing local level measures with all associated financial and professional incentives. As Ungdata continues to run in its seventh year, the system now generates ‘conclusions on trends and developments’ (NR16, p. 1), enabling the primary objectives of Ungdata to expand to also include *evaluation* of local preventive and health promotive efforts directed at youth in general and the teenage population in particular.

### **4.3 Scope**

The target population of the Ungdata survey system are youths and adolescents attending lower and upper secondary school, with the majority of the surveys carried out on lower secondary school pupils (n=224 400). In total 331 000 teenagers have participated in Ungdata from 2010-2016 covering 375 out of 426 municipalities across all seven Norwegian provinces. Ungdata has grown considerably since its inception. Since the first pilot survey in 2010 when 17 municipalities participated, it has expanded from 29 participating municipalities in 2011 to 45 in 2012, 111 in 2013 and 311 between 2014 and 2016, providing a coverage of 73% of municipalities (NR14, NR15, NR16, M2). Municipalities of all sizes and from all seven provinces have taken part, but there has been a clear under-representation of municipalities with fewer than 2000 inhabitants and municipalities from the northern region<sup>9</sup> (M2).

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<sup>9</sup> Nordland, Troms and Finnmark

#### **4.4 Area of interest**

The Ungdata survey system covers various aspects of the local youth environment. Not surprisingly, considering the involvement of the regional Drug and Alcohol Competence Centres (KoRus), questions relating to drug and alcohol abuse are present. The questionnaire however expands to include topics within themes such as relationship with parents and friends, recreational activities, academic standing and future aspirations, high-risk behaviour and violence as well as issues relating to health and well-being, including topics within both physical and mental health. To some degree, information on themes such as sexuality, cultural and religious values, politics and societal issues are also sought out (M1).

The questionnaire consists of a fixed, basic module. Additionally, a number of elective questions are offered in supplementary modules from which municipalities can choose based on needs and wants. The local authorities are also able to add self-composed questions to be used at the local level if deemed necessary. The fixed, basic module consists of 158 questions (NR16). The supplementary module, along with questions developed by the individual municipality, has the potential to reach an ample amount, however Ungdata recommends that the number of supplementary questions added should not exceed one hundred, giving a advised maximum of 250 questions (M1).

#### **4.5 Mental health topics**

The fixed, basic module of the questionnaire contains nineteen questions designed to measure mental health and ‘captures depressive symptoms’ (NR16, p.72). These consist of eight questions regarding depressive mood, six questions on perceived level of anxiety and five questions relating to self-image. In the first rounds of Ungdata surveys from 2010 to 2013 only the eight questions on depressive mood were part of the basic module, whereas the questions on anxiety and self-image were offered as part of the elective, supplementary

modules. Both latter sets of questions were included as part of the fixed module during the revision of the questionnaire in 2013 (M1).

Six of the eight questions regarding depressive mood are derived from a limited selection of questions from acknowledged, but more extensive checklists, the Hopkins Symptom Checklist (HSCL) (Derogatis et al., 1974) and the Depressive Mood Inventory (Kandel and Davies, 1982), in addition to two questions developed as part of the Ungdata survey (M1). All six questions relating to anxiety are adapted from HSCL, while the questions regarding self-worth are from a revised version of Global Self Worth from The Self-Perception Profile for Adolescents (SPPA) (Wichstrom, 1995). ‘These scales originally consist of a greater number of questions, but previous studies have shown that shorter variants have very high validity’ (M1, p. 41). The following is a complete list of the mental health questions on depression, anxiety and self-image as seen in the basic module of the survey. Note that the translations of the questions from Norwegian to English are Ungdata’s own (M1).

#### 4.5.1 In a depressive state of mind

<b>During the past week, have you been affected by any of the following issues?</b>
<i>1. Not been affected at all, 2. Not been affected much, 3. Been affected quite a lot, 4. Been affected a great deal.</i>
Felt that everything is a struggle
Had sleep problems
Felt unhappy, sad or depressed
Felt hopelessness about the future
Felt stiff or tense
Worried too much about things
Felt lonely
Been angry or aggressive

## 4.5.2 Anxiety

<b>During the past week, have you been affected by any of the following issues?</b> <i>1. Not been affected at all, 2. Not been affected much, 3. Been affected quite a lot, 4. Been affected a great deal.</i>
Suddenly felt scared for no reason
Felt constant fear or anxiety
Felt exhausted or dizzy
Been nervous or felt uneasy
Been easily moved to tears
Tended to blame yourself for things

## 4.5.3 Self-Image

<b>Below there are some statements suggesting how happy you are with your life.</b> <i>1. Very true, 2. Quite true, 3. Not very true, 4. Not at all true</i>
I am very happy with the way I am
I am often disappointed with myself
I do not like the way I live my life
I am generally happy with myself
I like myself the way I am

## 4.6 The practical execution of the survey

Although NOVA and the regional Drug and Alcohol Competence Centres (KoRus) are professionally responsible for the survey, the municipality and the local school administrators are in charge of the practical execution. ‘Through the Ungdata surveys, local government administrations and politicians gain knowledge on how the youth are doing and how they think of where they live’ (M3, p.5). There is room for local adjustments in how the survey is organised and carried out provided that it is in accordance with the Ungdata instruction guidelines that are developed with the intention of ‘ensuring data quality’, ‘protection of privacy’ and that ‘all surveys are carried out in a similar manner’ (M3).

The Ungdata material is collected during school hours, on school premises, in regular classrooms in the continuous presence of the class teacher or other selected adult. The

questionnaire is executed digitally through the Ungdata website using the students' own, or school computers, by logging in with a unique username and password. The adult present in the classroom during the survey is responsible for ensuring, in adherence with the instruction guidelines, that all students are informed of the objective of the survey as well as advised that participation is voluntary (M3).

The execution of the survey is estimated to be achievable within one school period of 45 minutes. However, the average time used on the basic module is only 17.3 minutes (18.9 min in lower secondary and 15.6 min in upper secondary school)<sup>10</sup>, well within the allotted 45 minutes (M2). If one divides time used by the number of questions in the basic module, the average time used per question is 0.12 minutes or 6.9 seconds (7.6 seconds in secondary and 6.2 seconds in upper secondary school). The school contexts in which the surveys are executed, in a manner of small personal inconvenience for the participants, is likely to be at least part of the reason for the consistently high response rate of 82% of lower secondary and 66% of upper secondary school pupils<sup>11</sup> (NR16).

#### **4.7 Epistemology**

'Our experience is that the vast majority take Ungdata seriously and that the survey therefore provides a true picture of the situation of youth in general' (NR16, p7). The Ungdata survey is described by NOVA as a quality-assured, standardised system able to accumulate and process vast amounts of data in a cost effective and time sensitive fashion facilitated by the advances in information and communication technologies. Ungdata produces and publishes current, extensive and wide-ranging public health images of the youth of the nation and in doing so is 'regarded as the most comprehensive source of information on adolescent health and well-

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<sup>10</sup> Calculated from Ungdata-based surveys that took place in autumn 2012

<sup>11</sup> 2014-2016

being at the municipal and national levels'(NOVA, 2016a). Ungdata is promoted as an example of a public health mapping system able to produce just the kind of *high quality scientific data* upon which evidence-based policies and practices are *conditioned* (Helse og Omsorgsdepartementet, 2013, World Health Organization, 2013).

Ungdata's influence and authority is derived from a combination of sources. The system is validated through traditional values within the science of epidemiology deriving from methodological advantages such as their large sample, high response rate and sound use of statistical processing (M1). Furthermore, the collaborative nature of the project, with joint venture partners at national, regional and municipal levels as well as association, participation and endorsement from governmental agencies lends gravity to the efforts. In addition, the newsworthiness of the results and the user friendly and graphically pleasing ways in which they are presented has allowed Ungdata to become one of the nation's most prominent mapping tools in modern public health research.

## 5 From truth to the production of truth

### 5.1 A critical take on the knowledge production processes.

In the previous chapter, I have presented the structure and implementation of the Ungdata survey as far as it is relevant to the theme of this thesis. I attempted to do so in a descriptive manner, staying within what I perceive to be the onto-epistemological framing of the system itself, as indicated by NOVA documents and their associated vocabulary. In this chapter, I shift away from the assumptions at play within Ungdata. Instead, from a theoretical perspective that allows me to view the mapping system as a knowledge production infrastructure, both material and social, which not merely *represents* the world but *actively produces it*, I will critically explore selected aspects of the epistemological basis, linguistic choices and transaction costs associated with Ungdata with regard to their recursive consequences.

