Exploring adolescent males’ consultations with general practitioners in the context of psychosocial health

JOHANNA HARALDSSON
Abstract


This thesis aimed to explore adolescent males’ experiences of consultations with general practitioners (GPs) with a particular focus on confidentiality in relation to poor mental health and health-compromising behaviours.

First, a model describing the covariation of poor mental-health symptoms, associated somatic symptoms, and health-compromising behaviours was developed through explorative and confirmative factor analysis (paper I). The model was then applied in a structural equation modelling approach to study whether these symptoms and behaviours influenced how adolescent males valued and experienced confidentiality as well as whether they were comfortable asking sensitive questions during their GP consultations (paper II).

Next, to gain a deeper understanding, adolescent males’ experiences with GP consultations were further explored through a qualitative lifeworld-based approach. Interviews were analysed with thematic analysis (paper III) and video observations with a phenomenological–hermeneutical method (paper IV).

The findings revealed that by providing confidentiality, here defined as private time without parents and explaining the meaning and boundaries of professional secrecy, GPs can facilitate discussions on sensitive topics and make adolescent males feel more comfortable to raise their own concerns. This might be a fruitful approach to address any unmet health needs, which can be achieved through the split-visit consultation model.

Another finding was that the studied consultations were very complex. Due to their ongoing development, inexperience with GP consultations, and notions of masculinity, the adolescent males struggled with cognitive, emotional, and relational difficulties while negotiating their right to define the problem and be responsible for their health. The adolescent males emphasized the importance of being listened to and taken seriously, which entails that all aspects of the consultation must be adapted to their individual needs and to their lifeworld. This aligns with Larsen’s consultation model, where the GP strives to understand the patient’s experience and to connect their medical findings to the patient’s lifeworld. Given that both the split-visit consultation model and Larsen’s consultation model offer valuable frameworks for addressing essential, but different, aspects in adolescent males’ GP consultations, the thesis proposes a synthesis of the two approaches.

Keywords: Adolescent, confidentiality, general practitioners, physician-patient relations, mental health, risk taking


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To all adolescents around me,
who have helped and inspired me,
but above all,
to my dearly beloved daughters,
Hannalina and Hilda
List of Papers

This thesis is based on the following papers, which are referred to in the text by their Roman numerals.


III. Haraldsson, J., Johnsson, L., Tindberg, Y., Kristiansson, P., Nordgren, L. (2023) They are my worries, so it’s me the doctor should listen to—adolescent males’ experiences of consultations with general practitioners. Submitted

IV. Haraldsson, J., Johnsson, L., Kristiansson, P., Tindberg, Y., Nordgren, L. Struggling in no-man’s land between childhood and adulthood—a phenomenological hermeneutical video-observation study exploring adolescent males’ encounters with general practitioners. Submitted

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Abbreviations

appOR  approximative Odds Ratios
CFI    Comparative Fit Index
GP     General Practitioner
RMSEA Root Mean Square Error of Approximation
PROBIT PROBability unIT (Binary Response Model using Normal Distribution)
SEM    Structural Equation Modelling
TLI    Tucker-Lewis Index
WLSMV  Weighted Least Squares, Mean and Variance adjusted
Y2U    Year 2 in upper secondary school (approximately 17 years old)
Y9     Year 9 mandatory school (approximately 15 years old)
I had never met him before

Black hoodie
Hood up, headset on
Head down
I put the stethoscope to his chest
It is still warm
It is so quiet
Too quiet
I listen but I only hear the distant sobbing from the living room
I don’t want to go in there
I don’t want to talk to his parents
I look out through the window
Near the blooming lilacs, some girls are standing
Close together, hugging, weeping
I don’t want to go out
I don’t want to pass through them

Why didn’t you tell?
Why didn’t you ask for help?
We could have helped you
If you had asked
We would have listened
Maybe offered you some pills
We would have tried to comfort you
Tried to instil some hope
But we didn’t know
You never told
And now
It is too late

I will never meet him again
Introduction

The Swedish textbook in adolescent medicine states (page 206, my translation (1)): We know that young men often are reluctant to visit Youth Health Centres, potentially harbouring an unmet need for medical advice [when visiting a general practitioner]. Here, we have a group that would benefit from a bit more attention from general practitioners.

One young man that would have benefited from a bit more attention from me and my colleagues is the one that I presented in the preface. It is now a long time since I met him, but I will never forget him.

I hope that that this thesis will contribute by directing a bit more attention to, and slightly increasing knowledge about, adolescent males among my colleagues.

Adolescence

Adolescents are, according to the World Health Organization, individuals aged 10 to 19 years (2, 3). During adolescence, a rapid biological, cognitive, emotional, social, and sexual development occurs, in which the child who has so far been completely dependent of their family grows up to an autonomous citizen (1, 4-6). As the neurocognitive development continues into the mid-twenties (4, 6) it has been suggested that the term adolescence should encompass individuals 10 to 24 years old (6).

This thesis focuses on 15- to 19-year-old males, here referred to as adolescent males. Other applicable terms would have been youth (individuals 15 to 24 years old) or young people (individuals 10 to 24 years old) (7).

Biological, neurocognitive, and social development in adolescence

Adolescence is roughly divided into three phases: early adolescence (ages 10–13), mid-adolescence (ages 13–18), and late adolescence (ages 18–23) (1). The biological development during adolescence is characterised by puberty, length growth, and changes in the patterning of muscles and fat (1, 4). The development of secondary sex characteristics occurs mostly in early adolescence (1, 4). Most adolescent males have reached their full height at the end
of mid-adolescence, but growth, particularly muscle growth, can continue into
late adolescence (1, 4). Adolescent males may during this process worry that
they may not be normal, feeling for instance too tall and skinny (1).

The neurocognitive development is characterised by increased levels of do-
pamine and maturation of the prefrontal cortex, the limbic system, and the
connections between these regions (1, 4, 8). Heightened activity in the limbic
system results in more intense emotions, which explains why feelings, such as
shame, disgust, or happiness can be overwhelming at this age (1, 8). Informa-
tion processing and abstract, hypothetical thinking both progress (4) and as
the prefrontal cortex matures, self-regulatory functions improve (1, 4). During
this process adolescents are more inclined than adults to take risks when the
rewards are high and the risks are low (8), wherefore their curiosity and will
to explore life can sometimes have them end up in risky situations (1). Al-
though most of them return from their adventures unscathed and wiser (1, 8),
some establish unhealthy habits that will persist into adulthood and have a
long-lasting adverse impact on their health (4, 9).

Adolescence is also a period of identity seeking, transforming relations,
and growing independence (1, 6). The adolescent male begins to have a life
outside the family from which his parents are excluded. He seeks to find him-
self, yet be accepted by his peers (1). He seeks a romantic partner and explores
his sexuality (1).

Health-compromising behaviours and Jessor’s Problem

Behaviour Theory

As a part of the exploration of the world and one’s own identity that normal
development entails, many adolescents engage in various behaviours that
might affect their health or development negatively (1, 10). Such behaviours
are here called health-compromising behaviours and include for instance use
of tobacco, alcohol, or drugs, sexual risk taking, and delinquent behaviours
such as truancy or shoplifting. Although most adolescents learn from their ex-
ploring experiences, some of them seem to get stuck, engaging in several
health-compromising behaviours to a large extent (8, 10). This clustering was
also seen in the studies that eventually led up to The Problem Behaviour The-
ory by Jessor (10, 11). According to Jessor, the clustering of health-compro-
mising behaviours depends on an underlying factor that makes the adolescent
prone to these kinds of behaviours (10). The underlying factor responsible for
the covariation is not a well-defined, single factor, but rather a vulnerability
for engaging in health-compromising behaviours. Such a vulnerability proba-
bly arises from a complex interplay of biological, psychological, and social
factors (10).
Health of adolescent males

Since the 1950s, the health of children and adolescents has greatly improved worldwide, largely due to reduced mortality from communicable diseases and malnutrition (12, 13). However, improvements in the health of adolescent males have lagged behind (12, 13). In Sweden as well as in many other developed countries, adolescent males’ overall mortality is twice that of younger males as well as that of their female peers (13, 14). Much of the morbidity and mortality of adolescent males is associated to lifestyle, health-compromising behaviours, and mental health issues such as injuries, substance use, and suicides (3, 13, 15). Despite their higher, and often preventable, health risks, adolescent males use less healthcare than their female peers (16, 17), restricting their access to professional help and making them still more vulnerable.

Poor mental health

Poor mental health problems, such as depression, aggression, anxiety, and self-harm soar during adolescence (4). During the past four decades, self-reported symptoms of poor mental health have been increasing in the Nordic countries (18-20). In Sweden, where this development seems to be most pronounced, the frequency of symptoms of poor mental health has doubled since the 1980s (19, 20). Some ailments seem to be growing even more rapidly; the proportion, for instance, of Swedish 15-year-old males that report “feeling blue” every day has tripled since 2011 to be around 10% in 2021 (18). It has been argued that the rising frequencies of these symptoms can be partly attributed to shifts in their interpretation over time or reduced stigma surrounding poor mental health (21). Be that as it may, there appears to be an actual rise in symptoms of poor mental health, judging by the fact that prescriptions for antidepressants and visits to psychiatric healthcare are increasing in Sweden (18, 19). The development has been suggested to be due to school factors and higher demands in the labour market (18-20).

Somatic symptoms, such as headache or stomach ache, increase in adolescence compared with childhood (4) and are particularly common in adolescents with poor mental health (22). Much of the increase in such pain symptoms reflect heightened pain sensitivity, rapid body growth, and increasing social and educational demands, all of which are components of the normal development (1, 23). However, pain symptoms can also be bodily-expressed psychological problems, particularly when chronic or clustering (23). Headache, stomach ache, and back pain are in some studies, for instance in World Health Organization’s Health Behaviour of School-aged Children study, regarded as symptoms of poor mental health (18, 19, 24).
Adolescent males in primary care

Provision of primary care for adolescents varies between countries. In addition to general practitioners (GPs) or family doctors, paediatricians or (retrained) internists can provide primary care to adolescents (25-27). These differences can complicate international comparisons of primary care. Even so, it appears that many adolescent males visit a GP or an equivalent primary care provider at least somewhat regularly (28, 29). In Europe, more than half of adolescent males have visited a GP at least once during the past year (30-34), most often for respiratory tract infections (35, 36).

An adolescent male that visits a healthcare centre in Sweden most often encounters a GP (specialist i allmänmedicin) or a physician training to become one (residents in general practice, ST-läkare i allmänmedicin) (37, 38). He might also see other kinds of physicians, for instance a junior doctor (intern, AT-läkare), as training in general practice is necessary in order to get licence to practice (39).

Adolescent males’ experiences of GP consultations

Good experiences of GP consultations can facilitate adolescent males’ future help-seeking in primary care (40, 41). For some adolescent males, however, the consultation becomes a negative experience (40-44). The latter group report having met unhelpful, dismissive, uncompassionate, and unengaged GPs that neither listen nor believe them (40, 42-44). They also describe difficulties in talking about sensitive issues with the GP (40, 42). Moreover, it seems that adolescent males struggle more to reveal themselves as vulnerable compared with their female counterparts (45, 46). However, most studies on adolescents’ GP consultations include both sexes without explicit analyses of sex differences, leaving the possibility of undiscovered sex differences.

Adolescent males’ expectations of GP consultations

Adolescent males prefer to encounter GPs that they already know (40, 44, 47). They want honest and respectful dialogues with accepting, non-judgemental, and caring GPs (32, 40-42, 47-49). They want to be seen as persons and that the GPs try to connect to and understand them (40, 41, 48-50). They also expect the GP to ask the right questions, to explain clearly, and to give them the opportunity to ask questions (32, 40, 41, 44, 48). They would like to discuss their psychosocial health (30, 51), but are unsure whether this would be within the GPs’ field of knowledge (43, 52).

Adolescent males worry about what is going to happen during the consultation (42). They fear that the GP will neither care nor help them, but dismiss them as attention-seeking teenagers or even laugh at them (40-43, 48). They
hesitate to reveal their concerns, fearing that the GP will tell their parents or feel that they are wasting their time (40, 43).

General practitioners’ experiences of adolescent males

GPs describe challenges in their consultations with adolescent males (53). For instance, GPs can perceive that adolescent males do not fully reveal their concerns, instead leaving out important things (54). This is in line with adolescent males’ reports of not daring to trust the GP because they fear broken confidentiality or don’t want to burden the GP or waste their time (40, 41). GPs’ descriptions of these consultations as professionally challenging also accord with indications of physicians communicating less well with adolescent males compared with their female peers (55).

Consultation techniques

Confidentiality facilitates sensitive discussions

For several reasons, the recommendation from medical organisations such as the World Health Organization and the Society for Adolescent Health and Medicine to ensure confidentiality in adolescent males’ consultations with GPs may be a sound one (56-58). First, confidentiality facilitates discussions about sensitive issues, such as poor mental health or health-compromising behaviours (29, 59, 60). Confidentiality also promotes healthcare seeking, because adolescent males, particularly those suffering from poor mental health, may forgo needed healthcare due to confidentiality concerns (59, 61). Confidentiality, then, may be key to improving adolescent males’ consultations with GPs.

In this thesis, confidentiality is defined as a composition of two components: receiving *private time* and *having professional secrecy explained* to one. Private time means that the adolescent male spends time alone with the GP, without a parent or guardian present. This allows for subjects that intersect with psychosocial or sexual health—troublesome relations, substance use, or contraceptives, etcetera—to be broached without the adolescent male needing to worry about being overheard. To have professional secrecy explained means that the GP explicitly explains to the adolescent male what professional secrecy entails. Even though adolescent males often recognise the concept of professional secrecy, they may be uncertain of its meaning, its boundaries, and when it must be breached (42, 47).

Adolescent males report in international studies that they want confidentiality (41, 62, 63), yet receive it in less than half of their medical encounters (62, 64-66). Approximately 20–45% of adolescent males reported experiences of private time (62, 64, 66), and 40–42% experienced having had professional
The split-visit consultation model of adolescent medicine

To introduce and normalise confidentiality, and to build relationships and trust with adolescent males and their parents, a standardised split-visit model can be useful (1, 56, 66, 67). According to this model, the GP begins the consultation by explaining the concept of private time and the meaning and the limits of professional secrecy to the adolescent male and any accompanying parents. This preamble is followed by the first phase of the consultation, during which most of the medical history is taken. In the second phase, the “private time”, the adolescent male gets to be alone with the GP without parents or guardians. During this phase, the GP turns to the more sensitive parts of history taking, including any psychosocial aspects, and conducts the physical examination. Finally, the GP and the adolescent male summarise the assessment and proposed actions to the parents, now returned to the GP’s office, simultaneously considering (and eventually balancing) the adolescent males’ autonomy and need of parental involvement.

HEEADSSS

HEEADSSS is an acronym for a youth-friendly approach of conducting psychosocial assessments in adolescents, covering various essential health domains (67, 68). While not an intrinsic part of a split-visit consultation, it is often mentioned as a tool that the GP is encouraged to use during private time (67, 68). It covers the following essential health domains (each exemplified with a question that might be asked of the youth):

- Home—with whom do you live?
- Education—tell me about school?
- Eating—what do you think about your weight and body form?
- Activity—what do you do in your spare time?
- Drugs—have any of your friends tried smoking (cannabis)?
- Sexuality—how is your love life right now?
- Suicide—how are you enjoying life?
- Safety—tell me about the last time you felt scared?

