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Invisible Inequalities of Austerity: Everyday Life, Mothers and Health in Stockton-on-Tees

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Invisible Inequalities of Austerity:

Everyday Life, Mothers and Health in Stockton-on-Tees

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Abstract

Austerity in the UK has been ongoing since 2010 and is contributing to widening health, economic, gender and social inequalities. There has been little contemporary qualitative research into the gendered inequalities of austerity in the context of health inequalities. This thesis presents findings from research with mothers in Stockton-on-Tees, a borough in the North East of England with wide health inequalities. The research focuses on the interplay between the macro and micro consequences of austerity for mothers – the impact of welfare retrenchment, public sector cuts and local labour market conditions, and how these effect everyday life in the context of unpaid care work and mothers experiences of depletion through social reproduction. This is contextualised through the lens of feminist political economy as an essential framework for diagnosing the symptoms of austerity and proposing productive alternatives. Qualitative longitudinal interviewing and ethnographic research are used to draw out the perspectives of respondents in relation to austerity and everyday life. The 'intersectionality' of inequality is emphasised – how gender interacts with age, class, place, ethnicity and disability to produce complex effects on health and wellbeing. Findings indicate that austerity is making Stockton-on-Tees a more uneven place - once-strong ties to communities are perceived to be deteriorating, and the socio-spatial distribution of inequality increasing. Mothers expressed a need for more space and time to care without the pressures of welfare reform and the associated risks. 'Invisible inequalities' are depleting the mental wellbeing of many mothers. This research provides a contribution to the growing body of evidence indicating that austerity is damaging to social equality, widening the health gap, contributing to worsening mental health, and intensifying intersecting inequalities for women. It is unique in its application of the concept of intersectionality to health inequalities in the context of austerity, and the novel contribution of a feminist political economy approach to the study of health and austerity.

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Abbreviations

CAB	Citizens Advice Bureau
CAMHS	Child and Adolescent Mental Health Services
DWP	Department for Work and Pensions
ESA	Employment and Support Allowance
EU	European Union
FPE	Feminist Political Economy
IMF	International Monetary Fund
JSA	Job Seekers Allowance
NHS	National Health Service
OECD	Organisation for Economic Cooperation and Development
QLR	Qualitative Longitudinal Research
WHO	World Health Organisation

Declaration

I declare that this is my own work and has not been submitted for the award of a higher degree anywhere else.

Statement of Copyright

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1. <u>Introduction</u>

1.1 Background context

I decided to undertake this PhD because I was troubled by the sense that inequalities in the UK were widening further in the age of austerity. The implications of neoliberalism – the financialisation, privatisation, deregulation and atomisation were becoming so entrenched, and I was concerned at how the welfare state, the NHS, the public services and the labour movement I held in high esteem were being eroded. Low-income, deprived and working class communities were being affected materially, and the insidious and pervasive misrepresentations of these communities were disturbing. It appeared that the UK was approaching a juncture – unwilling to confront the classed, gendered and racialised stratification that permeated society, intent on blaming individuals for failings which were structural in origin. Set to this backdrop, it seemed likely that the introduction of austerity would have negative consequences. I was keen, in my own small way, to make a positive contribution to the opposition of austerity.

I was concerned, also, about the path being followed by advocates of mainstream liberal feminism, with their all-too comfortable relationship to neoliberal market-oriented individualism. It seemed that under the guise of empowering and offering women more choices, women were being expected to take on even more work. They were expected to do everything men did, do the housework and childrearing, the rhetoric of 'choice' fading into a set of obligations, the structural and ongoing discrimination forgotten. I saw a connection between the cuts, widening health inequalities, deepening class polarities, and the increasing stress on the women who did the invisible work to keep it all together. I wanted to further explore the relationship between these factors by using qualitative methods, such as ethnography, to share the narratives of those impacted by austerity. I knew that through undertaking a PhD I could share stories that needed to be told and contribute to a body of work investigating the impacts austerity policies were having.

Austerity has been in place in the United Kingdom since 2010. A major budget deficit occurred following the Global Financial Crisis of 2008, and under Prime Minister David Cameron a period of austerity was introduced to address this (Konzelmann, 2014). It was in some sense a natural continuation of the neoliberal logic of welfare spending cuts and privatisation already taking place (Blyth, 2013). Simultaneously, in order to make this series of cuts palatable, the Conservative government drew on the long-standing 'scrounger versus striver' narrative, the concepts of public sector and welfare overspend, and fallacious comparisons of the national budget to a household budget (Bishop, 2016; Painter, 2017). The series of cuts and reforms have affected different places across the country in uneven ways. Differing degrees of service provision and cuts, localised labour market changes and local council service provision (Beatty and Fothergill, 2016; Dunatchick et al., 2015; Hastings et al., 2017, 2015) have not impacted regions or localities equally. Austerity has had a negative impact on many communities and groups and is contributing to the increase in pre-existing spatial and health inequalities (Bambra and Garthwaite, 2015; Pearce, 2013) and gender inequalities (Bennett, 2015; Greer Murphy, 2017).

This research was undertaken to understand the everyday experiences of one specific group – mothers in Stockton-on-Tees, and examine what impacts the contemporary period of austerity might be having on their everyday life. Stockton-on-Tees, a borough in the North East of England near Teesside, has been adversely affected by austerity and has very wide health inequalities – the widest gap for men in all of England (Public Health England, 2015). Mothers were chosen as the focus for a number of reasons. Firstly, there is a concentration of women in low-paid and insecure work which is income- and status-limiting (Rubery and Rafferty, 2013: 133). Secondly, welfare retrenchment, service and public sector cuts and welfare conditionality produce multiple inequities for many women (Fawcett Society, 2013) which may exacerbate inequality for those living in deprived contexts. Finally, the role of social reproduction – unpaid labour provided by members of families and communities which is integral to the capitalist economy but not commodified (McGrath, 2016: 4) – is not adequately addressed in economic or public policy (Holloway and Pimlott-Wilson, 2016).

The emphasis on individualised responsibility (McGuigan, 2005) which runs through so much policy rhetoric is contrary to the collective effort that is required to care for children and communities. In this austerity era, intersecting inequalities are increasing social inequality which may adversely affect health inequalities (Marmot, 2010; Mattheys et al., 2017). This is taken in the context that the health gap for women, although smaller than it is for men, is beginning to widen more quickly, indicating deteriorating health for women (Barr et al., 2017). Taking these factors into consideration, the focus on mothers in Stockton was an attempt to unmask the dynamics of welfare reform, austerity and the invisibility of social reproduction on the situated everyday experience in an age of austerity.

1.2 Research aims

This PhD draws on critical work from the fields of health geography, health inequalities, sociology and feminist political economy. It aims to provide a contribution to the growing body of evidence indicating that austerity is damaging to social equality, widening the health gap, contributing to deteriorating mental health, and intensifying intersecting inequalities for women. In this thesis the exploration of health inequalities and experiences of mental health centres on lay experience and knowledge (Popay and William, 2006) grounded in the everyday lived experience of austerity.

The key research aims and questions are described below:

Aims:

- To understand the everyday effects that austerity measures (specifically welfare reform, public service cuts, and labour market reforms) are having on mothers in Stockton-on-Tees.
- To examine how these experiences vary across class, income, and geographical location, and the intersectionality of these.

Questions:

- How do mothers in Stockton-on-Tees talk about and conceptualise austerity, welfare reform, and their position in relation to these?
- How is austerity impacting the lives of mothers from different socio-economic contexts in Stockton-on-Tees?
- How can engaging with mothers enhance our understanding of gendered health inequalities?

While there has been sociological, geographical and social policy research into the gendered dynamics of austerity, there has been little contemporary research into the gendered inequalities of austerity in the context of health inequalities. My research explicitly focuses on the interplay between the macro and micro consequences of austerity with a particular emphasis on the 'intersectionality' of inequality – how gender interacts with age, class, place, ethnicity and disability to effect health and wellbeing.

This research is one of the first to draw on the health geography context/composition debate in direct relation to the 'lived experience' of health inequality and gender. The incorporation of a gendered political economy perspective is unique in this respect. This advances the debate by suggesting that, rather than focussing on either the dynamics of places *or* individual actors in produce health inequalities, it is how they interact with political, economic, social and, in the case of this research, gendered factors, that determines the health gap.

The methods used in this thesis were qualitative longitudinal interviewing and ethnography. These methods were rigorously applied and were highly effective in drawing out the nuanced and longitudinal experiences of everyday life in a period of austerity. They represent a point of departure from conventional research into 'place and health' in health geography, which typically employs quantitative methods (Cutchin, 2010). Focus on the lay experience in health inequalities has been peripheral to more quantitative research into health at the population level (Davidson et al., 2008). While there is a small body of literature which focuses on the 'lay experience' of austerity (Garthwaite and Bambra, 2017; MacKenzie et al., 2016), this particular study utilised these methods in conjunction with a gendered political economy perspective, which is unique.

1.3 The Stockton Project: Research Context

This PhD is part of the project 'Local Health Inequalities in an Age of Austerity: The Stockton-on-Tees study' (https://research.ncl.ac.uk/health.inequalities). This was a five year, interdisciplinary case study to examine key debates around localised health inequalities in an age of austerity. Stockton is a borough near Teesside in the North East of England encompassing both urban and rural areas. It is a space of localised and wide economic and health inequalities. Some areas have very low levels of deprivation in contrast to other areas very close by, illustrating the localisation of certain inequalities (Bhandari et al., 2017). Deprivation is higher than the national average – about 30% of people fall into the most deprived quintiles, higher than the national average of 20% (Public Health England, 2015). Differing experiences of health and wellbeing, years of life

lived in good health and overall life expectancy vary enormously. At the time of carrying out this research, the gap in life expectancy for men stood at 17.3 years and 11.4 years for women (Public Health England, 2015). This was the largest gap of any local authority in England. It was within this context that we sought to understand the causes and contributing factors to the health gap in Stockton.

Stockton and Teesside's historical legacies and current trajectories have been the subject of much academic research – the Teesside region has anecdotally been referred to as both 'research laboratory' and 'policy laboratory' (Shildrick et al., 2010). By having this rich body of research to draw on, we are better able to understand contemporary and future patterns of the dynamic ways of life in this place. The different types of research, from sociological examination into the impacts of poverty on everyday life (Shildrick et al., 2010), industrial development and decline in the area (Beynon et al., 1994) to the effects of participatory research on social justice (Banks, Herrington and Carter, 2017; Banks et al., 2013) enhance our understanding of Stockton and allow us to understand the 'biography of place' (Warren and Garthwaite, 2014a) from multiple angles, incorporating individual, spatial, economic and community biographies.

Figure 1. Public installation of Stockton-Darlington railway

This richness has the capacity to inform research in a positive and emancipatory sense, through drawing out the intersections of individual's lives and the history of where they live (Wright Mills, 1959), and by taking into account the distinct and unique character of given places in a way that does justice to it, rather than representing it as deviating from a set of norms or stereotyping it (Warren, 2017). This backdrop provides a dynamic and rich setting in which to carry out this research, and it is with this in mind that I carried out the research. The historical legacies of a place shape the routes through which people produce forms of belonging and attachment to it (Emery, 2018), which in turn influences how places evolve.

The area has undergone multiple periods of industrial, social and economic change. It was once a site of a major port and prosperous shipbuilding industry, and the first steam locomotive, the Stockton-Darlington railway, operated there. The shrinking of industry and the loss of economic prosperity in recent years has generated great consequences for the area. A wide variety of policy initiatives have been undertaken to solve these economic issues and corresponding social problems relating to health, employment, housing and welfare. These have ranged from broad economic plans such as The Northern Powerhouse to initiatives

within Stockton-on-Tees Borough Council to bolster early years development through A Fairer Start. Austerity now presents significant challenges to policy-makers and inhabitants of the area.

1.4 Central argument of this thesis

The central arguments of this thesis are as follows – the uneven socio-spatial distribution of resources such as quality housing, money and community centres are contributing to poorer health, particularly mental health, for respondents in less affluent areas of Stockton. In a broader sense, the causes of poorer health in less affluent parts of Stockton are due to complex historical, political and economic processes which have created socially stratified experiences of everyday life leading to different health outcomes. Austerity is contributing to this socio-spatial distribution and the widening health gap in Stockton-on-Tees, with specific consequences for mothers. These consequences are indicative of a gendered 'invisible inequality'. This invisible inequality relates to multiple intersecting factors detrimental to mothers' economic, social and mental wellbeing. These factors include extensive time spent in caring duties, the shortage of quality paid work to fit around this caring, reliance on partners and the state for income in the context of welfare state retrenchment and declining wage growth, as well as the closure of many public services. These intersecting factors have led to issues relating to mental and physical health, indicative of intensifying depletion experienced by mothers.

This thesis goes on to demonstrate that conceptualising the consequences of austerity through the lens of feminist political economy [FPE] represents a valuable framework for diagnosing the symptoms of austerity and proposing productive alternatives. This point is threefold – firstly, social reproduction [SR] is a time-consuming facet of many women's lives and its value goes unacknowledged in economic and social policy generally, perpetuating a disproportionate burden on women which if unacknowledged cannot be addressed. Secondly, austerity has distinctly gendered effects. Under austerity many of the mechanisms through which women access a reasonable standard of living – through benefits, access to services and public sector employment, have been gradually withdrawn, generating risks for many women. Finally, the application of FPE would provide an effective set of solutions to the harms of austerity. This perspective would allow us to acknowledge invisible inequalities, the disproportionate work of social reproduction women engage in and the unequal access to power and decision-making positions in public life available to many women, in order to explicitly challenge austerity.

1.5 Thesis Structure

This chapter has introduced the background, research aims and questions and wider research project the PhD is part of. **Chapter Two** explores the literature most relevant to this thesis, emphasising its interdisciplinary nature. I first discuss the literature on the sociology of everyday life to illustrate how the everyday has nuance and merit as a site of academic investigation. I then discuss the welfare state and consequences of welfare reform on social and public policy by highlighting the negative effect many reforms are having. I subsequently draw on the health geography literature examining austerity and health, drawing on the evidence base for the relationship between social stratification and health. I then discuss the developing research on the

intersectionality of overlapping inequalities such as gender, class, race and disability that impact health inequalities.

In **Chapter Three** I discuss the qualitative methods and methodology I used. I then discuss the research design, sampling and access issues, as well as analysis. The next portion of the chapter discusses research ethics and evaluates the effectiveness of the research. The final portion comprises of a reflection on the ethics of interviewing and fieldwork practices in the context of reciprocity.

Chapter Four is the first of two chapters which discuss research findings. It focuses on the importance of 'place', opportunity structures in the local physical and social environment and how these matter for meaning-making in everyday life. It examines the impact of austerity on Stockton-on-Tees, respondent's perspectives on their areas and opportunities available to them. Findings indicated that respondents held the concept of 'community' in high regard but felt that their once-strong communities were being affected by social change – from the loss of money and resources, to tvs keeping people inside and away from chatting on the street. The chapter closes by arguing that the emphasis on individualised characteristics of people and areas side-lines the socio-spatial inequality of austerity.

In **Chapter Five** I present the second discussion of research findings. Respondents' perspectives on the social determinants of health are discussed. In particular the impacts of housing, community centres and financial insecurity on respondents are addressed. The deteriorating mental health of many respondents under austerity is discussed in the context of a intersecting classed, gendered and socio-economic dynamics which were deleterious to mental wellbeing. The chapter maintains that austerity is making everyday life harder for respondents. This is framed through their experiences of 'invisible inequalities' – the unpaid and unacknowledged caring and household work respondents were undertaking.

Chapter Six presents the core argument of the thesis, namely, that austerity is implicitly gendered and that the invisibility of social reproduction constitutes the primary mechanism of women's 'invisible inequality'. I then present a summary of the key aspects of this thesis, the main emerging themes, how successfully the research questions were answered, and a list of policy recommendations.

2. <u>Literature Review</u>

Intro**duction**

In this chapter I provide an overview of the core literature relevant to this thesis. This literature review emphasises the cross-cutting and interdisciplinary nature of the research. Significantly, the thesis draws out three complementary themes – the value of everyday life when researching the impacts of austerity, the interplay between macro and micro factors determining the political economy of health, particularly in relation to gender, and the intersectionality of inequality underpinning the lives of many respondents.

This thesis is embedded in, and contributes to the literature in a number of areas. Firstly, it contributes to the health geography research on the impact of austerity on health and wellbeing, emphasising the intersectional nature of inequalities and gender as an aspect of health inequalities. It feeds into the literature on the consequences of welfare reform on social and public policy by highlighting the negative effect many reforms are having. For example, macro level factors such as policy changes to the conditions for receiving a certain benefit have a micro impact when an individual in need no longer qualifies but is not able to generate income elsewhere, leading to financial insecurity. This chapter builds on the literature on the sociology of everyday life by emphasising the detrimental impact of austerity on women's lived experience.

In this literature review I begin by setting out the research into everyday life. Initially this centres on a discussion of the legacy and emergence of the field. I then move on to a discussion of the specific contribution of this field in the UK such as the contribution to human geography, and the overall use of the application of 'everyday life' as a conceptual tool across disciplines when critiquing austerity. I emphasise in particular the relevance of examining women's everyday lives, adding that this has a valuable contribution to make to the debate around a political economy of health in an age of austerity. The second section provides an overview of the literature relating to the introduction of welfare state capitalism and subsequent economic and political shift to neoliberalism. The introduction of welfare state capitalism is discussed in relation to the characteristics of the current liberal welfare regime.

Following on from this is a discussion of the gendered nature of the welfare state, reiterating that the welfare state has never sufficiently accounted for the different gendered experiences of work and welfare provision. The next section reflects on the past, indicating that women have always and continue to face classed and gendered barriers and face societal pressure due to the private nature of their care work. In the following section I introduce the context and characteristics of the neoliberal state. Following this, the background to austerity as economic policy is set out. The next section provides a point of linkage between the neoliberal state and austerity, emphasising the core features of austerity – intense welfare reform, retrenchment of the public sphere and labour market deregulation. Following from this is a discussion of the consequences of austerity on the everyday lives of women.

In the third section I discuss the field of health inequalities research. I provide an overview of the discipline and present the different framings of the causes of health inequalities and the important framing of the 'social

determinants of health'. Following this I discuss the specific context of health inequalities in the UK and the contribution that the field of health geography has made, in particular in relation to the debate around context and composition in explaining health inequalities. In relation to the literature on health and place I discuss the role of neighbourhoods in the research.

Next I discuss the significance of a political economy perspective on health as a tool for viewing the interaction between micro and macro factors, in particular in the context of austerity where health inequalities are seen to be widening. In the penultimate section I discuss gender and health inequalities. I emphasise that, fundamentally, a gendered political economy of health is an important way of viewing the consequences of austerity for women, and briefly clarify the different meanings 'political economy' holds in respect of this research. Finally, I discuss the significance of the burgeoning application of intersectional theory to the field of health inequalities. I demonstrate that intersectionality is a novel concept when applied in this field in particular, and my application throughout the thesis is unique.

2.1 Examining everyday life

2.1.1 The sociology of everyday life

Defining 'everyday life' is not straightforward. There is difficulty in trying to define something that is 'so taken for granted, not just in terms of how it is lived, but more importantly…how it is critically (or not critically) understood' (Storey, 2014: 122). The concept can be 'slippery', both everywhere and nowhere (Ebrey, 2016). Sociological enquiry into everyday life is a relatively recent endeavour, emerging in the 1920s as an innovative way of studying human relations (Bennett and Watson, 2002). Erving Goffman (1959) was influential in the emergence of the field. His work sought to demonstrate that identity management and self-control was a huge part of participating in public life, and that we engage in complex and context-specific acts of presentation in different social settings (1959). His later work examined the role of stigma and the ways people present themselves when they have aspects of their personality others might consider 'spoiled' (1963). This work relates to the everyday experiences of mothers living on low incomes and young mothers in particular, who are often the subject of prejudice in society, and stigmatising rhetoric in policy and media discourse.

Contemporary research, such as that from Hamilton (2012), Skeggs (2012) and Shildrick and MacDonald (2013) corroborates this earlier work, illustrating how social class stratification reinforces the stigma that poorer women experience as they negotiate the sticky boundaries of poverty, consumption and raising their families. Most recently, Shildrick (2018) has provided a valuable overview of the research and perspectives on poverty to date, as well as insights into the everyday lived experiences of poverty and life on a low income. C. Wright Mills, also a prominent thinker in the arena of everyday life, wrote that to better understand individuals we should examine the social and historical context of their actions. His work on utilising 'The Sociological Imagination' is highly useful, as it emphasised the importance of historical legacy, how individual biography plays out in specific social settings and social structures – the interaction of institutions, the importance of power and how social norms are maintained (1959). He crucially argued that this project

should exist to take personal, individualised problems, and emphasises their wider structural and political significance.

Lefebvre was another key thinker relevant to this field. His interest in the everyday was to decipher man's alienation under capitalist society, how the 'bureaucratic society of controlled consumption' (Lefebvre, 2000) created inequality and atomisation. He argued that industrialisation, followed by urbanisation were shaping forces of everyday life. He saw space and time as little-explored but central points of critical enquiry. He argued that everyday life was a complex interplay of illusion and truth, power and helplessness, 'the intersection of the sector man controls and the sector he does not control' (1947: 40). His critique of society centred on the need for praxis in order to identify the root causes of and solutions to man's alienation (1947).

His work focused on everyday life as an under-researched area of sociological enquiry – especially in relation to capitalist society which, he argued, changed the relationship to everyday life greatly, colonising it into an area centrally about consumption. As a Marxist theorist, he was concerned with how space and everyday life has been co-opted to reproduce capitalism (1991: 26). His work on space has been of great influence on human geographers such as David Harvey (2008, 1985, 1982, 1973) who has analysed the implications of urbanisation on periods of crisis and the 'spatial organisation of capitalist production and reproduction' (Charnock, 2014: 319).

2.1.2 Everyday life research in the UK

In the UK, the field emerged through the work of sociologists such as Richard Hoggart and of E.P. Thompson. Hoggart founded the Centre for Contemporary Cultural Studies (CCCS) in Birmingham and was later influential at Goldsmiths College. Some of his work focussed on how language is used between and across class groupings in the UK (2003). E.P. Thompson wrote on the shifting nature of class and practices of the working class. His text 'The Making of the English Working Class' (1980) sought to emphasise the experiences and everyday lives of the working class through history, refuting the heterogeneity that had been applied to the diverse experiences of those belonging to the broad categories of 'working class'.

These works formed part of the 'turn to the quotidian' in UK scholarship – an emphasis on mundane and everyday practices (Warde, 2014). Bennett and Watson (2002) have highlighted three factors which influenced the emergence of the study of everyday life. Firstly, certain identities and experiences deemed 'in-common', ordinary or shared in a public sense have been identified and proliferated through television, the media and popular discourse. Secondly, this imagination had led to 'the emergence of new forms of social discipline' providing an avenue for visibility and critique of the everyday. Finally, they argued, new social movements, such as feminism, 'were productive of new understandings of the power relations of the everyday and ways in which it might be lived differently' (2002: xi–xiii).

The Understanding Everyday Participation (UEP) project is a contemporary example of empirical research into everyday life. It has examined and widened understandings of public cultural participation and value-

making (Miles and Gibson, 2016). It has emphasised the significance of 'place' (Miles and Gibson, 2017) in how levels of public and cultural participation are shaped and examined how spatial inequalities permeate everyday life as a consequence of austerity. Les Back (2015) has written at length about everyday life, providing a powerful critique of class in modern society. He has argued that 'the "everyday" brings the seasons of society into view … how liveable lives are made in the midst of the social damage produced by widening class divisions'. Central to his work on 'the everyday' is the relationship between history, culture, class and biography (2015). This enhances our understanding of the relationship between policy and reform on the one hand and personal perceptions and day to day activities on the other, the interaction between macro level structures and micro level effects. Examining everyday life allows social scientists to look at society not as a 'set of structural arrangements' but as a moving and dynamic entity that has a rhythm and a temporality (2015: 820).

Human geography has played a valuable part in the field. Massey (2005, 1994, 1991) has produced seminal work on the notion of place as non-normative, embodying multiplicities and complexities and meaning different things to different people within those spaces (1991). This relates clearly to everyday life, as it is through the experiences of the everyday that places are made and remade. Storey (2014) has illustrated how Massey's work is an asset to the understanding of everyday life – it explicitly provides us with a framing of the relationship between place and everyday life that is non-normative, fluid and complex. It allows us to see space as continuous and always in a state of becoming. Cresswell (2009, 2004) has critically evaluated Massey's work on place – pointing out Massey's contestations of normative constructions of place, the need for a 'progressive sense of place'. From this he has provided a concise definition of place – 'locations imbued with meaning that are sites of everyday practice' (2009: 178). Others, such as Hall (2016a, 2016b) are interrogating shifts in family life in an everyday sense in contemporary austerity society, that interpersonal family relationships are central to 'getting by' in times of austerity. These works, focussing on place, space and time in terms of the ordinary, routine and 'everyday', represent a tangible contribution the field of human geography can make to empirical work.

The field of research on everyday life, through the 'turn to the quotidian', represents an important distinction from work on 'culture', such as that focussing on consumption – which has been argued to be individuating and thus possible to be co-opted by a neoliberal policy agenda (which stresses individual responsibility over collective) (Warde, 2014). The field of 'everyday life' scholarship remains separate to this and provides a powerful tool with which to mount an intellectual challenge to austerity – focussing not on individuals as atomised, but on the broader and rich worlds they are immersed in and the complex contexts of choice, habit and practice. Ebrey (2016) has proposed that sociological enquiry into everyday life can be examined as an 'intellectual history' of the everyday. This perspective presents everyday life as both a form of knowledge and a set of practices (2016: 158). Crucially, it can be used to inform policy, shifting it away from a 'market orientated mentality' (McGuigan, 2005: 229).