### 5.2 Transaction costs and their consequences: Ungdata as a dLTC Survey

If there is power in statistical numbers (Rose, 1999), then the extraction of such numbers and the potency of such an endeavour is in part dependent on what I refer to as their *transaction costs*. In fact, I argue that much of Ungdata's success hinges on its cost-effectiveness as a mapping tool, which is in part due to low transaction costs and the use of already existing infrastructures.

The concept of transaction costs is a key aspect of economic theory and other social science, typically defined as 'the costs of undertaking a transaction and the opportunity costs of non-fulfilment of an efficient transaction' (Rao, 2002, xvi). In other words, how much does the process of transacting something cost and what are the costs associated with the transaction not taking place? Be advised that I use the word 'costs' in this respect not in a

monetary sense, but as *effort, sacrifice, labour* or *exertion*. The study and analysis of transaction costs is a discipline in its own right. For my purposes, however, I endeavour to use the term when referring to Ungdata as a digitalized Low Transaction Costs Survey (dLTC Survey) when claiming that a) Ungdata as a survey system has distinctly low transaction costs associated with it and b) this in turn has recursive consequences.

To illustrate what I mean by this I will contrast the process of obtaining a psychiatric diagnosis through, on the one hand, encounters with health care professionals<sup>12</sup> and, on the other hand, a rate of depression through a digital survey. I am doing so fully aware that in the former I am referring to an individual diagnosis and in the latter; I am referring to a classification of a group. Furthermore, the discursive-material form of the apparatus of measurement is constitutive for the phenomenon produced. Different apparatuses equals different phenomena, hence, the depressive symptoms reported by Ungdata and diagnoses set by psychiatrists do not have the same objective reference. Nonetheless, the comparison<sup>13</sup> illustrates what I mean by transaction costs and can be used as a gateway into a discussion of the recursive significance of such transaction costs.

Imagine that you are 17 years old and that you have been feeling down lately. You are unusually tired, cry often and for no apparent reason and you feel dejected and discouraged. You are starting to wonder if there might be something medically wrong with you. The road from this self-assessment to a potential diagnosis of depression down the line might go as follows. You might dwell on it for a time first, see if the feeling passes. Eventually you contact your GP. You might have to wait, days or even weeks, for an available appointment.

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<sup>12</sup> Health care professionals in this instance could refer to general practitioners (GP), psychologists or psychiatrists.

<sup>13</sup> Note that the comparison of the processes of a dLTC Survey with a doctor's appointment is done purely for the purpose of contrasting differences in transaction costs. I do not believe that they are addressing identical phenomena nor do I not hold encounters with health care professionals as examples of "best practice". The practices of generating diagnosis in health care settings are in no doubt also filled with processes worth examining critically.

Maybe you are nervous; even reschedule once or twice to not have the appointment clash with your upcoming driving lesson or a midterm paper. When the day comes, you have to show up at the medical centre, maybe even spend money and energy to get there. You have to hang around in the waiting room for a while. When it is your turn, you have to talk about why you have come; how you are feeling, doing and thinking. The doctor will hopefully listen. He or she might ask you some questions, fill in some checklists and take your vitals. You will in all likelihood get some bloodwork done<sup>14</sup>. You might be diagnosed with some form of depression right away, if the doctor judges your scores, symptoms and case history to be sufficiently consistent with the diagnostic criteria (Helsedirektoratet, 2009). More likely, you will be asked to return for another appointment when the bloodwork has come back from the lab, or you will be referred to someone else, a psychologist, psychiatrist or therapist of some kind. Meaning there will be other appointments, more waiting, more tests and more thinking and talking before an eventual diagnosis is set. Treatment, pharmaceutical or otherwise, will be agreed upon. Before you leave, you will have to pay for the appointment in accordance with national tariff regulations (Forskrift om dekning av utgifter hos lege, 2016:9).

Imagine instead a situation where you during school hours are informed about an upcoming digital survey. Free, anonymous, no particular preparation needed. Still, you might think about it, but “everyone” is doing it and it means there will be no chemistry lesson. When the day comes, you do the exact same thing you do every other day. You show up at the usual place (school), at the usual time and at some point during the day, you spend 17.3 minutes ticking a minimum of 158 checkboxes. Your index finger might be tired, but you do not have to say anything. You might hardly have to think. After a few days or weeks, the newspaper informs you that the screening has shown that ‘young girls struggle mentally<sup>15</sup>’. A

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<sup>14</sup> Relevant blood analysis to exclude somatic causes would be hemoglobin, CRP, ESR, leukocytes, HbA1c, FT4 and TSH, ALAT, creatinine, folate, Na, K, Ca, ferritin, Vitamin B12, Vitamin D and IgA-TG2.

<sup>15</sup>‘Unge jenter sliter psykisk’ Dagsavisen 27.08.14

representative from The Norwegian Directorate for Children, Youth and Family Affairs is interviewed. ‘The result is in no way surprising. This is something we know’ (Lindholm, 2014).

These hypothetical accounts illustrate how the effort, time and money involved differ between obtaining a diagnosis based on consultations with health care professionals and one obtained through a digital survey such as Ungdata. It seems obvious to say that the ways in which one *creates* such diagnostics has consequences for the diagnostic rates one obtains.

Ungdata surveys are implemented through a linear hierarchical system of execution. Responsibilities and duties are transferred to the regional KoRus centres, municipal councils, school administrations, teachers, digital technologies and in the final instance, the subjects themselves, who with the click of a button ‘*index*’ their emotional state into neat checkboxes appropriate for statistical processing (Day, 2014). Together with the political emphasis on population health surveillance, this system, utilising already existing technologies and institutions is one of the main reasons behind the rapid expansion of Ungdata.

There are two features of particular interest when discussing transaction costs within the Ungdata knowledge production system.

- The use of the school system as both the administrator and the stage of the survey.
- The use of digital technology and existing data infrastructures to collect, assemble and process data, as well as to publish results.

These two features affect statistical power and response rate as well as influence to what degree conclusions from the survey gain truth-value.

The use of the school system as both the administrator and the stage of the survey is of strategic importance, from the perspective of statistical power. The surveys are performed on school premises, during school hours, on the subjects own computers with school personnel

overseeing it (M2). Recruitment and execution are embedded in everyday school routines, negating many of the factors typically associated with low response rate (Fan and Yan, 2010). The consistent high response rate<sup>16</sup> of the survey speaks to this effect (M1). There is no real recruitment of participants, KoRuS recruits municipalities, but the teenagers themselves are recruited almost by default. The teenagers are advised in adherence with the instruction guidelines that participation in the survey is voluntary but the person giving them this information, and who stays present throughout, is the same form teacher (or other authoritative adult) which assigns them homework and decides on their grades (M3).

This mode of execution demands little in terms of administration but the lack of effort for the teenagers to participate is perhaps even more notable. The survey takes place on a regular school day, with regular classes before or/and after, with normal demands of attendance. The teenagers therefore do not have to do anything different from any other day. As one of the focus group participants described the process: ‘We show up, a survey happens, everybody moves on’ (FGm). The fact that the survey takes place in a school period where the students would otherwise have a normal lesson means that it might even be perceived as a break. One of the female participants described the digital survey as ‘a bit boring, but at least we got to go home early’ (FGf). As far as the execution of the survey goes, these two quotes were pretty much all explicitly said from both focus groups.

The use of digital technology and data infrastructures to collect, assemble and process information influence the knowledge generated in several ways. Data is produced not only in the processes of their collection, but also through the algorithms that *compile*, *scrub*, *mine* and *statistically present* them. The knowledge production within this digital processing has consequences and could also be explored as to their productive and recursive effect. Due to the constrictions of my thesis however I will not mention these aspects further, except to

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<sup>16</sup> Response rate: 82% of secondary- and 66% of upper-secondary school pupils

address how the digital nature of the survey influences the time spent answering the survey questions.