Thus, HEEADSSS offers a standardised approach to assessing common health risks regarding lifestyle, health-compromising behaviours, and poor mental health by proceeding from less threatening questions to more personal issues (68).
Larsen’s model of consultation

Larsen’s consultation model is a widespread consultation method in Swedish primary care, being taught, for instance, at Uppsala University’s medical school and in professional development courses for GPs (69-71). Larsen’s model of consultation emphasises dialogue and exploration of the patient’s ideas, concerns, and expectations (71-74), and is thus tightly connected to the core values of general practice as defined by The European branch of WONCA, the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (75). Although age is not explicitly discussed in Larsen’s papers, the model is supposed to be applicable to patients of any age.

Larsen’s consultation model has three parts (71, 73, 74). First, during the “Patient part”, the patient tells their story without interrupting questions, supported by verbal or non-verbal emotional validation that demonstrates the doctor’s understanding. The doctor summarises the patient’s story to confirm that they have been listening, and encourages the patient to add details that were overlooked and correct any misunderstandings. The patient’s ideas, concerns, and expectations are also elucidated. During the “Doctor part”, the doctor gathers additional information, conducts a physical examination, and explains their findings. Finally, in the “Shared part”, the doctor relates the findings to the patient’s ideas, concerns, and expectations, thus connecting the patient’s lifeworld (further elaborated below) to the world of medicine (71, 72). The treatment plan is negotiated and adapted to the patient’s everyday life (71, 72).

Theoretical and philosophical assumptions

This thesis comprises two fundamentally different paradigms, the quantitative paradigm and the qualitative paradigm, with disparate views of the world (ontology) and of knowledge (epistemology). As it might appear contradictory to combine two different paradigms in one thesis, I shall in what follows make explicit my ontological and epistemological assumptions. Next, I provide a brief résumé of Reflective Lifeworld Research as described by Dahlberg et al. (76). This is followed by a short description of Danish philosopher Knud Ejler Christian Logstrup’s writings about The Ethical Demand (77). I hope to make evident throughout this thesis that both of these very different theories can be used to gain a deeper understanding of the multifaceted medical encounters studied here.

Ontological and epistemological assumptions

To approach my research questions in a comprehensive and thorough manner, I have seen fit to use both quantitative and qualitative methods. Consequently,
the thesis is grounded in both the quantitative and the qualitative paradigm. Usually, the researcher in the quantitative paradigm searches for generalisable descriptions of an objective reality, aiming for results unbiased by the researcher’s own assumptions and theories (78). In the qualitative paradigm, the researcher reflexively and critically uses their pre-understanding to interpret a multifaceted world, aiming for a contextual and subjective, yet transferable, description (78).

At first glance, it might seem odd to alternate between such different views. Nevertheless, this is what I do every day in the clinic. As a GP, I assess symptoms, test results, and risk of disease based on my knowledge of statistically significant findings discovered by quantitative research. Effect sizes and probabilities generalised from whole populations are applied to the actual patient to determine what advice or treatment might be helpful. But to understand how to help my patients, I need to do more than detect and classify measurable data. I also have to seek to understand how they experience and interpret their symptoms, and to find out their view of the situation, their worries, and how they want to be helped (73).

What takes place in these encounters can be described as balancing the voice of medicine with the voice of the patient’s lifeworld (72). Helpful tools for this purpose can be found in patient-centred approaches, such as Larsen’s model of consultation, which recognises and takes into account the patient’s lifeworld (71, 72). In Dahlberg’s Reflective Lifeworld Research, I found my clinical experiences reflected in its ontological and epistemological assumptions (76). Thus, it became a natural choice for me to use Reflective Lifeworld Research as the theoretical foundation for my qualitative studies. Just like I in the clinic alternate between the objective voice of medicine and the subjective voice of the lifeworld depending on the demands of the moment, I also in research alternate between the objective, quantitative paradigm and the subjective, qualitative paradigm depending on the research question.

A brief introduction to Reflective Lifeworld Research as described by Dahlberg et al.

Reflective Lifeworld Research is rooted in phenomenological and hermeneutical philosophy, drawing particularly from what the two traditions share, such as the lifeworld theory (76). The lifeworld theory was first described by Edmund Husserl and has later been further developed by Maurice Merleau-Ponty, Martin Heidegger, and Hans-Georg Gadamer. The lifeworld theory describes a shared world in which we all live and seek meaningfulness. But since we all experience the world differently, each of us can be said to have their own lifeworld, our own unique lived reality. We have access to the world through our bodies; our subjective experience of being in the world, our lived
experience, would be inconceivable without our lived bodies. The lived experience, a concept attributed to Wilhelm Dilthey, means something to us. Thus, research based on the lifeworld theory investigates the meanings that we attribute to our everyday world (76).

In Reflective Lifeworld Research, as described by Dahlberg et al., the aim is to understand and describe the essence of a phenomenon in the lifeworld, i.e. the meanings that are constitutive of the phenomenon, those without which it would not be the same phenomenon (76). In other words, the meanings that make the phenomenon that very phenomenon. Patterns of meaning in lived experiences are sought with sensitive openness, so that the phenomenon can show its many sides as truly and comprehensively as possible. To be open and sensitive to the phenomenon requires curious closeness as well as a reflective distance while striving to see the phenomenon beyond the expected. Understanding without presuppositions is impossible, but pre-understanding can be bridled (76). A bridled attitude entails being open to the phenomenon, not letting personal assumptions restrain this openness, but daring to endure incomprehensibility to avoid hasty or slovenly conclusions. Furthermore, pre-understanding, as well as the development of understanding and the whole research process, is questioned and reflected upon (76).

A brief introduction to Løgstrup’s Ethical Demand

Early in the qualitative analysis, vulnerability was identified as a central feature, prompting us to seek for theories of vulnerability to deepen our understanding. Together with my co-authors, I thus turned to Løgstrup’s writings on human vulnerability and how we should respond to it (77). According to Løgstrup, it is integral to human nature that we meet each other with trust. Whenever we encounter another human being, we become aware of a fundamental ethical demand on us. According to this ethical demand, we must, when someone trustingly reveals their vulnerability to us, take care of what is laid in our hands. This is not a matter of being courteous or pandering to the wishes of the other. To the contrary, the ethical demand requires us to use our own understanding of life to deem what serves the other best. We should do this selflessly without intruding or encroaching upon the other, but with respect for the other’s individuality, will, and responsibility for their own life. When the ethical demand is not adequately responded to, but instead met with rejection or indifference, the other’s trust is betrayed, potentially evoking feelings of embarrassment, disappointment, and of having been mistreated (77).
Rationale

As described above, the biological, neurocognitive, and social development in adolescence bring forth unique demands during the adolescent male’s consultations with the GP. His (almost) mature and therefore embarrassing body, easily provoked feelings of being watched, life outside his parent’s knowledge, ongoing exploration of his body, life, sexuality, and identity, and the health-risks that he runs while so doing—all of these highlight the need for confidentiality when visiting the GP.

Confidentiality for adolescents is scarcely discussed in the context of European primary care. Some studies report confidentiality from the physicians’ point of view (27, 79, 80), but few studies have presented adolescent-reported frequencies since the study of Rutishauser et al. in 2003 (62). How often adolescent males receive private time or an explanation of professional secrecy when visiting a GP in Sweden is, to the best of my knowledge, not known.

Moreover, even fewer studies address whether adolescent males can voice their own concerns. They may hint at their issues, hoping that the GP will ask the right questions (32, 40). Given the communication challenges reported by GPs, this underscores the importance of adolescent males feeling comfortable enough to express their concerns, even sensitive ones.

Furthermore, it is not known if expectations or experiences of confidentiality is associated with the adolescent male’s health or lifestyle, i.e. whether at-risk adolescents with poor mental health or health-compromising behaviours receive (enough of) the confidentiality that they need to reveal their troubles to the GP. To investigate these associations, the clustering of symptoms of poor mental health, somatic symptoms, and health-compromising behaviours that can be expected based on previous research must be taken into account statistically. However, the precise structure of this clustering has, as far as I know, not been sufficiently described to enable such analysis.

Good communication is key to a successful consultation (81). Nonetheless, as described above, there seem to be communication difficulties in adolescent males’ GP consultations, even though GPs report that they strive for responding to each patient’s needs (82). Although a deeper understanding of adolescent males’ lived experiences of GP consultations may contribute to a better understanding of what takes place during adolescent males’ GP consultations,
few qualitative studies focus on adolescent males exclusively (83). The adolescent male’s perspective is of course central to such an understanding. In addition, since GPs may be unaware of how their communication is perceived (84), observation studies may add new, unexpected insights.
Aims

Overall aims
The overall aim of this thesis was to explore adolescent males’ experiences of consultations with general practitioners with a particular focus on confidentiality in relation to poor mental health and health-compromising behaviours.

Specific aims
I. To develop a factor model of the clustering of poor mental-health symptoms, somatic symptoms, and health compromising behaviours in adolescent males using exploratory factor analysis and confirmatory factor analysis.

II. To investigate to what degree adolescent males
i. value confidentiality,
ii. experience confidentiality and are comfortable asking sensitive questions when visiting a general practitioner, and
iii. whether self-reported symptoms of poor mental health and health-compromising behaviours affect these states of matters.

III. To explore and describe how adolescent males understand and assign meaning to their experiences of consultations with general practitioners.

IV. To explore and describe adolescent males’ encounters with general practitioners in Swedish primary care through a lifeworld perspective.
Methods

Both quantitative and qualitative methods were used to explore adolescent males’ experiences of consultations with GPs. A model describing how symptoms of poor mental health, associated somatic symptoms, and health-compromising behaviours co-vary were developed by use of explorative and confirmative factor analysis (paper I). The model was then used to study whether poor mental health and health-compromising behaviours were associated with how adolescent males valued and experienced confidentiality during their GP consultations using structural equation modelling. The study also investigated whether adolescent males were comfortable asking sensitive questions in relation to experienced confidentiality, poor mental health, and health-compromising behaviours (paper II).

Thereafter, to gain a deeper understanding of adolescent males’ experiences of GP consultations, their experiences were further explored with a qualitative lifeworld-based approach through interviews analysed with thematic analysis (paper III) and video observations analysed with a phenomenological-hermeneutical method (paper IV).

Table 1: An overview of the studies included in the thesis.

<table>
<thead>
<tr>
<th>Paper</th>
<th>Design</th>
<th>Data collection</th>
<th>Age</th>
<th>Participants: n (response rate)</th>
<th>Method of analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Quantitative, cross-sectional study</td>
<td>Questionnaire: Life and Health in Youth, Sörmland, 2011 and 2014</td>
<td>15 to 18 years</td>
<td>2011: 2,823 (80%) 2014: 2,358 (85%)</td>
<td>Explorative factor analysis Confirmative factor analysis</td>
</tr>
<tr>
<td>II</td>
<td>Quantitative, cross-sectional study</td>
<td>Questionnaire: Life and Health in Youth, Sörmland, 2014</td>
<td>15 to 18 years</td>
<td>2,358 (85%)</td>
<td>Structural equation modelling</td>
</tr>
<tr>
<td>III</td>
<td>Qualitative</td>
<td>Individual semi-structured interviews</td>
<td>15 to 19 years</td>
<td>9</td>
<td>Reflexive thematic analysis</td>
</tr>
<tr>
<td>IV</td>
<td>Qualitative</td>
<td>Video observations</td>
<td>15 to 19 years</td>
<td>9</td>
<td>Phenomenological-hermeneutical method</td>
</tr>
</tbody>
</table>
Design
Papers I and II: Developing a model and Confidentiality in relation to health
A descriptive and cross-sectional design was used in papers I and II. To develop the model in paper I, two analogous, but independent samples were required; one for exploring the data and constructing a preliminary model, and another for validating this model. Thus, data from two different occasions of a school-based triannual census, *Life and Health in Youth, Sörmland*, were used.

Data from males in year 9 mandatory school (Y9) and year 2 of upper secondary school (Y2U) were utilized, corresponding approximately to ages 15 (Y9) and 17 (Y2U).

Papers III and IV: Adolescent males’ experiences and Observations of GP consultations
A qualitative design with Reflective Lifeworld Research as theoretical framework was used to explore and describe adolescent males’ experiences of GP consultations.

Setting
Papers I and II: Developing a model and Confidentiality in relation to health
Papers I and II were based on data obtained from *Life and Health in Youth, Sörmland* which is a school-based, triannual census that targets all schools in Region Sörmland. The survey is conducted by the Department of Welfare and Public Health (formerly Centre for Public Health) and the Centre for Clinical Research, Region Sörmland. Region Sörmland is socio-economically comparable to Sweden as a whole, except for a slightly higher proportion of adolescent males born outside Sweden (85).

In Sweden, most students transition to upper secondary school after completing mandatory school (14). Both mandatory and upper secondary schools are tuition-free for students, whether they are public or independent, privately operated institutions (known as *friskola* in Swedish).
Papers III and IV: Adolescent males’ experiences and Observations of GP consultations

Papers III and IV were based on a study conducted in spring 2022 at two public healthcare centres in Region Sörmland. Healthcare centre A is situated in a small town with demographics roughly as Sweden as a whole, except for slightly higher levels of income and education. Healthcare centre B is situated in a medium-sized town, which compared with Sweden as a whole has higher unemployment rates, a larger population born outside the European Union, and fewer adolescents who complete mandatory school with grades that grant access to upper secondary school (86).

Data collection

Papers I and II: Developing a model and Confidentiality in relation to health

Life and Health in Youth

The surveys were conducted in March 2011 and in March 2014. School employees distributed the questionnaires to the students, who anonymously completed them in their classroom during ordinary school hours. Students who were absent on the day of the survey were offered a second opportunity to participate within two weeks, before all the completed questionnaires were returned to the Centre for Clinical Research. The number of students that attended the second occasion was not reported by the schools, wherefore only the total number of participants is known. Nor were the reasons for non-participation reported, but the main reason in prior surveys has been absence due to illness, holidays, or scheduled practical work (87). Students and parents received written information about the survey, including the fact that it would be completely voluntary, beforehand. In order to protect the identity of the students, no formal written consent was signed. Instead, a completed questionnaire was regarded as an informed consent. Parental consent is not needed for research participants aged 15 and above (88).

There were slight differences between the two surveys. In 2011, questionnaires were not only distributed in the schools, but also in a few cases by mail to reach adolescents who lived in the region but attended school outside of it. The reason was that in three municipalities, more than a fifth of the adolescents in Y2U travelled to schools in nearby regions. In order to obtain reliable data about these three municipalities, questionnaires were mailed to the commuting adolescents. In 2014, no questionnaires were mailed. Another difference was that in the 2014 survey, schools for children with intellectual disabilities were invited to the survey. Data from those schools are not included in this thesis, due to differences in the questionnaires.
In 2011, 62 out of 65 eligible schools participated (figure 1). The three non-participating schools were smaller, independent institutions located in three different municipalities. Two of these were mandatory schools, while the third was an upper secondary school. In the participating schools, the response rate was 80.4%, with a somewhat higher response rate among the younger students (84.0% in Y9 as compared to 77.1% in Y2U). Among the 296 mailed questionnaires, the response rate was 33.8%, i.e. 100 completed questionnaires returned.

In 2014, 64 out of 68 eligible schools participated. As in 2011, all four of the non-participating schools were independent schools. Three of these schools were mandatory schools, one of which had around 230 students, while the other two had less than ten eligible students each. The fourth non-participating school was an upper secondary school with about 30 eligible students in Y2U. The response rate in the participating schools 2014 was 84.5% (85.5% in Y9 and 83.6% in Y2U).
Figure 1: Participation in *Life and Health in Youth* 2011 and 2014.

The county of Sörmland was incorporated into the Region Sörmland in 2019.