2.1.3 Women's everyday lives

Oakley (1993) has challenged the notion that 'the goal of intellectual work is to rise above everyday life as if this were seen as tedious, trivial and boring and not at all, incidentally, the realm of women…' Sociologists, in particular those employing a feminist perspective, have used the lens of everyday life to explore women's lived experiences of motherhood and gender relations and gendered practices. The exposition of private life and everyday acts of women's lives has been an important subject of attention from feminist researchers and academics. Wierling (1995), for example, argued that the everyday constituted a form of knowledge 'of which the most learned are women' (1995: 154). Felski (2000) has written in relation to time and routine, space and the home, and modality and habit in the lives of women, particularly in a classed sense.

Skeggs (2008a; 2005; 1997) has written about everyday practices as classed and gendered, and the value judgements made about and through them. Holmes (2009) has examined a series of practices which 'gender' women, from intimate relationships to how children are raised. Oakley (2016, 2000, 1993, 1980) has written extensively about the experiences of women and specifically the feelings associated with becoming a mother (1979), arguing for the continued inclusion of everyday life in social enquiry. Oakley sought to challenge an enduring idea about women in society – 'that women are not central in their own lives, and that women are always waiting for something; in shopping queues, antenatal clinics, for men to come home, for children to grow up, at a school gate, waiting for love or freedom or re-employment, waiting for the future to liberate or burden them and the past to catch up with them' (1979: 11).

There has been a steady growth in the application of the concept of everyday life in empirical research, and the particular need to focus on women's everyday experience. Central to my research is the importance of examining and placing value on the experiences of everyday life – an area which is re-emerging in empirical work relating to contemporary austerity. Two areas of the literature on everyday life are particularly significant. Firstly, the literature on the evolving and shifting nature of everyday life in the United Kingdom in relation to processes shaping life trajectories – class, geography, value systems, gender relations and historical contexts. Secondly, the literature relating to women's 'everyday lives', acknowledging the marginalisation of women's lives from mainstream sociological enquiry and health research. This PhD contributes to the literature by placing at the fore the experiences of mothers in a time of austerity, referencing literature which emphasises the inherent political importance of this work.

2.1.4 Austerity and everyday life

A number of publications in recent years have built on academic investigation into the everyday consequences of austerity in the North East of England (Bambra and Garthwaite, 2015; Garthwaite and Bambra, 2017; Garthwaite et al., 2014; Greer Murphy, 2017; Mattheys et al., 2016; Raynor, 2017) and in the United Kingdom more generally (Hall, 2018; Hitchen, 2016; Lewis and West, 2016; McKenzie, 2015; Milbourne and Cushman, 2014; Patrick, 2017, 2016; Pimlott-Wilson and Hall, 2018). Garthwaite (2011), for example, discussed the media portrayal of disabled individuals and the impact this rhetoric had on conceptualisation of self. In-depth

interviews with respondents in the North East of England found that self-esteem was low and that respondents had themselves internalised a deserving/undeserving dichotomy in relation to welfare benefits. McKenzie (2015) has examined life within a specific council estate and how residents negotiated their experience in relation to the wider community. Patrick's (2014) work longitudinally examined the experience of those on out-of-work benefits and found that those managing on a low income were finding their material circumstances deteriorating, and were under extreme pressure, describing feelings of stress, anxiety and depression.

Stanley et al. (2014) have explored the ways debt is transforming everyday life during austerity. Their research examined how debtor/creditor relationships emerged online and offline in an era of increased indebtedness. Bhattacharyya (2015) has written a timely and compelling book about everyday life under austerity, arguing importantly that austerity's highly negative impact on women does not represent a contrasting elevation of the position of all men, but rather that through classed, racialised and gendered subjectification it impacts different groups in different ways (2015: 149). Pemberton et al.'s. (2014) work on life on a low income in austere times explored lived experiences for individuals on low incomes during austerity. They demonstrated that, while many had already been poor and deprivation was not a new experience, the extent of the deprivation and intensity of the 'emotional injury' associated with it seemed to have increased (Pemberton et al., 2014: 37–38). Respondents in this study discussed feeling stigmatised through negative media and political rhetoric, experiencing greater material struggle, and an increasing feeling of insecurity.

An enquiry into the everyday provides a route through which to understand the intersections of class, gender, place and other categories (Ebrey, 2016). This has been an important feminist pursuit for some time (Oakley, 1979). Examining the everyday can provide an important political challenge to processes of austerity and rising inequality (Back, 2015; McKenzie, 2015). Thus far there has been relatively little sociological enquiry combining gender austerity and everyday life to understand inequality and health inequalities. There is an ongoing need for rigorous qualitative work which engages with the importance of the everyday while advancing the debate around a political economy of health in an age of austerity. My work has sought to make important connections linking the micro and macro, between the everyday and broad structural changes, emphasising the importance of space and place, and the intersectionality of inequalities stemming from austerity politics, emphasising the need for interdisciplinary critique.

2.2 Austerity, neoliberalism and the changing welfare state

2.2.1 Austerity in the United Kingdom

Austerity in the UK has been ongoing since 2010. Then Prime Minister David Cameron argued that spending on welfare, and benefits, had reached an unsustainable high in the face of bank bailout, rapidly increasing national debt and falling tax receipts. Painter (2017) has noted that 'the political discourse associated with this world-view invokes a distinctive vocabulary and set of metaphors: "the nation's purse strings", "the national piggy bank", "taxpayers' money" and "maxing out the nation's credit card" feature prominently'. As he has

noted, this discourse of 'sound public finances' is just as entrenched on the centre left as it is by Conservatives (2017: 37). Austerity measures were first introduced in the UK with the 20th October Comprehensive Spending Review by George Osborne (HM Revenue, 2010). This has been accompanied by multiple redistributive changes, in tax credits and welfare entitlement, as well as erosion of the universal entitlement of some social benefits such as child benefit. In July 2013, Cabinet Secretary Jeremy Heywood warned that austerity was 'not a two year project or a five year project, but rather a 10–20 year 'generational battle' to restore the economy'.

Austerity measures adopted in the UK have explicitly focused on deficit reduction through a reconfiguration of the state, cutting public spending (including substantial welfare reform) and reductions to public sector employment, thus 'further entrenching the neoliberal model' (Hall et al., 2013: 4) The universality of access to certain services, one of the core tenets of the originally conceived-of welfare state, has been eroded (Hanen, 2013: 5). In a survey of welfare states in Europe after the financial crisis, Diamond and Lodge (2013) argue that austerity should prompt a debate, not just about choices regarding public spending, but about the role of the state, its position and involvement in people's lives.

Placing the centrality of citizenship in an individual's ability to earn a wage denies the realities of networks of identities, positions and family structures, as well as the realities of our post-industrial labour context. By choosing not to invest in human capital and in growth-oriented policies that encourage gender equality and aid families to save and spend, a new variety of 'social risks' emerge (Diamond and Lodge, 2013; Hanen, 2013). The role of the family is in many ways central to economic growth. Families are the unpaid care givers; family units enable people to work and learn and it is families who are the consumers of goods and services (2013: 3). Denying value to the work mothers and families do in caring and reproductive labour (Skeggs, 2014) fails to acknowledge the multiple forms of 'socially useful' citizenship that take place for a healthy, functioning society.

2.2.2   Austerity as policy

Austerity has been interpreted in a number of ways which vary by context, country and time period. As a macroeconomic theory its aim is to reduce government budget deficits (Konzelmann, 2014). Its application has been varied – in some instances it was a requirement with a bailout package from the IMF, as with the PIIG nations (Portugal, Italy, Ireland and Greece) post-2008 financial crisis, to demonstrate to potential buyers of future issuances of government debt and the agencies that rate the debt (Moody's Investors Service, Standard and Poor's, and Fitch Ratings) that a government is 'fiscally responsible' (Konzelman, 2014). It follows that to attract investors a government must show that meeting interest payments and controlling overall debt levels is a key priority, so much so that it will save money by enacting cuts to public spending at a time of reduced revenue for a country.

Economists Reinhardt and Rogoff (2010) published a paper which acted as a catalyst for the most recent turn to austerity as a policy solution to the crisis many countries experienced after the 2008 crash. However, this

work has since been exposed as theoretically and mathematically flawed (Mencinger et al., 2014). Despite its debatable and contested success in isolated incidents, such as Ireland, austerity has intensified inequalities which have been steadily widening over the past three decades (Regan and Brazys, 2016). Indeed, the International Monetary Fund, at one time a driving force behind austerity, has finally acknowledged that austerity policies 'not only generate substantial welfare costs due to supply-side channels, they also hurt demand and thus worsen employment and unemployment' (Ostry et al., 2016: 38).

2.2.3   From welfare state to neoliberal state

To understand the impact of austerity policies today one must appreciate the genesis of the state institutions that are being reformed and cut back. In the UK and across Europe in the 20th century welfare states were established upon Universalist principles exemplified by The Beveridge Report (1942) or 'Social Insurance and Allied Services'. This report greatly influenced the direction of the welfare state in the UK. It highlighted five 'Giant Evils' in society – squalor, ignorance, want, idleness and disease – and identified five key – housing, education, health, employment and material need in which improvements could take place (1942). Beveridge advocated for flat-rate universal payments and universal service access. Esping-Andersen (1990b) has famously classified the main welfare state regimes, moving beyond solely theoretical concerns of power, industrialisation and capitalism, instead asking what a welfare state is, to what extent its social policies are emancipatory, whether they aid or abet market processes, and what type of 'basic' supports they offer (Esping-Andersen, 1990a: 102). Under his classification, the UK is a classic example of a Liberal welfare regime (Esping-Andersen, 1994).

Its features include relatively conditional entitlement to social security with low payments, labour market activation, and higher rates of inequality in terms of income, health, wealth and social mobility than the social-democratic regime (Bambra et al., 2014). Much of the earlier welfare state inception and development took place under a liberal government. Historian Derek Fraser (1989) explained that the UK welfare state

> *Germinated in the social thought of late Victorian liberalism, reached its infancy in the collectivism of the pre- and post-Great War statism, matured in the universalism of the 1940s and flowered in full bloom in the consensus and affluence of the 1950s and 1960s. By the 1970s it was in decline, like the faded rose of autumn. Both UK and US governments are pursuing in the 1980s monetarist policies inimical to welfare.* (1989: 233)

It has been argued that a welfare state should promote and provide the circumstances for social citizenship by granting social 'rights' through decommodification – reducing their reliance on wage labour and market dependency (Marshall, 1950). Its role could also be seen as promoting social cohesion while mitigating the conflict-generating tendencies of market capitalist societies (Taylor Gooby, 2016: 712). Since the 1970s we have seen a gradual move away from the founding principles upon which the 'Golden Age' of the welfare state was built. The structure of society, a globalised, financialised economy, the changing nature of gender relations such as the shift from a 'male breadwinner' to 'dual earner' model as well as changes to the type and quantity of work available have resulted in vast modifications to the welfare state. Alongside that, the traditional working class, employed primarily in manual and industrial work, has lost its place in the labour

market as the service sector becomes the largest employer – alongside societal shifts in measurements and understanding of class. We have seen a deregulation of the labour market and of wages, stimulating growth in employment but increasing inequality (Epsing-Andersen, 1994) which has led to a widening health gap.

2.2.4 Deepening the neoliberal state

Harvey (2005) framed neoliberalism as a political project carried out by the elite capitalist class who felt threatened by labour's economic and political power in the 1960s and 1970s and needed to curtail it. Wacquant (2010) has described the neoliberal remaking of the state over the past quarter-century as an era of 'fragmented labour, hypermobile capital, and sharpening social inequalities and anxieties' (2010: 202). This state has been the 'manager of social turbulence created by three decades of economic deregulation and the fragmentation of wage labour' (2009b). It can be characterised by the core processes of privatisation, financialisation, and retrenchment of the welfare state and the weakening of labour power through flexibility of workers (Mercille, 2017). Tyler (2013) describes neoliberal political discourses as 'state-phobic', yet demanding of and requiring constant intervention by the state (2013: 6). Peck and Theodore (2010) have characterised it as a flexibly mutating regime of market rule.

Since the 1980s, a consequence of adopting neoliberal policies has been slowing down GDP growth, with deep recessions during the 1980s and early 1990s that played an important part in decimating manufacturing and increasing import dependency. Advanced economies have since experienced economic slumps, followed by unsustainable bubbles, inflated by increasing supplies of low-cost credit from the progressively deregulated financial sector, in turn followed by prolonged recession (Konzelmann, 2014: 732). The concert of policies initiatives enacted since the early 1980s, characterised as neoliberalism, are contemporaneous with increasing economic instability and financial inequality. This instability has been so great that by 2008 governments and tax payers across the EU and US were required to take on massive debts resulting from bank bailouts to prevent a severe collapse of global financial capitalism. This shock to the public finances led inexorably to austerity, and in a sense neoliberal policy acted as midwife to austerity.

Oakley and Williams (1994) have argued that contemporary shifts towards broad and encompassing marketised and individualised reforms to the welfare state have not brought, as its reformers have argued, increased choice and lessening cost. Rather, through consistent and long-term changes to healthcare, education, housing, and social security provision, more choice has been afforded to a few, and a lower quality, rolled back service for many. Through the 'cumulative deepening' of the neoliberal state (Peck et al., 2018), there has been a withdrawal of many publicly funded services, causing some service providers to engage the help of volunteers, and privatised other core services. Core features of the neoliberal state which have emerged include decentralisation, welfare pluralism with a strong place for the private sector in providing core services, labour market flexibility, minimising social expenditure, and implementing 'workfare' principles (Jessop, 1991; MacLeavy, 2011; Schrecker and Bambra, 2015). This is being particularly intensified under the current austerity regime.

2.2.5   Welfare state retrenchment

Dowling (2016) has described how the welfare state has become 'retrenched' as a consequence of ongoing neoliberal privatisation, a reduction in spending, an emphasis on 'workfare' and labour market activation policies (Betzelt and Bothfeld 2011; Dowling, 2016). Taylor-Gooby (2017) has compellingly argued that the contemporary welfare state faces a 'double crisis' – of short-term and long-term consequences. The short-term consequences pertain to dealing with the fallout from rising inequality and rising poverty owing to economic instability and austerity. Long-term consequences relate to an ageing population and requiring ever-increasing spending on health, social care and pensions, and governments directing their attention to national competitiveness in a context of globalised and technological changes. A core component of welfare reform in recent decades has been the shift to 'workfare' states – imposing strict time limits on welfare receipt and an emphasis on training to become 'work ready'.

The literature on the relationship between welfare and work, economy and society in a neoliberal context indicates that we are moving away from 'passive', universalist welfare, to 'active' entitlement based on contribution, means testing, flexibility alongside labour market precarity and insecurity (Schrecker and Bambra, 2015; Bezanson and Luxton, 2006). This 'worker citizen' model is a shift away from universal entitlement (Lewis, 2002) and a move towards 'welfare contractualism' (Lister, 2003). This process was intensified under New Labour (1997–2010), and the Coalition (2010–2015) and Conservative (2015–time of writing) governments. There is a shifting emphasis from entitlement to eligibility, from rights to responsibilities, and an emphasis on encouragement (or compulsion) into work and 'making work pay' (Giullari and Lewis, 2005).

Significant aspects of this turn have intensified inequalities, particularly, as this research has focussed on, invisible inequalities affecting women's lives. They include the 'simultaneous erosion and intensification of gender' whereby the differing needs of women are erased from policy considerations and the 'simultaneous demands for autonomisation and responsibilisation' (Bakker, 2007). This takes place through 'the progressive detachment of individuals from social networks and supports, while at the same time, responsibility for systemic problems' is handed to the individual (Bakker, 2007; Brodie, 2003). It is essential that we interrogate the reconfiguration of the models of welfare and work. We must consider both the role of social reproduction (Fraser, 2013; Girón, 2015) and the gendered dynamics of work, welfare and social life in a neoliberal and austere context.

2.2.6   The neoliberal state in an age of austerity

The era broadly encompassing the period from the beginning of neoliberal policy-making at the start of the 1980s to the present austerity state has been designated as 'globalised financial capitalism' by Fraser (2016b: 104). It is important to draw a conceptual link between the turn to neoliberalism within many states and the contemporary manifestation of austerity to illustrate that austerity is not merely a short-term deficit-reduction

plan but a deliberate strategy integrated into an overarching framework of political, economic and social policies. Esping-Andersen has commented that:

> *The virtually instantaneous mobility of capital in unregulated markets seriously affects the capacity of governments to regulate national economies; competition for capital and markets increases pressure to adopt a low wage strategy, including a reduction in the cost of social benefits and weakening of labour standards; and the twin goals of maintaining acceptable levels of employment and defending the principles of equity and solidarity seem increasingly incompatible* (Esping-Andersen, 1994: i).

Manufacturing has shifted to low-wage regions, women have been integrated into the workforce and the state has divested largely from welfare provision. Care work has been externalised to families, communities and the market while 'simultaneously diminishing their capacities to perform it' (Fraser, 2016b).

Austerity has been read as a continuation of a class project concerned with the reinforcement of power for an elite group in society, and a corresponding withdrawal of welfare and security, leading to widening inequality between the top 1% of the income bracket and others (Blyth, 2013). Navarro (1978) has argued that power blocs and class conflict are the main determinants of social change. This thesis incorporates this perspective into an intersectional analysis which acknowledges that class inequality alone is not the sole indicator of rising inequality. While austerity can, and should be viewed as a form of class politics, it is not solely this. Austerity in the UK has had a number of intersecting geographically delineated, classed and gendered consequences.

The slow return to economic stability since the 2008 financial crisis has been coincidental with regressive redistribution mechanisms, including quantitative easing from Central Banks (Green and Lavery, 2015), tax reductions on capital and corporation profits, as well as stagnation of real wages and subsequent erosion of living standards for many. Schrecker and Bambra (2015) have characterised the 'neoliberal turn' in social policy, as one example, as consisting of a preoccupation with cutting costs, a presumption of undeservingness of benefit recipients and the privatisation of core public services (2015: 67). We are now seeing the reversal in upward trends in social mobility, child poverty reduction and health improvement (Konzelmann 2014: 721). This is viewed by many as a continuation of a neoliberal economic project which has been evolving over three decades (Taylor-Gooby, 2012). Two core features of the neoliberal austerity state – labour market precarity and welfare reform – are particularly relevant to this thesis, and shall now be discussed in more detail.

2.2.7 *Precarious labour markets*

One of the important results of neoliberal reform and austerity policy is labour market precaritisation (Harvey, 2005). This precaritisation has a number of core features. Firstly, it is characterised by labour market insecurity. Secondly, it has geographic and sectoral variations. Finally, it reinforces gender and class stratification. Academic literature has classified this as the 'New Economy'. This literature first focussed on a broad analysis of increasing employment in the knowledge-based field and services sectors in the context of an increasingly unstable economy (McDowell and Dyson, 2011). Later, there was more of a focus on the rise of the low-wage economy (Bennett, 2015; Standing, 2011; Warren, 2015). Holloway and Pimlott-Wilson

(2016) have characterised this New Economy as consisting of rising individual risk and profound labour market insecurity (MacLeavy, 2011). This shift has taken place through a move away from Fordist production to a knowledge-based economy, and globalising forces have had a large part to play in this process. Increasingly, individuals experience difficulty in earning a living wage through a rise in low-pay, zero hour contracts, insecure contracts and a lack of full-time employment (MacInnes et al., 2014).

The move in and out of low paid work and onto temporary benefits such as Job Seekers Allowance has been termed the 'low-pay, no-pay cycle' (Shildrick et al., 2010). There has been a huge push to reintegrate recently unemployed individuals and to integrate ever more groups into the labour market, such as women and those with long-term disabilities. As Chandola and Zhang (2017) have illustrated, formerly employed individuals who enter poorly-paid and insecure work are more likely to experience chronic stress than those who remain unemployed. Therefore, job quality is of great importance, as psychosocial stressors generated through poor quality work could be as bad for health as being unemployed (Bambra, 2011; Broom et al., 2006).

Welfare reforms have withdrawn supports to those on low incomes, women, those with disabilities and young people at a time in which the availability of quality work is decreasing. Combined with the regressive redistribution mechanisms outlined above these processes have increased social stratification. There is the danger that, in this kind of society, 'the burdens of reciprocity then fall with inequitable heaviness on the shoulders of the least well-off' (White and Gardner, 2000: 99). The Institute of Fiscal Studies has produced numerous reports on the impact of a fall in living standards and a rise in income inequality across the UK (2017, 2016, and 2015). Furthermore, the Welfare Conditionality study, a large ESRC-funded project, has produced numerous publications on the impacts of welfare conditionality specifically (Dwyer and Wright, 2014; Fletcher et al., 2016; McNeill et al., 2017; Povey, 2016). These publications present a cohesive body of work indicating that austerity is ubiquitously negative for many groups including women, children and those with disabilities.

Job opportunities are geographically uneven, and there is limited acknowledgement of non-market forms of 'productive contribution'. In Stockton-on-Tees, the industrial decline experienced since the 1980s has resulted in a sharp rise in flexible labour practices, as has been the case in the entire North East region. The guarantee of a 'job for life' has been withdrawn and rising unemployment exists alongside a reduction in labour and collective bargaining power leading to a decline in employment in traditional industries and in worker's rights. This precarity has been mostly experienced in the service sectors of the local economy and low-skilled routine work became more common (Beynon et al., 1994: 155). Female participation in a variety of sectors such as the service industry, retail and the private sector (financial services such as customer care and data entry) has increased (Beynon et al., 1994; Shildrick et al., 2012). Warren (2017) has indicated that recent attempts to reinvigorate the local economy have not had lasting success. Low wage levels have persisted and globalisation has led to industry relocating permanently to less expensive regions of the world.

2.2.8 Reformed welfare landscape

A great deal of the changes which have taken place due to welfare reforms have targeted those already living on low incomes (Duffy, 2013). These regressive reforms have hit those relying on in-work and out-of-work benefits to a great extent, having a hugely negative impact on poorer families and communities (Hill, 2014). As a result, waves of broad and comprehensive welfare reforms have taken place affecting many groups, particularly women, those with disabilities, and those out of work, and undermined the health and capacities of vulnerable communities across the country (Green et al., 2017; Patrick, 2016; Pimlott-Wilson and Hall, 2017). Key reforms that have taken place include the Welfare Reform Act (2012) and the Welfare Reform and Work Act (2016). Specific reforms that have taken place under these changes include reforms to housing benefit, the introduction of a benefit cap, and move to Universal Credit for certain welfare recipients, a commitment to full employment, reforms to disability payments, and increasing welfare conditionality (DWP, 2017). Research for the Joseph Rowntree Foundation (JRF) by Hirsch, Padley, and Valadez at Loughborough University (2017) has indicated that out-of-work households and single headed households will be significantly worse off by 2022 under recent welfare reform policy – the proposed introduction of Universal Credit.

Beatty and Fothergill (2016) have noted that the impacts of welfare reform are substantial. They estimate by the beginning of the next decade claimants will experience 'a loss of income of almost £13bn a year as a result of the post-2015 reforms, and cumulatively more than £27bn a year as a result of all the reforms since 2010'. This would translate to an average loss of £690 a year for every adult of working age across the whole of Britain, although for some individuals and regions the loss of income is much greater as the financial losses arising from the reforms hit some places much harder than others. In the most extreme cases this amount is three times greater (2016: 35, 36). Middlesbrough, located beside Stockton-on-Tees, would lose £550 per adult, placing it in the top 10 hardest hit areas (2016: 16). Beatty and Fothergill (2017) emphasise that the biggest financial losses for claimants have come, not from the measures that have attracted the most public attention, such as the 'bedroom tax' and Benefit Cap, but from the 'overall jigsaw of welfare reform' and specifically changes to Tax Credits (£4,210 million a year), Child Benefit (£3,030 million) and the 1% uprating (£2,700 million) which have all had a huge impact (2017: 5).

2.2.9 Women and austerity

The impact of policies such as benefit and taxation changes on the material and social experiences of women across the UK have been reported by third sector organisations such as the Women's Budget Group (2017, 2015, 2013a, 2013b, 2013c), Women's Resource Centre (2017, 2013, 2012), Trade Union Congress (2011, 2010) and The Fawcett Society (2017, 2013). The Women's Budget Group have recently produced an important report highlighting the intersectionality of inequalities for women under austerity (Hall et al., 2017) highlighting that low income families, lone parent-headed households and BAME households have been particularly affected. Rubery and Karamessini's 'Women and Austerity' (2014) provides an update of Rubery's (1988) 'Women and Recession', focussing on the distinct nature of the 2008 financial crisis and the context in

which austerity policies are being enacted within the context of twenty years of sustained labour market activity for women. They argue that there is the potential for the current austerity programme to represent a turning point which could roll back decades of women's progress towards equality in paid work and economic independence.

Women's caring needs, their pregnancy and maternity needs, lower income and relative economic inequality and the fact that they compromise the majority of lone parents, put them in a unique position of policy attention. Increasing welfare conditionality and a rise in insecure working practices mean that women of working age, with young children, are in a particularly vulnerable situation. National figures for the UK show a disproportionally rising rate of unemployment for women over 50, and Robson and Robinson argue that women over the age of 50 are 'bearing the brunt of the government's economic policies while often trying to cope with the increasing burden of caring for relatives' (Robson and Robinson, 2012: 6). Women, as the main carers, will bear the brunt of these cuts (2012: 8). It is clear that the value of maternal care and social reproduction is not acknowledged under this paradigm of public policy (MacLeavy, 2011a; McDowell, 2005).