### **5.3 The value of time**

The predominant narrative from the focus groups on the execution of the digital survey was that of no detailed recollection. This was despite the fact that the last round of Ungdata took place only a week before the first focus group discussion. The Ungdata digital questionnaire consists of 21 different themes and between 158 and 250 questions<sup>17</sup> (Bakken, 2016). Hardly any of the participants could mention a single question and overall only six themes were mentioned, and then in very general terms. There were no perceptible differences between males and females on how well they remembered the Ungdata survey in terms of the questions and themes addressed within it. It seemed as if the survey had made strikingly little impact. I argue that this lack of memory speaks; not only of the low transaction costs previously mentioned, but that it makes problematic the certainty with which the Ungdata results are presented.

It takes the teenagers an average of 17.3 min to answer 158 questions. It is difficult not to wonder at this, less than 20 minutes to map everything from relationships with family and friends and after-school activities to mental and physical well-being. Producing a ‘quality assured image of the local youth environment’ (NR2) is quick work. The average time per survey question is 0.12 minutes, or 6.9 seconds (M2)<sup>18</sup>. In comparison, allocated time for doctors’ appointments in Norway is 15-20 minutes and a session with a psychologist 45-60

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<sup>17</sup> The number of questions depends on the amount of supplementary modules added to the survey. A minimum of 158 questions (basic module) and a recommended maximum of 250 questions.

<sup>18</sup> It is important to specify that NOVA themselves does not operate with this number in their report, rather they report the slightly higher number of 12 seconds which is the amount of time per question based on the time used for 95% of the pupils to complete the questionnaire. However, using NOVA’s own data on average time used, the seconds per question are calculated at 6.9.

minutes. In addition, the gender differences and the overall rate of depression among females are noticeably lower when based on diagnostics from consultations with health care professionals (Lunde, 2007, Eurostat, 2017). The reason for this discrepancy, if one were to adhere to an understanding that both refer to a common, objective referent, could be that of under-reporting or even errors in diagnosis (Jorm, 2000, Richardson and Katzenellenbogen, 2005, Olsson et al., 2005). Even so, it is relevant to question whether aspects of the survey system itself and characteristics associated with digital survey research influence the reported gender differences. Studies have shown that participant response fatigue (Egleston et al., 2011, Galesic and Bosnjak, 2009), rating dimensions and rating scales (Schwarz and Strack, 1985, Schwarz et al., 1991, Menold and Tausch, 2015, Schwarz, 1999), formulation and phrasing of questions (Tourangeau et al., 2000), available response options (Borgers et al., 2003) and the allocated *time to think* also play their part.

It is of course impossible to claim that the outcome of a question is exclusively dependent on the amount of time used on it. There is however, a consensus on what cognitive processes are involved when *optimally* answering survey questions. Krosnick (1999) outlines this process along a four-step pattern where each of the steps involve a great deal of cognitive work.

- The interpretation of the question and the deduction of the question's intent.
- The searching of memory for relevant information.
- The integration of retrieved information into a single judgement.
- Said judgement is translated into the selection of one of the offered alternatives.

This 'optimised' process where each cognitive step demands effort, but ensures an optimal answer to every question throughout the survey is considered the ideal. Life is however seldom ideal and respondents sometimes deal with the strain of answering copious amounts of questions by 'satisficing' or becoming increasingly mindless. Instead of expending the effort

to optimise answers, they compromise, becoming less thorough in some or all cognitive steps, integrating information carelessly or selecting responses imprecisely. In the worst-case scenario, they might even skip the retrieval and judgement steps altogether and respond based, not on relevant internal psychological cues, but rather on the wording of a question, perceived expectations or even select an answer arbitrarily (Vannette and Krosnick, 2014).

Naturally, how much time an optimised cognitive process takes will vary depending on a series of factors. It is nonetheless noteworthy that such a monumental conclusion as the one that a quarter of Norwegian teenage girls are suffering from depressive symptoms is solely based on a questionnaire that takes so little of the subjects' time and energy.

#### **5.4 The meaning of ✕: I am feeling particularly '3' today.**

If in a conversation you were asked if you during the last week have 'felt hopelessness about the future'<sup>19</sup>, your immediate response would most likely not be: "*Well, on a scale from one to four, I would say that my feeling of hopelessness is about a three*"<sup>20</sup>. Even if you were to answer this question from a physician in such terms, it is likely that you would be asked to elaborate, meaning that you would have to provide information about e.g. *why* you have felt such hopelessness lately, or in *which* situations the feeling has presented itself most strongly. Even *how* the last week differed from your normal state of hopefulness for instance. In doing so you would also have to *think* about what you *mean* by saying your feeling of hopelessness is '3'. Through reflection and substantiation, '3' would become more than a number. It would become meaningful, not only to the other, but also to yourself. Your narrative of it would contextualise and validate the number. You might even change your '3' to a '2' or a '4' as

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<sup>19</sup> One of the survey questions on depressive mood.

<sup>20</sup> For the record, and in reference to the prior section on time, just reading aloud the sentence *Well, on a scale from one to four I would say that my feeling of hopelessness is about a three* takes approximately 6 seconds. This in contrast with the average of 6,9 seconds total for reading and understanding a Ungdata survey question and its response options and providing an answer in the available checkboxes.

you had time to think about your initial assessment through dialogue (internal or with others). Even if you still wanted to present your state of hopelessness in a numerical value, you might have changed the range, saying it was 6 out of 10 or 55%. What rating scale is used has been shown to matter in terms of where participants place themselves on that scale (Schwarz et al., 1991).

The response options in Ungdata do not present themselves only as a numerical value. There are verbal labels attached to each value. This might take some of the wind out of my previous arguments, alleviating my concern about the substantiation of the numbers, because surely words are more *meaningful* than numbers. Normally I would be inclined to say yes. In a study by Toepoel and Dillman verbal labels are shown to take precedence over numbers when answering survey questions (2010). We are accustomed to talking and thinking in terms of words and therefore, words would most likely be a more accurate vessel for *transferring* emotional states. The labels in question and, dare I say it, the very nature of feelings speak against this.

The response options on mental health are not clear-cut and might demand a similar level of interpretation and assignment of individual meaning to them as the numbers. The questions about depressive mood and anxiety are all given the response options of ‘not been affected at all (1)’, ‘not been affected much (2)’, ‘been affected quite a lot (3)’ and ‘been affected a great deal (4)’<sup>21</sup>. None of these options are clear. What does it mean to have been ‘affected’? What is ‘much’? Where does ‘quite a lot’ end and ‘a great deal’ start? How often would one say you have to have felt nervous during the last week to say you were ‘affected a lot’ by nervousness? Twice during the last week? Three times? Or are we then talking about a ‘great deal’ of nervousness? For how long would a couple of flutters of dizziness have to

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<sup>21</sup> Ungdata’s own terminology and translations extracted from *Ungdata- Lokale ungdomsundersøkelser. Dokumentasjon av variablene i spørreskjemaet. NOVA 2015*

have been present for it to count as '*not affected much*' as opposed to '*not affected at all*'? There are of course no determinate demarcation lines here. The same goes for the labels on self-image ranging from '*very true (1)*' to '*not at all true (4)*'. The response options are themselves subjective. Due to this ambiguity, *not at all*, *not much*, *a lot* and *a great deal* might not be of any more substance than 1,2,3,4.

According to Nikolas Rose numbers are a force of power because of their ability to calibrate and quantify feelings: transforming lives and opinions into numeric scales and percentages (1999). Numbers make data interpretable and comparable. The request for comparable data across the nation was to a degree what led to the initiation of Ungdata. This numerical fixation, despite its inherent advantages, also has considerable disadvantages.

Concerns that do not fit into the kind of research that explicitly produces strong data either drop off the radar or are confined to forms applicable for statistical processing and numeric outcomes whether appropriate for such a process or not. This might be the case even for matters that in being counted would be turned into 'misrepresentations' of health (Adams, 2013, p.81-82). The quantification of psychological well-being as represented by Ungdata could easily be seen as such a 'misrepresentation'. The value of statistics should not be underestimated. Rather, our way of talking of numbers and statistics, as a claim to certainty and truth, needs to be explored (Adams, 2016). We lose something in this monistic numerical approach to mapping, particularly in relation to teenagers, and when such truths are arrived at through medicalised terms. In the following section, I zoom in on the framing and phrasing of some of the survey questions to elaborate on how Ungdata contributes to the medicalisation of teenagers.