**The questionnaires**

The questionnaires used in *Life and Health in Youth* comprised almost 90 questions, in Swedish, concerning somatic, mental, and sexual health, use of healthcare, health-compromising behaviours, spare time, school, and socio-demographic background (89). Some questions consisted of multiple sub-
questions. The questionnaires differed slightly between Y9 and Y2U, and between 2011 and 2014. In 2011, the questionnaire comprised 87 questions in Y9 and 89 in Y2U. In 2014, there were 86 questions in the Y9 questionnaire and 87 in the one used for Y2U. The questions about drug use were more detailed in the Y2U questionnaire than in the one for Y9. Many of the questions are derived from validated questionnaires, such as the Swedish translation of Health Behaviour in School-aged Children study, but the questionnaires have never been validated as a whole. However, they have been used in previous research (90, 91).

Papers III and IV: Adolescent males’ experiences and Observations of GP consultations

Data were collected through interviews (paper III) and video-recorded consultations (paper IV) at two public healthcare centres in Region Sörmland from 4 March to 20 May 2022.

At the two healthcare centres, all physicians that could be perceived as GPs by adolescent males were invited to participate in the video recordings. This included fully trained GPs, residents in general practice as well as junior doctors as long as they worked in a GP-like manner. Fourteen physicians, eight women and six men, volunteered for the study. They were 26 to 72 years old with clinical experience ranging from 0.75 years in clinic to 39 years as fully trained GPs. Hereinafter, they are all referred to as “GPs” for simplicity.

All adolescent males who visited a participating GP for any reason were invited to participate. They were, if possible, invited by phone a few days before the appointment, or else on arrival to the healthcare centre.

All participants received oral and written information about the study’s aim and procedure and signed a written consent before participation.

Before each video-recorded consultation, the adolescent male and the GP discussed whether the researcher (JH) should be present in the room or not. In all consultations except one, the researcher started the video-recording and left the room. The camera was directed towards the chairs in which the adolescent male, accompanying relatives (if any), and the GP were seated. To protect the adolescent male’s privacy, the examination couch was kept out of sight and the GP was instructed to turn away the camera or put the lens cap on if needed. One adolescent male agreed only to be audio-recorded and was therefore seated out of frame during the entire consultation.

Immediately after the consultation, a semi-structured interview was conducted with the adolescent male about his experience of the consultation. The adolescent male and the researcher were seated in a vacant consultation room facing each other while accompanying relatives waited outside. One adolescent male had a really sore throat and was therefore interviewed two weeks later by phone. The interviews were conducted in Swedish and digitally audio-
recorded. They all started with the question: *You have just met Dr X. How was it?* and continued with open-ended questions covering his experiences of the consultation, the GP, the communication, and relatives’ impact on the consultation, as well as any negative experiences. Questions such as *Why is that important to you?* and *How do you mean?* were frequently asked to clarify the answer and deepen the understanding. An interview guide was used to ensure that all areas of interest were covered, but the order and wording of the questions varied to continually improve and individualise the interviews (paper III, supplement 1).

Notably, to further elaborate their stories, the adolescent males were asked to compare with prior experiences, which generated several descriptions of previous unsatisfying appointments in primary care and otherwise. Although these previous experiences fell out of the scope of paper III, the way that they contrasted with the current ones turned out to facilitate the understanding of the latter. Thus, the prior unsatisfying appointments are summarised in text-box 2 in paper III as contextualising information.

After the interview, each adolescent male received two cinema tickets for their trouble.

**Respondents**

**Papers I and II: Developing a model and Confidentiality in relation to health**

Data from males in Y9 and Y2U were used. Y9 corresponds approximately to the age of 15 and Y2U to the age of 17, but as the surveys were conducted in March, some of the adolescents had already turned 16 (Y9) or 18 years old (Y2U). Furthermore, some might have been even younger or older, for instance due to having started school a year earlier or later than usual.

In 2011, all completed questionnaires from male students (n=2,823) in the 2011 survey were used (figure 1).

In 2014, of 2,364 questionnaires from male students, six were deemed unreliable and discarded due to an unrealistic answering pattern (affirmative responses on the most severe form of all chronic conditions asked for). As a result, 2,358 questionnaires from the 2014 survey were used in the analyses.

**Papers III and IV: Adolescent males’ experiences and Observations of GP consultations**

All males 15 to 19 years old who visited a participating GP were invited to the study regardless of their reasons for visiting. To keep the inclusion simple, year of birth (2002 to 2006, i.e. those who were 15 to 19 years old on 31 December 2021) was used instead of actual age on recruitment. Three adolescent
males were excluded from participation due to insufficient skills in Swedish. Another, but never used, exclusion criterion was severe illness.

The number of participants was not decided beforehand. Instead, the inclusion was ended when the gathered data were sufficiently rich and varied to provide acceptable information power (92, 93).

Rich and varied data were sought by inviting participants who differed with regard to their age and background. The original plan for data gathering was to initially invite all eligible adolescent males and to transition to purposeful sampling later on. During the first predefined data gathering period, nine consecutive consultations were sampled. Since the variety of the participants’ characteristics, as well as the richness and variety of data in the nine interviews and observations were considered sufficient, it was determined that purposeful sampling was unnecessary and no more data gathering periods were initiated.

Of fifteen eligible adolescent males, nine wanted to participate. Five of them participated at healthcare centre A and four at healthcare centre B. Five attended the GP on their own, three were accompanied by a parent, and one by his girlfriend. Of the nine participants, three had parents who were born outside Sweden; one of these three was himself Sweden-born. These proportions are comparable to those in Region Sörmland. Three of the adolescent males visited GP1, and two visited GP2. The four remaining adolescent males visited four different GPs, GP3 to GP6 (figure 2).
**Figure 2:** Characteristics of the participating adolescent males and general practitioners (GPs) in papers III and IV.

As a result of using year of birth instead of actual age, Majed was included, even though he already had turned 20.

### Data analysis

#### Paper I: Developing a model

In paper I, the aim was to develop a model that describes how poor mental-health symptoms, somatic symptoms, and health-compromising behaviours co-vary in adolescent males. First, exploratory factor analysis was used to explore and understand the structure behind these variables. Data from *Life and Health in Youth* 2011 were used. Next, the resulting model was validated in...
data from *Life and Health in Youth* 2014 using confirmatory factor analysis. Thus the model was developed in one set of data and validated in another—analogous, but independent—set of data.

**Exploratory factor analysis**

Exploratory factor analysis was used to identify the assumed underlying vulnerabilities, the underlying factors, in data from male students in Y9 and Y2U in the 2011 survey. An underlying factor is a real, but unobserved latent variable that causes the co-variation among observable variables.

Exploratory factor analysis is a data-driven statistical method which aims to identify underlying factors by analysing the correlation between observable variables. It is an iterative process that searches for variables that are strongly related to only one underlying factor without being affected by other underlying factors. By finding variables that are unique to each factor, the factors can be understood and the structure among the measured variables described in a model. The goal of exploratory factor analysis is a model with a reasonable theoretical interpretation and good model fit (94). To reach this goal, the researcher may need to develop and evaluate several models before finding an acceptable solution. To validate the model, the model can be tested in a different, but analogous set of data using confirmatory factor analysis.

Exploratory factor analysis is, according to Costello et al. “a complex procedure with few absolute guidelines and many options” (95). Some of the many decisions that the researcher has to make during the process can be guided by the nature of the data or theoretical knowledge of the field, but in other cases, it might be fruitful to combine several options and compare the results (94).

One decision regards what variables to include in the analysis. While the area of interest needs to be covered as comprehensible as possible, including too many, too few, or irrelevant variables may entail that the true factor structure remains undiscovered (94). When they are included in a factor analysis, variables are called items.

Another decision for the researcher is to determine the number of factors to extract. As the number of underlying factors is unknown, the researcher can explore the data in various ways to define a reasonable number of factors to start the exploration with. Specifying too few factors (under-factoring) results in more severe errors than over-factoring, because the true factor structure is obscured when two factors that ought to be separate become combined into one (94).

A third decision concerns the criteria used to determine whether an item is unique to a factor or not. To be considered unique to a factor, the item needs to have a sufficiently high factor loading on that very factor and sufficiently low factor loadings on the other factors. As these unique items are those that are selected for the next iteration of the analysis, the criteria defining these cut-off values are called criteria for item selection.
Variables

All variables in the *Life and Health in Youth* questionnaires that might measure an underlying vulnerability, i.e. an underlying factor, for symptoms of poor mental health, associated somatic symptoms, or health-compromising behaviours were selected. To be considered as measuring an underlying vulnerability, a variable had to reflect feelings, actions, or other possible manifestations of the vulnerability. For instance, variables about being depressed and using violence were used, as they could be interpreted as different expressions of an underlying vulnerability (or vulnerabilities). However, a variable about being bullied was not included in the analysis. While being bullied can contribute to poor mental health (96), I viewed it as actions inflicted upon the individual by others rather than an expression of an intrinsic vulnerability within the adolescent male.

Fifty-six variables were found in the 2011 questionnaire that could potentially measure underlying factors. Five of these variables differed between the 2011 and 2014 survey, and were therefore excluded in order to enable the forthcoming validating confirmatory factor analysis. The 51 selected items were equally worded in the four different questionnaires (Y9 2011, Y2U 2011, Y9 2014, and Y2U 2014). Of these, four binary items were excluded, because there were ordinal scale items that represented the same symptom or behaviour while being richer in information (97). In addition, five pairs of nearly analogous items were found, such as *drinking alcohol* and *binge drinking*, and the least useful in each pair was excluded, because highly correlated items should be avoided in exploratory factor analysis (98). Thus, 42 items were selected for analysis.

All the included items were ordinal with response options that varied from three- to seven-point scales, except for one item (age at first sexual intercourse), which consisted of continuous data. The healthiest option was given the value of zero and the most risky or unhealthy option was given the highest value. Two items need a more detailed explanation. First, the item about use of contraceptives was created by recoding a multiple answer question into a six-point scale. To avoid a large proportion of missing values, the zero-coded option was defined as corresponding to never having had sexual intercourse, and the next option to the safest method for contraception and infection prevention (condom combined with an intrauterine device or the pill). The second item that needs to be explained is the drug use item. As the Y2U questionnaire contained more detailed data about drug use than the Y9 questionnaire, the drug use item was operationalised slightly differently in Y2U than in Y9. In the exploratory factor analysis, the equally worded question about drug use that was found in both the Y9 and the Y2U questionnaire was used (How many times have you ever used illegal drugs?). However, the question seemed to be less sensitive than the more detailed questions in the Y2U questionnaire. In cases where the responses differed, the option indicating the highest health
risk was used. For instance, an adolescent male in Y2U who had answered “never” on the question about using illegal drugs, but “yes” when asked specifically about use of cannabis, was regarded as having responded with “yes” on the first question too, i.e. the drug use item. This might have resulted in incorrect differences between Y9 and Y2U, but the aim of the study was not to report proportions, but to develop a model, wherefore it was deemed to be more important to identify all risks than to avoid spurious differences between Y9 and Y2U.

**Missing data**

The proportion of missing data for each item varied from 0.6% (poor general health) to 5.2% (back pain) in the 2011 survey and from 1.3% (poor general health) to 6.9% (bought anything stolen) in the 2014 survey. For details, please see Paper I, table II and III. Although the degree of missingness was small on each item, the total missingness was deemed too large for complete-case analysis (28% in the 2011 survey and 30% in the 2014 survey). Thus, multiple imputation by chained equations was used to create twenty datasets on which the analyses were conducted (99).

**Determining the number of factors**

A scree plot and Kaiser’s criterion were used to determine the number of factors (94, 95). For each of the twenty imputed datasets, a scree plot based on the polychoric matrix was computed. Thirteen of the twenty scree plots suggested three factors and seven graphs suggested four factors. The results were plotted together into a single graph (please see Paper I, Supplement Figure 3). In addition, Kaiser’s criterion, i.e. using the number of factors with eigenvalues greater than one (94), was applied to each imputed dataset. Kaiser’s criterion suggested three factors in fourteen of the datasets and four factors in the remaining six datasets. When the tests are ambiguous, the analysis can, as a rule of thumb, be conducted using the suggested number of factors as well as with one factor more and one factor less (95). Therefore, the analysis was conducted three times, retaining three, four, and five factors.

**Criteria of item selection**

In the present study, an item was considered as unique to a particular factor if its loading on that factor was at least twice as high as its second largest factor loading (100). Items with less difference between their two highest factor loadings were interpreted as cross-loading and excluded from further analysis unless theoretical important (97, 100). No lower limit was set for factor loadings, i.e. as long as an item loaded at least twice as high on one factor than any other, it was kept in the model.

Factors with at least five items with factor loadings of 0.50 or above were considered as strong factors, while factors with two items or less were considered too weak and excluded from further analysis (95).
Model fit indices
To assess model fit, Root Mean Square Error of Approximation (RMSEA), Comparative Fit Index (CFI), and Tucker-Lewis Index (TLI) were used. For RMSEA, values less than 0.05 suggest good fit, 0.05 to 0.08 acceptable fit, 0.08 to 0.10 marginal fit, and greater than 0.10 suggest poor fit (94). For CFI and TLI, good model fit is achieved with values greater than 0.95 (101) or greater than 0.90 in a large dataset (97). Correlations between factors were considered strong when larger than 0.5, moderate in the range of 0.3 to 0.5 and weak in the range 0.1 to 0.3 (98).

Computation of the model
Three independent analyses were conducted: The first in the full sample (n=2,823), the second in data from Y9 only (n=1,437), and the third in data from Y2U only (n= 1,386).

The exploratory factor analysis was based on polychoric correlations, the extraction method Weighted Least Squares, Mean and Variance adjusted (WLSMV), and the oblique rotation geomin. Polychoric correlations and WLSMV are suitable methods for skewed categorical data (102). Oblique rotation provides more accurate solutions compared with orthogonal rotations when the factors might be correlated (94).

The model was iteratively analysed until no cross-loadings appeared and the model had no weak factors. This procedure was done with three, four, and five factors in the full dataset using 42 items. However, none of the three-, four-, or five factor-models reached acceptable model fit. The models were discussed both internally and externally and their theoretical content assessed. As a result, nine additional items were excluded due to consistently low factor loadings, and one item, snuffing, due to high associations with smoking. Finally, 32 items were included in the analysis. The included items are presented in detail in paper I, table II and III.

Using 32 items, the model was iteratively analysed with three, four, and five factors in each of the three datasets (the full sample, Y9, and Y2U), rendering nine models. However, in all three datasets, the fifth factor was deemed too weak and thus all five-factor models collapsed into four-factor models. A weak factor also appeared in the four-factor model in the Y9 dataset, but by keeping two cross-loading items (headache and stomach ache) in the analysis, the fourth factor could be retained. The three- and four-factor models were compared and were all deemed as theoretical meaningful. In all three datasets, the four-factor models had the best model fit and was therefore chosen as the final model. Finally, the meaning and naming of factors were discussed thoroughly and reflectively until consensus was achieved among the authors.
The confirmatory factor analysis
The four-factor model was validated in the dataset from the 2014 survey. First, the model developed using the full sample, the full model, was tested in the full sample (n=2,358), in Y9 only (n=1,139), and in Y2U only (n=1,219). Confirmatory factor analysis with polychoric correlations and WLSMV estimation were used in imputed datasets from the 2014 survey. Likewise, the Y9 model was tested in Y9 data and the Y2U model was tested in Y2U data. To evaluate the impact of missing data on the model development, the full model was also tested using complete cases (n=1,650) and diagonally weighted least squares estimation. Finally, in the full model, differences between Y9 and Y2U were analysed by the use of multiple indicators and multiple causes model (103). The same model fit indices were used in the confirmatory factor analysis as in the exploratory factor analysis.

Paper II: Confidentiality in relation to health
In paper II, the model from paper I was used in a structural equation modelling (SEM) approach to investigate whether psychosocial health affects how adolescent males value and experience confidentiality and are comfortable asking sensitive questions in a GP consultation. The SEM approach was used because it allows statistically taking into account associations between variables, in this case those between various symptoms of poor mental health, somatic symptoms, and health-compromising behaviours. SEM allows for the use of latent variables, enabling the utilization of the underlying factors identified in paper I instead of the individual variables representing symptoms of poor mental health, somatic symptoms and health-compromising behaviours.