2.2.10 *Social reproduction and work*

McGrath and DePhillips (2009) have noted that the work of social reproduction is largely conducted in private, outside the realm of labour protection, not inherently viewed as 'work' in a quantifiable sense. When it is reconfigured as wage-labour it is often unregulated and poorly paid, diminishing the intrinsic value of this important work (2009: 80). Feminist economist Marilyn Waring has noted that the system 'cannot respond to values it refuses to recognise' (Waring 1989: 4). Two points can be made in relation to this. Firstly, caring work was from the beginning of the welfare state not explicitly acknowledged as providing worth in an economic sense. Secondly, the gendered division of labour under the early welfare state was idealistic and tokenistic, characteristics that have endured through time. It did not reflect the everyday lives for working class women and children who had to work outside the home (McGrath and DePhillips, 2009: 68), and contemporary narratives which classify working class women who are outside of full-time labour market participation as 'work-shy' ignore their caring responsibilities.

The stigmatisation of poorer families and young mothers permeated the period of welfare state formation, and is mirrored in modern processes of normalisation and stigmatisation (Jensen and Tyler, 2015). Many women, particularly those from working class communities and young mothers, frequently experience stigma and judgement in daily life (Wenham, 2015) which undermines and devalues the intrinsic importance of social reproduction. Jackson, Paechter and Renold (2010) have argued that the phrase that women now 'have it all' does not reflect the everyday lives of many women, particularly working class women, who are subject to the 'sociocultural artefacts of class, nation and gender' (Mannay, 2015). Many women are limited in their access to public life and responsibilities in private spheres. As women reproduce, they are subject to the inequalities inherent in the social contract of 'new motherhood', expected to also hold down a full-time job (May, 2008; Wall, 2013).

2.2.11 Gender in a changing welfare state

Literature on the inception of welfare states has by and large neglected the gendered presupposition of welfare entitlements (Orloff, 1996). In the original plans for the welfare state outlined in the Beveridge Report (1942), a degree of gender bias in welfare provision was assumed, reflecting the social climate of the time. It was assumed that marriage was the norm and that the relationship would consist of a male breadwinner and his female dependent (Orloff, 1996). In earlier iterations of the welfare state, the 'family wage' was promoted, although inequality of income and opportunity meant many families failed to secure this. The early success of the welfare state in achieving near-full employment and eradicating much of the visible poverty in the inter-war years led to a prescribed orthodoxy that poverty in the UK had been abolished (Atkinson, 2000). Declining rates in absolute poverty have given rise to the perception that 'few or no people could be counted as being poor' even if relative measures show that one third of the British public were living in poverty in the 1980s (Shildrick and MacDonald, 2013: 294). This is a gender issue as women such as lone mothers and working class women have consistently experienced high rates of poverty while engaging in low-paid and insecure work alongside caring duties and household management.

The welfare state is mainly produced and consumed by women (through public sector employment, work in caring roles and in claiming benefits), but controlled and managed by men (Pierson, 1991: 70). In addition, while the welfare state in many ways benefits women, for example through economic and social autonomy (albeit limited) for single mothers, flexible work and tax-free earning allowances, childcare and the encouragement for women to gain high levels of education and engage in the labour market, it is also a site of oppression of women by men. This has been written about at length within the Marxist feminist tradition, which is concerned with the subjugation of women and certain class dynamics produced through society (Meehan, 1990: 190).

Bambra (2007) has established that the classification of welfare states is itself open to problematisation and critique. Three major critiques come to the fore, which are of central importance to this thesis. Firstly, the typologising of welfare state regimes has been criticised for being gender-blind (Sainsbury, 1994), utilising the concept of decommodification – the strength of social security entitlements to protect citizens from their dependence on the market – without acknowledging its inherent gender bias. Secondly, it does not make explicit the sustaining role of women and the family in the provision of welfare. Finally, it lacked due consideration to the role of gender as a form of social stratification (Bambra, 2007: 1100).

Stratification refers to the relative social ranking of individuals within a society based on socio-economic status, wealth, occupation and power (Saunders, 1990). Gender is one of the most ubiquitous forms of stratification – in patriarchal society, social roles are often based on gender norms, rights may be afforded to or denied to certain groups based on their gender, and privilege is concentrated in the hands of those with more power, in this case men (Collins, 1998). Kregier et al. (1997) have argued that social stratification has an intrinsically exploitative dynamic, with the advantage of one group coming at the cost or disadvantage of another.

To interrogate the political economy of the welfare state from a feminist perspective is to delve further into the highly gendered and normative nature of its foundation and evolution. Welfare states were conceptualised under a model which assumed normative characteristics of families, gender roles and labour (Fraser, 2013: 111). At the time of the welfare state's inception, women's role as mothers and wives were embedded in the domestic realm, not as wholly equal social citizens, but ones who had both choices and responsibilities which differed from men's. For generations of women growing up in the UK since the 1940s their everyday realities, biographies and identities have been shaped by the policies of the welfare state. These realities are now being reshaped during the age of austerity. It is the actions of these macro forces on the micro scale of everyday life of mothers in Stockton-on-Tees that this research sought to unravel and explore.

2 Health inequalities

2.3.1 Defining health

Health can be defined as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity' (WHO, 1995). The interconnectedness of physical, mental and social wellbeing is particularly emphasised in much research on health and wellbeing (The Lancet, 2009). Health develops holistically; the health of an individual operates within broader social and physical environments. The 1986 WHO Ottawa Charter indicates the complex combination of factors that contribute to health:

> *To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities* (WHO, 1986).

The health inequalities literature acknowledges that there are different experiences of health within a given population, existing along a social gradient. The higher an individual's social position the better their health is likely to be, the lower their social position the worse their health is likely to be, manifesting in lower life expectancy and higher rates of chronic and life-shortening illness (Marmot et al., 2010). Graham (2004) has characterised this as 'the health consequences of poverty' (2004: 118). Addressing this social gradient of health requires a comprehensive set of policies with a common goal – 'one that subsumes remedying disadvantages and narrowing health gaps within the broader goal of equalising health chances across socioeconomic groups' (Graham, 2004: 125). Blaxter (1990) identified eight main perspectives, suggesting that health is variously viewed and is a complex and dynamic concept. Health might be seen in different ways and at different times as 'not ill/diseased', as a reserve, as behaviour, 'a healthy life', health as physical fitness, as energy/vitality, health as social relationship, as function or as psychosocial wellbeing. In Pill and Parry's (1988) work with working class mothers in South Wales health was, for example, seen as an absence of illness in terms of functional capacity. They found that mothers who were more aware of the effects of lifestyle factors on health were also those who could perceive the dynamic relationship between individuals and their environments.

2.3.2 The social determinants of health

It is recognised that good health outcomes are predicated upon the 'social determinants of health' rather than through access to health or medical care (Marmot, 2006). The social determinants of health are widely accepted to include working conditions, unemployment and worklessness, access to housing, access to services like sanitation, food and water, and access to healthcare (Dahlgren and Whitehead, 1991; Bambra, 2016). Policy responses focus on the social determinants of health, which are defined as follows:

> *The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world.* (Commission on Social Determinants of Health, 2008)

Dahlgren and Whitehead's 'rainbow of health' model (1991) has been extensively used in public health research to illustrate this. Working on this model, the World Health Organisation in 2010 produced further work on the social determinants of health model. The Commission on Social Determinants of Health (CSDH) made a number of relevant points. By framing health as a social phenomenon, it becomes a matter of social justice that health inequality is addressed. Health equity – the absence of otherwise avoidable and unfair indifferences in health among groups – becomes a guiding principle of health research. Finally, the CSDH framed this social justice and health equity issue as a human rights issue, with the state as primary actor in ensuring the wellbeing of its citizens. In this sense the WHO challenges the notion that human rights discourse is individualistic or exclusionary, instead drawing on its historical use in securing collective wellbeing and empowerment and solidarity movements (2010: 4).

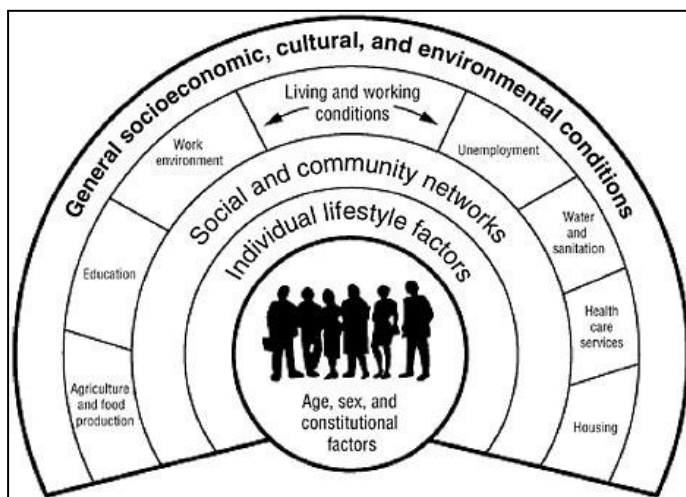**Figure 2. The Dahlgren-Whitehead model of the social determinants of health (1991)**

In my research I have drawn on the interplay of these micro and macro level factors in influencing health. In health inequalities research it is widely acknowledged that measuring population health is complex, with academics increasingly emphasising the need for a theoretical framework that can accommodate the multitude

of factors that shape health inequalities, ranging from individual factors to the role of institutions (Beckfield et al., 2015; Krieger, 2012, 2011).

2.3.3 Explaining inequalities in health

Bartley (2004) has proposed five theories to explain health inequalities which were later elaborated on by Sisson (2007) and Bambra (2011). These are: materialist (income level and what relative incomes allow), cultural-behavioural (instances of health-damaging or healthful behaviours), psychosocial (impact of status, subordination, inferiority or superiority) and life course (the accumulation over a lifetime of health-damaging or healthful experiences on the body and mind) (Bartley, 2004: 16). The supremacy of the cultural-behavioural perspective by policy-makers in recent years has been heavily critiqued (Bartley, 2004), and it has been emphasised that these explanations are not mutually exclusive, but interplay with each other. The political economy perspective (Bambra, 2011) which will be discussed in more detail later refers to the integration of multiple political, economic and social factors in influencing life trajectories and thus, health. These theories emphasise the interlinking of socio-economic status, geography and environmental factors within societies in influencing population health.

The World Health Organisation (2010) has argued that material deprivation, through a lack of income for example, is a major contributor to health inequalities. Their work has indicated that income inequality results in processes that reinforce unequal social hierarchies that cause chronic stress, leading to poorer health outcomes for those at the bottom of the income spectrum. It also erodes social bonds, decreasing trust and civic participation in society. Furthermore, fewer economic resources are shared with poorer groups, leading to fewer opportunities, poorer housing and less access to quality education (2010: 31). While it may be problematic to overemphasise the role of material deprivation in causing health inequalities, it is widely documented that countries with less income inequality have narrower health gaps (Jayasinghe, 2011). As the political economy approach indicates, it is not a lack of money per se, but the economic, political and social context of a society which allows such stratification to be magnified, that creates the circumstances for wide health inequalities to proliferate.

2.3.4 Socio-economic status

Socio-economic status is a key determinant of health inequalities (Graham, 2000: 90). Social processes related to income distribution are involved in the deep ways our personal and class characteristics are constituted (Bourdieu, 1984). As Williams (1995) argues, 'it is the (class-related) habitus which…determines not only lifestyle and the chances of success, but also class-related inequalities in health and illness'. Of great significance are the early childhood influences on social and cognitive development which affect both health and social mobility and are important in social class differentiation (Wilkinson and Pickett, 2007). Therefore, while socio-economic status and class are key determinants of health and wellbeing, the routes to this are complex, embedded in early childhood experience, life course situation, gender, race and geographical location. The field seeks to first understand and secondly to counter the causes of differences in mortality and

morbidity across population groups (Smith et al., 2016), producing evidence which indicates that those with more socio-economic resources have a greater array of life chances and better health than those with less, and that greater cohesion within society contributes to better health for more in that population (Marmot et al., 2010: 3; Wilkinson and Pickett, 2007: 1973).

The literature indicates that socio-economic status or social class is a key indicator of health inequalities. Social class is 'written' on the body in many ways; it is inscribed in our experiences of health and our chance of premature death. The lived reality is that men and women in higher socio-economic groups can expect to enjoy better health across longer lives than those in lower socio-economic groups (Graham, 2000: 90). A variety of factors – age, ethnicity, gender and sexuality – mediate the influence of socio-economic position on health. Measuring socio-economic position, and its relationship to health outcomes, is not straightforward. In the UK, occupational class and employment status are the primary method of measuring an individual's social class or socio-economic status (Rose and O'Reilly, 1997).

Health inequalities research goes beyond investigating the effects of behavioural and individual 'lifestyle choices' (Schrecker and Bambra, 2015: 29) to look at systemic, structural causal factors that can influence health across generations, population groups and communities. Socioeconomic position remains the main social determinant of health used to measure health inequalities (Gkiouleka et al., 2018). Kreiger (2011) has illustrated the need to establish an explanatory framework for measuring population health which integrates the interplay of macro and micro, with the economy and ecological system at one end and jobs, dignity, family, housing and relationships at the other. My research has attempted to do this, to examine how systemic and structural factors impact interplay with the local context and groups of individuals in localised settings. In this sense, the application of a qualitative inquiry into aspects of inequality – one of which is health – is unique.

2.3.5   Health inequalities in the UK

Health inequalities became an area of policy interest subsequent to the publication of the Black Report in 1980 (Townsend et al., 1986). This document made a compelling and clear connection between health and social class. Its suppression by the Thatcherite government in 1980 coincided with the starting point for a Conservative consensus of privatisation and welfare reform which, arguably, has done much to increase health inequalities by widening social inequalities over the past three decades (Scott-Samuel et al., 2014: 53). Core aspects of the report which might have addressed and reduced health inequalities, such as increasing maternity grant and child benefits, were not taken on board. Addressing health inequalities was a core policy concern in the UK during the period Labour were in office from 1994 to 2010 (Smith and Hellowell, 2012) and a large body of health inequalities literature has been published in the UK since that time (Acheson, 1998; Bambra et al., 2010; Bartley, 2004).

Much of this literature has indicated that 'upstream' factors (social disadvantage, social inequality) acknowledging the social determinants of health are required to address health inequalities (Mackenbach,

2010a, 2010b; Popay, 2010; Timmermans et al., 2011; Whitehead and Popay, 2010). Persistent health inequalities have been tackled through diverse policies over the past 40 years (Mackenbach, 2011). Despite this, inequalities in life expectancy have continued to widen. The reasons for this are complex – due in part to the entrenched nature of the class system, but also, Mackenbach has argued, to ineffective policies not delivered at a broad enough scale (Mackenbach, 2011). Contemporary academic research has indicated that austerity is likely to widen health inequalities. This is due to cuts to state supports and welfare state retrenchment which are likely to impact lower socio-economic groups considerably (Bambra, 2016; Stuckler and Basu, 2013).

2.3.6   *Geographies of health inequality*

Geographical research has made important contributions to the field. Understanding how and why space and place influence health and illness through the theorisation of the links between places, people and health (Butler and Parr, 1999: 339). The field of health geography is broad and ranges from those who examine subjective accounts of wellbeing (Atkinson et al., 2015; Scott, 2014) and take affect, emotion and relationality as central conceptual groundings, to geographers examining the implications of space, place and time on health through the application of quantitative methods such as Geographical Information Systems (GIS) (Bhandari et al., 2017; Milojevic et al., 2017). GIS, a computerised system for collecting and visually representing spatial data, is highly important for both research into health outcomes and how it can be practically applied in health care provision (Pearce, 2007), supporting public health.

GIS has been used to visually present the connections between the built environment, increasing levels of obesity (which is a risk factor for certain types of cancer, coronary heart disease and chronic diseases like hypertension) and diet (Frank et al., 2004). My qualitative approach is complementary to this as it utilises the narratives and testimonies of individuals to bolster and illuminate quantitative findings. The literature has explored elements of the environment that can promote good mental health, such as access to green spaces, and places that can have a negative impact, such as poor-quality housing and poorly-maintained public spaces (Cairns-Nagi and Bambra, 2013; Curtis, 2010). One of the main contributions of health geography to the understanding of health inequalities has been in examining the relationship between health and place. This has been framed largely through the ongoing academic debate regarding contextual and compositional factors.

2.3.7   *Composition, context and relationality*

A key component of this PhD and in the wider project it belongs to is how the place that you live in impacts health. The debate in health geography of the contrasting effects of 'contextual and compositional' factors is therefore highly relevant. Within this debate, compositional factors refer to the characteristics of individuals living in a given place (Bambra, 2016; Curtis, 2004), while contextual factors refer to the place itself. There is a large body of literature on understanding the connection between place and health. Qualitative studies which have done this include Airey (2003), Frohlich et al. (2001), Popay, Williams, et al. (1998) and Popay, Thomas, et al. (2003). These studies contend that life in certain places influences health, and seek to illustrate causality

between environmental factors and individual health (compositional factors). For example, work from Popay et al. (1998) has articulated the concern that the literature at the time had a tendency to fail to address the relationship between agency and structure, and that 'place' as well as time needed to be given greater theoretical prominence.

Later work from Popay et al. (2003) examined the role of agency of individuals and collective groups of individuals in relation to how they conceptualised place and health. They found that normative ideas of 'proper places' affected respondents, and that this jarred with their lived experience of place, with consequences for their health. The same is true of papers which focus on contextual factors (the influence of place or environmental factors specifically) such as Chaix, Merlo, and Chauvin (2005), Duncan and Jones (1993), Diez-Roux (1998, 2004), Raudenbush and Sampson (1999), Sampson, Morenoff, and Gannon-Rowley (2002). Chaix et al. (2005) found that conceptualising space as a continuum rather than a fixed place within a boundary yielded more relevant information on the spatial distribution of outcomes. Sampson, Morenoff, and Gannon-Rowley (2002) demonstrated the importance of moving beyond traditional measures of places, such as concentrations of poverty, to understand the salience of social interaction and institutional mechanisms in accounting for neighbourhood effects of different phenomena.

Macintyre et al. (2002) have emphasised moving beyond this binary, focussing on the 'collective' aspects of living in certain areas, arguing that individuals living together in places share behaviours, values and norms. 'Place' is more than simply a location within a given space, rather, it is a fluid and relational concept. It requires membership; of a community, family, state, neighbourhood. Place creates and contains social, economic and political relations as well as physical resources (Bambra, 2016: 23). Cummins et al. (2007) suggest the need for a relational perspective in understanding the mutual co-dependence of compositional and contextual factors. As Warren and Garthwaite (2014) have stated, places and the people living in them cannot be easily separated as they are mutually reinforcing and change over time. Accounts of how the dynamics of places, people and their 'collective social functioning' (Macintyre et al., 2002) influence health inequalities should therefore include accounts of how places and the people in them change and shift over time and are co-depending and co-constituting.

2.3.8   The 'neighbourhood effect'

The literature on the impact of neighbourhoods on health inequalities is highly relevant to this thesis. A neighbourhood can be defined as 'a bundle of spatially based attributes associated with a cluster of residences … in conjunction with other land uses' (Glaser, 2001: 2112). They are relational spaces which are fluid and dynamic, providing a localised space in which individuals live, work and spend time (Graham and Healey, 1999). Glaser further states that, when coupled with the notion of 'externality space', this way of framing neighbourhoods allows for the potential empirical identification of behaviourally meaningful, multi-scaled boundaries' which affect health inequalities (Glaser, 2001: 2112). When referring to neighbourhoods, I am not specifically referring to geographically demarcated bounded spaces, but rather to where people feel they themselves belong and where they spend time (Bernard et al., 2007). The different neighbourhoods with

Stockton are places of distinct character, with different socio-economic experiences, housing types and health experiences. The factors linking places and health inequalities existing within them can be understood on a variety of scales – from national and international factors such as globalisation and national politics, down to the smallest neighbourhoods or areas (Cummins et al., 2007). Like Crossley (2017), this thesis has addressed the need to bring together questions of policy and welfare reform with geographical concerns for place and space.

In health geography, neighbourhoods often refer to any place of geographical closeness that has an effect on health (Tung et al., 2018). Within the field of human geography the role of neighbourhoods is emphasised in creating health gaps (Bernard et al., 2007; Cummins et al., 2005; Ellaway and Macintyre, 2009; Lupton, 2003). Lupton (2003), for example, has argued that looking at such minute localised contexts provides a powerful tool to understand geographical health inequalities. Neighbourhoods constitute a space through which opportunity structures – resources that shape lives, thereby impacting on health – operate (Bernard et al., 2007). The abundance or scarcity of resources may suggest some neighbourhoods are healthier than others (Macintyre, 2007).

Slater (2013) has articulated the neighbourhood effects on health as 'where you live affects your life chances' but further argued that 'your life chances affect where you live'. He suggests that these factors are interrelated and mutually reinforcing – it is impossible to separate the consequences of living in a certain place from the wider politics of why places and people develop as they do. While a relational understanding of health inequalities is an important way of explaining how inequalities are played out through everyday life, places, individuals and communities, it cannot delve deeper. Therefore, a political economy approach is a useful framework for delving deeper, to the 'causes of the causes' of health inequalities.

2.3.9   *The political economy of health*

The political economy of health literature seeks to uncover the political, social and economic forces that generate health inequalities. Individual or localised factors, it argues, should be subsumed under a greater understanding of political and economic structures governing society and lives (Bambra, 2016). Inequality is not the result of one specific government's choices or historically specific policy-making, but the product of a globalised order based on an alliance between dominant classes and groups against the redistribution of resources that would adversely affect their interests (Navarro, 2004: 2). The political economy of health perspective looks at the 'causes of the causes' of health inequalities. Individual and place-based characteristics tell us a great deal, but are limited. A greater understanding of political and economic structures governing society and lives (Bambra, 2016) is crucial to delve deeper into the causes of the inequality experienced by mothers in Stockton in an age of austerity.

The 'political economy of health' perspective incorporates a socio-structural and political perspective into understanding how health is constituted by social, political and economic structures (Bambra, 2011). The

World Health Organisation has acknowledged that this structural inequality perpetuated by economic and social policies plays a large part in health inequalities:

> T*he poor health of the poor, the social gradient in health within countries…are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of people's lives. This unequal distribution of health-damaging experiences is not in any sense a 'natural' phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics.* (CSDH, 2008)

A large body of political economy research emphasises the importance of political and economic systems for population health and health inequalities. Beginning with Engels' study of the conditions of the working class in Manchester (1909) and Doyal and Pennell's examination of poor health and capitalism. (1979), to Coburn's (2004) examination of income inequality and social class, these studies articulate that individuals within societies do not begin on an even playing field, and their chances through the life course are determined by political, social and economic forces as well as classed inequalities. In the field of epidemiology, Karanikolos et al. (2013), Kentikelenis et al. (2014), Stuckler and Basu (2013), and Stuckler et al. (2009) have used quantitative methods to demonstrate the contribution of political and economic inequality to increased health inequalities in the Eurozone and globally post-2008 financial crisis and during subsequent austerity. Bambra (2011) has linked work and the socio-economic class polarities it creates to inequalities in the distribution of morbidity and mortality via uneven exposure to physical hazards and psychosocial risks in the workplace as well as through inequalities resulting from exclusion in the labour market and the absence of paid work (2011: 187).

Coburn (2004: 41) studies the health effects of income inequality with social and class changes including the spread of neoliberalism, the decline of the welfare state, differences between nations regarding welfare regime type and the relationships between class, economics and human well-being. Navarro (2013, 2004, 2000, 1999, 1998) has consistently referenced the political economy of inequality as a leading cause of health inequalities globally. In the UK, Schrecker and Bambra (2015), Bambra (2016) and Schrecker (2016) have been advancing the debate on the enduring significance of a political economy approach, emphasising the clear public health risks that austerity and neoliberalism present. This body of work presents a challenge to the 'discursive dimensions of neoliberal health promotion' (Schrecker, 2016) and the 'lifestyle drift' taking place in public health (Hunter et al., 2010). Schrecker and Bambra (2015) have emphasised the importance of redistributive welfare states and equitable societies for narrowing the health gap within countries, arguing that the type of welfare state and economic system one lives in shapes society and compounds stratification.

While the political economy perspective is useful at getting to the heart of the causes of inequality, it is not entirely without critique. The field has been criticised on a number of grounds, for at times being gender-blind or assuming an androgyny of experience – the fundamental issue that men and women experience social life in different ways remains in the background (Spike Petersen, 2005). It is for this reason that a FPE perspective has been incorporated. Secondly, the field examining the political economy of health is often

dominated by quantitative studies which take socio-economic status as the main determinant. In the UK, there is generally little incorporation of gender or other factors into the measurement of health inequalities (Bambra et al., 2010; Gideon, 2014), in spite of an acknowledgement of the multiple pathways throughout which socioeconomic position impacts health (Bartley et al., 1998). This approach does not readily account for a complex understanding of the numerous forms of stratification that affect groups of individuals concurrently (Krieger et al., 1997). Therefore, a gendered political economy of health which interrogates the intersections of gender and other stratifying characteristics, as my work has done, can provide an innovative contribution to the field of health inequalities.