## 5.5 Check here if you are mad, bad or sad: Medicalisation through survey questions

Nearly all of the Ungdata survey questions designed to measure mental health are negatively framed. When I say nearly all, I mean that 16 out of the total 19 questions<sup>22</sup> measuring mental health do so in terms of *ill-health*. They use words such as *'struggle'*, *'problem'*, *'worried'*, *'tense'*, *'stiff'*, *'scared'*, *'lonely'*, *'exhausted'*, *'uneasy'*, *'nervous'*, *'blame'* and *'disappointed'* to name a few (M1)<sup>23</sup>. When Ungdata asks about the psychological well-being of adolescents, they do so in a manner that does not make for happy reading. This emphasis on deficiencies, problems and shortcomings is maybe not surprising considering the source of the questions being DSM-IV derived diagnostic checklist. It is nevertheless notable and serious considering the survey is targeting a normal population of teenagers with the aim of providing an overview of the youth environment in general.

Furthermore, several of the questions are directly medicalising in their formulation. I will go as far as to say that some of the questions themselves produce images of unhealthy mental state in and of themselves. I will illustrate what I mean by this through a closer look at three of the questions, two of which are from the depressive mood question set and one from the anxiety question set (M1).

During the past week, have you been affected by any of the following issues?

- Felt unhappy, sad or depressed
- Been angry or aggressive
- Felt constant fear or anxiety

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<sup>22</sup> Total amount of questions within the theme of 'mental health' in the basic module. 8 questions on depressive mood, 6 questions about anxiety and 5 questions concerning self-image.

<sup>23</sup> Ungdata's own terminology and translations extracted from *Ungdata- Lokale ungdomsundersøkelser. Dokumentasjon av variablene i spørreskjemaet. NOVA 2015*

I would like to draw attention to two features of these questions: a) The simultaneous appearance of adjectives describing *normal states of emotions* and *diagnostic terminology and* b) the use of the connective word ‘*or*’.

‘Sadness’, ‘anger’ and ‘fear’ are normal emotions present in various intensities, at various points, in *every* human being. They are general and universal responses throughout life and included in Robert Plutchik's eight basic emotions (1997). ‘Depressed’, as in suffering from depression and ‘anxiety’ speaks to medical diagnosis, sickness and pathology as recognised in a range of anxiety and depressive disorders in various diagnostic manuals. ‘These disorders are diagnosable health conditions, and are distinct from feelings of sadness, stress or fear that anyone can experience from time to time in their lives’ (World Health Organization, 2017, p.5).

A similar medicalisation drive is present in the use of the term ‘aggressive’. Aggression is not to be seen as a generalised feeling, rather it is defined in terms of ‘offensive action, attack, or procedure (...) the practice of making assaults or attacks: offensive action in general’ (Oxford English Dictionaries online (2017)). It is also closely associated with mental disorders, especially those that fall under the DSM umbrella of ‘disruptive, impulse-control, and conduct disorders’ and/or ‘personality disorders’ (American Psychiatric Association, 2013). Although the term is not directly identified in one specific medical diagnosis, there is no ‘aggressive disorder’ in the International Classification of Diseases (ICD-10) for example; conduct disorders in particular are linked to aggressive behaviour and the violation of rules and social norms (World Health Organization, 2016a)

This leads us to the use of the connective word ‘*or*’. This tiny word, hardly noticeable when reading the question, is highly significant. *Or*, as used in these survey questions, means *either*. One or the other. Thus it follows that the question that asks whether the participants have ‘*felt unhappy, sad or depressed*’ during the last week *equates* unhappiness (the absence

of happiness) with sadness (normal emotion) or depression (mental disorder). The same goes for the other two examples:

- Angry (normal emotion of feeling resentment) *equate* aggression (violent conduct)
- Fear (normal emotion of feeling scared or being alarmed) *equate* anxiety (mental disorder).

This lack of differentiation between what are perfectly normal emotions, perhaps particularly in hormonal teenagers, is not only medicalising in and of itself. After all, a governmentally funded cross-national survey scheme is telling you that there is only an arbitrary line between feeling sad and being depressed. Furthermore, this pathologisation of language will have a considerable effect on the ‘representative image of Norwegian youth’ (NR16, p.5).

If I were to tick the checkbox representing ‘3: been affected quite a lot’ this input would be exactly the same whether I felt that I had been ‘a lot sad’ or ‘a lot depressed’ during the past week. The indexing does not allow for differentiation. A 3 is a 3 is a 3. A break up with a boyfriend, dissatisfaction with results from pop quizzes and a two-pound weight gain might read similarly to a response of serious dejection.

The three Ungdata questions selected to illustrate the medicalisation processes are not one-offs. I find that tendencies of medicalisation are, in various degrees, present in a large proportion of the questions designed to measure mental health. This in turn raises a serious question as to why and how the conclusions from the survey come to be that teenage girls suffer from *depressive symptoms* (NR13-16, NRMH) as opposed to more moderate, and less pathological, conclusions of for instance *being emotional* or *feeling overwhelmed*.

## 6 The enactment of gender identities

### 6.1 Introduction

While the previous chapter discussed aspects of the Ungdata knowledge production machinery, the low transaction costs associated, the use of diagnostic terminology and the medicalisation processes at work, I will now shift attention to the recursive influence of this knowledge production as it presents itself through focus groups with the teenagers themselves. So far, I have followed how information from Norwegian adolescents is sought, extracted and processed through the Ungdata system. Although these elements all have recursive consequences, the primary discussion has revolved around how input becomes output; moving from teenage girls to reported depression rates.

The premise for my research question however dictates that I follow the life of the Ungdata results after they are presented and re-presented. What does it look like when one rejects the linear logic and instead explores recursive effects? In other words, how do the results relate back to and influence the subjects whose inputs they are generated from in the first place? In this chapter, I explore gender-related differences and similarities, concurrence and dissensions identified through the analysis of the focus group discussions. Furthermore, I discuss how these could be understood as recursive consequences of a gender-biased narrative of which Ungdata takes a part.

Overall, the principal findings that derived from the focus groups are related to the tension between what the teenagers describe as essential aspects of being a teenager in general, and what I call *the enactment of gender roles* when encountering topics of mental health in particular. There were surprisingly few gender differences in the perception of interests, concerns and preoccupations when addressing topics not specifically pertaining to depression or mental health. Despite this, when faced with the Ungdata conclusions on depression or topics regarding psychological problems, there were perceptible differences

between the female and male focus groups. Contrary to expectations, however, these differences presented themselves not in the use of pathological terminology, in accounts of adversity or pressure, but rather in expressions of what is *typical* or *expected* of the respective gender to say, do or concern themselves with. In other words differences in how they *enact* their gender when encountering topics of mental health.

## **6.2 Life as a teenager: The dog that didn't bark in the night-time.**

In addition to bringing into attention all that was said, done and hinted at during the focus group discussions, it might be of equal importance to point out what was not there. In this respect, one of the most glaring findings was that neither mental health nor gender was mentioned when asked to discuss 'how life is like as a teenager' or 'what it is like to be an upper secondary school student today'.

Neither sex mentioned mental distress or used diagnostic terminology typically associated with mood disorders, nor did they describe strain of a nature normally linked with depression. Perhaps even more notable was that neither sex spontaneously identified gender as a factor in answering these questions. On the contrary, the answers from both first-stage focus groups were staggeringly similar. Reflections on grades, gaining entrance to desired higher education, new national regulations for lesson attendance and social relationships were the primary topics addressed by both groups. When answering questions not specifically concerning mental health or the reported gender differences, the response from the focus groups were in fact virtually inseparable.

These similarities and the *lack of presence* of psychological issues are in and of themselves expressive. Despite being given prior information on gender differences in mental health as the primary theme of the focus groups, and in contrast with the Ungdata conclusion that 1 in 4 girls are suffering from depressive symptoms (NR14-16), it seems almost

conspicuous that it is not an aspect immediately noticeable as part of being an adolescent girl. Particularly if one of the key characteristics of depression is the disease's tendency to influence every aspect of life and affect the individual's capacity to function (World Health Organization, 2016b).