Structural equation modelling
SEM can be used to test a hypothesis using observable and latent variables (103). The hypothesis to be tested has to be described in terms of a SEM model (103). In SEM, regression analyses test associations between variables in several steps simultaneously, which means that multiple associations can be tested at the same time (103).

Variables
Both observable variables (outcomes and covariates) from Life and Health in Youth 2014 and latent variables (exposure) discovered through factor analysis were used.

Outcomes
The outcome measures used in paper II were operationalised as questions developed specifically for this study. Before including them in the 2014 questionnaire, they were tested face-to-face with adolescents of both genders. All
respondents were asked about the value of confidentiality (outcome 1), but only those who had visited a physician at a healthcare centre in the past year (outcome 2) were encouraged to answer the questions about experienced confidentiality (outcome 3 and 4).

The newly developed questions were as follows (translated from Swedish):

1. Do you value
   a) to have the opportunity to speak with the physician in private without your parents? (yes / no)
   b) to have the meaning of professional secrecy explained to you? (yes / no)

2. Have you visited a physician at a primary healthcare centre during the past year? (yes once / yes several times / no / I don’t know)

3. When you visited the physician at the primary healthcare centre,
   a) did you get the opportunity to speak with the physician in private without your parents? (yes / no)
   b) did the physician explain the meaning of professional secrecy to you? (yes / no)

4. Would you, if you wanted to, have been comfortable to ask about
   a) your body and appearance (yes / partly / no)
   b) love and relationships (yes / partly / no)
   c) sex (yes / partly / no)

The questionnaire used the wording läkare på vårdcentral (physician at a primary healthcare centre), because the Swedish terms for GP (specialist i allmänmedicin or allmänläkare) are not commonly used and might be difficult to understand for adolescent males. It might also be difficult for them to recognise whether the physician at the primary healthcare centre was a fully trained GP, a resident in general practice, or a junior doctor. As most physicians in Swedish primary care are GPs or residents in general practice (STläkare i allmänmedicin) (37, 38), the term “GP” hereinafter is used instead of the more cumbersome “physician at a primary healthcare centre”.

**Exposure**

Self-reported symptoms of poor mental health and health-compromising behaviours were represented by the four factors developed in paper I: unsafety, gloominess, pain, and deviancy. Here they were used as latent variables in the analyses of how adolescent males value confidentiality, which concerned the full sample, and experience confidentiality, which only concerned those who had visited a GP the past year (henceforth referred to as “GP visitors”). The model, however, was developed in the full sample, including both adolescent males who had visited a GP and those who had not. Therefore, a validating confirmatory factor analysis, as described above, had to be conducted in the subset of GP visitors before using it in that very subset.
Covariates
Two covariates were included in the analysis: grade (as proxy for age) and impaired connectedness. Given the rapid biological, neurocognitive, and social development in adolescence (1), differences related to age are probable in matters of health or perceptions of confidentiality. Being connected to family, peers, or school are strong protecting factors against symptoms of poor mental health and health-compromising behaviours in adolescent males (104, 105), and thus impaired connectedness was deemed as posing a risk for such symptoms or behaviours. Impaired connectedness was operationalised through four observable variables: difficulties talking about worries with mother, father, or other close adult, and lack of a close friend.

The SEM models
To test whether self-reported symptoms of poor mental health and health-compromising behaviours affect the extent to which adolescent males value and experience confidentiality, these outcomes were analysed in relation to the four latent variables developed in paper I (unsafty, gloominess, pain, and deviancy) and adjusted for grade and impaired connectedness (figure 3; model 1).

Model 1 was also used to test whether symptoms of poor mental health and health-compromising behaviours affect to what degree adolescent males are comfortable asking sensitive questions. Since experienced confidentiality can facilitate sensitive discussions (29, 59, 60), experiences of being comfortable asking about the body, relations, and sex were studied in relation to experienced confidentiality. In model 2 the outcomes were adjusted for experienced private time and in model 3 for experiences of an explanation of professional secrecy. Model 4 adjusted for both experienced private time and experiences of an explanation of professional secrecy. Like model 1, models 2 to 4 also adjusted for grade and impaired connectedness.

Conducting the SEM analysis
The analyses concerning whether adolescent males value confidentiality (outcome 1) were carried out in the full sample (n=2,358). The analyses concerning experienced confidentiality and being comfortable asking sensitive questions (outcome 3 and 4) were only carried out among GP visitors (n=1,200).

The analyses were made in imputed datasets from the 2014 survey, previously used in paper I, and adapted for skewed categorical data. Binary Response Model using Normal Distribution (PROBIT) and theta parameterization were used. To facilitate interpretation, the regression coefficients between the studied variables were transformed to approximative odds ratios (appOR) (106). Pearson’s chi-squared test was used to analyse differences between GP visitors and non-visitors.
Software
Descriptive statistics in papers I and II were calculated with IBM SPSS, version 22. Imputations, scree plots, confirmatory factor analysis, and structural equation modelling were carried out with R 3.5.1 in R studio (version 1.1.463; package psych, mice, and lavaan). For the exploratory factor analysis, Mplus version 8 was used.
Figure 3: Four SEM hypotheses for testing whether poor mental health (operationalised as unsafety, gloominess, and pain) and health-compromising behaviours (operationalised as deviancy) affect to what degree adolescent males value and experience confidentiality and are comfortable asking the GP sensitive questions. Although not shown, all models were adjusted for grade and impaired connectedness. Previously published in Haraldsson et al. (107).

Seven different outcomes were used in model 1: The value of private time, the value of having professional secrecy explained, experience of private time, experience of having had professional secrecy explained, being comfortable asking about body and appearance, love and relationships, and sex.

Three outcomes were used in models 2–4: being comfortable asking about body and appearance, love and relationships, and sex.
Paper III: Adolescent males’ experiences

To fulfil the aim of paper III, an approach was required that could inductively identify and describe patterns in adolescent males’ lived experiences of GP consultations. Since reflexive thematic analysis as described by Braun and Clarke (108-110) is a flexible approach that previously has been used with the lifeworld theory (111), it was deemed useful for this purpose.

Reflexive thematic analysis

Reflexive thematic analysis can generate rich descriptions and unexpected insights (108). It can be used both inductively, as it is here, and deductively (108-110). Patterns are sought across a set of data to develop themes that are internally consistent and clearly separated while still sharing a unifying concept (108-110). Reflexive thematic analysis according to Braun and Clarke comprises six steps (108, 110, 112). First, the researchers must familiarise themselves with the data to get a sense of its contents as a whole. Second, codes are generated, which means that each part of the data that might be relevant to the research question—i.e., each data extract—is labelled with a few describing words (a code). Next, patterns of meaning are searched for among the codes, and initial themes are created. In the fourth phase, the initial themes are developed and reviewed by checking them against the coded data extracts and the entire set of data, sometimes using a thematic map to visualise the patterns. The themes are then further refined by working out each theme’s focus and giving it an informative name. In the final phase a report is written, in which the analysis is illuminated with rich quotations and contextualised in relation to relevant literature.

Conducting the reflexive thematic analysis

The analysis in paper III was guided by openness as prescribed by the lifeworld theory and by the six-phase process as described by Braun and Clarke (108, 110). To familiarise myself with the data, I transcribed the interviews and checked the accuracy of the transcripts against the audio files. The transcripts were read until I felt confident that I had grasped their contents. The texts were then read systematically, and every meaningful data extract was condensed and labelled with a code. Rich data extracts received more than one code. Each time a new code was introduced, the already coded data were revisited in order to find any overlooked occasions of the new code. Patterns among the codes were searched for and initial themes were constructed. A thematic map with codes and themes was generated. The initial themes were then thoroughly revised by comparing them to each other and reflecting upon them in terms of their codes and data extracts. The initial themes were thereby developed into three themes overarched by a main theme. In this process, codes were also reviewed and sometimes renamed, split, or fused together. The themes were further refined by articulating the core content of each theme
in order to find out its scope and its limits towards the other themes as well as a suitable name. Notes from the entire process of analysis were reflected on in relation to the themes. To seek a nuanced interpretation, all steps in the research process were collaboratively discussed among three of the authors (JH, LJ, and LN). The refining and naming of the themes were discussed among all authors.

Paper IV: Observations of GP consultations

The aim of paper IV was to explore and describe adolescent males’ encounters with GPs in Swedish primary care through a lifeworld perspective. To reach a deeper understanding of what happened in the encounters, a qualitative design with phenomenological-hermeneutical video observations based on a lifeworld approach were chosen. A phenomenological-hermeneutical approach can be used when the aim is to understand lived experiences of clinical encounters through observations (113, 114).

Video observations in primary care

Video observations have been used to study consultations in primary care since the 1970s, due to the ability to capture more details in a clinical encounter than what is possible with direct observations (115). It can for instance be used for analysing non-verbal communication or how GPs’ self-assessments differ from their observable behaviour (115).

Hermeneutic observations

Hermeneutic observations, direct or via video recordings, can be used as a data collection method in hermeneutical research (116). Hermeneutic observations are useful for studying clinical interactions and for understanding what actually happens in an encounter. New perspectives can be explored, as the observer strives to see the deeper meaning. For instance, experiences that are too complicated to articulate in an interview can be uncovered. Hermeneutic observations may also be less influenced by the participants’ opinions compared with interviews (116).

To observe a situation is to interpret what happens (116). Interpretation presumes pre-understanding, but depends also on the observers’ skill for verbalising what is seen and perceived. In seeing and interpreting meaning in an observed situation, the observers must also maintain a reflective distance and an awareness of their own pre-understanding and subjectivity (116).

The phenomenological–hermeneutical method

Phenomenological–hermeneutical research aims to understand the meaning of a phenomenon by exploring lived experiences (117, 118). It can be used to explore meanings of phenomena in our everyday life and illuminate different ways of being in the world (118). A better understanding of the lifeworld of
others can be helpful in improving care, and thus the phenomenological–hermeneutical method can be useful in healthcare research (118). Phenomenological-hermeneutic research can use data from interviews (117) or observations (113, 114).

Phenomenological–hermeneutical research starts in concrete reflection, when the researcher attempts to express what mattered in the situation. In the process of phrasing and rephrasing the lived experience, an understanding begins to evolve. The analysis comprises three methodological steps: naïve understanding, structural analysis, and comprehensive understanding. The analytical process follows the hermeneutical circle that moves between understanding and explanation, from the whole to the parts (117, 118).

The hermeneutic circle also illuminates that understanding presupposes (pre)understanding (118). Without pre-understanding, no meaning can be found (117, 118). In order to see the meaning of the phenomenon, the researchers have to stay open, to let themselves being touched by the observed situation, and to refrain from judging and concluding. In other words, the researchers must put their judgement into brackets in order to be open to the phenomenon (117, 118).

Conducting the phenomenological–hermeneutical analysis
The first methodological step was to generate a naïve understanding. The observers approached the video recordings with openness and reflective distance aiming to see the meaning of the observed situation as a whole. Together, two or three authors analysed each video recording with a focus on the adolescent male’s experience of the consultation, taking both verbal and non-verbal communication into account. The authors reflected together on the observed situation and concluded their observations in a short résumé for each video recording. I synthesised the nine résumés into an initial naïve understanding, rewatched the video recordings, and rewrote the synthesis until all authors agreed on the initial naïve understanding.

The second step in the phenomenological-hermeneutical method is the structural analysis. This step was guided by the intrinsic structure in the consultation. During the first step of analysis, the authors had noted that all nine consultations comprised three phases. First, the adolescent male describes his problem to the GP (describing the problem). Second, the physical examination occurs (examination). Finally, the GP explains their findings and gives advice or suggests treatment, further examinations, or referral (explanation). Each video recording was analysed phase by phase by me and at least one another author. We reflected together on our observations and wrote a short description of each phase. The short texts were sorted according to the phase to which they belonged, divided into meaning units, and each meaning unit was labelled with one or more codes. Patterns were searched for among the texts and codes, both phase by phase and in all three phases simultaneously, and thus themes
were developed. Each theme spanned all three phases. Before moving on to the third step of analysis, the naïve understanding had to be validated by the structural analysis. This process resulted in minor amendments of the naïve understanding.

In the third step, the naïve understanding and the themes from the structural analysis were synthesised and reflected on as a whole in relation to appropriate literature and the authors’ pre-understanding so that a new deeper understanding, a comprehensive understanding, could evolve. Here, the philosophy of Løgstrup was used to discover new aspects of the data.

**Software**

No software designed for qualitative analyses was used in paper III and IV. Instead, Microsoft Word, Microsoft Excel, paper, scissors, coloured pens, and lots of paper clips were used.

**Ethical considerations**

**Papers I and II: Developing a model and Confidentiality in relation to health**

The questionnaire *Life and Health in Youth* contains several questions that might be considered intrusive. To protect the participants’ privacy, the survey was therefore fully anonymous. As a consequence, no signed written informed consents could be collected. Instead, given that the students were informed beforehand that participation was voluntary, a completed questionnaire was regarded as an informed consent. According to Swedish law, no parental consent is required for adolescents over 15 years (88). The regional Ethical Review Board in Stockholm approved the study design (Dnr 2008/1855-31/5, 2014/1955-32 and 2017/709-32).

**Papers III and IV: Adolescent males’ experiences and Observations of GP consultations**

Interviews about private matters and video-recorded consultations assign a great responsibility to the researchers to ensure the privacy and protect the dignity of the participants throughout the research process. The oral and written information was therefore particularly detailed regarding methods for secure data storage and privacy protection.

The adolescent males received two cinema tickets each after the interview was finished. To avoid undue influence of this gift on the decision to participate, it was not mentioned in the study information. The Swedish Ethical Review Authority in Linköping approved the study design (Dnr 2022-00075-01).
Results

In this section, the main findings are presented. More detailed descriptions can be found in the papers attached at the end of this thesis.

Paper I: Developing a model

The study population consisted of 2,823 adolescent males in the survey *Life and Health in Youth* 2011 and 2,358 adolescent males in *Life and Health in Youth* 2014. Most of them were healthy with high well-being and they enjoyed school and spare time. Nevertheless, many adolescent males, particularly the older ones, engaged in health-compromising behaviours. For instance, one in four adolescent males drank alcohol every month, one in six smoked regularly, and one in eight had used illegal drugs at least once. Moreover, a quarter of the adolescent males exercised less than once a week, and one in eight had committed burglary.

The resulting model of the co-variation of poor mental health, associated somatic symptoms, and health-compromising behaviours comprised four factors that were named *unsafety, gloominess, pain,* and *deviancy* (figure 4). The first factor, *unsafety,* comprised six items about feeling unsafe at home, in school, and in the neighbourhood. The second factor, *gloominess,* comprised five items concerning dissatisfaction with life and spare time as well as a lack of good health, joy, and exercise. *Pain* comprised four items about pain: pain in the head, neck, back, or stomach, and the last factor, *deviancy,* comprised ten items concerning substance use, delinquent behaviours, and sexual activities without contraceptives.

Factor correlations

*Gloominess* correlated moderately with *unsafety* and *pain,* which in turn correlated weakly with each other. The relation between *gloominess* and *pain* was also apparent during model development, as items about low mood, worry, insomnia, and stress were connected to both of them. These items thus had to be removed from the analysis.
Figure 4: The exploratory factor analysis resulted in four factors: unsafety, gloominess, pain, and deviancy; here presented with their including items.

Age differences in the co-variation of symptoms of poor mental health, somatic symptoms and health-compromising behaviours

To evaluate age differences, models for Y9 only and for Y2U only were developed. They contained the same four factors but differed slightly on the item level in the factor gloominess, as well as with regard to factor correlations.