2.3.10   The diverse meanings of political economy

This thesis utilises various phrases which incorporate the phrase 'political economy'. It is important to briefly outline how and why they differ. The thesis employs the important theory of a 'political economy of health', and the closely related but superseding 'gendered political economy of health'. Finally, I incorporate the theory of feminist political economy. I recognise the broad and interdisciplinary field of 'political economy' as a basic grounding of these concepts. In the most general sense 'political economy' refers to the highly interdisciplinary study of the economy, of political life and of social interaction to understand how political systems, social life and economic structures interact to impact societies. Both public choice theory and critical and radical political economics (particularly Marxist perspectives) have helped to form the field. The fields most overtly related to this are economics, sociology and political science (Weingast and Wittman., 2008). Political economy is broadly concerned with three separate but related areas: the role of power relations in resource allocation, international political economy (IPE) and the economic impacts of international relations, and finally the class and power dynamics of these economic practices (Collins Ed., 2008).

2.3.11   Feminist political economy

The field of feminist political economy [FPE] is of great importance in this thesis. This field incorporates perspectives from feminist economics, gender and development and gendered international political economy. FPE is a critical alternative to the political economy field. Political economy has been accused of being gender-blind, and of perpetuating 'economistic, modernist/positivist and masculinist' rationales (Spike Petersen, 2005: 507). FPE is one of the heterodox branches of economics, and is interdisciplinary, reaching a variety of fields, from critical international development studies and human geography to gender studies. The approach 'reveals and clarifies how gender determines or influences the social and political relationships and structures of power and the differential economic effects that flow from these relationships and structures' (Interpares, 2004: 4). In the context of research on women's experiences of austerity, it is useful to go a step beyond a political economy perspective and to engage with a FPE view.

A FPE of UK austerity has been written about by a select number of academics. A recent special edition of 'British Politics on Inequality and Insecurity in British Households' covered the topic, with contributions from Dowling (2016) and Nunn (2016) proposing that social reproduction and the invisible work of women

must be reckoned with when critiquing austerity. Dowling proposed that unpaid reproductive labour endured as a source of surplus value, with an ongoing devaluation of social reproduction. Meanwhile Cain (2016) has emphasised how, through welfare reform, contradictory gender messages about responsibility are framed through reinforcing the 'work' parents must do to seek a job or risk a sanction, undermining their economic capacities and taking away from time spent caring for their children. Others, such as Montgomerie and Tepe-Belfrage (2016) have produced empirical work which found that their lay participants utilised language and concepts relating to care and debt that indicated an understanding and acceptance of the significance of feminist political economic principles. They also utilised an 'everyday life' lens in their work. In order to form a coherent analysis of and challenge to austerity, a feminist political economy perspective provides a unique and multidimensional lens through which to do so.

2.3.12 Health inequalities in an age of austerity

Following the 2008 financial crisis and subsequent global recession, governments in Europe pursued the route of austerity which had wide-reaching consequences for their populations. For some states, the austerity policies were a prerequisite for being provided with a bailout from the IMF. Austerity has been articulated as a public health concern by those working in epidemiology and public health (Bambra and Schrecker, 2015; Stuckler and Basu, 2013: ix). Stuckler and Basu demonstrated through their research how austerity (the opposite of stimulus as government intervention) is harmful (Stuckler and Basu, 2013: ix). They have argued that governments might be able to protect their populations by budgeting for measures that keep people employed, helping those who lose their jobs cope with the negative effects of unemployment, and enabling unemployed people to regain work quickly (Stuckler et al., 2009: 322).

Increased social welfare spending has been shown to be associated with a decrease in mortality (Karanikolos et al., 2013: 1326). The recent financial crisis and subsequent austerity is likely to have significant and lasting implications for a number of social outcomes, not least population-level health and wellbeing. The material impacts of the financial crisis are not evenly distributed. Using population health as an example, and examining it from the multi-dimensional perspectives of geography, public health, and social policy can help to make sense of the human cost of austerity (Pearce 2013: 2030).

In the UK a picture is emerging that austerity is negatively impacting health inequalities. Emerging findings suggest that the gap between richer and poorer children in the UK is beginning to widen. In 2015 this gap widened for the first time in a decade (ONS, 2015). As Taylor-Robinson and Barr (2017) have noted, since 2010 the rate for the poorest children has been increasing while continuing to decline for more advantaged groups. What this means is that health inequalities affecting infants, a telling and accurate indicator of the consequences of socio-economic inequality affecting children, are widening. Child poverty is rising as support services have directly impacted children, and indirectly hit them through their families' falling incomes (Taylor-Robinson et al., 2014). Concordantly, it has been recorded that there has been a gendered aspect to this – the gap in life expectancy between the poorest and wealthiest females in England is now at a record high (ONS, 2018).

It is important to note that the health gap for men is wider than women, but is widening at a slower rate, indicating worsening inequalities affecting women at this time. Several studies have indicated that austerity cuts may be responsible for this (Barr et al., 2016; Green et al., 2017; Hiam et al., 2017a, 2017b). Barr et al. (2017) have stated that current government policies are potentially to blame for the reversal in gains in reducing health inequalities, and that future approaches should learn from the 1997–2010 programme to reduce health inequalities. Bambra, Garthwaite and Greer Murphy (2018) have illustrated the geographical effects of austerity on health inequalities in Stockton-on-Tees, arguing that different experiences among different neighbourhoods and places and socio-economic groups are leading to widening health inequalities.

2.3.13 The gendered politics of health inequalities

Since the 1970s, gender and health inequalities have been a source of academic interest, beginning as an attempt for second wave feminists (the period of feminist activity from approximately the mid-twentieth century to the 1980s. It focussed on broad social issues such as equality within the family and workplace, sexuality, reproductive rights and legal inequalities) to challenge the detrimental effect of patriarchy on women's health. The earlier wisdom of this field, that 'women get sicker but men die quicker', while retrospectively an over-simplification, represented an important starting point and has led to research which attempts to be sensitive to the complexities of individual life trajectories (Emslie, 2014). Since the 1970s, broad social changes have taken place in the lives of women and men. More women are now in work, attend third level education, and are delaying marriage and having children (Annandale and Hunt, 2000: 2, 3). Doyal's (1995) work 'What Makes Women Sick' has been a highly influential text – identifying some of the areas common to women's lives that may make them ill such as the psychosocial pressures on women in contemporary society to juggle work and care, and the physical and mental health consequences of reproduction.

Earlier work in the 1960s and 1970s emphasised the subordination of women as one of the key determinants of their poor health, with academic and activist endeavours overlapping, such as in the case of the publication of the popular text 'Our Bodies, Ourselves' (1971). They emphasised social and economic subordination although a coherent theory of how gender inequalities affect health is still lacking (Weisman, 1998). Some, such as Stein (1997) have examined women's health from the perspective of women's agency – how health-related decisions, social organisation and political decisions may impact their health. This framework does not seek to challenge the former 'subordination' theory, but enhance it, emphasising the actions women take to circumvent or challenge their oppression. Stein notes that measuring the effect of female empowerment on health is theoretically and empirically difficult, but she asserts 'by reducing inequality, increasing the power and status of women, and interacting with other factors that affect health (such as education), empowerment may prevent or mitigate the negative impacts of development policies on women and improve women's health' (1997: 607). Others, such as Wiesman (1998) have advocated for using this research to affect policy change in order to improve women's health, focussing specifically on healthcare policies rather than the broader social determinants of health.

Annandale and Hunt (2000) have maintained that a gender-comparative approach is useful when examining gender inequalities in health, to understand the complex way that the social relations of gender operate and the effects this has on both men and women. They argue that social change is located in power dynamics, and not something that 'happens to' men or women (Annandale and Hunt, 2000: 23). In this framing, health must be understood as 'an intricate, non-linear, tangled web of factors, some of which are socio-political' (Stein, 1997: 89). This PhD has not engaged in gender-comparative work, instead focussing on the distinct risks facing women in this period in history. However, it takes on board Annandale and Hunt's call for historical and contextualised health research, accounting for the complexity of respondents' roles and narratives. In this sense, the emphasis on 'everyday life' is important.

Annandale and Hunt (1990) have argued that there is a tendency to conflate biological sex and gender in the literature, although there is overlap between these concepts. Hibbard and Pope (1983) and Verbrugge (1985) have suggested that sex differences in health may be a consequence of different levels and types of risk acquired by occupying social roles and that women's higher morbidity is 'real' and firmly rooted in their life circumstances and experiences with an added and unaccounted for psychosocial aspect compounding women's poorer health (Nathanson, 1977). Two questions are pertinent when examining the gendered aspects of health inequalities, and were highlighted when designing my PhD research – firstly, what are the reasons for health differences between women and men, and secondly are health inequalities between social groups significantly different between men and women? There are numerous studies which have addressed this question from different angles (Annandale and Hunt, 2000; Arber and Cooper, 1999; Bartley, 2004; Lahelma et al., 1999; Ladwig et al., 2000; Macintyre et al., 2000). Of significance is the fact that women in the UK historically and contemporarily live longer than men but appear to have more instances of ill health, particularly mental ill health (Blanchflower and Oswald, 2008; Nathanson, 1975; Verbrugge, 1976, 1980; Waldron, 1976; WHO, 2016).

While there is an acknowledgement of the multi-faceted causality of socio-economic health inequalities, little empirical research has uncovered how these factors intersect with gender in the aetiology of health inequality (Arber and Cooper, 1999; Skalicka et al., 2009). My research cannot engage with this question in a quantitative or definite way but has examined, through the use of qualitative methods, how place-based factors and the everyday lives of respondents as women and mothers have impacted their health – particularly their mental health. There remains a lack of empirical research or evidence collecting into the health impacts of austerity in the UK for women (specifically mothers and their dependents). This gap can be filled by building on the body of scholarship in the field of human geography which emphasises the interconnectedness of understanding population health, well-being, and inequalities (Pearce, 2013: 2032). A greater degree of interdisciplinarity can also benefit the field (Smith and Garthwaite, 2016). My thesis bridges a gap between sociological and geographical knowledge of health and wellbeing by examining motherhood and place in an area of localised spatial inequalities, incorporating an intersectional perspective to contribute to the body of empirical evidence on the gendered consequences of austerity.

2.3.14 Intersectionality and health inequalities

In designing the research project and in the utilisation of specific methodologies and methods, intersectionality provided a conceptual space through which to understand how processes of oppression or privilege interacted in everyday life (Crenshaw, 1994, 1991). It guided the principle that, as Hancock (2007: 64) has stated, 'more than one category should be analysed, that categories matter equally and that the relationship between categories is an open empirical question' (Hancock, 2007: 64). As a 'form of analysis' it 'denaturalises' that which is assumed, providing a toolkit through which to explain that grand narratives are inadequate explanations of political life (Dhamoon, 2011: 231). Some intersectional approaches have stressed the importance of place and location (Anthias, 2012) and have made use of geographical metaphors, conceptualising intersectionality as a crossroad (Crenshaw, 1991) or as axes of difference (Yuval-Davis, 2011).

Intersectionality is the consideration of 'multiple, co-constituted differences'. It is important to note however that intersectional theory is subject to some criticism. Skeggs (2005b) argues that debates about intersectionality do not sufficiently address class production and political economy. This is part of a long-standing debate about the ontological basis of categories of difference from theorists such as Butler (1990) and Yuval-Davis (2011). It is an important but underutilised way of framing the social context of health. It views social positions as relational and acknowledges the 'multiple positionings that constitute everyday life' (Dhamoon, 2011: 230). There is a pressing need to incorporate an intersectional perspective into the study of health inequalities, something which has been engaged with in a limited sense thus far, as the framework is very much in its infancy. Hill (2016), for example, has outlined important work which has been done on inequalities in smoking which takes gender and ethnicity as central determining factors (Graham, 2004; Hill et al., 2005; Wallace et al., 2009). An intersectional analysis emphasises the importance of different and diffuse causal pathways to understanding health inequalities and health outcomes. Both individual and structural components are at play as 'the interaction between gender, race, and other categories of difference in individual lives, social practices, institutional arrangements, and cultural ideologies and the outcomes of these interactions in terms of power' (Davis, 2008: 68).

Intersectionality is a concept which has not frequently been applied to the consideration of health inequalities, but which can provide a theoretical tool to enhance our understanding of them in both a compositional (characteristics of individuals) and contextual (characteristics of place) sense. In this sense, my research provides a fresh perspective from which to examine health and inequality. The concept stems from gender and critical race theory, which seeks to integrate the study of race/ethnicity, gender, and class as social structures, acknowledging that norms and standards of behaviour for women and men are not viewed or performed in the same way across groups (Collins, 2009; Glenn, 1999; McCall, 2005). Where there is a focus on social dynamics rather than social categories, recognising that experiences of advantage and disadvantage reflect the exercise of power across social institutions, the application of intersectionality to enhance our understandings of health inequalities can be successful (Kapilashrami et al., 2015).

Focusing on individuals at the intersection of two or more structures reveals the linkages between interlocking systems of oppression (Glenn, 1999). Its application recently in work by Gkiouleka et al. (2018) has emphasised the acknowledgement of the complex interaction of micro and macro factors which would allow the field to move beyond socio-economic stratification as the main determinant of health inequalities. Health researchers often focus on one particular aspect of social identity in order to better understand its significance (Karlson and Nazroo, 2007). However, it is necessary to move beyond treating any identity as homogenous. None of these social constructs 'is a stand-in for any other, and all are necessary for generating adequate depictions of social inequalities in health' (Barbeau et al., 2004: 273). Intersectionality is important for health as the dynamic nature of social positions has major implications for policy interventions into health.

An intersectional perspective can raise questions about power and knowledge, critiquing normative socio-political assumptions. It has the potential to produce data that is situated and experiential, rooted in storytelling, biography and narratives. Hancock (2007: 64) has stated that intersectionality is not simply a 'normative-theoretical argument but also a research paradigm'. It pushes against 'hegemonic disciplinary, epistemological, theoretical and conceptual boundaries'. As a paradigm it is itself interpreted diversely and flexibly, meaning different, sometimes conflicting things to different schools of thought. It has been reflected on as a 'burgeoning and contested framework' (Dhamoon, 2011: 230). In spite of its contested nature, there are a number of points which define it. Intersectionality aided the framing of the research design by understanding that: 'the complex, irreducible, varied and variable effects which ensue when multiple axes of differentiation – economic, political, cultural, psychic, subjective and experiential – intersect in historically specific contexts' (Brah and Phoenix, 2004: 76).

Conclusion

This literature review has identified a number of key areas of academic concern, as well as spaces where research is required to enhance our understanding. It has shown that researching everyday life is important – it allows us to reflect on the mundane and seemingly uninteresting facets of life that hint at how roles and social norms are played out across lifeworlds. It discussed the literature surrounding austerity, a concept which is at the core of this thesis. This literature emphasises the specifics of austerity and how these sets of policies relate to the neoliberal state. It discusses the specific UK context and the literature around changes to the welfare state and labour market. There was then a discussion of the field of health inequalities research – placing research and practice in context, discussing health geography, contrasting theories of health inequalities, and then the UK austerity context. It discussed the political economy perspective, and the importance of lay experiences in informing our understanding of health inequalities. There was also a discussion of the emerging considerations of gender and health inequalities, focussing on an intersectional perspective.

Brown and Spencer (2014) have articulated that 'collective development of an understanding of the global financial crisis and ensuing austerity requires an alliance between sociology, "heterodox economics" and related disciplines within the broad tradition of "political economy"'. Therefore, I argue that disciplines

borrowing from each other can enhance the debate. Curran (2011) has posited the question, 'given that the crisis is an interdisciplinary phenomenon with social, political, economic, cultural, and material dimensions, should sociology and other social sciences continue 'business as usual', or should it shift in its self-understanding of its task and areas of primary focus to better address the crisis?' He raised the important point – 'does exploring the intersection of personal biography and social structure demand an interdisciplinary approach to phenomena such as the financial crisis and its lived reality?' I argue that it does.

This literature review has emphasised the cross-cutting themes which make this thesis original – the application of everyday life to the study of austerity, the interaction between macro and micro factors, and the intersectionality of inequality (in specific relation to health inequalities). My work provides a new and significant perspective by applying the lens of 'everyday life' in an empirical challenge to austerity by focussing on the lives of mothers in particular – a subgroup of women experiencing distinct and complex challenges. This thesis makes a novel and important contribution to health geography, contributing to the context, composition and relationality debate by proposing the need for greater depth and complexity through a FPE perspective. There is a gap in the literature in relation to a fully articulated FPE debate when examining health (Shirin and Waylen, 2013) in a contemporary austerity context which this thesis addresses.

3. <u>Research Methods and Methodology</u>

Introduction and Research Context

In this chapter I outline the methodology and methods employed in this PhD project, how they were selected, and the rationale for designing the research in this way. First I present the core research aims and questions and the wider research context this PhD is situated within. There is then a discussion of the design of the research – the qualitative methodological framework employed and the methods used, qualitative longitudinal interviewing and ethnography. These distinct methods complemented each other as the ethnographic fieldwork created the environment for ongoing and deep engagements with a group of women, while qualitative longitudinal interviews allowed for repeat semi-structured interview encounters with a sample of women to delve into their perspectives and narratives. Sampling techniques and access issues are discussed followed by a presentation of the fieldwork process and data collection. The modes of analysis are discussed next, followed by a discussion of the presentation of the findings.

In the next section of this chapter focuses on a critical evaluation of the effectiveness of the research design and methods, and a justification of the undertaking of this research from a feminist standpoint. It reflects on researcher reflexivity and privilege and ethical integrity. This section stems from ongoing dialogue – with supervisors, other PhD students, staff at my department, fellow conference attendees, research participants and feminist praxis (Stanley, 2013). Particular attention is given to a reflection on the ethics of interviewing and fieldwork practices in the context of women researching with women. This section considers the ethics of representation and how to conduct research which attempts to do justice to accurately reflecting the lives of respondents.

This study was part of the Leverhulme Trust funded Local Health Inequalities in an Age of Austerity project. This was a mixed-methods study focused on the borough of Stockton-on-Tees as a site of wide economic and health inequalities. My PhD comprised Work Package 5: Health, Welfare and Austerity and examined how austerity affects the health of women and families through changes to the welfare state, public sector and labour market. A qualitative methodology was chosen to examine these issues. Qualitative methods are well suited to generating insight into perspectives and opinions about austerity, welfare reform, and everyday life in Stockton and to engage with complex discussions about health and health inequalities (Elliot et al., 2016). Other researchers on the project examined health inequalities in an age of austerity in Stockton from historical and biographical, (Warren, 2018), ethnographic (Garthwaite, 2016), mixed methods (Mattheys et al., 2016) and geographical (Bhandari et al., 2017) perspectives.

This research sought to examine the lived experiences of mothers living in Stockton-on-Tees during the period of welfare reform and austerity from 2010 through to the period of research completion at the end of 2016. Central to this was the aim of understanding how mothers in Stockton conceptualised welfare reform and austerity in relation to their everyday lives, perceptions, choices, and reflections on their health and wellbeing. Emphasis was placed on the significance of 'everyday lived experiences', values and decisions.

These were understood as existing 'intersectionally' within classed, gendered, historical, spatial and cultural contexts.

3.1 Methodology

3.1.1 Grounded theory

The grounded theory (GT) methodology guided the data collection and analysis. GT is an inductive methodology which originated in the Chicago School in the 1960s. Sociologists Glaser and Strauss (1967) developed it as a method concerned not only with data generation, but so the researcher could fully commit to 'representing all understanding, all knowledge and actions of those studied (or, participating), as well as their own' (Clarke, 2005: 3; Strauss, 1987: 110). Timonen et al. (2018) have recently published work arguing that different variants of GT incorporate a shared set of procedures that can be incorporated into work across ontological and epistemological viewpoints. This 'shared core' of the GT method is articulated as the principles of taking the word 'grounded' seriously, capturing and explaining context-related social processes, pursuing theory through engagement with data, and pursuing theory through theoretical sampling (2018: 1).

When using this methodology, I began with a general area I wanted to understand (everyday life and experiences of health inequalities in a period of austerity), and let the theory emerge from the data (Strauss and Corbin, 1998: 12). GT consists of purposive sampling, initial coding, ongoing data collection, generation, analysis, theoretical sampling, constant comparative analysis, and category identification (Birks and Mills, 2011:13). The method is exploratory and explanatory rather than descriptive (Baker et al., 1992). The timing and structure of the research process was informed by the data collection process and the data itself. The research process was iterative – data collection, analysis, returning to the text, follow-on interviews and ongoing ethnography were overlapping.

Data was systematically gathered and analysed through the research process (Strauss and Corbin, 1998). I began data collection six months into the PhD programme, after an initial literature review had been completed. This gave me a large amount of time in which to conduct participant observation and to recruit respondents for qualitative longitudinal interviews. It afforded extra time to work around the limitations of participants, acknowledging that the complexity of their lives sometimes led to large gaps between interviews, and to seek new avenues of enquiry should some become unavailable. Transcriptions were completed promptly after each interview. Initial analysis and a broad coding was completed promptly after interviews, with re-reading and further analysis taking place iteratively – after six interviews, after the first round was completed, after several interviews in the second round, and after the second round was completed. The initial analyses informed the content of the second wave of interviews. With regards to fieldwork notes, the same re-reading, coding, reflection and analysis took place. After twelve months of data collection I was left with a window of three to four months to do ongoing analysis alongside the reading of new literature and material relating to these emerging themes alongside writing.

Grounded theory has the ability to 'reach across more thematic and disciplinary boundaries' and facilitate conversations across different disciplines. Constructivism allows for a research design whereby feminist perspectives can 'bridge' epistemological divisions (Spike Petersen, 2005: 504). It provides a framework for understanding how gender codes across categories, subjectivities, institutions and activities. This does not simply refer to male-female relations or emphasising the status and experiences of 'women' a priori. Rather, it allows researchers to address the inequality, in this research context, of those whose work and experiences are devalued through being feminised and incorporate into this an analysis of how hierarchies of gender, class, geography and disability intersect (Spike Petersen, 2005: 518). Furthermore, a longitudinal element enhances this, by demonstrating how experiences shift and evolve as circumstances change over time.

3.1.2   The epistemology of grounded theory

GT offered a qualitative approach rooted in ontological critical realism and epistemological objectivity (Annells, 1997). My concern in conducting this research was to produce an account of a set of experiences that constituted an accurate and useful contribution to academic research on austerity, health and inequality for women, and also that did justice to the agency and perspectives of participants. This required engaging with the epistemological underpinnings of the grounded theory method, so as to form a coherent rationale for the set of claims I might make.

Earlier applications of GT rested on a postpositivist paradigm (Glaser and Strauss, 1967), a product of a time in which there was a strong desire to prove qualitative research as robust and able to stand up to criticisms that it was unscientific (McCann and Clark, 2003). In this traditional version, the aim was to uncover an emerging theory that fit and explained a process, and was understandable to those involved in the process (Levers, 2013). Later work, such as from Corbin and Strauss (2008) moved on to favouring an interpretivist paradigm, in many ways the opposite of a postpositivist perspective. This paradigm has a relativist ontology and subjectivist epistemology, aligned with postmodern thought on knowledge as 'relative to particular circumstances –historical, temporal, cultural, subjective – and exists in multiple forms as representations of reality; (Benoliel, 1996: 407). It is within this paradigm that my own work sits. Embedded in this is the importance of accepting multiple meanings and ways of knowing, and acknowledging that reality is only captured through representations (Denzin and Lincoln, 2005: 5). The interpretive paradigm focuses on recognising and narrating the meaning of human experiences and actions (Fossey et al., 2002).

3.1.3   Research Methods

The research was designed to delve into the subjective and contextual nature of the experiences of mothers in Stockton. I wanted to understand how macro-level processes at a national level (neoliberal policies of austerity and welfare reform) could shape localised lives and contexts (Holland et al., 2006). Qualitative methods produce data which allows us to gain insight into how people live, experience, perceive value and make choices. As a mode of enquiry it enhances our understanding of the fluidity of experiences, perceptions and engagements with evolving social realities. Quantitative methods remain the prevalent form for interpreting

statistical data for use in economic, socio-political, administrative, policy evaluation and general governance (Holland et al., 2006). These methods are useful in providing substantive insight into broad trends and patterns. Qualitative research, as a contrast, provides rich contextual insights into the stories which comprise these trends. I used two qualitative methods in this research – ethnography and qualitative longitudinal interviews. Ethnography or participant observation allowed me to become immersed in the social world of a sample of mothers living in Stockton, to try to understand their everyday lives and experiences in the setting of a women's group. This women's group was run by the anti-poverty charity Thrive and they met once a week for tea and a chat. I conducted qualitative longitudinal interviews, repeat interviews with individuals to gain insight into how respondents experienced austerity and everyday life.

3.1.4   *Emphasising lay experience when researching health*

'Lay experience' or non-professional viewpoints on health have been an important component of this research, making it innovative in the study of health inequalities. Health is a complex concept that combines a number of dimensions. Baum (2008) has argued that there are an 'enormous number of ways of defining health and disease which are held by ordinary people' and that these have intrinsic value. Although methods which emphasise the lay experience do not have to be qualitative, they are well suited to a qualitative design. Annandale and Hunt (2000) laud the incorporation of qualitative methods into a new framework for studying health, which could help us understand how men and women engage with the gender order and how it affects their health (Annandale and Hunt 2000: 30, Thomas 1999: 11). Sociological research can make a valid contribution to the development of critical health inequalities research on gender (Graham, 2007). Qualitative research methods for understanding health are increasingly looking at, rather than differences between men and women, or the 'men die, women get sick' discourse, but rather at how individual men and women seek to creatively act on their own situations, invoking agency in their own actions (Popay et al., 2003).