If one were to apply the Ungdata rates (NR15) to the focus group, one would get the following composition. Approximately 3 of the 12 girls would have been experiencing symptoms of depression, 4 out of 12 would be dissatisfied with themselves and 2 or 3 would have been experiencing physical health problems that very day. Not to mention the amount of friends and classmates who would be undergoing one symptom or another at any given time. Based on the focus groups however, these issues were hardly even hinted at during the general discussion. This sort of direct transfer of results from a massive national survey to a small selection of teenagers in a qualitative setting is of course a futile exercise, and inaccurate at best. Nonetheless, even when taking into consideration the extremely limited sample and the constraints and potential bias within a focus group setting this appears conspicuous. Relying on the Ungdata conclusion that 'there are systematic gender differences in the health of adolescents' (NR15), one might assume this to have presented itself in the youths' representations. Rather, when asked to describe their own life as a teenager, the narrative of both genders revolve around academic issues, surprisingly removed from the depressed *reality* depicted by Ungdata.

Having emphasised the absence of gender differences in what the focus group participants dwelled on when discussing life as a teenager in general, it is however a completely different matter when the topics of discussion shifted to revolve around mental health and gender in particular.

### 6.3 The brevity of teenage boys: less to say and more time to say it

One of the primary differences between individual interviews and focus groups is the role of the researcher and the interactions between participants. Although the execution of focus groups and the topics that serve as points of departure reflect a clear research driven agenda, the method is designed to facilitate group interactions; leaving room for the participants to play off one another, expand on ideas and statements, agree and disagree (Halkier and Gjerpe, 2010). The administration of the all-male focus group did not follow this pattern. Instead, as opposed to the all-female group, and to a lesser extent, the mixed gender group, I found that it took the form of a more traditional interview setting. As a methodological note, this is mentioned in a previous chapter. The contrasts in the focus group process are however not just a potential bias or something one accounts for in an attempt to achieve transparency, but also a finding in their own right. Different ways of doing narrative analysis allowed me to not only zoom in on *what was narrated*, but also *how it was narrated*.

The differences in the level of elaboration and persuasion of the thematic questions with respect to mental health were evident between the genders, as was the frequency of digressional statements and the introduction of more or less adjacent themes. The girls in general had more to say about the topics introduced. They seemed more exuberant in regards to the questions and more fervent in getting their points across, they were more prone to actively agreeing or disagreeing with each other, more likely to interrupt and expand on each other's statements, and offered more details in their considerations.

They were also more liable to play off one another when commenting, using statements such as *'I get what you were saying before, but...'* (FGm/f), *'it's like that one discussion between us when...'* (FGf) or *'do you remember that time we...'* (FGf). The girls used predominately a personal language to express opinions, such as *'I feel that'*, *'I think'* or *'in my opinion'* and a seemingly more active use of body language (FGf, FGm/f). There

seemed to be less need to help the conversations forward with prodding comments or follow-up questions and the focus group had a more fluent transition from one topic to the next.

Another important observation is that the girls to a far larger degree reflected on the accuracy and meaning of the reported gender differences. They were much more inclined to offer an active opinion about the Ungdata results and consequent media coverage. All in all the challenge as a moderator during the all-female focus group was to avoid complete derailment while allowing room for the various opinions to flourish and simply observing where the discussions would lead. This contrasted with to the all-male focus group where the task seemed to be to get the boys to elaborate on statements and answer with more than short words.

It is perhaps not prudent to quantify qualitative data<sup>24</sup>. Still, it is seems worth noting that there were four times as many words uttered in the same amount of time during the all-female focus group than in the male group. The girls also needed significantly less deliberation time before answering questions. They generally needed 1-2 seconds, versus the boys where 4-5 seconds was the norm and where there were several instances of long silences. In addition, twice the amount of prodding questions were utilised during the all-male focus groups and *'I do not know'*, *'I haven't really thought about it'*, and *'There isn't much to say'* were some of the more commonly used phrases (FGm).

It is important to specify that the gender difference in responsiveness was present to some degree throughout the focus group discussions. The differences in how expressive and reflective the teenage girls were compared to their male counterparts could be interpreted in several ways. Group dynamics, maturity, the gender of the researcher (female) or even natural inclinations to mention but a few possibilities. There are some indications that speak against

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<sup>24</sup> Counting mediator comments, words uttered and utilising a stopwatch when analysing the focus group recordings provided a series of interesting results I would not otherwise have produced.

such interpretations however. One is that these differences were decidedly more pronounced when the topics of discussion revolved around issues of mental health. There is therefore a case for arguing that this expressiveness could be understood as a consequence of how *present* these themes are in the lives of teenage girls and how acutely *aware* of the existence of a gender-based narrative they are. It was evident that these discussion topics were not new to them. The collective impression was that they had heard, discussed, and thought about them before and as such the narratives are understood as culturally available *resources* or *templates* for enactment (Nelson, 2001). This leads me to the second main finding from the focus groups: how there is a gender bias in the susceptibility for and exposure to the narrative of the *stressed and depressed girls*.

#### 6.4 Susceptibility (to influence)

I comprehend a double layer in the socio-narrative of gender differences in mental health. The first and most obvious relates to the observation that the story is presented through the narrative of the *suffering teenage girls*. This is crucial. The gender differences could have been presented through stories about how boys are three times *less likely* to experience depressive symptoms, about the *robustness* of teenage boys or about how mental health problems among male adolescents have *decreased* slightly in recent years. This is not the case. The narrative told both in NOVA documents (NR14-16)<sup>25</sup> and in the media<sup>26</sup> is presented through the image of *struggling, stressed* out girls and the underlying societal pressures at ‘the root’ of the problem.

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<sup>25</sup> Examples [my translation]: ‘Girls are affected more [by depression and anxiety] and seek help more often’ (NR16). ‘We should take a closer look at body ideals in today’s society to understand why so many girls struggle with psychological problems’, (NR15). ‘The problems seem (...), to have increased among girls, while the trend has been stable, or even declining among boys’ (NRMH).

<sup>26</sup> Examples [my translation]: ‘1 in 4 girls in the 10th grade experience symptoms of depression’ (Aftenposten, 02.09.14). ‘The pressure on young girls is so great that they overstrain themselves’ (NRK, 12.08.14) ‘It is not the clever girls who suffer the most mentally’ (Dagbladet, 18.08.15).

This might seem like hair-splitting, but it is not. To borrow terminology from Arthur Frank, in the story of adolescent mental health as asserted by the media, the teenage girls are the ‘lead characters’. The boys are merely ‘cast’ in supportive roles to contrast with the female effort to come to terms with the ‘trouble’ that is mental strain. The ‘point of view’ is that of the laboured girls, while the contrasting perspective of their male counterparts merely creates ‘suspense’ and context (2010 p.27-41). Every story, including this one, I might add, has one or more perspectives. This in itself is not problematic, the worry only occurs when a chosen perspective is presented as the only one that exists. As previously mentioned in relation to the use of diagnostic terminology: framing and phrasing matter. What is emphasised and what is not creates a version of events and we are affected by this version whether we know it or not.

If the first layer of the story is about the *suffering girl* as the central protagonist then the second layer, as interpreted based on the focus groups, is that teenage girls are an attentive audience to this narrative. This is maybe not surprising considering they are performed as the main protagonists of the stories, but notable nonetheless. The male participants referred to next to no outside sources during the focus groups. When prodded directly about specific headlines, TV series or mental health related discourses in social media they have very little to say. The predominant reply was that they were aware of the existence of such and such, but have not followed it themselves, nor did they express a particular interest in doing so. *‘None of us pays much attention to those series. I’m more of a Game of Thrones kind of guy’ (FGm)*. Neither did they discuss these media productions among their peers. When asked directly if there is much talk about mental health at school or among friends, the answer from the all-male focus group is directly summed up as: *‘no’* and *‘not at all’* (FGm). This appears as a stark contrast to the girls’ accounts, which at various points in the discussion refer to ‘Facebook, ‘Twitter’, ‘Instagram’ ‘blogs’, ‘bloggers’ as well as various TV series, newspapers

and magazines (FGf). This attentiveness to the various outlets that mediate the image of a generation of depressed girls render possible a recursive influence which would affect boys and girls differently, augmenting the gender differences.

Based on these two related issues of teenage girls as both the protagonist of the narrative and as attentive listeners to it, it is possible to argue that the Ungdata survey not only presents an unbalanced portrayal of gender differences in mental health, but that the *asymmetry* in the alertness to this narrative *reinforces* these differences. In a recursive dynamic consisting of repeated rounds of surveys, media attention, political ministrations and teenage adaptation, the narrative accelerates. The latest NOVA report that show a further increase in depressive symptoms among girls and a slight decrease among boys since 2010 (NR16) could lend support to this argument.