The connection between gloominess and pain seemed to be stronger among the younger adolescent males, because in the model developed in Y9 data only, headache and stomach ache loaded on both factors (although to a greater extent on pain than on gloominess). However, in the model developed in Y2U
data only, *gloominess, unsafety*, and *pain* correlated strongly with each other, which contradicts the hypothesis that the correlations would be weaker among the older students. Overall, minor differences of unclear relevance were found due to age.

**Testing the model**

In the full sample based on data from the 2011 survey (n=2,823), the exploratory factor analysis resulted in a model with 25 items and acceptable to good model fit (RMSEA 0.06, CFI 0.94 and TLI 0.92). The model was then validated in data from the 2014 survey with acceptable to good model fit (RMSEA 0.06, CFI 0.95 and TLI 0.94) by the use of confirmatory factor analysis. The items’ factor loadings were roughly the same in the exploratory and confirmatory factor analyses.

Furthermore, the model fit was acceptable to good when testing the full model in the Y9 subset and in the Y2U subset as well as in the full sample using complete cases as method for handle missing cases. This indicates stability in the developed model.

**Paper II: Confidentiality in relation to health**

In paper II, adolescent males’ valuing and experiences of confidentiality was studied in relation to their self-reported mental health and health-compromising behaviours. Confidentiality was here defined as consisting of two parts; spending private time with the GP and having professional secrecy explained. Self-reported mental health was operationalised as *unsafety, gloominess*, and *pain*. Health-compromising behaviours were operationalised as *deviancy*.

The studied population in paper II consisted of the 2,358 adolescent males that participated in the 2014 survey, i.e. the same dataset that was used for confirmatory analyses in paper I. Half of them (53%) reported that they had visited a GP in the past year. Compared with adolescent males who had not visited a GP in the past year, GP visitors reported higher frequencies of pain symptoms and health-compromising behaviours, and seemed to exercise more frequently.

**Valuing confidentiality**

Spending private time with the GP was valued by almost all respondents (86%, n=1,865). Likewise, having professional secrecy explained was valued by around the same amount (83%, n=1,771). The older adolescent males (Y2U) valued confidentiality higher than their younger peers (private time: appOR 1.32, p<0.001; explanation of professional secrecy: appOR 1.15,
Experiences of confidentiality

Experience of private time with the GP was reported by 837 (74%) of the 1,200 adolescent males who had visited a GP in the past year. Experience of having had professional secrecy explained was reported by 456 (42%) of the GP visitors. Adolescent males who engaged in many health-compromising behaviours were more likely to get professional secrecy explained compared with peers engaged in fewer health-compromising behaviours (figure 5). Likewise, compared with their younger peers, the adolescent males in upper secondary school (Y2U) were more likely to experience private time with the GP (appOR 1.42; p<0.001). Symptoms of poor mental health did not impact confidentiality in this study (figure 5).

![Figure 5: Adolescent males’ experiences of receiving private time and an explanation of professional secrecy in relation to poor mental health and health-compromising behaviours when visiting a general practitioner. The results are shown as approximative odds ratios with p-values in parentheses. Data from 1,200 adolescent males in Life and Health in Youth 2014.]

Being comfortable asking sensitive questions

Around half of the GP visitors reported that they would have been comfortable asking the GP sensitive questions (response option “yes”), although the frequencies varied depending on the topic. A higher number reported that they would have been comfortable asking about the body (57%) compared with asking about love and relationships (45%) or sex (45%). An additional quarter responded that they would have been “partly” comfortable asking about the body (22%), love and relationships (24%), and sex (24%).
Adolescent males who had experienced confidentiality were more often comfortable asking sensitive questions than those without that experience (figure 6). Of those who had received neither private time nor an explanation of professional secrecy, 41% were comfortable asking about the body, 30% about love and relationships, and 30% about sex. Among those who had experienced both private time and an explanation of professional secrecy, the corresponding numbers were nearly twice as high; 70% were comfortable asking about the body, 56% were comfortable asking about love and relationships, and 56% were comfortable asking about sex.

Figure 6: Proportions of adolescent males who reported that yes, they would have been comfortable asking about body and appearance, love and relationships, and sex in relation to received confidentiality. Confidentiality was operationalised as experiences of private time with the GP and as experiences of receiving an explanation of professional secrecy. The figure is based on data from 1,200 adolescent males that reported having visited a GP in the past year in Life and Health in Youth 2014. Modified from Haraldsson et al. (107).

The impact of confidentiality was also apparent in the SEM analyses. Confidentiality, particularly spending time with the GP, facilitated asking sensitive questions in all models. Adolescent males who were engaged in many health-compromising behaviours were more comfortable asking about sex than peers with fewer health-compromising behaviours. In table 2, results from the most complex SEM model, model 4 (figure 3), are presented.

Adolescent males’ patterns of connectedness also affected how comfortable they were asking sensitive questions. Those who reported not having any close friend or adult (other than parents) in whom they could confide were less comfortable asking sensitive questions compared with peers with close relations outside the family. Symptoms of poor mental health did not affect how
comfortable adolescent males reported being with asking sensitive questions (table 2).

Table 2: Adolescent males’ reports of being comfortable asking the GP about their body and appearance, love and relationships, and sex in relation to received confidentiality, symptoms of poor mental health, and health-compromising behaviours. Results from SEM model 4 (figure 3), shown as approximative odds ratios (appOR) and p-values with significant values in bold. (The PROBIT-coefficients were transformed to approximative odds ratios to facilitate interpretation.) The model was adjusted for age and for impaired connectedness. Adjusted from Haraldsson et al (107).

<table>
<thead>
<tr>
<th>Comfortable asking about… (yes/partly/no)</th>
<th>Body and appearance</th>
<th>Love and relationships</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>appOR</td>
<td>p-value</td>
<td>appOR</td>
</tr>
<tr>
<td>Confidentiality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private time (experience of)</td>
<td>1.54</td>
<td>&lt;0.001</td>
<td>1.43</td>
</tr>
<tr>
<td>Explanation of professional secrecy (experience of)</td>
<td>1.25</td>
<td>0.010</td>
<td>1.34</td>
</tr>
<tr>
<td>Poor mental health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unsafety</td>
<td>0.85</td>
<td>0.100</td>
<td>0.87</td>
</tr>
<tr>
<td>Gloominess</td>
<td>1.09</td>
<td>0.389</td>
<td>1.04</td>
</tr>
<tr>
<td>Pain</td>
<td>1.15</td>
<td>0.080</td>
<td>1.12</td>
</tr>
<tr>
<td>Health-compromising behaviours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deviancy</td>
<td>0.97</td>
<td>0.699</td>
<td>1.08</td>
</tr>
<tr>
<td>Older age</td>
<td>1.04</td>
<td>0.549</td>
<td>0.98</td>
</tr>
<tr>
<td>Impaired connectedness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulties talking about worries with…</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>…mother</td>
<td>0.88</td>
<td>0.061</td>
<td>0.89</td>
</tr>
<tr>
<td>…father</td>
<td>1.03</td>
<td>0.742</td>
<td>1.03</td>
</tr>
<tr>
<td>…other close adult</td>
<td>0.85</td>
<td>0.012</td>
<td>0.87</td>
</tr>
<tr>
<td>Absence of a close friend</td>
<td>0.84</td>
<td>0.006</td>
<td>0.85</td>
</tr>
</tbody>
</table>

Paper III: Adolescent males’ experiences

Nine adolescent males were interviewed about their experiences of a GP consultation. The informants described the encounters as “good” and the GPs were perceived as “really kind” and “professional”. The analysis generated one over-arching theme—To be listened to. In addition, three themes were developed. The first was named To handle insecurity and uneasiness, the second To be understood and cared for, and the last theme was called To get
parental support on his terms (figure 7). To stay true to the voices of the adolescent males, the themes are presented in the third person singular. Thus “he” does not represent any specific informant but rather serves as a fictional male character describing the findings to the reader.

Over-arching theme: To be listened to

To be listened to means being understood and taken seriously. The GP listens carefully and attentively to him and demonstrates their understanding by adapting all aspects of the consultation to him. He cannot take for granted that he will be listened to, but when it happens, he dares to believe that the GP will help him. He might bring a parent to ensure that the GP will listen, but then he risks the GP listening more to the parent than to him.

To handle insecurity and uneasiness

To handle insecurity and uneasiness means to face an unfamiliar and potentially embarrassing or painful situation without knowing how to handle it. It also means to worry about being dismissed without getting any help and how to reveal his vulnerability while still maintaining his dignity.

A consultation with a GP is an unfamiliar situation, and he does not know what to expect or how to behave. He doubts his capability to clearly explain his problem and to fully understand what the GP says and what is happening.

He dreads the embarrassment that follows from exposing himself as vulnerable when revealing his body and his worries. Having been taught that men do not reveal their pain or feelings, he is unsure of how to reconcile being help-seeking with being a man.

He fears that the GP will not listen to him nor take him seriously, but instead humiliate or neglect him. He worries about being dismissed without help, as he would then have revealed himself as vulnerable in vain.

He can handle his insecurity by preparing beforehand what to say or by bringing a relative as support.

To be understood and cared for

To be understood and cared for means to feel that the GP understands him, cares about him, and intends to help him. It is about trust, hope and being safe.

The GP is perceived as interested, skilled, and truly wanting to help him. The GP devotes sufficient time, asks about a lot of details, and makes an effort for his benefit. He is respectfully listened to and invited to correct any misunderstandings. Thus he feels safe and understood. He is at ease and dares to confide in the GP or ask those questions to which he needs answers.

The GP demonstrates their understanding by adapting language, pace, and actions so that he can understand what happens, what is bothering him, and
what to do next. He gets helpful advice that fit into his understanding of the problem as well as his everyday life. He can start to hope for an end to his troubles.

To get parental support on his terms

To get parental support on his terms means to balance between independence and need of support from his parents. He needs privacy and to be the one that the GP listens to while also needing his parents’ help.

As his needs vary between and during the consultations, support must be adapted to his fluctuating demands. Parental support can be irrelevant when it has become natural to visit a GP on his own. He can also find their presence insignificant, without any real impact on the encounter. The parents are welcome but not required; rather, they are taken for granted. Thirdly, the parents can provide appreciated safety or practical assistance, such as answering tricky questions. Finally, parental presence can be inhibiting when he needs privacy, for instance to talk about substance use or sexual activities. Moreover, the parents can also be inhibiting when their view of the problem overshadows his. The worries being his, the GP must listen to him, not to how anybody else perceives the matter.
Figure 7: In the thematic analysis of adolescent males’ experiences of GP consultations, one over-arching theme, To be listened to, and three themes, To handle insecurity and uneasiness, To be understood and cared for, and To get parental support on his terms, were generated.

Paper IV: Observations of GP consultations

In paper IV, adolescent males’ GP consultations were further explored by watching the video-recorded consultations and analysing them with a phenomenological–hermeneutical method. To deepen the researchers’ understanding, the observations are reflected upon in the light of Løgstrup’s writings on The Ethical Demand (77).

The results are presented in accordance with the three methodological steps of phenomenological hermeneutics: naïve understanding, structural analysis, and comprehensive understanding. The first two are based on the studied data only, whereas in the latter, relevant literature, in this case Løgstrup, is incorporated into the analysis. The comprehensive understanding is presented in the Discussion section.

As in paper III, the findings are presented in the third person singular without representing any specific participant. In each excerpt relating to a specific observation, the pseudonym of the adolescent male in question is provided.
Naïve understanding

The adolescent male has to exert himself to the utmost to meet the challenges that a consultation with a GP entails. He concentrates hard to explain his problem and to answer the GP’s questions competently, while simultaneously considering the extent to which he dares confide in them. He listens attentively to the complicated words that are offered in a frenetic pace as he tries to understand what the GP means.

He is uncomfortable and exposed, sometimes watchful, worried, or embarrassed. If he feels seen and acknowledged, he can relax a bit. He seems to trust the GP’s advice and starts to hope to get better.

He has prepared the encounter in advance, and he wants to take an active part in the decisions. He might need support, but even though parents can be helpful in explaining what happens and in answering tricky questions, they can also take over the discussion or just make him feel still more embarrassed. Even absent parents may affect the encounter. For instance, he may have to consider the risk that his parents will find out later on what he has disclosed to the GP.

Structural analysis

In the structural analysis, a main theme was identified: Struggling in no-man’s land between childhood and adulthood. Also, four themes were formulated. They were called To be strained by incomprehensibility, To mitigate and endure vulnerability, To be respectfully seen and cared for, and To navigate initiative and responsibility.

Main theme: Struggling in no-man’s land between childhood and adulthood

Struggling in no-man’s land between childhood and adulthood describes the adolescent male’s endeavours to balance his independence with his need of support as he faces the cognitive and emotional challenges posed by a GP consultation.

He is old enough to take (some) responsibility for his own health and to be an active part in the discussion while still not having enough experience of GP consultations to know what to expect or how to behave. Untrained in expressing bodily sensations and medical symptoms, he struggles to clearly explain what bothers him. He devotes much effort to understand complicated questions or explanations. He endures embarrassment and vulnerability while he struggles to maintain his dignity. He may need parental support in practical matters or as protection from misunderstandings and dismissal. Nevertheless, he may have to restrict his parents’ interference, lest he might lose the right to define his problem or the responsibility for his own health.
To be strained by incomprehensibility

To be strained by incomprehensibility means mustering all his energy to handle an important, unfamiliar, and partly unintelligible situation without knowing how.

The GP consultation is an unfamiliar situation. He does not know what is expected from him or what to expect, and thus he dreads what will happen. He strains every nerve to explain his troubles well enough to make the GP understand them. He carefully answers the GP’s questions and clarifies any misunderstandings. He tries hard to understand the GP’s explanations, which often consist of complicated words delivered at a rapid pace or obscure wordings that he cannot relate to his troubles. The strain eases when the discussion turns to more familiar subjects or when he finds that he understands. His efforts to overcome the incomprehensibilities that he is facing makes him exhausted. Sometimes he does not get a clear explanation of his troubles, but is left in incomprehensibility, such as when he needs to wait for further examinations or referrals.

The GP rises abruptly from the chair. Nasir follows her with his gaze, watchful, attentive. The GP does not explain what she is about to do. Nasir waits quietly and cautiously.

To mitigate and endure vulnerability

To mitigate and endure vulnerability means to cope with various degrees of exposure, embarrassment, objectification, and defencelessness.

In order to get help with what is troubling him, he has to reveal himself as vulnerable and to endure the objectification that is intrinsic to being a patient. He protects his family (or sometimes, pets) by glossing over unfavourable details or fiercely denying that they would impact negatively on his health. Attentive and watchful, he submits to unpleasant examinations involving nakedness, physical closeness, and awkward or painful procedures. He strives to maintain his dignity, to reduce shame, and to guard his boundaries. The GP and his parents may mitigate or aggravate his vulnerability. The GP can reinforce objectification by talking to his parents while examining him. The parents, in turn, might try to correct him or otherwise behave in ways that he finds humiliating. His vulnerability can also be acknowledged and responded to by parents or the GP, such as when the GP asks for his permission or when his parents step out of the room during the examination.

Axel is apparently not at ease. He is fidgety, fiddling with his hands. He has to pull himself together before he starts talking. /…/ He looks at his father for help. /…/ Axel shifts on his chair, fidgeting with his glasses and with his hands. He laughs briefly, apologises for his behaviour.

To be respectfully seen and cared for

To be respectfully seen and cared for means to be met with interest and trust, and to be seen as a person.
He encounters attentiveness, kindness, and friendliness. The GP is interested in his everyday life and demonstrates that they care about him and are willing to help him. His suffering is acknowledged, emotionally and verbally, and he feels affirmed and comforted. His vulnerability is recognised and acted upon in words and actions. His experience is not questioned; he is trusted. As he recognises that the GP has adapted their assessment, explanation, and plan to his needs and to his lifeworld, he feels that he has been taken seriously. He can also be comforted and encouraged by present relatives.