Qualitative research methods can help explore axes of difference as they often provide a way of delving into people's own accounts of their lives and health experiences. My research has attempted to do this and feeds into a body of geographical work focussing on lay perspectives on health (Davidson et al., 2008, 2006; Garthwaite and Bambra, 2017; Graham and McDermott, 2006; Hodgins et al., 2006; Popay, Bennett et al., 2003; Popay, Thomas et al., 2003;). These texts go beyond discussions of health in a clinical sense (Popay and Williams, 1994: 90). As Popay and Williams (2006) have illustrated, these testimonies and experiences while presenting an alternative perspective, have not been systematically collected so as to be of considerable benefit to reforming medical practice. However I maintain that the narratives people present, the stories they tell to make sense of their lives, past, present and future (Graham 1984; Mattingley and Garro 1994) are an invaluable resource in reconceptualising our notions of health, and help us to interpret gendered patterns of health and perceptions of health and wellbeing. They bridge the gap between identity, agency and social structure, as well as the multiple identities people occupy across space and time.

It is of great importance in this time of austerity to understand how actors such as mothers perceive and manage their own health (Annandale and Hunt, 2000: 65; Popay and Williams, 1994: 97). In respect of

understanding how lives were being affected by austerity and what these changes meant for everyday life in Stockton, quantitative methods could yield a valuable overview. However, qualitative methods such as ethnography and qualitative longitudinal interviewing add colour, meaning, complexity and other, equally valid forms of knowledge production by uncovering how it feels to live in this place, at this time.

3.1.5 Ethnography

Ethnography, also called participant observation, is a distinct method for studying how people engage, create their social worlds, and share experiences. It involves spending extended periods of time with participants, writing fieldnotes about the encounters and reflecting on these. Ethnography refers to both the process of carrying out research – of spending time, writing field notes and becoming immersed in the field, and the research product itself. It allows the researcher to generate 'thick data', that is, data which is concerned with the wider social context of an individual or a setting, and the meaning attributed to both the actions undertaken and the world they take place within (Geertz, 1973). The ethnographic data became an integral part of the overall research project. Carrying out ethnography was very productive - it provided me with a reason to spend time every week in Stockton with the same group of people, gathering useful data and gaining unique insights into their everyday life, charting the group's evolution and understanding more about the organisation and the unique challenges people in this area faced.

I began carrying out the ethnographic research after I initially met with gatekeepers who introduced me to the managers of a specific charity, an anti-poverty organisation named Thrive Teesside (http://www.thrive-teesside.org.uk). Thrive is a community organisation with an anti-poverty focus, whose key aim is to 'support and enable people living in poverty and on the margins of society to improve their livelihoods. It works to ensure equality of opportunity to participate in meaningful activities that would promote and build stronger communities with more active citizens working together to tackle their problems' (thrive-teesside.org.uk, 2016). The staff at the organisation expressed an interest in the research I was conducting and I arranged through email to run a focus group at the women's group they hosted. The group I attended was formed through 'Big Lottery' funding to engage women in the local area and to move them towards labour market participation. Distinct from this group was the outreach work of the charity, which was more focussed on crisis or one-off assistance to vulnerable members of the community. As Paula, the manager stated:

> *Most of my work is one-to-one, I don't have a lot of time to do the managing and monitoring and the financial sustainability. Most of it is actually going out and dealing with a presented crisis and it's usually to do with council tax, rent arrears, gas, electric, and referral to the food bank.* (Wave I)

This distinct need within the community explains why the official purpose of the group varied from its everyday existence. Many members of the community were not in a position to 'move towards the labour market' due to complex needs, and there was a lack of quality work in the area, especially for women with caring responsibilities. Those who attended the group were those who had relatively stable home lives, had relatively good mental state, and wanted to use their time to contribute positively to their community in this way.

Initially I had intended to attend the group to conduct a focus group and to enquire about recruiting for interviews. However, upon arrival and explaining about my project, it was suggested by the group that instead of conducting a focus group, which would be time-limited, that I should just attend as a member. That way I could get to know them and what they were about, and they would appreciate the bolstering of their numbers. I then began conducting participant observation. The group comprised of a core membership of seven to eight women, with two men who used the services of Thrive occasionally joining in too. New members would come and go sporadically. In regards to confidentiality and anonymity, all staff, volunteers and women's group members agreed that identifying the organisation in my research was something they agreed with, but I anonymised individual names. I sought verbal consent for my presence at the group periodically. Once I had built rapport and had been frequently attending I asked if any members would like to be interviewed so that I could gather their perspectives and stories in a more formal way. I interviewed five participants of the group on a one-to-one basis.

Ethnographic fieldwork, which began on the day of the 7th May 2015 General Election, took place from May 2015 to October 2016. I attended the weekly coffee morning which took place at the Thrive offices in a local community centre every week during this period, except for several weeks during the summer months. The women's group, while funded with an explicit purpose, functioned effectively as an opportunity to co-ordinate further endeavours of the organisation. During meetings members worked on social media, had discussions about broad social issues and discussed trials and tribulations at home. We gave each other advice, provided support, and got into deep discussions. We networked with other community-based groups, engaged in workshops and training for community organising, and attended community-building activities such as protests and workshops.

During the group, we would have a tea or coffee, and often brought homemade baked goods along too. We would sit around the table, some of us with laptops out doing social media work or, in my case, writing field notes, and discuss different topics, such as budgeting for Christmas, local news, recent welfare reforms, or broad questions such as whether suffrage had brought an end to the need for an explicit feminist movement. I would also meet up at the community centre or in the local pub for a coffee to talk through a task or just have a general catch-up. Staff, volunteers, and myself also attended events and training around the borough. Some of the events we attended included a Church Action on Poverty event about food poverty, an event about LGBT rights and hate crimes in Teesside, training on community organising and networking coffee mornings and meetings with other similar organisations in Stockton.

Figure 3. home baking at the women's group

Oakley (1993) has proposed that research based on engagement and co-operation on a personal level is as valid as research viewed simply as the extraction of data. The suggestion that I not conduct a focus group but instead participate in the group as a member shaped the direction of the research. It demonstrated that the group members welcomed my participation as both researcher and participating member. They appreciated that I took a sincere interest in them and the organisation; they found it interesting that I was conducting research into something that touched their lives, and they enjoyed the topical and political conversations we had. This illustrates how ethnography can foster strong relationships and a feeling of reciprocity with participants (Fuller 1999; Hall 2014; Valentine, 2005).

In terms of my positionality in the group, I was keen to conduct myself in a way that did not make members feel uncomfortable. I made it clear that I was not there to challenge beliefs or stereotype. I was also keen to emphasise that my membership of the group had a time limit; I would eventually stop coming to begin writing my thesis, although I would still pop in occasionally. I made it clear to new members and visitors who I was at all times and always asked if it was ok that I took fieldnotes as they spoke. My actions were not unusual in this respect as, stated above, many members of the women's group had also taken on voluntary roles within the organisation, such as social media promotion and would usually have a notebook or laptop open on the table.

Carrying out the ethnography did from time to time require me to grapple with my identity as a researcher and feminist, and to reflect on the differences between the group's participants and myself. One specific instance related to a discussion around 'undeserving benefit claimants and immigrants, and I found it very difficult to negotiate. I reflected in my fieldwork diary on this, as the following extract indicates:

> *The ethics of how I behave in the group is weighing on me when it comes to how I react to statements I view as problematic. Comments relating to immigrants such as 'I'm not racist but…' feel very uncomfortable. I do not want to remain silent while awkward statements are being made but I also don't want to alienate anyone, that isn't my role here. I keep quiet as much as possible, preferring to let others speak, because I don't want to tell*

them 'how it is'. I don't want to come across as a teacher, or one who has all the knowledge. (Fieldnotes, 10.06.2016)

While the instance cited above, and a number of other encounters were uncomfortable, I made the decision to not engage in conversation over these issues. My research was examining everyday life in a period of austerity – therefore that is what I collected my data on. I accepted that some participants in the group held views I found uncomfortable, but no moreso than in encountering any group. I decided that I didn't want it to focus on this aspect of my research, as what I valued were the everyday lived experiences of a period of welfare reform and not opinions about the deservingness of refugees or immigrants, nor did I have a monopoly on truth on these issues.

The ethnographic process was a very important way of meeting respondents and becoming immersed in some aspects of their social worlds. Through it I gained a deeper understanding of some of the issues women living on low income in Stockton-on-Tees faced. Members of the group willingly accepted me as attendee, researcher and student, acknowledging the various roles I, as well as they, occupied. They also took a keen interest in my research and were supportive of it. The gradual withdrawal from the field was done sensitively. At that time I was leaving the UK to write up my thesis in Ireland, so it was known to members that I would no longer be attending for this reason, and that my data gathering had come to an end (Anzul et al. 1991; Iversen, 2009). On a practical level, the group helped me to learn the place-names of Stockton, how certain areas were perceived by locals, local slang, and also where I could access further respondents. I learned which estates had 'good' or 'bad' reputations and how the high street had changed since its regeneration. Having spent time in the group gave me confidence interviewing other women. Carrying out the ethnography and being a member of the group provided me with invaluable local knowledge and the background context I required to carry out my qualitative interviews with a sense of confidence and competence.

3.1.6 *Qualitative Longitudinal Research*

Qualitative Longitudinal Research [QLR] and qualitative longitudinal interviewing emphasise depth of understanding over breadth of participants (Patton, 2002). I wished to identify a small group of individuals from within a specific group with experiences relating to the topic I wanted to understand (Cresswell and Plano Clark, 2011). They also needed to be available and willing to talk on more than one occasion. I was keen to build relationships to allow this to take place (Bernard, 2002; Spradley, 1979). Fifteen women were interviewed. The only non-mother was a participant in the women's group and, as she attended with her mother, I interviewed them to gain insight into their intergenerational perspectives as members of the same family. Women were recruited from across the socio-economic spectrum, with differing levels of income, family composition, from different employment backgrounds and education levels. Having respondents from across socio-economic groups and other demographic within the borough emphasised the differences of experience dependent on social class, type of housing and experiences of education.

Interviews took place over a one year period between September 2015 to September 2016. Mothers ranged in age from late teens to mid-sixties. Two interviews were conducted with participants to explore everyday lived experiences of austerity. The QLR method was useful for emphasising how experiences evolved over time (Neale, 2012). Our discussions of imagined futures (Adam and Groves, 2007; Patrick, 2017) provided insight into hopes, fear, and alternative versions of life respondents envisaged. This was particularly important in the ongoing period of austerity, when cumulative waves of cuts and reforms were taking place in quick succession. Follow-up interviews were arranged around respondents' changing circumstances – to capture the experience during the school year and the school holidays, shift from living with a partner to living alone, or the beginning and ending of instances of unemployment of a partner.

Interviews were semi-structured and audio recorded, and took place in a variety of settings, from coffee shops to participants' homes. Myers and Newman (2007) have noted that the semi-structured interview allows for flexibility, since the questions are open-ended and allow the researcher to return to points of interest and seek clarification or amendment. Respondents were encouraged to discuss their everyday lives freely and discussion was prompted on a range of topics, from maternity services to housing, and from food shopping to effects welfare reform might have had on them and their families. A £10 'Love to Shop' voucher was offered to all interview respondents. This was to emphasise reciprocity; an offering to them for their time and generously sharing their experience, in exchange for allowing me to use their testimonies and experiences in highlighting certain aspects of their lives (Limerick et al., 1996). Qualitative interview data was collected by audio recorder and transcribed verbatim. All respondents were assigned a pseudonym and the only source of their real name lay on consent forms, which were stored securely. The importance of choosing appropriate pseudonyms has been discussed by Ruth and Wiles (2016), and the inherent power dynamics within choosing a pseudonym have been deliberated on.

Pseudonyms were carefully selected to be reflective of the age of respondents and to be sensitive of the need for anonymity some respondents clearly expressed (Kaiser, 2009). The appropriate storage of interview data and the ongoing need to protect the privacy of respondents has been highlighted by Wiles et al. (2008) and was of the utmost importance during the research process. A copy of the consent forms, information sheets used for recruitment and interview questions are located in Appendix B. As Hall (2015) has noted, research should be imbued with responsibilities towards participants – protecting their anonymity (Meth and McClymonth, 2009: 912) and accurately presenting their experiences (England, 1994).

Interviews took place in the community centre where the women's group met, in coffee shops, or in women's homes. As I was keen to meet mothers in a relaxed setting and wanted the interview to be as 'natural' and un-invasive as possible I encouraged mothers with young children to bring them. When meeting in private homes I always took biscuits along and tried to be as non-intrusive as possible in this intimate space. Mothers would sometimes show me around the house, or bring me into the kitchen to see what they were preparing for dinner. I was keen to emphasise the informality I aimed for when conducting these interviews. I made

sure the tape recorder was not invasive, but clearly present and put casually to one side, in order to make the interview as relaxed as possible.

The qualitative longitudinal research method (QLR) provided an opportunity to examine changes in a spatial, temporal and dynamic way (Pettigrew, 1995; Holland et al., 2006). At the core of QLR is the interest in understanding the meaning of the experiences of social actors in their social context, both for the actors, and through an analytic and interpretative process for the researcher. As a challenge to purely positivist truth representation, qualitative longitudinal research is a suitable method for investigating and interpreting change over time and the dynamic processes of social contexts (Holland et al., 2006: 1). The choice of method was influenced by a number of longitudinal, qualitative studies (Charlesworth, 2000; MacDonald et al., 2005; Oakley, 1979; Patrick, 2017; Reay, 2003; Skeggs, 1997). These studies employed a 'bottom up' approach and were concerned with the subjective understanding of actors as conceptualised within their own worlds (MacDonald et al 2005: 3). Each participant was interviewed twice, with interviews ranging from forty minutes to two hours. Interviews took place in waves with different core themes being addressed in Wave I and Wave II, and time ranging from three months to twelve between the first and second interview.

The qualitative longitudinal interviews consisted of repeat interviews with women from all over the borough, recruited from a variety of sources. In total, fifteen women were interviewed twice. In the first wave, 15 interviews were conducted from September 2015 to March 2016. Transcription was completed shortly after each interview, and initial coding conducted on an ongoing basis during the interview process. The knowledge I sought was related to their lives in Stockton, their experiences of becoming and being mothers, perspectives on welfare reform and austerity, and general insight into their everyday worlds. Upon contacting individuals, I emphasised that the interviews would not take up too much time, that they would take place at a time and in a location convenient to the respondent, and that it would hopefully be a positive experience and a chance to give opinions on topics which affect their lives. This was part of the 'ethic of reciprocity' I wished to cultivate (Neale, 2013: 9).

3.1.7   Accessing the field

Access to gatekeepers and respondents emerged from a few key points of contact. I began contacting community stakeholders to act as gatekeepers from March 2015. These gatekeepers ranged from managers and staff at council-run services, and managers and staff of specific charities. My supervisor put me in touch with a contact from the Citizens Advice Bureau [CAB] and he then suggested charities he had contacts in. From April 2015 I spent eight weeks attending the CAB in the town centre. Due to concerns gatekeepers had regarding consent and access with their clients, I did not contact any respondents through the CAB. However, I sat in on interviews with clients and took detailed notes. This provided important insight into the issues clients with more serious welfare issues faced at that time. It also helped with networking opportunities in the community. I maintained good relations with CAB throughout the research process. The experience gave me first-hand insight into the array of complex, often multi-dimensional issues individuals using CAB services are experiencing. Until this point my knowledge of welfare reform had stemmed mainly from the

literature. Therefore this was an important opportunity to become acquainted with the experiences of those utilising and providing welfare rights services.

As stated in the ethnography section of this chapter, through a sanctions awareness event run by CAB and Stockton Welfare Advice Network (SWAN) I met the managers of Thrive, an anti-poverty organisation, where I would later conduct ethnographic fieldwork. They were interested in my research about women and health, and invited me along to conduct a focus group with the members of the women's group who met weekly in the town centre. The group I attended was formed to empower women in the local area and move them towards labour market participation. Although I initially had intended to attend the group to conduct a focus group and to enquire about recruiting for interviews, participants instead encouraged me to regularly attend as a member. That way I could get to know them and understand their lives in more depth over a longer period of time, and they would appreciate the bolstering of their numbers. I then began conducting participant observation at the women's group and also recruited a number of its members for in-depth qualitative interviews.

Various stakeholders; the manager at the Citizens Advice, supervisors, the staff at Thrive and other community stakeholders I spoke with suggested contacting local children's centres to recruit mothers. The former Sure Starts in Stockton were managed and run by a social enterprise called Big Life Families. They managed centres located in a number of locations across the borough. A Fairer Start was a three year project (2014-2017) funded by Stockton-on-Tees Borough Council Public Health, NHS Hartlepool and Stockton-on-Tees CCG (Clinical Commissioning Group). The project had a focus on health inequalities, and its key aim was to improve life chances, through a focus on child development (A Fairer Start, 2016). Big Life Families were one of the agencies piloting the project, and therefore had an interest in projects seeking to understand inequalities in the borough. Through connections made by my supervisor we attended a meeting with the centre manager who was amenable to the project we were undertaking. They contacted parents involved in the centre's organisation and who sat on the Parents Forum, and provided me with a list of eight potential contacts. Through this, I interviewed three mothers.

3.1.8   *Sampling*

I utilised a simple sampling strategy which integrated theory and process, similar to the one highlighted by Robinson (2013). It consisted of defining a 'sampling universe' – specifying inclusion and exclusion criteria for participation. In this case that would consist of mothers living in Stockton-on-Tees. When using grounded theory, sample size is dependent upon theoretical saturation – when data accumulation was sufficient to be able to reasonably address the research questions, sampling was wound down (Glaser and Strauss, 1967). After completing 12 interviews it became clear that a saturation point was being reached as a variety of different experiences were being discussed and I had a wide variety of age groups, demographics and backgrounds represented. I continued to interview 3 more respondents and after this I felt it was an appropriate time to stop recruiting new participants, as my sample was suitably diverse. A sampling strategy

was chosen – theoretical, purposive and snowball sampling. Finally, sampling sourcing is planned, which includes how to recruit, retain and incentivise participants. Issues relating to informed consent, confidentiality and anonymity should be considered throughout. The extent to which these factors are addressed has an impact on the quality, transparency and fairness of the research (Robinson, 2013).

The study employed a combination of initial purposive sampling and snowball sampling (Corbin and Strauss, 1990; Strauss and Corbin, 1998). I was keen not to assume identities, perspectives or experiences of those I wish to interview, as in Poorman's (2002) research into perceptions of 'thriving' by women . Rather, sampling began from a basic idea, that mothers may be affected in unique and particular ways by welfare and public sector reforms under austerity and that mothers may have distinct and powerful insights to share regarding how their everyday lives and families were interacting and coping with these processes. Sampling methods should maximise efficiency and validity and must be appropriate to and consistent with the aims of the study (Morse and Niehaus, 2009).

In applying a sampling strategy, I was keen to emphasise depth of understanding of the experience of individuals over breadth of participants (Patton, 2002). Identifying individuals from within a group who were perceived to have knowledge on a specific area (Cresswell and Plano Clark, 2011) available and willing to talk, on several occasions, as well as ability to communicate experiences and opinions with honesty and comfort was important (Bernard, 2002; Spradley, 1979). In recruiting, I wanted to integrate a set of narratives from middle-class and middle-income experiences as well as working class, low-income perspectives. This contrasting of experience across the socio-economic spectrum would highlight the different lived experiences of inhabiting and moving within certain contrasting spaces, such as living in Hartburn, a relatively affluent area, versus Hardwick, a deprived area. It would also shed light on the classed and gendered nature of austerity (Holloway and Pimlott-Wilson, 2016; Warren, 2015) and explore the implications of aspects of austerity beyond cuts to out of work benefit.

3.1.9   Theoretical sampling

The primary aim of theoretical sampling was to recruit participants whose thoughts and experiences could contribute to answering the research questions, until a saturation point had been reached (Sixsmith et al., 2003: 582). This lent itself, not to representative sampling, which is more sought after in quantitative studies, but a varied sample, which should lead to a rich and diverse representation of experiences (Strauss and Corbin, 1998: 214). The sample comprised of mothers of all ages who lived in Stockton. The initial rationale was to choose mothers with young children, as they might be more sensitive to changes in the benefit system and use more public and local council services. I later decided to recruit from a broader pool, of women who were mothers of children of any age. Women with very young children might be insulated from some of the more punitive aspects of welfare reform. This led to the recruitment of women ranging in age from eighteen to mid-sixties, with children, grandchildren, in different kinds of relationships, caring roles and living situations, from diverse socio-economic backgrounds, and stages across the life course.

3.1.10 *Snowball sampling*

Snowball sampling relies on respondents and key actors acting as a point of contact for meeting new, relevant respondents. It involves taking advantage of readily available social networks to increase the pool of potential contacts, assuming a pre-existing link between relevant groups (Vogt, 1999; Thomson, 1997). It is a common choice of sampling in qualitative studies, as it offers practical advantages, including widening the pool from which respondents can be recruited, and acting as a reassurance for the respondent that the researcher is known within their wider social network (Hendricks et al., 1992). I used it effectively within my own research, recruiting friends, colleagues and family members of participants in both the ethnographic portion of the research and the qualitative interviews. Being able to reference interviews with other respondents facilitated building rapport and interviewing women who knew each other and occupied similar spaces provided interesting contrasts and points of reflection.

Participants in Qualitative Longitudinal Interviews

Name	Age	Interview I	Interview II	Recruitment site
Pat	45-54	25/09/2015	15/03/2016	Thrive
Dee	18-24	25/09/2015	15/03/2016	Thrive
Kelly	25-34	14/09/2015	02/03/2016	Social media
Jill	35-44	08/12/2015	13/09/2016	Thrive
Lucy	45-54	22/12/2015	09/03/2016	Social media
Lisa	45-54	11/11/2015	04/03/2016	Social media
Trish	35-44	02/11/2015	15/04/2016	Children's centre
Jodi	18-24	02/11/2015	15/04/2016	Children's centre
Becky	18-24	05/11/2015	08/04/2016	Children's centre
Emily	35-44	16/12/2015	03/05/2016	Social media
Sam	45-54	22/12/2015	03/03/2016	Durham University
Paula	45-54	08/12/2015	13/09/2016	Thrive
Brenda	45-54	26/02/2016	12/04/2016	Snowballing
Carol	35-44	03/02/2016	04/05/2016	Snowballing
Anne	65-74	08/03/2016	07/09/2016	Thrive

Participant Vignettes

Anne comes across as quite matriarchal and appears to be the boss in her large extended family. She lives in a council house with her husband, and at different times her sons and grandchildren have lived with her. She used to own a home and be a market trader, but for complicated reasons she gave it up and gave up the house. She is passionate about community organising and volunteers a great deal of time to it. Anne believes that, as a pensioner, she gets off lightly when others relying on social security have to deal with cuts. She says she's never had it so good. She is very energetic, passionate, and keen to debate. She was diagnosed with diabetes in late 2016, and suffers from depression, but remains positive about her health.

Becky comes across as quiet and relaxed. Becky lives with her little girl who is three. She lives in a 'nice enough' flat, although there's some dealing that takes place around the area. She has had a tumultuous upbringing, moving from London to Hartlepool, back to London and back to Hartlepool to be with either her mum or dad. She doesn't have any relationship with her dad any longer. Her mum is now divorced as her ex-husband was violent and an alcoholic. She has a sister in Hartlepool. Becky's partner was made redundant at the SSI steel works which closed just before Christmas 2015, and finding another job was a very stressful ordeal for them. Becky gets depressed; she feels a lot of weight on her. She is very involved in the local Children's Centre; she does courses and volunteering there. She has ambitions to work in early childhood education.

Brenda was put in touch with me by Emily, who gave Brenda welfare rights advice. Brenda is re-married. Her first husband wouldn't let her work outside the home and was abusive. Brenda has two children, one lives with them and is working towards becoming a manager at a fast food restaurant. Her son lives in Newcastle, where they lived for many years and is a homeless drug addict. Brenda has multiple disabilities; she suffers from very poor mental health, and is struggling to deal with issues from her past, including abuse as a child. Brenda loves talking – both times I interviewed her I stayed two hours.

Carol was a journalist in Africa, but left because she was in danger, and sought asylum in the UK. She met her husband in Stockton and they have two children. They live in the city centre. She is an outspoken advocate of female genital mutilation awareness and runs training on the issue. Before she got Leave to Remain she did this voluntarily, and is now trying to start a business. Her husband is in training and hoping to start work soon. He needs to prove that he was claiming asylum during the period he was, which is proving difficult as he is registered under his wife's name. He was sanctioned in the past for failing to look for enough jobs, and they really struggled to make ends meet then. She works hard and wants to work hard in the future to provide for her children.

Dee is Pat's daughter. She's in her mid-twenties, and lives with her parents and brother. When she was a teenager she was in a car accident which had a very negative effect on her. She and her mam are sick a lot – they have head colds every couple of weeks from the damp in their house. Dee loves history and family history in particular. In recent months she has availed of a grant to set up a small business which researches

and produces family trees as well as other products. She was able to sign off JSA and is now working to get her business up and running.

Emily is quite quiet. She lives in Stockton South with her husband and two children. She works for a housing association. In the past was made redundant by a local council where she was a welfare rights manager, due to cuts. She is now doing a part-time Masters. She speaks passionately about educating herself on, and advocating on behalf of, her daughter who had health issues the NHS were not adequately dealing with. Her husband was made redundant from his IT job in the past and there's worry that he'll be made redundant from this one. She enjoys living in Stockton and thinks the Teesside area has a lot to offer people.