## **6.5 Gender identities**

If one operates within the mapping framework of Ungdata, then my previous points about the gender differences in the level of responsiveness when talking about mental health and the awareness of the theme in the media could be seen as expressions of the very same ‘*generalised knowledge*’ (MI) that Ungdata asserts. Within this framework the depressive rates are presented as *objective* outcomes, generated on the basis of “raw data” that *reflect* an image of truth itself, *neutral* and *autonomous* (Gitelman, 2013, p.3-12). As such adolescent girls have more to say about mental health and are more aware of these topics *because* they are suffering from depression. I am going to counteract this unilateral understanding at play within the Ungdata knowledge production system.

The expressed opinions of the adolescents themselves, or at least my interpretation of them, offer an alternative point of departure. Based on the NOVA reports (NR14-16, NRMH), a coherent narrative, a correspondence between Ungdata-generated statistics and my

qualitative inquiry, would have the focus groups revolving around stories of mental strain, perhaps even expressions hinting at depressive symptoms. Rather the predominant impression based on my analysis is that of a generation of teenagers consisting of equals, but living with different expectations on how to act as representatives of their respective gender. It is the difference between the thought that ‘our lives become stories’ as opposed to an idea that might suggest that ‘our stories become lives’ (Frank, 2010, p. 74).

## **6.6 About a boy and the story of a girl**

To explore how gender could become enacted to the degree that it could influence the way teenagers *perform* faced with a set of self-assessing survey questions, one must look at how gender identities are displayed and what stereotypes come into play when narrating topics relating to mental health.

Boys ‘*do not care*’, talk or think about it, they ‘*do not seem to really want to*’ and they are not ‘*supposed to*’ (FGf). Boys have a ‘*tendency to take things more calmly*’ and they ‘*do not stress about it*’ (FGm). Boys are ‘*not supposed to have problems*’ (FGf); it is described as being ‘*less manly*’. One girl even goes as far as saying that focusing ‘*too much*’ on feelings is not in their ‘*nature*’ (FGf). Overall, this was the characterisation of the male adolescents by both sexes in regards to difficulties relating to mental health. In fact, according to the boys themselves, it is simply a question of ‘*deciding not to care*’, of ‘*not bothering*’ (FGm).

Boys are described as less prone to show emotion, less open and able to ‘*move on*’ more effectively. In fact, the boys themselves go a long way in expressing that they move on more effectively *because* they do not show or share emotions in any depth.

You might think about things less when you do not say anything. I think that people might have gone on and on about an issue, I would have to hear about it all the time, if I said something about it. Even when it was over (John, FGm).

Of course, it could be that if one talks a lot about something that really is just a minor concern and then you build it up into a huge deal that you end up thinking a lot about yourself. But among boys it is more likely that you just push it away because you are not planning to talk about it anyway and then it just doesn't turn into a problem (Arthur, FGm/f).

The girls seem almost concerned with this lack of sharing between boys, articulating an unease as to whether it results from a fear of not being taken seriously. The male participants however expresses little worry with this status quo. The predominant description of how they are doing psychologically is that they are doing *'just fine'* (FGm). Part of this understanding is underlined by the assertion that they would talk to someone if they were to experience what they refer to as a *'real problem'* (FGm/f), but that they in general discuss *'positive feelings not negative ones'* (FGm). It seems like there is a perceptible gender difference in the definition of what constitutes a *'real (psychological) problem'* (FGm/f) or at least what constitutes an issue worth sharing.

Eric: Well, hello! Now we are talking about something bigger than a normal problem.

Anna: But if you feel bad for some reason, which kind of, holds you back in any way. What do you do then? Contact somebody?

Eric: I don't know. I don't have any of those (serious) problems (FGm/f).

Girls on the other hand talk about *'problems'* (FGf, FGm/f), their own and others. They, share, interpret and analyse thoughts and feelings. They are *'supposed to'* (FGf). They *'typically overthink'* (FGm, FGf), they are described, and describe themselves as *'more hormonal'* (FGf) and *'are allowed'* (FGm/f) to take things more personally.

Elisabeth: We (girls) just have to tell each other about it. We talk and suddenly everybody has a massive issue (laughs). Still, I always call right away if something happens. If you feel unwell, mentally or physically, you should (FGf/m).

Simultaneously both groups give indications that they feel there is not as much of a difference between them as society claims there to be. The same demands and external pressures are identified, the same frame of reference.

Sara: I mean, how different is it really? We do almost exactly the same things, the same parties, same schoolwork and at this age, I mean, everybody struggles a bit. (FGf)

John: What kind of pressure I think boys feel? Probably the same ones as girls. (FGm)

Mia: I think there is kind of shame in boys expressing that they feel pressure. I think they are on the same level as us, but just do not allow themselves to act like it. I mean the expectations on them to be smart, good looking and successful are everywhere (FGf).

How the participants describe that they *act on*, or *act out* these demands and pressures however varies between genders. Interestingly enough the collective tale the participants seem most concerned with sharing with me is the following. Although they believe there are adolescents (boys and girls) '*out there*' (FGf) who have psychological problems, they also feel the story about depressed teenage girls is exaggerated and/or overexposed. The girls in particular want to make it known that they do not unquestionably accept and internalise this collective narrative.

Mia: There is a lot of talk about mental health, and along with that, it seems like there are more who struggle. I think it is on the verge of becoming a trend among girls to have a mental illness because there is so much emphasis on it (FGf).

Peter: Three to four girls in every class have depressive symptoms? It sounds like a lot (FGm).

Elisabeth: It's always, girls have mental problems, girls this, girls that. You do not hear a lot about boys and with that, well, then you think girls must struggle more, but then... (shakes her head). I sometimes think I must (!) have problems even if I do not actually feel like that (FGm/f)

One might argue that there is a discrepancy in my findings. The first part of this chapter presents an absence of psychological focus when discussing what it is like to be a teenager in general, while the rest of the chapter is devoted to an assertion that mental health issues are more prominent in the minds of teenage girls compared to their male counterparts. In my opinion however, there is an important distinction between these two arguments. On the one hand, the lack of focus on mental ill-health and the similarity between the male and female versions when discussing life in general suggests that there might not be a critical gender difference in perceptions of *realities/reality*. On the other hand, the presence, awareness and reflection on psychological issues and what is '*typical*' and '*expected*' of teenage girls when asked about such issues might influence how gender is *enacted*, including enabling a strong influence of this enactment on Ungdata *input*. To support this argument however an explanation of how I understand identity as something *performed* as opposed to *expressed* is necessary.

## **6.7 The enactment of gender identities**

Erving Goffman launched in 1959 a sociology concerned with the performance of self ([1959]1971). Humans, according to Goffman, present not themselves, but *a self*. They perform their identities and it is this *version of self* that is available for sociologists to study. Despite this assertion, Goffman believed in the existence of a real self. He just dissociated what happens backstage and concerns psychologists from what happens front stage and concerns sociology. Thus, he differentiated between *personal identity* as an underlying hidden reality producing performances on the one hand and the *public identity*, the performed self, on the other. Regardless of the actor's level of disconnection, the performed role is therefore perfectly real and produces effects: 'it defines the social as such' (Callon, 2007 p.328-329).

Judith Butler (2011) in her research on gender identities expands on Goffman's sociology, but rejects the understanding of a frontstage/backstage self, turning gender into a sociological topic as opposed to a psychoanalytical one. According to Butler, all roles are performances: there is no back office. There need not be a doer behind the deed but '(...) the doer is variably constructed in and through the deed' (quoted in Mol 2002 p.37.) People's identities do not precede their performances but are constructed in and through them. Butler talks of contrasting identities as they are performed in a variety of situations.

Annemarie Mol (2002) builds upon Butler's understanding, but takes a crucial turn in that she identifies natural entities and materialities as included in the performativity of gender. Performance, Mol argues, consists not just of human performance, but all sociotechnical and corporal elements contributing to the performance. 'Performances are not only social, but material as well' (p.40). It is because of this divide that Mol estranges herself from the concept of performativity and its traditional association with how humans act, and instead launches the term enactment. This understanding of gender identities as enacted *in*, not *through*, practices and the inclusion of materialities (things, objects, texts, technologies) as equal carriers of *agency* in the enactment of gender is what I adhere to. It should be noted that I use the term *gender identity* in reference not to individual enactments of self, but as shared and supra-individual perceptions and expressions of collective identity.