The GP leans forward, moves closer, slips his glasses atop his brow. He looks Ali in the eyes and speaks in a friendly tone.

**To navigate initiative and responsibility**

*To navigate initiative and responsibility* means to navigate between being the independent man who claims the right to set the agenda and takes responsibility for his health, the weak and vulnerable patient seeking the GP’s advice, and the ill child who needs his parents’ support.

He negotiates with the GP and his parents the right to be in charge of the consultation and take responsibility for his own health. He takes the initiative by claiming the right to define the problem and to be involved in his own care. He corrects any misunderstandings, and possibly challenges the GP’s understanding. The GP can accept him having the initiative, by listening attentively to how he experiences his troubles and by discussing with him their plan for future care. Likewise, his parents can accept him having the initiative by sitting quietly in the background. When invited, they assist him, but before they do, they check with him to ensure that their view of the problem is consistent with his.

He can be deprived of the initiative by the GP or his parents. In these situations, he accepts that the GP steers the discussion without allowing him to further elaborate on his concerns. He becomes powerless and passive. He replies to questions that he does not quite understand and submits himself to uncomfortable medical procedures. He accepts being interrupted and that the GP is in charge of the care plan.

His parents can start talking without being invited to. They can interrupt or contradict him and they can insist on being involved in the follow-up. They can also try to protect him from pain or embarrassment. Even absent parents can retain the initiative, for instance by setting the agenda while booking the consultation. Also, their view of the problem can be intertwined with his in his description.

The GP plans a follow-up by phone. Erik responds quickly and firmly that he wants the GP to call him, not his father. But Erik’s father interferes, suggesting that the GP call him instead, because Erik cannot answer the phone in school. Erik objects against this, but the GP accepts the father’s suggestion.
Discussion

Main findings

The model of self-reported symptoms of poor mental health, associated somatic symptoms, and health-compromising behaviours presented in this thesis comprises four groups, each of which is united by an underlying, but unknown, common factor: *unsafety* (a tendency to feel unsafe), *gloominess* (a general lack of well-being and joy), *pain* (a tendency to experience bodily pain), and *deviancy* (a tendency to engage in health-compromising behaviours). *Gloominess* was correlated to *pain*, particularly among younger participants, and to *unsafety*.

Confidentiality was valued by almost all participating adolescent males and was found to increase the odds of being comfortable asking sensitive questions about the body, relations, or sex. Self-reported symptoms of poor mental health or health-compromising behaviours did not substantially impact these findings.

In their consultations with GPs, the adolescent males wanted to be listened to, understood, cared for, and taken seriously as they feared to expose themselves as vulnerable in vain. They might need parental support, but the parents’ interference must be on their terms.

The adolescent males faced a complex challenge, in which they struggled to master the encounter despite its unfamiliarity and cognitive and emotional demands, while enduring embarrassment as well as navigating independence and parental support.

Contextualisation of selected results

First, I relate the findings of this thesis to questions about age and the biological, neurocognitive, and social development in adolescence. Second, I compare the findings with two consultation models to see to what extent the models can guide GPs to adequately meet the needs of adolescent males. Third, I move beyond healthcare and general practice into ethics, interpreting their experiences in the light of the Ethical Demand that, according to Logstrup, arises when a human being reveals their vulnerability to another human being.
Complex consultations as a result of biological, neurocognitive, and social development

The adolescent males’ consultations were notably complex.

**Vulnerability**

According to the findings in papers III and IV, the adolescent male’s GP consultation was a cognitive and emotional challenge, compounded by his inexperience and notions of masculinity. The adolescent male struggled to explain himself clearly enough to be correctly understood. To understand what was being said and what was taking place, he had to concentrate hard to be able to decipher complicated words delivered and procedures undertaken at a rapid pace.

He was worried, embarrassed, and uneasy. The vulnerability that is intrinsic to help-seeking (72, 119) was here exaggerated by his inexperience of GP consultations, as he did not know how to behave, what to expect, or how to describe his symptoms. His vulnerability was also compounded by traditional masculine ideals of strength and of being someone who solves his own problems. No longer a child, yet without much experience of being a man seeking healthcare, he struggled to maintain his dignity as a man while revealing his weakness and pain.

At the end of the consultation, he exhibited clear signs of exhaustion, suggesting considerable cognitive and emotional exertion, plausibly exacerbated by age-related heightened susceptibility to stress and emotions such as embarrassment, along with a dearth of experience to draw upon (1, 8).

The adolescent males’ endeavours contribute to explaining their desires as described in previous literature. It is known that adolescent males want medical procedures, findings and advice clearly explained without rush so that they have enough time to grasp what is taking place and what being is said (44). What is new, however, is the extent to which the consultation appeared to demand an effort on their part, evident through their intense concentration that led to observable exhaustion. This suggests that the aforementioned desires should be considered more in terms of *needs* derived from age, inexperience, and gender, rather than as mere *wants*.

**Understood, seen, and cared for**

The adolescent males wanted to be listened to, understood, and taken seriously (paper III). They valued being seen as persons and having their experiences and suffering recognised. Furthermore, they wanted to be trusted, acknowledged, and feel that the GP cared about them.

These features have previously been reported in studies concerning adolescents of both genders, younger as well as older, in primary care and in hospital care (40-44, 48-50, 120, 121). What the present studies add, however, is that he judged whether he was understood and listened to on the basis of how well
the GP adapted the consultation and advice to fit him as an individual. This means that GPs must, in addition to listening actively to their adolescent male patients, demonstrate their understanding by adapting their actions to meet his individual needs throughout the consultation. Such adaptions might be maintaining an unhurried pace, being sensitive to his pain or embarrassment, or phrasing their questions and explanations clearly and in alignment to his understanding of his problem.

Navigating initiative, responsibility, and parental support
Despite his insecurities and struggles, he claimed the right to define and handle his problem. Being well underway to becoming an autonomous man responsible for his health, he needed to be listened to, to have his privacy respected, and his view to take priority. He might still need parental support for safety or practical assistance, but their interference had to be on his terms (papers III and IV).

Adolescent males’ right to be involved in decisions regarding their health is supported by the United Nations’ Convention on the Rights of the Child, the World Health Organization’s concept of Youth-Friendly Health Service, as well as Swedish law (122-124). While adolescent males desire involvement in medical decisions, parental presence can both facilitate and hinder this (125, 126). Parents who are present may request information for his benefit and provide protection against being misunderstood or not being taken seriously (40, 42, 126). On the other hand, parents may also dominate the conversation and thus inhibit adolescent males’ engagement in decision-making and information sharing (125, 126). Their presence can also inhibit communication due to confidentiality concerns (41, 47, 56). The findings in papers III and IV illuminate in a way that is, as far as I know, novel, the ongoing navigation between striving for autonomy and needing support throughout the entire consultation. Even though the studied consultations addressed rather simple medical issues, the adolescent males kept balancing between these two extremes, one minute a grown-up man taking responsibility, the next a child cared for by his parent.

Confidentiality
Almost all adolescent males valued spending private time with the GP and having the meaning of professional secrecy explained to them. Moreover, those who had received confidentiality reported that they were more comfortable asking the GP whatever they needed about their bodies, relationships, and sexual lives compared with those without confidentiality (paper II). They preferred to discuss sexual activities or substance use without their parents and were embarrassed when they were asked about such matters in their presence. They admitted that they might lie to keep the parents in the dark, but they could also choose to be candid and direct, as a means for assuming responsibility for their health, even though the latter strategy carried a risk of them
being lectured by their parents. They could also feel uncomfortable being examined in the presence of their parents or when discussing matters involving them (papers III and IV).

This is in accordance with previous literature, in which confidentiality has been found to facilitate discussions of sensitive matters (29, 59, 66). Adolescents report that they want confidentiality to keep parents (and others) unaware of their private life (41, 42, 47, 49, 62, 63) and that being respected by the GP is not enough to be able to talk about personal matters (127). This can be explained by the normal development in adolescence which entails an increased need for privacy as sexuality and exploring behaviours come into play, while their parents still are very involved in their lives, for instance by accompanying them to healthcare visits (1, 128). Moreover, in Sweden, as in most European countries, adolescents are considered minors until the age of 18 (129). However, although it is known that confidentiality enhances adolescents’ willingness to talk about sensitive matters (29, 59, 66), few other studies have explicitly studied whether confidentiality may affect whether adolescent males feel comfortable expressing their own concerns.

Three quarters of the adolescent males that had visited a GP in the past year reported that they had received private time with the GP and two fifths that they had had professional secrecy explained (paper II). Similar frequencies of explanations of professional secrecy are reported in the literature (62, 64, 130). The frequency of private time in our study is higher compared to most studies conducted in Europe, North America, and Oceania (62, 64-66, 79, 80, 130-134), except for a few studies with provider-reported frequencies (25, 26) and one intervention study that tested a screening questionnaire (135). The high frequency of reported private time in our study might be a result of an educational intervention in adolescent medicine that had been provided to the GPs in the region a few years prior to the study, but this must be interpreted with caution as there are no other confidentiality studies in the region to compare with. In fact, to the best of my knowledge, this is the first study of received confidentiality for adolescent males in Sweden.

**Confidentiality in relation to symptoms of poor mental health, somatic symptoms, and health-compromising behaviours.**

Adolescent males who engaged in many health-compromising behaviours were more likely to receive an explanation of professional secrecy and were also more comfortable asking about sex than those who engaged in fewer health-compromising behaviours. Except these findings, neither poor mental health nor health-compromising behaviours affected how they valued or received confidentiality (papers I and II).

The association between health-compromising behaviours (which included sexual risk-taking) and an explanation of professional secrecy is reminiscent of findings from an American study, where sexually active adolescents were
more likely to discuss confidentiality with their primary care provider compared to their sexually inactive peers (60). Sexual activity has also been linked to the provision of private time (135), although the present study did not find such an association. It is also plausible that the association between health-compromising behaviours and receiving an explanation of professional secrecy is due to any of the other health-compromising behaviours encompassed in *deviancy*, even though the aforementioned studies found no associations between confidentiality and, for instance, substance use (60, 135).

The finding that sexually active adolescent males were more comfortable discussing sex might be an effect of the composition of the contraceptive variable that was included in *deviancy*. Specifically, all adolescent males who reported having had sexual intercourse were assigned a higher value for *deviancy* than those who had not engaged in such sexual activities. As the experience of sexual intercourse itself may facilitate discussions about sex, the association between high *deviancy* and being comfortable talking about sex is expected.

No associations between confidentiality and symptoms of poor mental health were found. Although this aligns with a small study (135), it also contrasts with other previous studies, in which self-reported depressive symptoms have been associated with higher odds of receiving private time (26) but also with higher levels of forgone healthcare due to confidentiality concerns (61). It is possible that more granular response options than *yes* or *no* on the confidentiality questions might have been more sensitive in this regard, as the perceived importance of confidentiality might vary in the population. The findings may also be explained by the fact that engagement in health-compromising behaviours can sometimes entail observable attributes, such as the smell of cigarette smoke or a bulge indicating a box of snuff in his pocket, which remind the GP to explain professional secrecy. In contrast, symptoms of poor mental health might be harder for the GP to detect.

It is also possible that the model of poor mental health and health-compromising behaviours was unfit to establish such relations (paper I). Associations relevant for depressive symptoms might have been underestimated as the model reflected poor mental health in more general terms to fit the wide scope of health assessments in primary care. For instance, three symptoms connected to depression (worry, insomnia, and low mood) were removed during the analysis due to their connections to both *gloominess* and *pain*. That means that both the factor *gloominess* and the factor *pain* can be expressed as worries, insomnia, or low mood. By separating them into *gloominess* and *pain*, potential associations might have been underestimated.

Another possibility is that *gloominess* and *pain* were two aspects of the same factor and that the relationships would have been more accurately represented by a three-factor model. This assumption is further strengthened by the fact that *gloominess* and *pain* correlated moderately to strongly in all models and that the items headache and stomach ache loaded on both *gloominess*
and pain in the Y9 model. On the other hand, the three-factor model that was developed was, due to poorer model fits, deemed inferior to the four-factor model. The model fits might have been skewed by the item exercise, which had consistently low factor loadings. Deletion of the item was discussed; however, as the criteria that were used for item selection did not specify any minimum values, the item was kept in the model.

The correlation between gloominess and pain was in concordance with previous studies, in which, for instance, headache and stomach ache have been reported to co-occur with depression and anxiety (22, 33, 136, 137). A plausible interpretation might be that symptoms of poor mental health can sometimes express themselves through the body rather than through language (23, 138). Another explanation may be that the correlation represents a not yet fully developed ability to identify, articulate, or distinguish symptoms of poor mental health from bodily symptoms.

The findings in relation to two consultation models

In relation to the split-visit consultation model and HEEADSSS

The findings demonstrated that the adolescent males, regardless of their health or health-compromising behaviours, valued and benefited from confidentiality, thus indicating that they would benefit from regularly receiving private time and an explanation of professional secrecy in their GP consultations. To provide and normalise confidentiality, a standardised tripartite consultation model can be used: the split-visit consultation. The GP opens the consultation by explaining the structure of the consultation, as well as the meaning and limits of professional secrecy. In this way, the adolescent male’s inexperience of GP consultations and confidentiality as well as his need of privacy are taken into account. As being granted confidentiality was associated with being more comfortable asking about one’s own concerns (paper II), I argue that this consultation model may facilitate adolescent males in bringing forth of their own concerns, even those regarding sensitive issues. If so, this would be a promising approach to address their unmet health needs. However, considering their struggles to express their concerns (paper III and IV), it is imperative that the GP provides opportunities for them to ask their own questions during the private time.

The private time is well suited for discussing psychosocial health (67), an area in which unmet health needs are common (30, 31, 51, 139). To quickly achieve a fast but rather comprehensive overview of an adolescent male’s psychosocial health, the GP may find the model developed in this thesis useful (paper I). The model describes the co-occurrence of symptoms of poor mental health, associated somatic symptoms, and health-compromising behaviours, which means that it may be enough to ask a few questions from each area to make a reasonable assessment of it. For instance, an adolescent male who does
not smoke, drink, or steal, is not likely to use cannabis either, and so the GP can move on to next area. On the other hand, an adolescent male who smokes regularly is more likely to use alcohol and engage in delinquent behaviours than a non-smoking adolescent male, which implies that the GP may need to explore this area further.

HEEADSSS is a common approach for discussing psychosocial health (68). As HEEADSSS partly overlaps with the symptoms and behaviours in the model of poor mental health and health-compromising behaviours presented in this thesis, I argue that combining these tools may be a fruitful way to assess psychosocial health in adolescent males. This can be done by incorporating questions covering the four factors while following the HEEADSSS concept. Unsafety can be most obviously assessed while asking about Safety, but as it describes feelings of unsafety in school, at home, and in one’s neighbourhood it also has implications for the Home and Education domains. Questions concerning gloominess, which is about a lack of joy and satisfaction, corresponds mainly to the Suicide domain; however, discussing Education and Activities might contribute with important nuances. Symptoms of pain may appear to sit uneasily within the HEEADSSS model and suit better among the medical questions. However, while considering pain as bodily expressions of psychosocial health, it might be natural to let questions about such matters precede and lead into the Suicide domain. Deviancy is about substance use, non-use of contraceptives, and delinquent behaviours, of which the former two groups of behaviours are covered by the letter D (drugs) and S (sexuality) in HEEADSSS. Delinquent behaviours may be included as questions about truancy when asking about Education, and about violent behaviours when asking about Safety (do you ever find yourself getting into fights?).