Jill lives in North Stockton with her partner, two sons and eldest son's girlfriend. She has been a single parent, and lived on a low income while claiming benefits in the past. She lives in private rental accommodation, her partner works for a housing association. They had hoped to buy a house in the past, but something always got in the way. Now they'd be paying much less in monthly housing costs, and that annoys her. She's the one in her house who does most of the housework and the cooking but rarely complains, just gets on with it. She's from Stockton and she has a large, close knit family who all live nearby. They often go on camping or caravan holidays. She's very passionate about the local community and is well known around Stockton.

Jodi is a young mum, at our last meeting she was 18, with a little toddler and another baby on the way. She lives with her partner who is out of work and can't read well, but does bits and bobs for extra cash. She relies on her mum Trish for a lot of advice about how to take care of her son and how to manage the bills. She didn't get a chance to finish her A-levels because she had her son. She has embraced motherhood and appears to take it in her stride. She had a C-Section and a difficult labour but wants her next birth to be a natural one if possible. She is glad of the Children's Centres because she is able to continue her education and meet other young mums.

Kelly lives in South Stockton with her two sons. She split from her partner between our first and second interview. They moved quite recently from a house that had damp, she was often sick then. She gets Carer's Allowance for her two sons who have additional needs. Kelly's early life was hard-her parents struggled financially and they had to make a lot of sacrifices. She trained in photography at Uni, but couldn't find a job. In the past she's felt stuck in Stockton but she thinks it's a nice place to raise children. She struggles financially, and her partner had taken out payday loans in the past; she had to get a Debt Relief Order. She volunteers at a charity. Kelly comes across as positive and hopeful. She finds her life stressful, but is full of understanding and loves her sons very much and wants to do everything she can to give them a decent start in life.

Lisa is originally from Durham. She lives in South Stockton with her mum, husband and children from her first marriage. Both herself and her husband are divorced, and did bad financially out of their marriages. They

live in private rental and move around a lot. She has nearly always worked in the public sector, went on an Access course when her son was 3, then on to Uni. She's now a student. Her husband is studying photography. They have struggled financially, had a Debt Relief Order, and moved in and out of low paid jobs. These days Lisa is doing fairly well, working on her studies and making sure her kids are happy.

Lucy lives in Stockton South in a privately owned home with her husband and two children. She has extended family all over the country and has lived abroad. Lucy thinks Stockton is a great place to live and raise children. During our interviews Lucy was calm and positive with a self-deprecating sense of humour. She and her husband are doing well with their careers and the children are healthy and happy. A theme which surfaced in our second interview was her worries for the future: both her parents and her husbands will require care as they get older, and she worries about how the care will be funded. Talk of houses being sold led to discussion of inheritance, and worries for her own pension entitlements.

Pat is from Stockton and I met her at the women's group. She is married and has two daughters and two sons, all grown up. One of her daughters, Dee, also attends the women's group. She lives on an estate with her husband, and youngest two children. The house has ongoing issues with damp and they are often sick as a result. She prides herself on being a homemaker and providing for her children. She does all the housework and most of the cooking. The family budget for food shopping very carefully and cook a lot from scratch. Pat also prides herself on being able to make food stretch, like her mother did. She speaks fondly of her parents and the sacrifices they made for her and her siblings.

Paula is the manager of a charity; she keeps it going on a daily basis. She has a husband, and was married once before. She has a daughter who has her own kids; she's very supportive of her daughter and does childcare for her. Her first husband was in the military so they moved around a lot. She has great insights and is passionate about fighting injustices. She is also very willing to speak openly about her experiences of struggling on low income, her husband's precarious employment, and her struggles with debt.

Sam is a single mum from a rural village which she classes as stereotypically middle class. She has two teenage children. Her parents moved out from London when she was a kid because there was racial tension (her dad is Indian) and they didn't want her to grow up near that. She has lived around Middlesbrough most of her adult life. She works at the University and does small bits of community and advocacy work. She believes that giving up career prospects so her children could have a stable and consistent parent around, and live in a comfortable area of Stockton was worth it, although she wonders about the future. She owns her own home. She has an international extended family, and is well-travelled.

Trish is a mum of 3, married, with two step children. She is also a granny and her stepdaughters both had kids in 2016. She lives in social housing and is trying to downsize as the house is too large, and it is damp. She and her daughter are both mothering young children fairly close in age. They attend the local Children's Centres and are on the Parent Forum, they do a lot of classes and training to acquire new skills. They also volunteer at the centre. Trish comes across as a 'no nonsense' kind of lady. She lived as a single mum on a

low income in Thornaby when she had Jodi. Jodi gets on well with her stepdad now, and mother and daughter appear to have a close bond.

3.1.11   Analysis

The data that was collected during ethnographic research consisted of extensive fieldnotes, which were recorded on a fieldwork notes form (Appendix B). Additional notes were recorded in a dedicated fieldwork notebook, where notes were recorded carefully and clearly (Lewis and Mills, 2007). Data collected as part of the qualitative longitudinal interviews consisted of audio recordings which were transcribed verbatim into Microsoft Word documents. The final product that was analysed in both instances was written text. To aid swift and careful analysis I kept organised and detailed field notes and transcribed important details to fieldwork documents after fieldwork sessions. All respondents were assigned a pseudonym and there is no written record of their real name, aside from on consent forms. I clearly labelled each document with the date and pseudonyms to facilitate record keeping. This represents the first formal analytical step. Documentation is central to the production of qualitative research. It is essential 'for keeping track of what will be rapidly growing volumes of notes, tapes and documents; it provides a way of developing and outlining the analytic process; and it encourages ongoing conceptualising and strategising about the text' (Schutt, 2012: 326).

The meanings derived from words and language is a vital aspect of qualitative analysis (Miles and Huberman, 1994). Qualitative analysis can take many forms, but follows the sequence of organising the data (in this case, as written text), categorising it into themes and core concepts which can be used to produce theories. I followed Miller and Crabtree's (1999) modes of 'reading the text' when analysing. Firstly, there was a literal reading focussing on content and form to familiarise myself with the narratives and perspectives of respondents. Next there came a reflexive reading, focussing on how my own perspective might shape the interpretation and focus of the data. Finally, the text was read interpretively, trying to interpret the multiple meanings. This process was repeated many times during the initial and subsequent analysis period. A thematic framework for analysis was derived in part from the study objectives and partly by identifying themes from ongoing analysis of transcripts.

Analysis was conducted in several stages. Firstly, the documentation of the data and the process of data collection took place. The data was then organised and categorised into concepts and themes. Next, the data was presented to demonstrate how concepts influenced and related to each other. Following on from that was the process of corroboration or legitimisation, broadly speaking to find explanations or alternative meanings behind the narratives presented. Finally, the findings were compiled (Schutt, 2012). A combination of NVivo and Microsoft Word were used for coding, classification and grouping. Microsoft Word was used for ordering texts, quotes and themes. Pen and paper was used for highlighting and drawing charts. This multi-modal method allowed the data to be viewed from a variety of angles. Eventually, themes and key concepts began to consistently emerge. There was an ongoing re-visiting of assumptions and themes throughout the writing period. This entire process was iterative and repeated throughout.

3.1.12 Coding

Coding is central to the analytical process of qualitative research (Corbin and Strauss, 1990: 12). In my analysis I worked with a combination of digital, handwritten and printed text. The aim was to organise this text into a coherent set of themes and key concepts which would form the basis of the argument. This led to the gradual generation of theories. I moved from description to theoretical engagement and from analysis to synthesis. Coding of both fieldwork notes and interviews was the base around which themes emerged. The grounded theory method involves constant and ongoing coding in gradual stages – open coding, axial coding and selective coding (Strauss and Corbin, 1998). In a traditional grounded theory methodology, interviews and fieldnotes are coded as they are completed.

After fieldwork was conducted and after interviews had been transcribed, I printed off fieldnotes and transcripts, read through them and coded in an open way, making broad categories and ordering the broad themes which emerged with a highlighter and pen. I kept track of 'themes' I had generated from coding in Word documents, and these informed the second round of interviews, as well as points of clarification I would seek in fieldwork sessions. I employed NVivo 11 to develop a set of codes which would lead to the key concepts and themes central to my analysis. This was done by highlighting interviews and fieldnotes in NVivo by code, with relevant quotes and excerpts placed in a folder relating to each quote. Subsequent to this, I moved to Word and, working from printouts which I had highlighted with the codes from earlier analysis and NVivo analysis, I generated separate Word documents for each code, refining this until I had 6 Word documents pertaining to the six main themes generated.

Main themes

- Being a mother
- Health
- Place and Community
- Work and Care
- Housing and Material Need
- Money and Cuts

Within each of these documents were the 'key concepts' relating to each theme. Relevant quote excerpts from each respondent which gathered together by theme. These were also cross-referenced through separate Word documents for each respondent. I utilised a number of different formats to visualise themes, as this helped refined both themes and key concepts. A combination of drawing Venn diagrams, mood boards (samples of these are available in the appendix.), Word documents and NVivo was used for this task. The analysis process took place in several stages and eventually became more refined. I intermittently printed off and read through interview transcripts, comparing old codes. Through preparing conference presentations in 2015-2016, I was able to conduct analysis by re-reading and coding interviews and fieldwork extracts, and refined the coding as the conference season progressed. As I got into the period of deep analysis over the summer of 2016, I

compared and contrasted earlier and later codes, notes and themes, discussing and refining. Eventually, I felt satisfied with both the themes and key concepts I had generated, and began writing, re-visiting these assumptions throughout the writing period. The main themes and core concepts listed below formed the basis for the findings chapters.

3.1.13 Further Analysis

Main themes

- Mothers
- Place
- Community
- Mental health
- Flourishing/not thriving
- Social determinants of health

Core concepts

- Intersectionality
- Feminist political economy
- Depletion
- Invisible inequalities

3.1.14 Research Ethics

There are multiple ethical issues that may arise as a result of doing research which involves repeat interactions with respondents, and featuring the sharing and discussion of private and personal information. Informed consent is a continuous process in longitudinal research. Richardson and McMullan argue that 'nobody involved in researching 'the social' can avoid confronting ethical issues' (2007, 115). Verbal re-consent was sought periodically during ethnography and QLR. Issues of data protection and confidentiality were treated with the utmost care. There is the need for reflection on the impact of repeat interaction with researchers for the participants; I will discuss this in the second portion of this chapter (Corden and Millar, 2007). Anonymity was guaranteed at all stages of the research process. Personal information and names were anonymised from the start. A verbal and written explanation of the research aims and requirements from participants was provided, and I recorded the discussion of ethics at the start of each interview. Consent was sought at all stages of the interviewing process, and interviewees have the ability to retract any information. Participants were offered the ability to read written results and provide feedback. I kept contact details for this purpose.

While all participant names were anonymised, the name of the organisation Thrive was not. This was a preference of all members of the women's group and managers of the organisation. Furthermore, not all participants in the longitudinal interviews expressed a desire for their names to be anonymised, but I made the

choice to anonymised all names to avoid the identification of any one individual. As Hall (2018) has noted, there is a clear need in this time of austerity to take care and behave responsibly when conducting research and to maximise 'empathy, connection and concern' (Stacey 1988, 22). I argue that an important part of this care is the obligation to uphold the agency of others. Therefore, I maintain that there is no contradiction in using the name of an organisation while anonymising member's names, as it recognises the important social justice work of that group while protecting individuals within it from personal identification.

In respect of the ethnographic research, it is important for ethnographers to be aware of how their research and research by others may be perceived by those facilitating and participating with them and to be sensitive to potential 'researcher fatigue'. There are some limited studies on the topic of 'over-research' (Clarke, 2008; Sukarieh and Tannock, 2012) but the issue requires further investigation. As Neal et al. (2016) argue, the tendency for certain sites to experience a proliferation of researcher attention must be mindfully considered. There is a tendency for some places and the people living in them to be the subject of repeat studies. These studies may inadvertently or deliberately add to generalising assumptions or even stigma which is carried across time and generations (Crow 2013; Gallaher, 1964).

As I noted in my introduction, the Teesside region has been the subject of much academic interest and research. While there is a tendency for certain geographical areas to experience a disproportionate level of focus from social researchers, the negative aspects of this can be ameliorated if researchers engage sensitively and appropriately (Neale et al., 2015). An emphasis on the agency of participants and the desire to engage in 'co-productive research relationships' in which to established 'circulations of communication' (Sinha and Back 2014: 473) can turn the experience into a positive one, including groups in research which gives them voice, which may challenge stereotypes and may, in the long run, impact policy.

Power dynamics may assert themselves in a research relationship if power and privilege are not considered throughout the research, including in the period after the research has been completed. The dynamics of power must be reflected on an ongoing basis when conducting qualitative research (Crozier, 2003; Hammersley, 1995). Researchers need to be aware of the risks inherent in how they use their role as academics (Tee and Lathlean, 2004) when working, in particular with community groups. University researching guidelines and ethical principles were adhered to (British Sociological Association, 2002) in relation to anonymity, privacy and confidentiality and copyright laws. The qualitative study involved extensive interaction with individuals with whom I had no pre-existing relationship; hearing their stories and collecting information about their personal experiences. Therefore, it was of importance to adhere to ethical guidelines that allow the research to be conducted in a sensitive, reflexive and confidential manner.

3.2 Reflexivity in qualitative research

If you expect someone else to talk about their experiences, don't you have an…ethical obligation, to be prepared for that to be an interaction, rather than "I am the questioner and you are the answerer?'' (Oakley, 2013).

3.2.1   Critical evaluation of the research: limitations and opportunities

In this section I discuss two key concerns from the research process – researcher reflexivity in terms of my positionality and conduct of feminist research, and the ethics of representation. Of specific relevance in this are the themes of power and reciprocity. There will also be a discussion of conducting feminist research, and a reflection on interpretations of conventional understandings of 'doing' research. Conducting feminist research involves an attempt to acknowledge the 'messier' aspects of knowledge production that other types of research can fail to mention. I was keen to make clear and acknowledge the inherent power imbalances in the research process, the ongoing struggle for objectivity and the ambiguity and non-linearity of relationships forged through longitudinal and ethnographic research (Kobeyashi, 1994).

The process of doing this kind of qualitative research is complex because the researcher is asking people to share their identities, biographies, histories and hopes. This lends itself to the divulging of highly personal information and the exposition of complex stories and narratives (Moss, 2002). There is the possibility of ambiguity, of misreading actions or misconstruing narratives. Therefore, we must be wary of making assumptions about the nature and meaning of experiences and their opinions. Social research can be an important and potentially emancipatory way to give greater visibility to the subjective situations some women face and how these experiences differ based on intersecting factors. Researching with women has been noted as being 'a strategy for documenting women's own accounts of their lives' (Oakley, 2015). But it is important to emphasise that what we see in the field is only a small portion of someone's life, and the amount we capture during interviews and fieldwork is only a fraction of their opinions, life stories, beliefs and values. It is crucial to be mindful of this when presenting research findings.

3.2.2   Reflections on the ethics of feminist research

The traditional scholarship on social research methods (Benney and Hughes, 1970; Galtung, 1967; Goode and Hatt, 1952; Kahn and Cannell, 1957) maintains that research production should aim to be impartial, unbiased and seeks to produce representative and robust findings. Interviews are an 'information-gathering tool' and the interviewer should aim to delve into the 'clichés and contradictions of the respondent' (Benney and Hughes, 1970; Goode and Hatt, 1952). Contemporary literature aims to be more critical of this process (Lincoln and Denzin, 2003).

Oakley (1995) has contended that certain research protocol – the extent to which a researcher discusses the emotions fieldwork or interviews bring up, or whether or not to form friendships with participants, is indicative of a distinction between 'legitimate' and 'illegitimate' forms of research protocol. This reflects a masculine model of both society and sociology – whereby an interview is treated as a means of gathering

sociological data, with 'distance and objectivity' being maintained at all times by an interviewer who is very much in charge. This model is not satisfactory when it comes to feminist research (1995: 31). Oakley (1993) argues that 'to produce work that comes out of, and hence resonates with, people's lived experiences is the very essence of the feminist challenge to knowledge' (1993: 220). Feminist geographers challenge 'traditional' normative research paradigms and aim to engage in critical qualitative research, questioning their own positionalities and power structures they operate through (Dowling, 2005; Kohl and McCutcheon, 2015; McDowell, 1992; Phillips, 1997).

This research acknowledges that gender is a governing code that 'pervades language and hence systematically shapes how we think, what we presume to 'know' and how such knowledge claims are legitimated' while not itself reinforcing the valuing of such norms inherently (Spike Petersen, 2005: 502). An important step in this process is the acknowledgement that social research is an inherently politicised practice of knowledge production. What we choose to research and from what standpoint reflects our own biases, background, culture, beliefs and external influences. The traditional goal, of achieving 'uncontaminated, objective observation' is not truly possible. Our observations and how we interact with the site of research affect the reality we are examining (Adam, 1994: 603).

3.2.3   Reflexivity and conducting 'feminist' research

Both my research methods (the techniques for gathering data) and the methodology (theory and analysis for how research should be undertaken) were informed by an underlying feminist perspective (Harding, 1987: 2). Feminist critique and opposition to 'positivist notions of objective, impartial and value-free judgements' have become more prevalent over the past 30 years (Valentine, 2002). Successive waves of researchers such as Stanley and Wise (1983), Oakley (1981; 2015) and Skeggs (2008b) have critiqued traditional epistemologies and drawn attention to the hierarchical and deeply gendered power relationships often present in researcher relationships. The broad category of 'feminist epistemologies' has emerged from this. This way of knowing is, in part, an attempt to 'speak truth to power', and to develop politically, practically and theoretically a way of understanding how gendered (and other intersecting) processes operate (Skeggs, 2008b). Spencer (1981), Stanley and Wise (1983) and Oakley (1981) have all critiqued traditional epistemologies, and drawn attention to the hierarchical power relationships inherent in researcher relationships.

From these points of critique feminist epistemologies have emerged. They highlight alternative forms of knowledge – this is important when studying health, as the perspective of clinical professionals and lay people may be quite different. They also highlight the non-neutrality of the researcher; the importance of sensitivity to power relations (Stanley and Wise, 1983); situated and context-specific knowledge (Haraway, 1991; Harding, 1991) and the need for self-reflexivity, to make our positions 'known' to overcome false notions of neutrality (McDowell, 1992). I reference the work of feminist epistemologies to acknowledge my bias, not to excuse it. I hope to acknowledge that the neat category of 'feminist research' is not unproblematic, and

cannot simply be summoned to set aside the political and power relations endemic in a researcher/participant relationship.

Through referencing feminism as a key influence of the research design and process I do not mean that I have sought commonalities with respondents solely on the grounds of being a woman or that our common gender renders other differences between us such as class, political views or education, invisible. Oakley (2015) has reflected on her earlier research and erroneous attempts to recall a natural 'sisterhood' (2015: 196). Spike Petersen (2005) also has in her comments on the uneasiness of feminists writing and working on feminism, working through sometimes-problematic definitions of 'woman', 'sisterhood' and the universality of these experiences (2005: 503). Rather, I mean that I have conducted 'feminist' research as an explicit acknowledgement that the experiences of women and women's lives are not incorporated sufficiently into social research generally and seeking to make this explicit through undertaking research which makes these invisibilities visible.

3.2.4   Researcher responsibility, power and representation

Power is not simply a neutral characteristic of human interaction but something meaningfully produced through our relationships, often through how one actor dominates another. It is productive, and permeates the micro-level of our social interactions (Foucault and Gordon, 1980). Its wielding can yield negative results, particularly when a student from an elite university enters an area of material deprivation.   Power is inescapable and ever-present in our social interactions. To assume I as researcher was 'more powerful' would be to over-state my own position. That being said, in the context of moving out of the fieldwork relationship and looking towards the future, there was a definite space for myself as researcher, armed with their narratives, to misrepresent their stories or to use their stories to further my own agenda. We need to think critically about researchers' accountability for the political and ethical implications of our research findings, and for the truth claims we make (Ramazanoglu and Holland, 2002: 11). No conceptual underpinning can place us outside the body of knowledge we seek to understand. We cannot achieve wholly unbiased, objective observation; our studying and engagement with individuals and contexts affects the 'reality' we investigate.

There were instances throughout the fieldwork that reminded me of my position as a researcher and as an outsider. These instances reminded me of my difference, and of the need to always behave appropriately and sensitively as a researcher. One such example resonated with me. I had finished the formal interview with Brenda and the tape recorder was turned off. Brenda asked me what else I was doing for fieldwork and I told her about attending the women's group in Stockton. It was, I explained to her 'participant observation', so I attended, as a member, but also observed what was going on as an outsider:

> Brenda: 'So it's a chance to see how the other half live?'
> Interviewer: '…something like that, I suppose you could say'
>
> Brenda (Wave II)

I didn't know what to say, and felt it uncomfortable. Brenda didn't mean any animosity in this statement, I could tell in her voice. However, it reminded me once more that, no matter how much I empathised with the women I was conducting my research with, I was not one of them. I would leave the field, go to write up my thesis, and I might never encounter them again. The reality is that I had, in many ways artificially, transplanted myself into a world that was not my own. This raises a host of issues relating to power and reflexivity in the research relationship including 'who can be a knower?' (Code, 1991), 'whose knowledge?' (Harding, 1991), and 'who speaks for whom?' (Code, 1995; Mohanty et al., 1991).

It also raised ethical concerns I had over feelings of researcher guilt (Crick 1992: 185) in relation to the challenges austerity presented for some respondents. It signified a point at which my identity as researcher came to represent one of tension and ambiguity (Cassell, 1982: 151). Fuller (1999: 224) argues that 'there is a need for the researcher to consider his/her place within the research process, not least because inclusion in this process is undeniable and unavoidable'. The significance of giving due consideration to the 'dynamics of power and social divisions between women' (Oakley, 2015: 197) must be acknowledged in relation to class, privilege, socio-economic position and race. Phoenix (1994) rightly argues that 'notions about feminist interviewing as a 'cosy enterprise' based on shared gender understandings ignore differences between women in terms of race, class, status, sexual orientation, politics, age' (1994: 5).

3.2.5   Reciprocity and the research relationship

The second factor which shaped the research process was 'reciprocity', a contentious yet important factor in conducting successful qualitative research (Corbin and Morse, 2003). I was aware of the power dynamics endemic in the research relationship. While I could acknowledge them, I could do little to change the hierarchical world myself and the respondent were embedded in, but I did try to emphasise 'reciprocity'. Traditional interviewing techniques suggest building 'rapport'; however, I decided that this did not go far enough. Cultivating a sense of 'rapport' is a skill which requires asking the right questions, presenting oneself a certain way and engaging in certain types of conduct. However, I felt that this was not moving far enough towards a reciprocal research relationship. I wanted the process to be a positive one, for respondents to feel validated by sharing their experiences and to feel that their time had been spent well. One way of framing this reciprocity could be to think of 'the gift'. What was being produced throughout the research process became clearer as I reflected on the transcribed fieldnotes and interviews.

What I came to see, retrospectively, was that an exchange had taken place. Limerick et al. (1996: 458, 450) characterise this quality of the interview process as 'the gift'. They have stated that researchers need to be accepting of a gift of 'time, of text, of understanding' – the gifts provided by the respondents. Respondents had sat with me, sometimes for two hours, shared intimate details of their personal lives – of the loss of children, troubled grown up children, of living in debt, of abusive past relationships, of joys and happy memories. We had also shared time, cups of tea and biscuits. I had been invited for a short time into the world of the respondent. Sat as she answered her phone, divulged a secret or shared a pleasant anecdote. I gave a £10 voucher for the time, some of which were used to buy groceries, others used to buy a treat. I

listened, I tried to be open and kind in how I interacted with respondents. This process could be characterised as a gift. It is important to note that this gift relationship and the notion of reciprocity are an ideal and something which needs to be negotiated and actualised in an ongoing way in the research process.

That being said, the concept of the gift relationship (Mauss, 1954), is not without issue. The finished product, the thesis and publications to result from the data which was collected, are beyond the control of the respondents and even often outside of their access owing to paywalls. This gift relationship, therefore, has limits. This is especially significant when researching during austerity (Hall, 2015) as we have a responsibility to engage sensitively and supportively with those affected by welfare reform. Hall has referenced the work of Lawson (2007, 4), who made the case for a 'relational social ontology', an understanding of the world and our responsibilities as geographers through the 'connections that bind us together' (Hall, 2015: 304). This could take the form of work which is 'for the other which is emotional, connected and committed' (Cloke, 2002: 591) but always demonstrating a concern 'for others' while making sure to represent without appropriating their voices (England 1994; McDowell 1992).

It is important to acknowledge that the production of research involves, to some extent, an asymmetrical power relationship with respondents. Being open about this and acknowledging the challenges and constraints it presents allows us to confront and move past some of the ethical dilemmas that may ensue. Within the interview process and during ethnographic fieldwork, respondents were free to challenge power dynamics by choosing what to talk about, and could of course shift the conversation or refuse to answer a question. However, the researcher eventually leaves the field, taking the data with them, and can exclude the respondent's story entirely from the research. Openness about this power, its' asymmetrical nature, and how both participant and researcher are constrained by it in various ways, is crucial. As Oakley (2015) stated in her own conclusion, 'the complex political and social relationship between researcher and researched cannot easily (or helpfully) be fitted into a paradigm of 'feminist' research' (2015: 209).