## 7 Conclusion

Realities, in my case the gendered enactment of mental health, are a combination of people, techniques, texts, technologies and natural phenomena (Law, 2004). This perspective allows for the following chain of argument as I have integrated, compared and interpreted data from NOVA documents and focus group discussions with teenagers.

*1. Materialities enact:* The enactment of gender identities in the knowledge production system that is Ungdata is determined not only by human actors (Norwegian teenagers), but also by the technological and infrastructural materialities in the production system (checkboxes, documents, computer systems, the media, etc.). The Ungdata survey scheme cannot be seen as an objective and omniscient force separate from the knowledge it produces. The practices of data collection, data processing, classification and digitalisation largely predict what narratives are possible. Consequences and effects of transaction costs, diagnostic framing and phrasing, restrictions of digital surveys and indexing via checkboxes as accentuated in Chapter 5 all address some of the various ways in which Ungdata materialities enact.

*2. Ungdata-generated public health images are both acting and acted upon.*

The Ungdata results are crafted in two-way traffic between enactments of gender identities on the one hand and realities on the other. Stereotypes, gendered public-health images, statistical claims, preventive measures targeted at teenagers and political mental health initiatives are both *outcomes* of gender identities and *enactors* of gender identities. They are presenting or responding to a narrative of gender differences in mental health as enacted by Norwegian teenagers but simultaneously they have agency. They *enact* gender differences in mental health by way of a narrative about depressed teenage girls. In doing so they are also co-producing the very image they are presenting based on the idea that individuals and groups

not only reconstruct, but reconfigure and even create identities, experiences and memories through narratives (Frank, 2010, Nelson, 2001).

3. *The enactment of gender identities by Norwegian teenagers is both medium and outcome.* The enactment of gender identities by teenagers are on the one hand, *data, input* and performance of *a reality*. At the same time, the collective enactment of gender identities, as far as they are interpreted in my focus groups, are also an *outcome* of the Ungdata-generated mental health images. This recursive process, self-generating and self-transforming, in which the social is both medium and outcome (Law, 1994 p.14-16) implies that enacted identity is not just the *basis* of public health images, but also *products* of it. Identities are narrative constructions. Nelson<sup>27</sup> operates with the concept of ‘infiltrated consciousness’ in her work on the moral agency of narratives (2001). According to Nelson, the narratives about us do not only construct identities, they predict our freedom of agency. In other words, others’ understanding of who we are narrows the scope of action available to us. It influences how we enact.

These perspectives allow me to suggest the following: Firstly, we are co-creating gender identities in asking subjects to inhabit the social realities embedded in the Ungdata survey system. In presenting teenage girls as suffering and attaching pathological attributes to the group, we are influencing the generation’s self-perception adversely. Secondly, these social realities in turn affect how Norwegian teenagers enact their identity. This means that girls might be more likely to index negative emotions because of the collective attributes and expectations placed on their gender. Thirdly, this enactment of female identity in medicalised terms might take place independent of whether the teenagers profess to believe in the medicalised narrative about them, as suggested by several of the female focus group

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<sup>27</sup> Nelson uses the term ‘identity’ primarily about individual identity and the freedom of agency for the individual. The concept of ‘infiltrated consciousness’, and its meaning and implications, is however also applicable to supra-individual perceptions and enactment of collective identities.

participants. Ungdata might be studying the social *enactment of identity* while imagining and depicting the knowledge production as a study of *essential truth*. If so, is it not legitimate to point out that this is problematic? This is especially so if the performance of gender is recursively influenced by the Ungdata narrative and as such creates gender-biased images of mental health and psychological well-being. In particular since the collective sense of identity, if not countered, is likely to grow more biased as Ungdata surveys are continuously administered on new generations of teenage contemporaries and the emphasis on female ill-health continues.

One could argue that the Ungdata conclusions are validated through the consistency of the gender differences reported from one year to the next. The cross-national survey scheme exhibits high levels of validity and reliability. The results are not random, ergo, they must be *true*, they depict *reality*, the mental state of the generation. This is in no way in contention with my argument of Ungdata as a co-producer of a biased narrative on mental ill-health. I am no more accusing the Ungdata claims of being random than I am accusing the project management of wilful distortion. On the contrary, I find the survey scheme to be the exact opposite of random. It is in their *ordering*, or rather in their profession of a *single order* (Law, 1994 p.2), that I take caution. Random and true are not antonyms. According to John Law, ‘If things seem solid, prior, independent, defined and single then perhaps this is because they are being enacted, and re-enacted, and re-enacted in practices.’ (2004 p.56)’. In other words, the stability of the Ungdata results is not necessarily a testament to the claims being *the truth* about gender differences in mental health, but could rather be interpreted as consequences of social e.g. stable processes of enactment.

Ungdata-generated conclusions and the consequent media coverage presents one *version* of, and explanation for, gender differences in mental ill-health. I have presented a different version. My version is based on my onto-epistemological understanding and

theoretical influences. Which version most accurately accounts for what really happens is not the issue. Subjective and flawed as my version might be, I at least hope to have raised a few interesting and relevant questions. My objective has not been to provide all the answers. Indeed this thesis provides a range of queries that go unanswered and for that, I apologise. I believe however that questions asked are often of equal importance to answers given.

My contribution to the vast field that is the study of knowledge production and the even bigger field of population health mapping is limited. In bringing methodological and theoretical resources from the humanities and social sciences in dialogue with knowledge production processes and the epidemiologically framed mental health images they produce, I wish to emphasise that there is a need for increased methodological diversity and a further study *of* and not just *on* Ungdata. How are the Ungdata images produced? What attributes make public health images medicalised? Do surveys entail sickness? Who benefits? What affects the reception of the public health images presented? What are the political, social and personal consequences of the increased focus on public health research and evidence-based medicine? All of these are examples of research questions that could be, and deserve to be, pursued.

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## Forespørsel om deltakelse i forskningsprosjektet

### *Den mentale helsen til norske tenåringer: opplevelse- og påvirkning av ungdata-undersøkelsen og den påfølgende mediedekningen.*

#### **Bakgrunn og formål**

Siden 2010 har Ungdata vært et tilbud til alle kommuner og fylkeskommuner i Norge. Ungdata er et samarbeid mellom de regionale kompetansesentrene innen rusfeltet (KoRus) og forskningsinstituttet Nova og er lokale ungdomsundersøkelser rettet mot elever i ungdomsskolen og under videregående opplæring. Ungdom fra hele Norge svarer på elektroniske spørsmål om ulike sider ved deres liv og livssituasjon med det formålet å gi en oversikt over den lokale oppvekstsituasjonen. I 2013 deltok ungdomsskoler og videregående skoler i Narvik kommune i undersøkelsen.

De nasjonale resultatene av alle Ungdata-undersøkelsene gjennomført i perioden 2012-2014 ble publisert i en omfattende rapport utgitt sommeren 2015. Rapporten konkluderer blant annet med at det er store kjønnsforskjeller i psykiske helse. Resultater som at nær 25 % av jentene fra 15-16 årsalderen sliter med depressive symptomer og at så mange som hver tredje jente er lite fornøyd med seg selv har fått omfattende mediadekning med overskrifter som "*Jenter i tiende klasse sliter mest med selvbildet*" og «*Norske jenter stresser seg syke*».

Jeg ønsker nå å se nærmere på hvordan UNGDATA-undersøkelsen og den påfølgende mediadekning oppleves av elever ved Narvik Videregående skole. Ved å intervju et utvalg av tenåringer søker jeg svaret på to spørsmål. For det første å finne ut hvordan UNGDATA resultatene blir oppfattet og forstått av de samme elevene som deltok i spørreundersøkelsen i 2013. For det andre å finne ut om de publiserte resultatene og påfølgende mediadekningen har hatt en innvirkning på oppfatningen av egen mental helse.

Prosjektet er en del av et masterstudie ved Institutt for samfunnsmedisin ved Universitetet i Tromsø-Norges arktiske universitet.

Jeg ønsker å komme i kontakt med 8-10 ungdommer i alderen 17-18 år som er elever ved videregående skole i Narvik og som deltok i Ungdata-undersøkelsen som fant sted ved ungdomsskoler i Narvik kommune i 2013. Dersom mange ønsker å være med i prosjektet vil ønsket antall deltagerne trekkes ut fra de som har meldt seg frivillig.