In relation to Larsen’s consultation model
Several of the most important features in papers III and IV are consistent with and could theoretically be achieved through the use of Larsen’s consultation model (71, 72).

The adolescent males struggled to explain their troubles and greatly appreciated to be listened to without interruptions. This aligns with Larsen’s recommendation of letting patients explain their troubles without being interrupted (71, 72). If the GP accomplishes this without escalating the pace or taking back the initiative, they also demonstrate their willingness to follow the patient (72), which might strengthen the adolescent males’ authority when negotiating their right to define the problem and set the agenda. This may also contribute to feelings of being understood, taken seriously, and cared about by a GP who truly wants to help him, experiences that may be further reinforced through emotional validation (73).

The adolescent males appreciated to be invited to correct misunderstandings, which according to Larsen can be done, for instance, by the use of sum-
maries (72, 74). In such a summary, the GP includes both explicitly and implicitly expressed information and checks their understanding with the patient (72, 74). As the adolescent male struggles to make himself understood, this may be particularly important to him and also serves to help him express what was previously difficult to articulate. While summarising, the GP also makes sure that they have understood the problem in relation to the patient’s lifeworld, thus augmenting the adolescent male’s feelings of having been seen and understood as an individual (71-73).

Verbal and non-verbal emotional validation can aid in making him feel that his difficulties are recognised (73). Emotional validation can also alleviate feelings of shame or embarrassment, and thus help him maintain his dignity, legitimate his help-seeking, and relieve his worries about revealing himself as vulnerable (73). This might be particularly important for adolescent males given their struggles in enduring vulnerability, inexperience, and difficulties communicating.

Besides, as a consequence of traditional notions of masculinity, adolescent males may have a particularly strong need of emotional validation, as help-seeking and illness clash with norms that require men to be strong, capable of solving problems and of dealing with pain (83, 140). They described their endeavours in remaining a man while seeking a GP’s advice, as they had been taught to neither talk about feelings nor reveal their pain.

To further complicate matters, non-verbal validation is easily misinterpreted. It has been suggested that adolescents may perceive facial expressions as more hostile than adults do (141), highlighting the potential significance of verbal emotional validation for adolescent males.

In Larsen’s consultation model, the relation-building occurs mainly in the “Patient Part”. Interestingly, our results indicate that GPs can make valuable contributions to the experiences of being understood and taken seriously also in the “Doctor Part”, for instance by clarifying the problem in painstaking detail through appropriate questions and examinations. Lacking experience with GP consultations, the adolescent male dreads what will take place. His vulnerability is exaggerated in the examination in which he endures objectification and is deprived of initiative. He finds it challenging to make sense of the GP’s comments on their findings—sometimes expressed through interjections such as “Looks good”—and to relate them to his suffering. His distress may be alleviated by an attentive GP, who handles him with care, adapting wordings and examinations to his needs.

The adolescent males valued to get a clear explanation that he could understand and relate to his experience of the problem. He emphasised that for him to feel trusted, understood and taken seriously, the consultation and advice must be adapted to him as an individual. It might be experiences like these that Larsen had in mind when suggesting that the GP ought to relate the explanation of medical findings to the lifeworld of the patient (71, 72).
Involvement in decisions about treatment and follow-up, as well as adaptation to everyday life, are important features both in the present findings and in the consultation model by Larsen (71, 72). The adolescent males wanted to take responsibility for their health, even though this might be questioned by their parents. Sharing responsibility with the patient builds trust and strengthens their growing autonomy (1, 72). The GP must, however, identify any overly optimistic views of his capability to take the required responsibility and make sure that they together develop a realistic, medically well-grounded plan (72). Larsen recommends that the GP wraps up the consultation by checking the adolescent males’ understanding of explanation and advice (72). Apart from being a medical safety net, an agreement check also signals interest and engagement (72), features valued by the adolescent males.

The findings in relation to the ethical demand
To gain a deeper understanding of adolescent males’ consultations with GPs, my co-authors and I chose to reflect on our findings in relation to Danish philosopher Løgstrup’s theory of the Ethical Demand (77). In this light, I first discuss the findings in paper III, and then the comprehensive understanding of the findings of paper IV.

**Paper III: Adolescent males’ experiences**
In the light of the Ethical Demand, the uneasiness that he feels when revealing his worries, captured in the theme *To handle insecurity and uneasiness*, can be interpreted as an instance of the vulnerability inherent in coming forward and laying oneself bare. His fears of not being listened to and correctly understood, but instead being dismissed, neglected, or humiliated can be interpreted as fear of a rejected ethical demand. This universal human fear of revealing one’s vulnerability to no end is here magnified because he knows that men are not supposed to be vulnerable, yet he is. Moreover, this vulnerability is exacerbated by his youth and inexperience.

Several features in *To be understood and cared for* can be seen as the ethical demand being properly responded to and acted upon. The GP takes care of what is laid in their hands by trusting him in return, sincerely wanting to understand his concerns, acknowledging him, and making an effort to find a proper solution. His individuality is respected when the consultation and advice is adapted to his needs and everyday life. The ethical demand is properly responded to when the GP succeeds in conveying that they are acting with his best interest in mind, without unnecessarily infringing on his personal life or right to be in charge of his own life, yet using their professional understanding to see what ought to be done. When this happens, he can accept other solutions than those that he had initially wished for. Hence, when the GP successfully responds to the ethical demand being placed upon them, the adolescent male feels understood and cared for.

In a GP consultation, the medical problem laid in the hands of the GP makes the ethical demand to come into play (142). In the present study, medical problems were generally addressed in a serious manner by interested and helpful GPs. What becomes strikingly apparent, however, is that the adolescent male reveals not only his medical problems to the GP, but also his vulnerability, derived from his inexperience of GP consultations as well as ongoing developmental challenges; furthermore, uncertainty regarding how to behave, embarrassment, difficulties to understand and make himself understood, and the struggle to balance independence and support all contribute to the complexity of the consultation. What is then delivered up to the GP is a complex mix of medical issues, worries, and emotional, cognitive, and relational struggles. In other words, the adolescent male trustingly reveals himself as very vulnerable, and according to the ethical demand, the GP should then take care of what is laid in their hands and use their knowledge to selflessly serve him while taking his will, individuality, and responsibility into account. In the present study, the GPs responded to it when they, in words and actions, took care of his vulnerability, for instance when recognizing his perplexity and explaining once more, comforting him by alleviating his worries, or sparing him embarrassment. The present study also illustrates that the GP may fail to fully respond to the ethical demand, such as when they let him endure unexplained medical procedures or messy, opaquely worded explanations in a frenetic pace. This might be due to lack of knowledge, time constraints, or being overwhelmed by the complexity of the consultation. Anyhow, following Løgstrup, in cases where the ethical demand is not fully responded to, the adolescent male has revealed himself vulnerable (partly) in vain, which can yield feelings of being let down, embarrassment, or distrust. This can explain the adolescent males’ reports of negative experiences of GP consultations as described in other studies, as well as GPs’ reports of professionally challenging consultations.

Methodological considerations

A strength of this thesis is that it combines studies with quantitative and qualitative approaches to explore and describe adolescent males’ consultations with GPs. The concepts used to assess the validity and trustworthiness of research findings differ between the quantitative and qualitative paradigms, and will thus be presented separately.
Quantitative studies

Validity

Validity is about measuring what one aims to measure (98). This concept is applicable to both the measurements used and the study as a whole.

The questionnaire, *Life and Health in Youth*, is not validated, but has been used in previous studies (143, 144). Furthermore, factor analysis can be based on data from validated questionnaires as well as not validated ones and is for instance often applied in the development of new questionnaires (94, 98). The confidentiality questions were purposefully developed for this thesis. They were tested face-to-face with adolescent males, who understood the questions in the way that they were intended; hence the questions had good face validity.

A model developed by exploratory factor analysis needs to be validated, for instance through confirmatory factor analysis (97), which means that the developed model is tested in comparable but unrelated data. A strength of the present study is that data from two different iterations of the same survey were used (*Life and Health in Youth* 2011 and 2014). The associations were explored in one set of data (the 2011 survey) and thereafter tested in another set of data (the 2014 survey) in order to validate the resulting model. The confirmatory analysis in the 2014 data had acceptable to good model fits, confirming the validity of the model. However, a model is necessarily a simplification, and as such cannot capture all nuances in a complex world. As George Box famously stated: *All models are wrong but some are useful* (145). To be useful, a model is at best an approximation containing enough details to say something important about the world, while being simple enough to be applicable in practice. That said, I argue that the present model can be a valid and useful tool when studying symptoms of poor mental health and health-compromising behaviours in adolescent males not least because it takes into account the clustering of the symptoms and behaviours.

One of the aims of the confidentiality study was to study the relationships between poor mental health, health-compromising behaviours, confidentiality, and being comfortable asking sensitive questions. This was done by structural equation modelling, in which the directions of the associations are predetermined by the hypothesis. However, the cross-sectional design constrains the possibility to establish causal relations. Moreover, the results might be biased due to omitted variables or missing confounders. Altogether, this means that the present study cannot provide decisive evidence that ensuring confidentiality caused the tendency to be more comfortable in asking questions. It might be, for instance, that GPs with a youth-friendly approach both succeeded in making the adolescent males comfortable and provided confidentiality. If so, one would expect the studied variables to be correlated without there being any causal connection between them. Nonetheless, compared with those who neither received private time nor had professional secrecy explained for them, nearly twice as many adolescent males were comfortable
asking sensitive questions if they had received both. This indicates a dose-response relationship, which strengthens the idea of causality (146). Moreover, confidentiality has in quantitative studies been found to facilitate discussions of sensitive issues (29, 59, 66). Qualitative studies have reported that adolescents desire privacy in fear that parents will find out their secrets (41, 42, 44, 47, 49), findings that align with descriptions of the normal development in adolescence (1). Altogether, as the results of the present study are consistent with previous studies as well as with neurodevelopmental theory, it seems plausible that provision of confidentiality makes adolescent males more comfortable asking the GP about their body, relationships, and sexual lives.

Reliability
Reliability refers to the precision of a measure or study, in other words its capability to yield consistent results across various occasions (98).

The questionnaire Life and Health in Youth has been used in Region Sörmland since 2004, initially every second year and since 2008 every third year. Considering available data and published reports, it has, as far as I can assess, produced results consistent over time and in relation to national surveys (18, 147, 148).

The model developed in paper I comprised four factors, two of which have been previously described. Deviancy is congruent with Jessor’s Problem Behaviour Theory as well as more recent studies (10, 11, 149, 150). Gloominess resembles the previously described vulnerability to dysphoria and anxiety (151, 152), which also has been linked to worry and pain symptoms (153, 154). This is partly consistent with our findings that gloominess and pain are correlated, possibly with dysphoria, anxiety and worry as a connecting link.

As discussed above, the results that regard the impact of confidentiality on adolescent males’ being comfortable discussing sensitive matters are consistent with the literature, which indicates that they are reliable.

Generalisability
A study’s generalisability is its ability to make claims that go beyond the studied sample, i.e. the extent to which its results are inferable to a wider population (98). The census used in this thesis, Life and Health in Youth, targeted all schools in Region Sörmland, and nearly all eligible schools participated in 2011 (62 out of 65) and 2014 (64 out of 68). As around 95% of Swedish adolescents attend upper secondary school (14), most of the adolescents in the region were exposed to the survey. The response rates in the participating schools were high (80.4% in 2011 and 84.5% in 2014). Even though the main reasons for absence from school on the day of the study were illness, holidays, or scheduled work placement (87), it is conceivable that adolescent males inclined to skipping school could have participated to a lesser extent than males without such tendencies, thus rendering a selection bias. As truancy is associated to delinquency (155), the study sample could be expected to engage a
little less in delinquent behaviours than the population from which it was drawn, but apart from that, it should be fairly representative of adolescent males in Sörmland.

Region Sörmland consists of small and medium-sized towns surrounded by rural areas. Around 3% of the Swedish population lives in the region, which in 2014, when the most recent of the two included surveys was conducted, corresponded to approximately 280,000 inhabitants (85). The same proportion, about 3% (n=8,180) of the population in Region Sörmland consisted of males between 15 and 19 (85); almost the same proportion as in Sweden as a whole (Sörmland 2.9%; national average 2.8% in 2014). Of these subpopulations, 18% of those living in Region Sörmland were born outside Sweden, compared to 15% in Sweden as a whole, in 2014 (85). The proportion of the population that was gainfully employed did not differ much between Region Sörmland (76.2%) and the national average (77.3%) (85). Except for the slightly higher frequency of adolescent males born outside Sweden, Region Sörmland may thus be considered as a small, but representative sample of Sweden as a whole at the time when the surveys were conducted.

Qualitative studies

In qualitative research, scientific quality is assessed differently than in quantitative research. Certain terms are ostensibly the same, but convey different meanings. Moreover, the terms vary within the qualitative field. I will here discuss scientific quality from the perspective of Reflective Lifeworld Research as described by Dahlberg et al., including perspectives from thematic analysis as described by Braun & Clarke and Sundler et al., as well as phenomenological hermeneutics as described by Lindseth et al. (76, 108-111, 117, 118).

Achieving valid descriptions of meaning that are transferable to and useful in other contexts requires openness, reflexivity, and a bridled understanding (76, 111).

Validity

Validity means that the conclusions are well-grounded and sound (111). The researcher has approached the phenomenon with openness and sensitivity, so that its many variations have been seen and its meaning found (76, 118). Validity also implies that new and unexpected aspects are presented that bring new understanding of the phenomenon to the reader (76, 118).

Validity implies that the researcher’s reasoning is thorough and that premature conclusions are avoided through a bridled understanding (76). The researcher is sufficiently educated, experienced, and aware of their pre-understanding to reach sound analytical decisions and conclusions (76). Interpretations are rigorously scrutinised and checked against the data to ensure that
they comprehensively cover them and that contradictions or internal inconsistencies are avoided (76, 117). The research process is clearly and transparently described and the most likely interpretation is presented (76, 111).

Openness, reflexivity, and a bridled understanding

In Reflective Lifeworld Research, a sensitive openness towards the phenomenon is emphasised (76). The researcher intends to approach the phenomenon with both emotional and intellectual openness, striving to see the phenomenon in all its variation. This requires a true willingness to see the otherness of the phenomenon, setting one’s assumptions aside to see beyond the expected (76).

Openness requires closeness, but also a reflective distance to the phenomenon (76). Throughout the research process, the researcher needs to adopt a critical reflexive attitude to become aware of their pre-understanding, thereby reducing its impact on their judgement and understanding of the phenomenon (76, 111, 117, 118). The researcher needs to question their understanding of the data and the themes they have developed, as well as the whole process of understanding (76, 111). Thus, understanding needs to be bridled.

The researcher seeks to bridle their understanding to prevent that their pre-understanding misleads their understanding and limits their openness towards the phenomenon (76). It is about to focus on the phenomenon with a watchful attentive attitude (76). It is also about to slow down the process of understanding and to dare to linger in incomprehensibility to avoid hasty and slovenly reached conclusions (76).

Transferability

Transferability refers to the findings’ usefulness, relevance and meaningfulness in other contexts (111). The findings and context must be clearly and richly described, so that the reader can assess whether they may be relevant and meaningful in their own context (76, 110, 111). It is when findings become integrated in the reader’s own world that they become useful (117, 118).

Validity and trustworthiness of papers III and IV

The validity of the results was strengthened by the choice of methods. In paper III, thematic analysis based on Reflective Lifeworld Research suited the aim to inductively seek patterns in lived experiences (111). In paper IV, phenomenological–hermeneutical observations were deemed suitable to understand meaning in lived experiences of clinical encounters (113, 114, 116, 118).