Conclusion

This chapter began by outlining the main aims and questions of this research project. Following on from this I summarised the research project that this study was a part of. I first discussed the methodology and research methods utilised. I discussed the application of the methods and the sampling strategies employed, as well as the discussion of access and the practicalities of the fieldwork process. Following this was a discussion of the analytical strategy and a discussion of ethical considerations. The methods used, ethnography and qualitative longitudinal research, were appropriate and effective for carrying out this research. Ethnography provided the space and time to 'get to know' the field and to develop relationships with a group of people with the context of their group membership and its' dynamics. I encountered a willing and generally enthusiastic group who had a space I could fill in a way that was sensitive and appropriate to the overall group dynamic. The use of qualitative longitudinal interviewing was also effective and an appropriate method to use given the research design. It allowed me to dig deep into the narratives of individuals in a quiet, uninterrupted space, gaining clarification and nuance on complex topics. These methods worked in conjunction and were complementary.

Recruiting respondents did not pose any major obstacles, and retaining them for further interviews was not difficult. Building rapport within the interview relationship was a skill that I developed and improved throughout the process. These methods produced data which complemented each other well, and which corroborated and upheld opinions expressed by respondents and fieldwork participants. Interview data often provided personalised and lengthy discourse on a topic mentioned during the women's group, and the open and frank nature of the women's group generated data which provided shorter reflections on similar topics, which could be followed up at different times.

In the next section I made a critical reflection of the research process from a feminist perspective, commenting on issues of reflexivity, power and ethical integrity. Ethical dilemmas in researching with women and the hierarchies of research relationships was reflected upon. It is important to retain and reiterate an ongoing awareness of power disparities in conducting research, and to reflect on how better to carry out research so that feminist ideals of equality, equity and fairness may be maintained, while good-quality research can be produced. The research sought to address a relative lack of empirical qualitative studies on the lived experience of mothers under austerity. It emphasised the importance, for research and policy, of considering the everyday lived experiences and narratives of those impacted by welfare reform and austerity (Garthwaite, 2016; Hall, 2015; Holloway and Pimlott-Wilson, 2016; Jupp, 2016; Patrick, 2014). The study highlighted the value of 'everyday' perspectives on health, life, choices and value-making. This research has attempted to take all of this on board and to design in a sensitive manner a study which is in-depth and acknowledges the distinct experiences of women in this age of austerity.

4. <u>Findings I: Unequal Places and Everyday Life in Stockton - 'It Can Be Nice Round Here, But Lately, It's Different'</u>

Introduction

This chapter illustrates how Stockton as a place plays a role in shaping the lives of respondents and their communities, and the ways austerity was altering this. The chapter is set out in three sections. Firstly, findings are presented which outline how Stockton's composition, location and environment have impacted the everyday life of respondents. Contrasts and commonalities between richer and poorer areas in Stockton are discussed. Findings suggested that boundaries between and within areas were felt in different ways and that this impacted perceptions of inequality, conjuring up emotions relating to respondents' sense of mobility (Closs Stephens, 2015; Ranciere, 2011; Shapiro, 2010). Respondents discussed boundaries around and within Stockton. Respondents also expressed the importance of different conceptions of time. Feelings of belonging and community were mediated by past, present and future relationships to certain places and spaces. Past experiences, such as the memory of where relatives and friends had previously worked and lived were felt to have shaped their present circumstances, and informed expectations for a future which for some held a great deal of uncertainty.

Secondly, there is a discussion of how some 'contextual' (place-based) factors are impacting people during austerity. The example of 'community' in Stockton is given, as it was an important site of everyday experience. The relative strength or weakness of a community as a source of cohesion is an important contextual factor that can impact health inequalities (Collins et al., 2017). It was felt that local communities were not as strong as they once were, and that this was indicative of the weakening of social fabric of their area and society more generally. The significance for respondents of Sure Start Children's Centres as spaces to facilitate flourishing is given as an example. Different places represented opportunity or, conversely, a lack of opportunity. Findings will be presented which illustrate, for respondents, a perceived fragmentation of traditional ways of life – family dynamics, routes to work and social engagement. Thirdly, there is a discussion of findings which demonstrate that austerity is impacting the vitality and health of communities and the lives of respondents through widening and persistent health inequalities. The chapter illustrates that place and health are intrinsically linked, illustrated by specific examples.

The chapter concludes by stating that the 'contextual' factors or opportunity structures in a locality have a huge effect on how it feels to live there, with implications for health. I argue that over-attentiveness to individualised 'failings' in certain areas overshadows socio-structural inequalities present in those places. This may be, in part, responsible for the failure to produce a systematic opposition to austerity more generally. As the emerging literature on Brexit (Hartmann and Leug, 2017; Outhwaite, 2017; Pottinger et al., 2017) indicates, people are directing feelings of anger and frustration outwards towards the EU, or towards foreigners within their own communities, rather than at their own government and elite political groups. We must seek to understand this distancing in relation to the legacy of growing inequality after several decades of

neoliberalism and recent austerity measures, and the negative effect they are having on places like deprived areas of Stockton.

4.1 'Placing' Stockton: contrasts and commonalities

Within this research, 'place' is not ascribed a normative definition. Instead, it is located in the social interactions tied together within certain spaces (Massey, 1994). This emphasis on fluidity and networks reinforces the idea of places and the social interactions they encompass as 'processes' rather than static entities (Massey, 1994: 155). These interactions flow through time in non-linear ways – processional and ongoing. Places are made and remade on an ongoing basis. Furthermore, they 'do not have single, unique "identities"; they are full of internal conflicts' (1994: 8). Place does not have to exist simply through counter position to the outside although the particularity of linkage to that 'outside' is itself a part of what constitutes the place. This is the conceptual grounding for my notion of 'place' in this research. It was not presupposed what respondents' conceptualisations of living and being in specific places would be, nor was it assumed that there would be an inherent set of shared experiences from those living in a given area, nor that living in a 'deprived' area produced a normative set of experiences of that area or shaped its inhabitants in superficial ways.

Demographically, Stockton has a lot in common with many areas in regions around the UK impacted by deindustrialisation (in the North East, North West, Midlands, Northern Ireland, South of Wales and West of Scotland). There are points of similarity in regards to the types of housing, work histories of many living there and in relation to contemporary patterns of employment, socio-economic experience and of growing inequality with urban centres such as London. Administrative divisions were anecdotally referenced as being emblematic of divisions within this place. Stockton is administratively divided into two parts - Stockton South and Stockton North. Stockton South contains some of the most affluent wards nationally. At the time of conducting fieldwork the MP in office was James Wharton, a Conservative. The seat is now taken by Labour MP Paul Williams. Stockton North has been a Labour constituency since the 1980s. Stockton North contains some of the most deprived wards nationally.

Place 'matters' when understanding and critiquing austerity; the effects of austerity and responses to it vary from place to place. A 'juxtaposition and transparency of deprivation and affluence between often-contiguous neighbourhoods within relatively small bounded areas' (Webster, 2003: 104) was evident in Stockton. Those in the deprived areas of North Stockton experienced poorer health overall (Garthwaite and Bambra, 2017). The economic, health and spatial facets of this are significant. Places have experienced differing levels of service provision and cuts, infrastructure development, labour market changes and local council service provision (Dunatchick et al., 2015). This in turn plays a part in shaping the experiences and practices of individuals, such as mothers, who live in different places and use spaces in them.

4.1.1   Bounded spaces

Respondents characterised their place-making of Stockton through boundaries around and within it. Boundaries served to reinforce difference within Stockton such as between Hartburn, an affluent ward in contrast with the Town Centre, close by but demographically full of contrasts. They also reinforced Stockton's difference and distance from other places such as 'Down South' where there were more jobs and prosperity, or places farther away, such as Europe. These boundaries were not finite and invariable; rather, they were contested, ambiguous and porous. One of the ways respondents articulated their sense of Stockton as a place was through reference to space as demarcated by different sorts of real and symbolic boundaries. These boundaries, and the challenges to mobility they represented, were symbolic of the challenges many respondents faced. Boundaries can be articulated as constituting something which distinguishes 'between an inside and an outside' (Massey, 1994) but are inherently more complex. Boundaries around areas are not fixed – perceptions change, certain individuals cross boundaries at certain times, movement is always taking place (Webster, 2003: 99).

Firstly, respondents discussed their ability or inability to travel away from Stockton, such as for a visit or, more permanently, to relocate for work. The inability to move as articulated by poorer respondents was limited due to a lack of material resources However; they did express a desire to experience and encounter difference. The vast majority of respondents expressed a desire to not move away permanently. In fact, they emphasised that they really valued being from and being in Stockton. Secondly, many respondents, particularly from lower-income contexts, did not frequently move around within the borough. Those from more deprived areas did not generally go to more affluent parts. They spent most of their recreational time in the town centre, shopped there, and used services there. For some the lack of a car made it impossible to leave the town centre in an everyday sense. For others, there was little need as their basic shopping and socialising needs were met by the town centre.

4.1.2   Moving away

For respondents from lower income households there was a clear sense of boundaries around Stockton. These boundaries were connected to imaginings and memories, of people and experiences that were now inaccessible and at a distance. Some respondents expressed a desire to get out and see things in the wider world, but of being unable to do so due to material lack.

Pat is from Stockton and I met her at the women's group. She is married and has two daughters and two sons, all grown up. One of her daughters, Dee, also attends the women's group. She lives on an estate with her husband, and youngest two children. The house has ongoing issues with damp and they are often sick as a result. She prides herself on being a homemaker and providing for her children. She does all the housework and most of the cooking. The family budget for food shopping very carefully and cook a lot from scratch. Pat also prides herself on being able to make food stretch, like her mother did. She speaks fondly of her parents and the sacrifices they made for her and her siblings.

For those with limited resources, the distance from other places, ranging from sites of interest in the North East to large supermarkets, was often framed through a lack of mobility and choice, such as when Pat stated:

> *Love to go away. Love to take her* [daughter, Dee] *to York and show her me mam's place and can't do that now.* (Pat, Wave I)

The literature on geographical immobility and experiences of deprivation has outlined how the inertia and inability to move which shaped the experiences of respondents living on low incomes could be characterised as a type of poverty, of cumulative relative deprivation (Green and Canny, 2003; Webster et al., 2004). Despite the lack of prospects for work, the declining quality of social housing and general feeling that there were a lot of issues in Stockton, there was little discussion of moving away permanently. Most respondents genuinely enjoyed life in Stockton and didn't want to move permanently away as they would miss it. They also appreciated the close proximity to the countryside surrounding them such as the scenic Teesdale valley, and many recounted memories of camping, fishing and roaming the countryside as children. Several respondents tried to replicate these experiences for their own children through borrowing or buying second hand caravans for holidays. Respondents reflections on Stockton were interpersonal and embedded within wider social networks – relating to children and loved ones, what Stockton represented in terms of opportunities or lack thereof, of being within it and what leaving might represent.

Kelly lives in South Stockton with her two sons. She split from her partner between our first and second interview. They moved quite recently from a house that had damp, she was often sick then. She gets Carer's Allowance for her two sons who have additional needs. Kelly's early life was hard-her parents struggled financially and they had to make a lot of sacrifices. She trained in photography at Uni, but couldn't find a job. In the past she's felt stuck in Stockton but she thinks it's a nice place to raise children. She struggles financially, and her partner had taken out payday loans in the past; she had to get a Debt Relief Order. She volunteers at a charity. Kelly comes across as positive and hopeful. She finds her life stressful, but is full of understanding and loves her sons very much and wants to do everything she can to give them a decent start in life.

There were numerous reasons why respondents were unable to move away. Kelly had wanted to live abroad with her partner, but when they discovered their son had a disability, they realised that would not be possible:

> *I was resigned to the fact that I was stuck here. And I remember I had all these plans, me and my partner. We wanted to get away and live abroad for a year. It sounds comical now, but that was the plan. And when my son was born, it was apparent quite early on that something wasn't quite right with him. He was very poorly all the time. He couldn't settle with anybody. I decided I'd put off going back to work another 6 months, and that kept going and going.* (Wave I)

4.1.3 Moving within

Respondents tended to not move far from their own areas in day to day life, and other parts of the borough were described as quite different and embodying different feelings, with different types of people living there. One example from fieldwork stood out as typifying the lived experience of symbolic boundaries which divided different experiences of life in Stockton:

> *One Tuesday the group attended a coffee morning run by a Methodist church in Hartburn. The women of the Methodist group, late 50s and early 60s bustling around busily offering tea and coffee, confident and well-dressed. They had stylish designer framed glasses, while Dee had told us earlier that she been wearing glasses with the wrong prescription for two years. Pat asked for coffee with sugar to which a woman sternly replied 'you'll put your own sugar in, it's on the table.' They talked about practicing pilates, one woman had a tshirt from a run she had done in Newcastle. They had broad smiles and open gestures. They were at ease. A couple of the ladies told us about the area, a coffee shop next door. They serve fresh cakes and 'light bites', 'just' things like paninis and sandwiches. The lady lauded the coffee shop as being in a 'Victorian' style, having fine bone china etc. After a while, we made our excuses and left. We went back to Thrive and made our teas and coffees* (Fieldnotes, 15/09/2015).

> **Trish** is a mum of 3, married, with two step children. She is also a granny and her stepdaughters both had kids in 2016. She lives in social housing and is trying to downsize as the house is too large, and it is damp. She and her daughter are both mothering young children fairly close in age. They attend the local Children's Centres and are on the Parent Forum, they do a lot of classes and training to acquire new skills. They also volunteer at the centre. Trish comes across as a 'no nonsense' kind of lady. She lived as a single mum on a low income in Thornaby when she had Jodi. Jodi gets on well with her stepdad now, and mother and daughter appear to have a close bond.

The town centre was a focal point of many respondents' lives. Trish's description of her day was quite typical for respondents with younger children, and illustrated how the town centre was an important space in her day:

> *That's all I do. Walk round, do my courses. I could say I near live in the* [children's] *centre cos I'm there near often enough. That's all I do really. I have my break on a Thursday, I go see me mam and we go out, have a game of Bingo, and town, town town.* (Trish, Wave I)

One of the major redevelopment projects in Stockton in recent years had been the regeneration of the high street. Certain changes, such as repaving and widening the high street, getting rid of some market space and opening branches of popular chains such as Costa Coffee, Topshop and Halfords, were prompted by the Portas Review (2011) (a report into the retail sector) and implemented by Stockton Regeneration Scheme. Respondents felt one of the aims of the regeneration had been to bring wealthier residents into the town centre to shop. They had, however, resisted coming into the space and continued to shop at retail parks to avoid the town.

Figure 4. Market day on Stockton high street

> **Emily** is quite quiet. She lives in Stockton South with her husband and two children. She works for a housing association. In the past was made redundant by a local council where she was a welfare rights manager, due to cuts. She is now doing a part-time Masters. She speaks passionately about educating herself on, and advocating on behalf of, her daughter who had health issues the NHS were not adequately dealing with. Her husband was made redundant from his IT job in the past and there's worry that he'll be made redundant from this one. She enjoys living in Stockton and thinks the Teesside area has a lot to offer people.

As Emily discussed:

> *The town centre has changed beyond belief. But the money is not shopping in the town. People with money are shopping at Teesside Park, Yarm, boutiques. I know the council are trying very hard to regenerate, but…* (Emily, Wave I)

Kelly expressed a similar experience:

> *It was 'Stockton's for the other people' and I was shocked because I always use Stockton and I always have with my mum and I think the market's great, I think it's just a nice place to be. And I like hearing all the different languages, you never had that when I was growing up. And now you can sit by the fountains and see all sorts of people and hear all sorts of people and it reminds me of being in the city. I'd ask had they not been there recently, and they'd go, "oh no, we wouldn't go in there. We wouldn't go to Stockton"* (Kelly, Wave I).

The regeneration attracted many chains and big businesses, and created a veneer of newness in the town centre. However, many respondents felt that although the town centre got a face lift, this didn't change their material reality. Garthwaite (2016a) has demonstrated through ethnographic fieldwork that those from more affluent wards in Stockton had little understanding of the struggles facing those living on low incomes that lived very close by, but some passed judgement about the perceived laziness of their lifestyles.

It is important to contextualise the regeneration of Stockton high street within the 'placed' consequences of austerity. There had been a proliferation of new businesses, displacing old traditional shops and market traders. There was also a stark contrast between these new shops and the expansion of certain aspects of the 'toxic' high street, such as a proliferation of betting shops, charity shops and a Pound Pub (Townshend,

2016). Opinions about who it was redeveloped for were ambivalent and mixed. There was a general feeling, however, that many in Stockton were doing badly under austerity, and this costly regeneration by the council sat uneasily with them, at a time of so many cuts.

Figure 5. Pound Pub on Stockton high street

Kelly described how people in the area she lived in now (she lived in private rental accommodation in a relatively affluent ward) did not like to venture into the town centre at all:

> *The attitudes of people in places like Hartburn and Fairfield, towards council money in the town centre that they didn't shop in, because Stockton's full of, and this is the quote from them, 'full of charity shops and bookies and things', they were horrified and really angry at the council.* (Kelly, Wave I)

While these individuals felt the council money had been wasted on the town centre because it was 'still' full of the sorts of shops they didn't like, respondents, particularly those at the women's group, had a different view about the town centre redevelopment. The loss of the market in its' traditional form was seen as a major blow. This was a space that had been very important as a place for shopping, leisure and a social space. There was a wider concern with whom the redevelopment was for, and a lack of respect for legacy and the past:

> *Well, they've ruined Stockton. In the 1960s if you look at the old photos, there's some lovely historic buildings. They've pulled 'em all down and built the Castle Centre. We had the widest high street in England and a famous market that used to have bus trips in. People on that market earned a living from working two days a week. And times got harder, and the council in their wisdom decided to uproot the high street and refurbish it. Then we got Teesside Park, which took a lot of trade away. And it's just been a case of charity shops, bingo places, the big shops, Littlewoods left, M&S did expand a bit. It's as if nobody has had any foresight to hold on to our heritage. They've made money by knocking down and rebuilding instead of rejuvenating.* (Anne, Wave I)

Anne comes across as quite matriarchal and appears to be the boss in her large extended family. She lives in a council house with her husband, and at different times her sons and grandchildren have lived with her. She used to own a home and be a market trader, but for complicated reasons she gave it up and gave up the house. She is passionate about community organising and volunteers a great deal of time to it. Anne believes that, as a pensioner, she gets off lightly when others relying on social security have to deal with cuts. She says she's never had it so good. She is very energetic, passionate, and keen to debate. She was diagnosed with diabetes in late 2016, and suffers from depression, but remains positive about her health.

The regeneration had, in some ways, altered the visual landscape and changed the topography of the town centre. But the changes hadn't necessarily facilitated the growth and development of community life or enhanced the lives of the people living there. They couldn't always afford to use the new Costa Coffee on the refurbished high street or shop in Topshop. They felt that the regeneration had been to directly attract the sort of people who, as Kelly had stated, didn't like to go into Stockton town centre. This brings into question the area-based policy focus of recent years, illustrating the failure of area-level interventions which do not engage with the people who spend most time in a given space (Crossley, 2017: 104).

4.1.4   The sense of time

Past and future time were frequent themes in the research. This was owing in part to the longitudinal method – asking people to recount their past experiences, compare and contrast, and imagine the future led to a bringing to the fore of 'change and continuity over time as a central focus of analytic attention and a conceptual driver' (Holland, 2011). Time in the research and analytical process was framed as having three main components. Discussions of time was loosely divided into 'biographical', 'historical' and 'generational' accounts. This has been discussed extensively in the Holland (2011) literature. 'Adding time into the mix' (Neale, 2013) highlighted the significance of this as a conceptual underpinning of respondents' lives. Biographical accounts linked time to the personal and individual – individual lives were framed through agency, causality and consequences. 'Generational' time referred to experiences through generations across generations and contexts. Finally, historical time related to how respondents located themselves in different external events, and wider social and structural conditions, both local and global.

Time was described in complex and multi-dimensional ways – embedded in a socio-historical past and projecting into the future (Adam et al., 2008). Articulations varied among respondents, but two distinct themes emerged. Firstly, in a personal sense, some respondents saw their lives as better now. They had lived in other places and had been unhappy, but upon settling in Stockton had found it a good place to raise children and geographically in a good location. For some, their present was financially secure. They were getting their children the best education they could, and their expectations for the future were generally positive. A more prevalent response, by and large those from lower income contexts, was ambivalence about the present, but holding a great affinity for the past they shared with a different version of Stockton. As the following section illustrates, the past held great resonance for them.

4.1.5   Looking to the past

The 'meaning' of life in Stockton for many participants was frequently ascribed through the availability of traditional forms of work (in heavy industry or manufacturing), traditional family structures, and rooted in an ideal of a working class, and male breadwinner headed family. Those who had grown up in Stockton (nine out of fifteen respondents) recalled their families, family history and how families moved to the area. They also focussed on the changing nature of work, community and family life. The following quote, from Kelly, was a window into the enduring insecurity of work in the area from the 1980s and the health consequences of it:

> *I was born in Stockton, in Hartburn. My dad was a docker. He lost his job when I was 7, when Thatcher changed the law. He said she'd never be able to do it. She'd never be able to change a law to suit herself, but she did. He lost his job and with his redundancy himself and me mam opened a hotel right near town. We lived there 'til I was 14. They worked night and day. They'd both get up around 05:30 to get breakfasts ready. We were all living in one room on the ground floor. We didn't even have our own bathroom. I wouldn't see them on a morning from being 7. It was awful for all of us. Me mum had some sort of nervous breakdown when I was 14 and we left, we moved to Fairfield. She still lives in that house. My dad died (of cancer) two years ago in December.* (Wave I)

The dynamics of inter-generational relationships and identities, and the shifting structures of family and kinship are of significance (Emmel and Hughes, 2010). Research has also shown that the needs and aspirations of families shift dramatically over time as children grow up and family members become elderly and require care (Jupp 2013). Respondents emphasised different aspects of time, and different times held resonance and meaning for them. Trish and Jodi spoke largely in terms of the recent past and of the near future. Both had young children and were themselves mother and daughter. They lived and cared in similar contexts but in many ways their lives were different– Trish had been a single mum when Jodi was small, but Jodi, although she lived with her partner, might experience different insecurities owing to welfare reforms that are less generous to young mothers.

> *It's different for me because I was a single parent with herself and it was only me and her til she were four year old. So…now having two kids and a partner, I wouldn't say a weight has been lifted off me shoulder but he does help around the house a lot, with the kids. He provides for the kids. Would I do anything different? With me daughter…I did have me family and that as well. She just never had a Dad to go to.* (Trish, Wave I)

The following fieldwork extract indicates how many members of the women's group saw their families as they extended back in time in Stockton as more solid and 'together' than their families today, which are fragmented, disharmonious, and not close, physically or emotionally:

> *Anne said in 'the old days' the family was a unit, if there was a problem you could go live with a relative, or take kids in if others didn't have enough money. Families stuck together, pooled resources and time. Anne's family were blacksmiths on the North Yorkshire moors. Now her family is fragmented, same as Pat's family. Pat doesn't have a good relationship with two of her four children.* (Fieldnotes, 13/10/2015)

Pat stated that new mums 'these days' have a harder time because they don't have the same type of support network she had:

My niece has just had a baby, and there was a young girl [in the hospital]*, she had her first baby and she was just left to get on with it. We got taught what to do, you know. The first feed, how you change them. First baby and she was given nowt. My niece went in to see if she could help her. We would have had the nurse, I would have had me mam and dad and me husband.* (Pat, Wave I)

There was an internal tension within some of these narratives. For example, Anne still did spend a great deal of her time and energy on caring for her extended family. She took in grandkids and sons for periods of time, co-operating closely with her son's mother-in-law regarding ongoing social services interventions for one of her grandkids. There was nothing in her current everyday life that would suggest these values were a thing of the past. Pat's narrative also suggested that women were more supported as mothers in the past, although her experience of that new mum's life was only second hand, and quite limited. Respondents strongly emphasised the importance of family and community ties, problematising modern and (perceived) less cohesive family formations and practices. There was a tendency to see the past as better than the present, which may be what Routledge et al. (2013) described as the psychological and wellbeing promoting act of nostalgia, whereby the expression of nostalgic sentiment can be used to enhance emotional wellbeing through heightened positive mood, bolstering a sense of social connectedness and existential meaning (2013: 812).

4.1.6   Imagined futures

Respondents imagined future, the future with more playgrounds, open community centres and activities for young people jarred with their expected futures, ones in which welfare reform intensified, the mould on the wall didn't get treated, health got worse, and no jobs came. Respondents described being unable to move away from material circumstances that were less-than fortuitous or stopping them, their partners or their children from getting on. A common reference point was the lack of work, and what this meant for 'getting on'. As Anne (Wave II) stated, 'there's not much chance of getting on in Stockton, cos there's not much jobs.' Central to the idea of 'getting on' is mobility. Mobility and 'control over mobility, both reflects and reinforces power' (Massey, 1994). There was the feeling that the type of education, training and apprenticeships offered weren't reflective of the types of work available. Without decent paying work, there was the feeling that young people had not got a lot of prospects for the future.