### **Hva innebærer deltagelse i studien?**

Jeg vil snakke med deg om dine erfaringer med Ungdata-undersøkelsen og dine tanker rundt de funnene om psykiske helse som har kommet frem.

Kjenner du deg igjen i de konklusjonene som trekkes? Hvilke tanker gjør du deg rundt de resultatene som har blitt presentert? Hvordan påvirkes du av de medieoppslag og overskrifter som er presentert i nasjonale medier?

Det vil bli gjennomført to gruppeintervjuer med et par ukers mellomrom. For å kunne fanget opp mest mulig av deres opplevelser, erfaringer og tanker vil intervjuene bli tatt opp på lydbånd. Samtalene vil ta 60-75 minutter.

### **Hva skjer med informasjonen om deg?**

Alle personopplysninger vil bli behandlet konfidensielt. Det er kun min veileder og meg som vil ha tilgang til lydbåndopptakene. Ved avslutningen av prosjektet vil alle innsamlede opplysninger anonymiseres og lydopptak slettes. Anonymiseringen innebærer at ingen enkeltpersoner kan gjenkjennes i materialet

### **Frivillig deltakelse**

Det er frivillig å delta i studien, og du kan når som helst trekke ditt samtykke uten å oppgi noen grunn. Dersom du trekker deg, vil alle opplysninger om deg bli anonymisert.

Studien er meldt til Personvernombudet for forskning, NSD - Norsk senter for forskningsdata AS.

Prosjektet vil bli avsluttet innen desember 2016.

Dersom du ønsker å delta eller har spørsmål til studien, ta kontakt med min veileder Ger Wackers. Kontaktinformasjon: mail: [ger.wackers@uit.no](mailto:ger.wackers@uit.no).

### **Takk for din deltakelse!**

Vennlig hilsen Marthe Rognmo

Universitetet i Tromsø, Norges arktiske universitet

[marthe.rognmo@uit.no](mailto:marthe.rognmo@uit.no)

Tlf 97665585

**Samtykke til deltakelse i studien**

Jeg har mottatt informasjon om studien, og er villig til å delta

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(Signert av prosjektdeltaker, dato)

***Den mentale helsen til norske tenåringer:  
opplevelse- og påvirkning av ungdata-undersøkelsen og den  
påfølgende mediedekningen.***

Semi-strukturert guide fokus gruppe

**Forklare litt om studien.**

**Introduksjonsrunde**

**Tidligere deltagelse i ungdata-undersøkelsen Ja/Nei**

**Tema: Livet som tenåring**

Hjelpespørsmål:

- Hvordan er det å være tenåring i dag?
- Hvordan er livet som elev på videregående?

**Tema: Gjennomføringen av Ungdata-undersøkelsen**

Hjelpespørsmål:

- Hva husker dere/vet dere om Ungdata-undersøkelsen og formålet med denne?
- Kan dere fortelle litt om settingen rundt og hvordan dere gjennomførte Ungdata-undersøkelsen i 2013? Hvordan oppleves gjennomføringen?
- Har dere noen tanker rundt de spørsmål og tema som ble berørt i undersøkelsen?
- Var det noen diskusjon/samtaler rundt undersøkelsen eller de temaene som ble berørt i etterkant av gjennomføringen i studien? Hva dreide i så tilfelle disse samtalene/diskusjonene seg om og hvordan opplevdes disse?

**Tema: Møte med ungdata-resultatene.**

Hjelpespørsmål:

- Hvilke resultater fra Ungdata-undersøkelsen kan dere huske å ha fått høre om? Hvordan fikk dere høre om disse?

- Hvilken reaksjon hadde du når du fikk høre resultatene? Ble du overrasket? Var det som forventet?
- Hvordan var din umiddelbare reaksjon når du fikk presentert resultatene? Hvordan føler du deg i møtet med disse resultatene?
- Tror dere resultatene er et godt bilde på hvordan situasjoner er for deg og jentene på din skole? Hvorfor, hvorfor ikke?
- Har det vært diskusjoner rundt Ungdata-resultatene etter at de ble kjent?

**Tema: Refleksjon rundt resultatene og mediaoppmerksomheten.**

Hjelpespørsmål:

- Hvilke tanker gjør du deg om at 25 % av jentene nasjonalt ble funnet til å slite med depressive symptomer og at så mange som hver tredje jente er lite fornøyd med seg selv»?
- Hvordan påvirker resultatene og mediadekningen deg?
  - egen psykiske helse?
  - andres psykiske helse?
- Det er gått 3 år siden gjennomføringen av den første Ungdata-undersøkelsen lokalt. Har du noen tanker om hvorvidt og eventuelt hvordan jenters psykiske helse har endret seg siden da? Hva er årsaken til dette?

**Jeg har ikke flere spørsmål. Er det noe annet dere ønsker å si før vi avslutter?**

## Artikler som omhandler ungdom og psykisk helse med «Ungdata» som søkeord i de tre største avisene i Norge i perioden oktober 2013 til dags mai 2017.

Tittel	Dato	Avis
"Sykt" bra ungdom!	10.10.13	Aftenposten
Derfor mener norske ungdommer de har dårlig helse	02.11.13	VG
Therese Johaug: - Det er et jag etter å se bra ut	08.03.14	Aftenposten
Kjære storbarnsforeldre	24.08.14	VG
1 av 4 jenter på 10. trinn har depressive symptomer	02.09.14	Aftenposten
Hver femte student sliter psykisk	03.09.14	VG
Ikke skyld på Sophie Elise	03.09.14	Dagbladet
Norske jenter stresser seg syke	15.09.14	VG
Debatt i kveld: Tre av ti jenter stresser seg syke	15.09.14	VG
Det tause opprøret	20.09.14	VG
Elevene lærer psykologisk førstehjelp	03.10.14	Aftenposten
Vi pusser på barna som de var gullbarrer	04.10.14	Dagbladet
De unge sliterne	29.12.14	Aftenposten
Barn oppfatter at det viktigste er å være flink	29.12.14	Aftenposten
Prestasjonspresset for ungdommen blir bare verre og verre	03.02.15	Aftenposten
Tomhetens runddans	05.02.15	Dagbladet
Psykolog Hanne Brorson lærer unge å knipse vekk tunge tanker	13.02.15	Aftenposten
Vi går dobbelt så mye til psykolog som for ti år siden	13.02.15	Aftenposten
Tom feminisme	07.03.15	VG
Karakterjaget: vi må sette grenser for våre barn	06.06.15	VG
«Joda, dere er flinke, men dere kan bli enda flinkere?»	14.07.15	VG
- Det er ikke de flinkeste jentene som sliter mest psykisk	18.08.15	Dagbladet

## APPENDIX C

«50 prosent av befolkningen vil få en psykisk helseplage i løpet av livet»	19.08.15	Aftenposten
Jenter i tiende klasse sliter mest med selvbildet	31.08.15	VG
Ida Storm: Hvorfor lærte vi ingenting om psykisk helse på skolen?	05.11.15	Aftenposten
Vi har nådd punktet hvor du er forpliktet til å føle kroppspress	15.01.16	Aftenposten
Flere jenter mellom 13 og 16 år mobbes	17.08.16	VG
«Mine foreldre forteller meg ofte hvor dum og håpløs jeg er»	24.08.16	Aftenposten
Jeg vet ikke hvorfor bekreftelse er så viktig for meg	26.08.16	Aftenposten
Ungdata-rapporten: - Er vi slitne, gir vi blaffen og dundrer på til vi ikke orker mer	26.08.16	Aftenposten
Barneprofessorer bekymret for skolestress: – Stadig flere søker hjelp	10.10.16	VG
Stadig flere unge legges inn med stress-sykdommer	22.10.16	VG
«Jubeluke» med testresultater, men disse tallene bekymrer Skole-Norge	12.12.16	Aftenposten
Ungdom betaler prisen for reklame- og mediebransjens skitne triks	05.01.17	Aftenposten
Norske pasienter venter lengst på behandling	23.02.17	VG
Til de eldre: Bytt liv med meg i en uke og se hvordan jeg har det!	24.02.17	VG
Min datter, du er god nok	04.05.17	Dagbladet