The variation in the data also strengthens the validity. The consultations that were studied in papers III and IV varied regarding the adolescent males’ age, origin, reasons for the consultation, and whether accompanied by a parent or not. The participating adolescent males were 15 to 20 years old and two of them were born outside Sweden, which was close to the frequency of adolescent males born outside Sweden in Region Sörmland (22%) and Sweden as a whole (20%) in 2022 (85). They visited mostly due to physical complaints,
some of which were painful or intimidating in nature. One was accompanied by his girlfriend, one by his mother and two by his father.

A limitation is that no consultations were about sexual or mental health, restricting the transferability onto such consultations. However, other sensitive and embarrassing matters were discussed and painful procedures were conducted, rendering parts of the consultations delicate to navigate.

Three of the authors were GPs, and their familiarity with the context can be viewed as both a strength and a limitation. While it aids in comprehending the observed situation, it also poses the risk of hindering openness to new aspects of the phenomenon (116). However, two authors were not GPs, and therefore contributed to contextual openness. They also contributed with knowledge of adolescent medicine and a huge experience of conducting qualitative studies, not least phenomenological–hermeneutical studies and hermeneutic observation studies.

Besides my experience as a GP striving to satisfactorily serve my adolescent patients, my preunderstanding is also shaped by my role as a mother to two teenage daughters and as an orienteering coach for adolescents. Thus, I am accustomed to talk with adolescents. Additionally, I am trained in interviewing in qualitative research. I am also a teacher at Uppsala University, where I teach medical students Larsen’s consultation model. Although my theoretical knowledge and experience of the consultation technique has several benefits, not least an increased sensitivity to subtle queues when viewing video-recorded consultations, my role might have the minor drawback of leading me to perceive that model as more advantageous than it truly is.

Throughout the entire research process, the authors strived for openness and curiosity towards the phenomenon as well as a bridled understanding. We fostered a reflexive critical dialogue among ourselves and thoroughly checked our understanding against the data. In paper III, guidelines for good reflexive thematic analysis were followed (110, 156, 157). To achieve valid results in paper IV, the analysis moved from the parts to the whole, from explanation to understanding, in a hermeneutic circle (116, 118).

The context and research process are transparently described in the manuscripts to allow the reader to assess their transferability. As the consultations had a large variation and all themes were found in each consultation, I argue that the results may be transferable to most adolescent males’ GP consultations in Sweden, but maybe also to similar contexts outside Sweden or outside primary care.
Clinical implications

Whenever one is studying human lives and human interactions, there is rarely a single truth to be discovered or a definite answer that is the only correct one. There is always more than one possible interpretation (116-118). What I present in this thesis is one perspective; my story of the data, interpreted through my (bridled, I hope) pre-understanding, as truthfully and as thoroughly as I could. I hope that you may find it useful in your clinical work.

Based on the findings in this thesis, I argue that adolescent males would benefit from being provided with private time with the GP and an explanation of professional secrecy whenever consulting them. Our results suggest that confidentiality is valued by adolescent males and makes them more comfortable with disclosing their own concerns. Confidentiality in this sense can be achieved through the split-visit consultation model. Moreover, this thesis provides empirical and theoretical arguments to the effect that Larsen’s consultation model is a suitable tool for respecting values that are crucial to adolescent males: being listened to and understood, receiving help to endure vulnerability, and having the consultation adapted to their lifeworld. However, there is, as far as I know, no studies about how to best combine these two techniques. Based on our findings, I will now suggest such an approach.

In a consultation with an adolescent male and an accompanying parent, it seems reasonable to proceed as follows. The GP starts off by describing the structure of a split-visit consultation—emphasizing that the adolescent male will be provided private time—and explaining the meaning and boundaries of professional secrecy to both the adolescent male and his parents. The GP then asks the adolescent male to describe his problem. His verbalization is encouraged by the GP patiently waiting for him to find the right words, providing verbal emotional validation, and using summaries to check their understanding. The GP supports him when he seeks advice from his parents, but also takes care to return the initiative to the adolescent male when the parents get too eager to advance their view of the problem. Here, it might be good to explore ideas, concerns, and expectations; on the other hand, such questions may sometimes be too private to discuss with parents present. However, at this point it is too early to ask the parents to leave the room, because in order to feel comfortable in leaving the room, the parents may need to have given their view of the problem first, and had their ideas, concerns, and expectations explored. The other horn of the dilemma consists in the fact that exploring the
parent’s ideas, concerns, and expectations before the ones of the adolescent male may divert focus from him and infringe upon his right to the initiative. I therefore suggest that when the adolescent male has finished his story about his problems, he is asked about his ideas, concerns, and expectations, followed by the same questions to the parent. Here, according to my clinical experience, parents are quite effective in describing their view of the problem when “finally” invited. Before the parents exit the consultation room, the GP checks medical details that the adolescent male can be expected not to know anything about, such as medical events during his first years of life.

The private time starts with a short summary to check whether he has any more details to add and thereafter explores his ideas, concerns, and expectations once more. Adequate medical and psychosocial questions are added, including all four factors (unsafety, gloominess, pain, and deviancy), for instance by use of the HEEADSSS model. An opportunity to ask about other concerns is given. The GP adapts their phrasing and pace to the adolescent male, being observant of signs that he might not understand, is in pain, or is embarrassed. Verbal and non-verbal emotional validation is abundantly provided to mitigate shame and vulnerability. The GP describes what will take place during the examination and clearly describes their findings.

When the examination is finished, the GP summarises the adolescent male’s description of the problem, including his ideas, concerns, and expectations. This is followed by a clear explanation of the findings and the GP’s assessment in which they address the medical problem as well as the adolescent male’s worries (71, 158). Thus, the GP connects their explanation to his lifeworld. The GP gives advice, which the two parties together adapt to his everyday life and they collaboratively decide what to tell his parents before letting them re-join the consultation. Together, they explain the findings and the agreed-upon plan to the parents and invite them to participate in further discussion.

The ethical demand may serve as a guide when meeting the adolescent male in all his vulnerability. The GP should use their knowledge to best serve the adolescent male without encroaching upon him, instead respecting his individuality, will, and responsibility for his own life. However, the ethical demand requires a lot of the GP. As these consultations are compounded by a complexity that may be overwhelming, particularly during short visits, GPs should also do their best to forgive themselves when time constraints or complexity hinder them from fully answering the ethical demand.
Suggestions for future research

The consultation model proposed in Clinical implications is a theoretical result of the findings in this thesis and would be interesting to study in practice. This could be done as a randomised controlled trial using “treatment as usual” as a control group. Such an approach will probably require many studied consultations to achieve power, and thus considerable resources.

Before testing the consultation model, it would be interesting to study how GPs experience consultation with adolescent males, for instance by use of a thematic analysis in a lifeworld-based approach. I would also like to delve into greater detail regarding what the GPs actually did that made them successful in making the adolescent males feeling listened to, taken seriously, and maybe most importantly, comfortable asking about their own concerns. One approach may be deductive thematic analysis of the video recordings, connecting consultation techniques to observable reactions and the adolescent male’s own description of the consultation. Such knowledge may be useful to develop the theoretical consultation model further, before testing it against reality.
Conclusion

I hope that this thesis will contribute to a deeper understanding of the needs of adolescent males when visiting a GP. By providing private time without parents or guardians being present and explaining the meaning and boundaries of professional secrecy, GPs can facilitate discussions of sensitive topics and make adolescent males feel more comfortable raising their own concerns. This might be a fruitful approach to address any unmet health needs and major health risks, many of which are in the domain of psychosocial health.

Despite the everyday nature of the complaints, the studied consultations were very complex. Due to their on-going development, inexperience of GP consultations, and notions of masculinity, the adolescent males struggled with cognitive, emotional, and relational difficulties while negotiating their right to privacy, to define the problem, and to be responsible for their health. The complex demands might, however, overwhelm the GP who, according to the ethical demand, has to take care of, and respond to, the adolescent male’s vulnerability. The adolescent males emphasised the importance of being listened to and taken seriously, which entails that all aspects of the consultation must be adapted to their individual needs and to their lifeworld. This aspect is consistent with the consultation model of Larsen, which emphasises understanding the patient’s experience, feelings, and lifeworld, and connecting medical findings accordingly. Given that both the split-visit consultation model and the consultation model of Larsen offer valuable frameworks for addressing essential, but different, aspects in adolescent males’ GP consultations, this thesis proposes a synthesis of the two approaches.

Känsliga samtal om t.ex. psykisk ohälsa eller ohälsosamma beteenden kan underlättas av att tonårskillen får egen tid med läkaren i enrum (utan föräldrar) och tystnadspliktens innebörd förklarad för sig. Vi vet från forskning i andra länder att tonårskillar sällan får något av detta vid läkarbesök, men vi vet inte hur det är i Sverige. Vi vet inte heller om möjligheterna till egen tid med läkaren och en förklaring av tystnadsplikten påverkas av psykisk ohälsa och ohälsosamma beteenden dvs. om de tonårskillar som har störst behov av enskilda, tystnadspliktsskyddade läkarsamtal är de som får möjlighet till det.

Vårdcentralsläkare berättar å sin sida att de kan uppleva att tonårskillar är ovilliga att berätta fullt ut om sina besvär, trots ideal om att försöka möta varje patient där den är. Det finns alltså en skillnad mellan vårcentralsläkarens intensioner och tonårskillars upplevelser, men också en gemensam upplevelse av problematisk kommunikation. Följaktligen skulle en bättre förståelse av vad som händer i möten mellan tonårskillar och vårdcentralsläkare kunna bidra till förbättrade konsultationer. Förbättrade konsultationer kan i förlängningen påverka tonårskillars framtida hälsa, eftersom goda erfarenheter av läkarkonsultationer ökar sannolikheten för att tonårskillen söker vård nästa gång han behöver.
Avhandlingens övergripande syfte var att studera tonårskillars möten med vårcentralsläkare med fokus på deras upplevelser samt erfarenheter av konfidentialitet i relation till psykisk ohälsa och ohälsosamma beteenden. Den består av fyra delarbeten.

Först utvecklades en modell över banden mellan symtom på psykisk ohälsa, kroppliga symtom och ohälsosamma beteenden (delarbete I). Med utgångspunkt i delarbete I, undersökte delarbete II tonårskillars önskemål och erfarenheter av egen tid med läkaren och av att få tystnadsplikten förklarad för sig. Svaren analyserades i relation till symtom på psykisk ohälsa och ohälsosamma beteenden med hjälp av modellen från delarbete I. Därefter genomfördes en kvalitativ studie med livsvärlden som grund för att nå en djupare förståelse av tonårskillars möten med vårcentralsläkare genom att dels utforska tonårskillars upplevda erfarenheter (delarbete III), dels observera tonårskillars möten med vårcentralsläkare och spegla dessa i den danske filosopen K.E. Løgstrups tankar om det etiska kravet (delarbete IV).


I delarbete II framkom att de flesta tonårskillar vill ha egen tid, utan föräldrar närvarande, med vårcentralsläkaren och att få förklarat för sig vad tystnadsplikten innebär. Man såg även att de som faktiskt fick egen tid med vårcentralsläkaren och tystnadsplikten förklarad oftare kände sig bekväma med att ställa känsliga frågor om kroppen, kärlek och sex. Dessa resultat påverkades nästan inte av de symtom på psykisk ohälsa eller ohälsosamma beteenden som tonårskillarna rapporterade. Oavsett hur de mår, så behöver alltså tonårskillar få egen tid med läkaren och få tystnadsplikten förklarad för sig för att de ska känna sig bekväma att diskutera sina hälsa med läkaren.

Delarbete III visade hur viktigt det var för tonårskillarna att känna sig tagna på allvar och lyssnade på av vårcentralsläkaren. Dessutom framkom det att tonårskillarna avgjorde om de hade blivit förstådda och tagna på allvar utifrån läkarens förmåga att anpassa sig till deras behov. Här avses både upplevelsen
av att den medicinska bedömningen utgår ifrån hur han har beskrivit sina be-
svår och upplevelsen av att läkaren anpassar sitt bemötande efter hans indivi-
duella behov, såsom lugnt tempo och enkla, tydliga förklaringar.

I delarbete IV framträder tydligt besöken komplexitet och tonårskillens
ansträngningar. Han måste anstränga sig till sitt yttersta för att förstå och göra
sig förstådd, hantera osäkerhet och utsatthet, men också för att navigera mel-
lan mannens självständighet och pojkens behov av föräldrastöd. Den mängd
av svårigheter som tonårskillen möter ställer höga krav på vårcentralsläkaren
som enligt det etiska kravet måste svara upp mot allt detta.

I avhandlingen diskuteras resultaten utifrån två konsultationsmodeller, som
båda kan bidra till att bemöta tonårskillens behov. Den första modellen bidrar
med en standardiserad struktur för att ge ungdomar egen tid med läkaren och
en förklaring av tystnadsplikten, något som avhandlingen har visat förbättrar
tonårskillarnas möjligheter att ta upp sina egna funderingar. I den andra mo-
dellen tillmäts patientens känslor och upplevelse av problemet stor betydelse
och patientens livsvärld införlivas i konsultationen. Ett sådant arbetssätt skulle
kunna bidra till att tonårskillarna upplever sig tagna på allvar och får den in-
dividuella anpassningen de efterfrågar. Modellen betonar även betydelsen av
att bekräfta patientens känslor, vilket skulle kunna underlätta konsultationen
för tonårskillen. Avhandlingen avslutas med ett förslag om hur dessa två mo-
deller kan kombineras.

Sammanfattningsvis kan den här avhandlingen bidra till en större förståelse
för tonårskillars behov när de besöker en vårcentralsläkare. Avhandlingen
visar hur vårcentralsläkare kan öka möjligheterna för tonårskillar att samtala
om viktiga och känsliga aspekter av hans hälsa, och på så sätt påverka tonår-
skillars största hälsorisker genom att träffa dem en stund i enrum utan föräldrar
samt förklara tystnadsplikten för dem. Den visar också att det är väldigt viktigt
för tonårskillarna att känna sig tagna på allvar, vilket innebär att vårcentral-
släkaren behöver bevisa sin förståelse och sitt fulla engagemang i ord och
handling under hela konsultationen. Man ser även att tonårskillar under en
konsultation med en vårcentralsläkare möter många kognitiva, emotionella
och relationella svårigheter, som de måste anstränga sig till sitt yttersta för att
hantera. Mötets komplexitet ställer även höga krav på vårcentralsläkare, som
can få svårt att leva upp till det etiska kravet att ta väl hand om alla aspekter
av tonårskillens sårbarhet. Genom att kombinera två befintliga konsultations-
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ChatGPT (open AI) has been used for assistance in expressions and finding synonyms. Upon generating draft language, I reviewed, edited, and refined the text to my own liking and retain full responsibility for the content presented in this thesis.
References

7. United Nations Department of Economic and Social Affairs. Definitions of Youth. New York,: United Nations Department of Economic and Social Affairs; 2016. [In English].
18. Psykisk hälsa och suicid i Sverige – Statistik om nuläge och utveckling fram till 2022 [Elektronisk resurs]. [The Public Health Agency of Sweden. Mental health and suicide in Sweden—Statistics on the current situation and development up to 2022.]: Folkhälsomyndigheten; 2023 10 October. [In Swedish].


87. Gustafson K. at Centre for Public Health, Sörmland county council. Personal communication. 4 September 2015.
98. Field A. Discovering statistics using IBM SPSS statistics : and sex and drugs and rock 'n' roll. Los Angeles ;: Sage; 2013. [In].
147. Folkhälsocentrum, FoU-centrum. 10 år med Liv & Hälsa ung. Hur mår tiondeklassare i Sörmland? Möjligheter och utmaningar.; 2014. [Centre for Public Health Sörmland, Centre for Clinical Research Region Sörmland. 10 years with Life and Health in Youth. How are ninth graders in Sörmland faring? Opportunities and challenges.].
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