The prospects for work are just not there. It's alright to say 'we'll send you to college, get you an apprenticeship', that keeps you ticking over and over, so they're off the books. And then at the end of the course there's no job for them. There's just nothing there. There's no hope for young people. I've got a grandson, 16 today. He's going in the army in September. (Anne, Wave II)

Lisa worried about the prospects for work in the future for her teenage children:

It does worry me, it really really worries me. My son was at Stockton College, one of the main reasons we moved him from there to Middlesbrough was that I was worried some of the courses there were just like holding pens, before they bump some kids out. Nowhere near the kind of qualifications and skills they'd need for the local labour market. I hope they'll be able to give him 3 or 4 years and give him a trade, but it does worry me. I need them to do the absolute best they can because I know it's not easy. (Lisa, Wave I)

Lisa is originally from Durham. She lives in South Stockton with her mum, husband and children from her first marriage. Both herself and her husband are divorced, and did bad financially out of their marriages. They live in private rental and move around a lot. She has nearly always worked in the public sector, went on an Access course when her son was 3, then on to Uni. She's now a student. Her husband is studying photography. They have struggled financially, had a Debt Relief Order, and moved in and out of low paid jobs. These days Lisa is doing fairly well, working on her studies and making sure her kids are happy.

The impact the absence of jobs and livelihoods on families was keenly felt, as the following fieldwork extract indicates:

> *In Redcar there's been 2,000 job losses. People will need to leave if there will be a future for their families. From the 1980s they took job security away. Shipyards, ICI and steel works, all gone. So many men without work, and what does it mean for their families?* (Fieldnotes 13/10/2015).

These perspectives, on opportunities and limitations in Stockton through different stages of the life course and different times; from birth, to the end of school, to a different time entirely when Stockton was 'better', represent some of the issues respondents had and have with Stockton and feelings of ownership or control over this space. They were embedded in an economic and social history in which financial successes and struggles came and went; tradesmen doing apprenticeships, embarking on long careers and losing out to ill health or redundancy, jobs and job losses in the chemical or steel industries, waves of industrialisation and deindustrialisation, the expansion and closure of the docks, up to modern day job insecurity and austerity reforms.

4.2 Stockton and community

The concept of 'community' holds multiple meanings, providing us with many possibilities and paradoxes. Urry (2000: 134) has stated that 'to speak of community is to speak metaphorically or ideologically'. Despite its' ambiguity, community remains a common point of reference, including for policy-makers (Crow, 2013). It is also an important factor influencing health inequalities (Syme, 2004). Bell and Newby (1971) have presented three useful ways of conceptualising community – based on geographical proximity; community as a local social system; and based on close social ties that exist across and between places. Wright (2015) has distinguished between 'neighbourhood' and 'community'. She distinguished between community, which was defined through relationships and interactions and neighbourhoods, seen as spatially demarcated. Neighbourhoods are sometimes seen as 'fluid and non-bounded, their make-up partially reflects broader macro-level social and economic processes that have accumulated over many years and decades' (Pearce et al., 2016: 194; Wacquant, 2008). It also possible to view community as a mix of all these factors.

In my research, a community was framed as a group of people who were linked by social ties, shared common perspectives, and engage in joint activities in geographical proximity (MacQueen et al., 2001). During

fieldwork and analysis it was acknowledged that the concept of 'community' was used by respondents in ways which were sometimes unclear. It was embedded in a set of values, aspirations, identification or dis-identification with contextual specificity. People's sense of 'place' was intimately bound up with their social relationships and communities and community belonging – they had an affinity to each other based on a shared understanding and shared values.

4.2.1   Community and everyday life

Respondents talked about how important a sense of community was. Some respondents had moved around different estates and areas, and were able to contrast their experiences of community in these different places. Pat talked about the sense of community where they used to live, which was very positive. She contrasted that to the area now, when there was too much traffic and people stay indoors on the computer or watching tv:

> There used to be [a community feeling], *in the old street. We knew everyone, you'd say 'good morning' and you'd stand outside ages talking to your neighbours. 'Til midnight on a nice hot summer. You used to sit out for hours but you can't do it at this road. It's a main road. Here you say good morning to 'em when you see them but that's about it, there's no spirit there. You don't even see the kids playing.* (Pat, Wave I)

Emily, who lived in quite an affluent area, had a positive perspective on her area:

> *Our street is 1950s houses. It's quite mixed really, the people that live in the street. We moved there because we're close to the children's school, you can walk to shops and the pub and the park, I didn't want to be in the middle of a big housing estate. I liked the thought of living in a community where you could get out and walk to places easily and obviously wanted to be close to family cos when you have kids it's really good to be close to grandparents that can mind em. So I'm really happy about where I live, I wouldn't want to live in a different part of the town.* (Emily, Wave I)

Respondents were clear that a strong sense of community and a positive neighbourhood were important for them. To be able to rely on and know your neighbours, share food and childcare, as respondents discussed above, was important for a sense of belonging and for a good quality of life. Over the course of longitudinal interviews, conflicting opinions emerged about how 'community spirit' was experienced and how this had changed and evolved over time. Respondents expressed a view that increasing instances of not knowing your neighbours, people moving in and out of the area and anti-social behaviour had led to deterioration of 'community feeling'. Their explanations fit neither the policy rhetoric of the 'Big Society', nor anti-social tropes used to characterise people in poorer communities – the lived realities were more ambiguous and complex.

'In policy-making, the pursuit of a 'community' as a normative ideal is often linked to the identification of the absence of community and the presence of social problems in certain 'problem areas' (Crow, 2013). McKenzie (2015) has argued that the notion has been used in government policy for decades to emphasise that working-class people and neighbourhoods lack what is needed to be of value (McKenzie, 2015). In the context of austerity this is relevant – as community resources are diminished in those areas most needing them, the rhetoric of the 'Big Society' as one such manifestation is especially stark. Under the guise of giving

power to localities, devolution of the responsibility for providing crucial services took place alongside cuts to the budgets from which local authorities would provide those services.

> *'We will give local councils the freedom to spend money on the things that matter to local people, and give local communities more power over how money is spent locally'.* (Conservative Party 2010: 3)

The 'Big Society' rhetoric has pinpointed middle-class voluntarism as the utopian ideal at the heart of Coalition's project of localism. Certain homogenising ideas of community have been played up, which has been intensified under austerity. This is particularly problematic in the disadvantaged areas affected by state retrenchment (Featherstone et al., 2011) where charities such as foodbanks step in where the state has retreated. Dowling and Harvie (2014) have pinpointed two of the main aspects of the Big Society rhetoric as the retreat of the state in service provision, the expectation that volunteers will plug any gaps in services, alongside the devaluing of the role of social reproduction, 'placing the associated costs onto the unpaid realms of the home and the community' (2014: 870). It simultaneously allowed tasks associated with social reproduction to be 'harnessed for profit – thus providing a potential source of new capitalist accumulation, enabling an increasing 'financialisation of daily life' (Martin, 2002) and a deepening of capitalist disciplinary logic (Dowling and Harvie, 2014: 870).

Figure 6. Foodbank collection at Thrive

4.2.2   Changing spaces and feelings of community

The removal and closure of commercial and community services previously situated in the locality was perceived to have changed the practices of those who used the services and thereby weakened the networks and relationships that had previously operated within these spaces. Pat and Dee, a mother and daughter, described both of these factors in our first interview. Pat described her estate and how the shops had all closed:

> *Well basically I've been on [the estate] since I was 7. So like, I have seen the changes. Like, we used to have a good set of shops, that's gone. And they're derelict. I think there's only one shop now, isn't there. There were all kinds of shops there once.* (Pat, Wave I)

Dee, her daughter, described how there was a feeling that it wasn't a safe place for children to be out playing:

Kids could play out before. When we were kids there was no fear. The kids now, they daren't play out. It's cos there's that fear. [The estate] *has got such a reputation.* (Dee, Wave I)

Dee is Pat's daughter. She's in her mid-twenties, and lives with her parents and brother. When she was a teenager she was in a car accident which had a very negative effect on her. She and her mam are sick a lot – they have head colds every couple of weeks from the damp in their house. Dee loves history and family history in particular. In recent months she has availed of a grant to set up a small business which researches and produces family trees as well as other products. She was able to sign off JSA and is now working to get her business up and running.

There were conflicting opinions about the extent to which 'community spirit' existed in either area. This was depicted in two ways. Firstly, through a deterioration of 'community feeling', not knowing your neighbours, people moving in and out of the area and anti-social behaviour. Secondly, it was mediated through the removal of community-based assets such as community centres and the services that existed in them. Jill, who lived in a deprived area, described this set of circumstances:

> [A 'community' feeling] *is getting less and less. People are dealing with their own issues, it is harder to think about their neighbour, or Joe Bloggs over the road. The added pressure is there for people.* (Wave I)

Jill lives in North Stockton with her partner, two sons and eldest son's girlfriend. She has been a single parent, and lived on a low income while claiming benefits in the past. She lives in private rental accommodation, her partner works for a housing association. They had hoped to buy a house in the past, but something always got in the way. Now they'd be paying much less in monthly housing costs, and that annoys her. She's the one in her house who does most of the housework and the cooking but rarely complains, just gets on with it. She's from Stockton and she has a large, close knit family who all live nearby. They often go on camping or caravan holidays. She's very passionate about the local community and is well known around Stockton.

Furthermore, her narrative illustrated how, not only were people she knew going through more hard times, but community resources were also being cut, causing further challenges:

> *In my local area we had a massive community centre. It was a place for people to go to meet, to have a moan, to have a coffee but also to get new skills, to do a computer course, there was a youth club, things for young people to do. There was a lot in that community centre and when the money was pulled that estate was devastated. That was their little sanctuary if you like.* (Jill, Wave I)

Emily, living in one of the more affluent parts of Stockton, and although she liked her area, she felt that some of the middle class people were more atomised. They were busy with work and didn't get to know each other. She thought the areas where she worked had better community feelings than where she was:

> *Community spirit is a difficult thing because I don't believe anymore that there's a community of neighbours in the sort of area we live. It's a difficult one isn't it, community. I think in some area where people have lived*

there for a lot of generations and all their families are nearby, for example some of the areas I go to with work, people know each other a lot better in the street, they're popping over to each other's houses and their relatives nearby. (Emily, Wave I)

The question of where community 'exists' was not easy to unpack. Respondents were sure there was a community out there somewhere but wouldn't say that they had a community of people on their own doorstep they would be able to rely on. Their idea of where a meaningful community experience existed was often 'elsewhere', and their own communities were often seen as lacking. Shildrick et al. (2012: 163) have stated that 'living and growing up in neighbourhoods of multiple and concentrated deprivation meant facing wider disadvantage beyond the difficulties in accessing decent, lasting employment'. This is relevant particularly for respondents from more deprived areas. These experiences of perceived declining community might contribute to the increased stresses and mental health issues respondents reported experiencing.

As opportunities for social engagement and for local people to build local networks and local communities decline, risks to mental health and wellbeing may increase. Himmelweit (1999) has argued for identifying policy changes that would weaken the hold that inequality has over lives through removing the social structures that create perverse incentives and that disempower people. As many people in poorer communities spent their time on activities necessary for their survival – cycling in and out of the 'low-pay, no-pay cycle', engaging in Workfare or applying online for jobs they were not suited for to satisfy a Job Centre Advisor. Causing people to spend their time on the struggle to survive prevents them from using their time for creative endeavours and life-enhancing activities for both themselves and their wider communities.

4.2.3   Spaces of vulnerability or flourishing

Experiences of uncertainty for the future were consistent with findings from Edwards and Irwin (2010) and Emmel and Hughes (2010) who found that a long-term experience of inequality shaped life trajectories. Emmel (2017) characterised these experiences as the 'longitudinal social spaces of vulnerability' and highlighted that basic material needs, when left unmet, curtail 'the range of possible ways of being' (Doyal and Gough, 1991) and the capacity to be. This is mediated through access to service providers (public and third sector). In keeping with Emmel's argument, this thesis is not concerned with 'an idealised account of society in which autonomy is defined as a desired state that allows all citizens to choose their mode of life and access to opportunities' (Emmel, 2017: 19). Rather, I argue that inequalities persist and can be exacerbated for those who are unable to develop the possibility to flourish should their material and basic needs go unmet in a context of retrenched provision under austerity. This may increase vulnerability and inequality.

Emmel (2017) suggested that social, economic and political relationships that individuals engage empower or disempower, producing vulnerabilities or, conversely, the ability to flourish. Empowerment is 'a multi-level construct that involved people assuming control and mastery over their lives in their social, economic and political environment' (Wallerstein, 1992: 197). In this sense I refer to the flourishing of collective groups rather than focussing on individuals (McLaughlin, 2012). 'Opportunity structures' are the social features of a place that affect health through the opportunities they provide, or lack of opportunity afforded (Macintyre et

al., 2002). Such factors might include public transport, access to schools and childcare, community centres, a local GP and access to affordable, healthy food. Respondents expressed how important it was for them to have a community of people around them that they felt an affinity with, that there were amenities nearby, and that there was the opportunity to be sociable. One of the consequences of austerity is that the ability to flourish is being undermined. This section illustrates the opportunities to flourish presented by Sure Starts, and the issues facing them as a consequence of austerity.

4.2.4   *Spaces to flourish: Sure Starts Children's Centres*

A focus on services and spaces to flourish for the collective good can illuminate the damage austerity is causing, particularly in already-unequal places. Sure Starts were one area that was universally recognised by respondents as being of immense importance for a wide variety of reasons. Sure Start centres were developed as part of Labour Government (1994-2010) initiatives to tackle health inequalities and are an important resource in less affluent communities (Exworthy, 2003). They took a community and area-based approach to support, representing possibilities for a 'solidaristic and universalist approach to risk' (Featherstone et al., 2014; Jupp, 2013). The Sure Start programme represented an attempt to examine issues and services in a holistic way within particular localities (Jupp, 2016). It was announced that as of April 2018 all twelve Children's Centres were abruptly closed, with four transformed into 0-19 'Family Hubs' (Stockton-on-Tees Borough Council, 2017). This may yield positive results if more families and young people are able to utilise services there, but should be examined more closely.

Geographical research into the experiences of families should attend to time as well as space in tracing how families may move between problems, troubles, resolutions, coping and 'normality': both within cycles of the everyday and also over the life course (Ribbens McCarthy et al., 2014). Within current contexts of increasing poverty and pressure on disadvantaged families, the type of everyday pressures experiences may be concerned with the short-term material demands of food, heating and housing, 'the politics of daily life' (Wekerle, 2004: 250). Mapping such material constraints brings back into view what may seem an obvious link between conditions of poverty and family 'troubles' (Dermott, 2012). Crucially, they show how the resources and risks navigated by families are not just located within families themselves but within the wider landscapes in which they are placed (Jupp, 2016). The importance of uniting the different, relational components of places and people which enhance or detract from wellbeing is emphasised here (Atkinson, 2013).

The children's centres had really helped Becky when she moved, as she was shy and found it hard to make friends:

> *It was the health visitor* [who told her about the Centre]. *I started using the one at Roseworth and I did a cooking course. So when we moved here I knew about that one so I thought 'right, better go there and make new friends.' And I'm glad I did because I'm a really shy person and I haven't got the confidence to go up to say anything. It's really helped me with my self-esteem, and it's helped* [her daughter] *with her separation anxiety. It's been really good. I enjoy using em. It's like the little courses you do, they benefit you instead of*

benefitting them. We're trying to get more people in but they won't give us anything to get them in, so we keep bugging them to let us do things. (Becky, Wave I)

Becky comes across as quiet and relaxed. Becky lives with her little girl who is three. She lives in a 'nice enough' flat, although there's some dealing that takes place around the area. She has had a tumultuous upbringing, moving from London to Hartlepool, back to London and back to Hartlepool to be with either her mum or dad. She doesn't have any relationship with her dad any longer. Her mum is now divorced as her ex-husband was violent and an alcoholic. She has a sister in Hartlepool. Becky's partner was made redundant at the SSI steel works which closed just before Christmas 2015, and finding another job was a very stressful ordeal for them. Becky gets depressed; she feels a lot of weight on her. She is very involved in the local Children's Centre; she does courses and volunteering there. She has ambitions to work in early childhood education.

Under the Coalition (2010-2015) and Conservative (2015-time of writing) governments, funds to early years' education and Children's Centres were cut substantially (ONS, 2016). In Stockton, a private organisation had taken over the running of several of the centres from the council. Most of my respondents made use of the Sure Starts, and they were hugely important resources for the mums of younger children. However, they were not uncritical of the ongoing privatisation and anti-social behaviour taking place in the areas surrounding the centres.

Jodi is a young mum, at our last meeting she was 18, with a little toddler and another baby on the way. She lives with her partner who is out of work and can't read well, but does bits and bobs for extra cash. She relies on her mum Trish for a lot of advice about how to take care of her son and how to manage the bills. She didn't get a chance to finish her A-levels because she had her son. She has embraced motherhood and appears to take it in her stride. She had a C-Section and a difficult labour but wants her next birth to be a natural one if possible. She is glad of the Children's Centres because she is able to continue her education and meet other young mums.

Here Jodi describes unsafe conditions near one of the centres:

> *The Sure Starts, they've all been took over by a company from Manchester. They only get so much from the council to what Sure Start got. We haven't mentioned where [one] centre is based either. It's based under flats, which are full of people who've come out of jail, drugs, alcoholics. One of the areas where the kids play, you've to go out every morning and clean it; needles, broken glass and that. We've told them to put a cat-proof net but they haven't come through yet. It's the best idea cos the staff has said they've walked down and seen needles. And if the kids are playing and they chuck something out they'll hit the kid. It's not fair. It never used to be like that, now it seems like it's all for prisoners and that. And you see them all the time stood outside, and you think "that shouldn't be beside the kids".* (Jodi, Wave II)

Furthermore, Jodi explained that it is not just Sure Starts, but resources in the community more generally that children and young people need.

> *They need more play areas. More community centres. Like they've got one up the end of my road but it's always shut, I've never ever seen it open. There's one behind me mam's but nobody goes there. They moan about obese kids but there's nowt for them to exercise. Need a little place where you go to, a little park.* (Jodi, Wave II)

Jodi became a mum for the first time while a young teenager, and was pregnant with her second child at the age of nineteen. Research has shown that motherhood brings 'increased responsibilities, social recognition, and a sense of purpose for young mothers' (Ngum Chi Watts et al., 2015). However, there is an increased risk of judgement and stigma for women who become mothers when they are young, particularly those from working class communities (Wenham, 2016). Jodi had used her experience to her advantage, and had gotten involved in recruiting other young mums to participate in the Fairer Start scheme run by Stockton-on-Tees Borough. She felt that it empowered her, gave her and her son a social outlet, and helped her meet other mums.

Trish, Becky and Jodi were all on the Parenting Forum for their local Children's Centres, and took an organising role in how the centres were run. This included trying to get more funding so families without a lot of extra money could still do activities.

> *They could do with more funding. We've been trying. We got one lot, we went to Stuart's Park for the day, all the families come with their kids for the day. There's nowt for the kids to do on the holidays. There's a place where you can pay, go in and play but…There's nothing for the younger children round this area anywhere that I know of. It's all for older ones. One near us has a youth centre. Nothing for me younger one. You can go to Fun City but not a lot of people have the money. This summer most of the 6 weeks it was raining. Nothing to took the bairn to. Just boring, the full six weeks. And when you've got two very hypo kids, it's a nightmare.* (Trish, Wave II)

The options available to mothers using the centres depended to a large extent on the areas they lived in. This meant, for those in the less affluent areas of Stockton fewer resources were available, and those living in these areas typically had less income to privately purchase services. As I shall discuss in the following section, these were not simply down to individual choice, or random chance. The limitations of their choices are about more than geography, demographics or personal preference. 'Choice' is a contentious phrase – not all choices are freely made, and for those with fewer resources, less so. As Popay et al. (1998: 640) have stated, 'people make their own history (and future) – but not always in conditions that they have themselves chosen'. They are constrained by broad political and economic decisions which are made on multiple levels. The capacity to flourish is crucial to achieving good health and to alleviating health inequalities. The structures, policies, laws, and incentives, financial or otherwise, that contribute to family, work and education must emphasise this (VanderWeele, 2017).

4.3 Local inequalities in Stockton

4.3.1 Everyday life in unequal places

The children's centres discussed above were identified as a place of flourishing by mothers. However, access to services depended to a large extent on where mothers lived. For those in the less affluent areas of Stockton, fewer resources were available to them as cuts and closures had affected children's centres in their areas. There had been cuts to services in the Sure Starts, such as breastfeeding support services at a children's centre based in the town centre, where mothers attending got their lunch. The mothers felt they had a lack of choice, both of the centres they could access and the types of services available at them. Boundaries can serve to separate the world into 'us' and 'them' as well as differentiating and providing context and meaning (Stoetzler and Yuval-Davis, 2002).

Jodi and Trish were involved in the Parenting Forum in a number of children's centres but still felt disempowered by how the catchment boundaries had been recently changed. This choice, by others with decision-making power, outside of their control, left them at a disadvantage and feeling stigmatised by virtue of where they lived (McKenzie, 2012).

> *The catchment area isn't good. I think there's a lot of poor* [people]. *Our catchment area, we don't like it do we. It's weird the way they've gone round. The map, it's like they don't like us, it's like someone's just gone like that* [draws line]. *I'd like to bring it up.* (Jodi, Wave I)

Many respondents lived in areas with multiple and complex issues of deprivation, clustered around a few specific estates. Dee had been told to take the name of her estate off job applications, to only use the postcode as the estate had a bad reputation. This is a pertinent example of territorial stigma (Wacquant et al., 2014) whereby certain places are rendered tainted or blemished. Trish explained the situation on her estate, which was the same place quite a few respondents lived or had lived at some point:

> *It can be nice round here, but lately, it's different. Things are different from when I first moved in. It was horrible when I first moved in. Police round every night. Then things quietened down. Last couple of months it's changed. Young guys on motorbikes round the streets. Where I live on the corner on a morning you get drug dealing. And they're there every morning. The atmosphere's not the same anymore. There's a community centre but it's not open. Jodi went to a meeting with the housing association a fortnight ago, she brought it up that there is a community centre there and to do something with it cos it's just getting ruined.* (Trish, Wave I)

This relates to work on place and stigma – places can obtain a 'spoiled identity' and be discredited (Bush et al., 2001; Wacquant, 2007; Wacquant et al., 2014). Garthwaite and Bambra (2017) found that stigma was having a negative impact on the mental health of those living in poorer parts of Stockton. Numerous studies have also reported that the stigmatisation of place can be linked with both poorer health and lower life satisfaction (Bush et al., 2001; Cattell, 2001; Keene and Padilla, 2010, 2014; Kelaher, 2010; Popay et al., 2003; Thomas, 2016). Respondents had, in many ways, accepted that authorities outside their control were imposing cuts and reforms that were altering the dynamics of their communities. Our discussions lacked opposition or practical challenge to the cuts. Their reflections on everyday life under austerity mirrored Garthwaite and Bambra's

(2017) work on health inequalities in Stockton, whereby 'fatalism' and generally low feelings of control were clear.

Significantly, respondents did not report feeling directly stigmatised. This might be, for example, that many respondents were involved in community organising and articulated the issues differently. However, they lived in places which they felt had the markers of stigma attached to them, and some discussed their estates as having negative attributes. Living in a disadvantaged area does have negative effects, and it is possible to say so 'without leaping to deterministic conclusions about the negative nature of those effects' (Crossley, 2017: 48). This reflection does not intend to undermine the legitimacy of feelings discomfort with visible drug dealing or the deterioration of a certain area's visible character. Rather, I have intended to demonstrate that, while 'place matters', it is not necessarily in the way politicians or the media may articulate – for example, through narratives of 'Breakdown Britain' (Social Justice Policy Group, 2006). Rather it is to demonstrate that the problems facing areas politicians might label 'problem areas' are of legitimate concern for those living there and are explicitly linked to policies enacted politically, particularly under austerity. Pearce (2012) has found that austerity will have implications for future health inequalities as a likely implication of decreased investment for communities with multiple social problems might be that such places become increasingly stigmatised. This is likely to be detrimental to the health of local residents.

4.3.2   'Placing' inequality in an age of austerity

Both an individualised focus and large-scale macro-level analysis risks masking everyday life and inequalities in Stockton. Garthwaite (2016a, 2016b) has demonstrated in her work on food bank use in Stockton-on-Tees that Stockton is both a highly unequal place in terms of health, life chances and area composition. In Stockton, there were those who lived in relative comfort and affluence, experienced relatively better health, and had a wide variety of resources and choices available to them, and there were those who did not have the same opportunities. While some had familial support to draw on, they had less money, fewer job prospects, less chance to access further education and poorer health. They had less choice about what food to eat, where to go for recreational activities, what mode of transport to take, what job to work in. My research is concerned with understanding, indeed, how people perceive their everyday lives in a time of austerity. But it is also about how inequalities intersect and amplify.

Anne, a pensioner, had lived in Stockton all her life and pointed out some of the issues she saw; from deprivation manifesting itself through drug use, food poverty and poorer women resorting to sex work, to some of the ways those in power masked inequality – revamping the high street or training courses to keep young people off the live register:

> Stockton is great, but when you scratch the surface there's a lot of things…there's an amount of homelessness, there is a lot of drug use, and I do believe we haven't got a dedicated drugs team here now. Stockton centre looks lovely but there's some deplorable living conditions not so far from it. On the outside it's fine, just don't look too deep. (Anne, Wave II)

Kelly shared some insight into the attitudes some people in her affluent community held about poorer parts of Stockton. They had, as Jensen (2014) has described, adopted a new form of 'common-sense understanding' about the lives of those in less advantageous positions, linking their poorer outcomes to a 'shirker' discourse framed in a neoliberal, individualised context.

> *There's a huge inequality in Stockton. In Stockton South, in particular, where I live, you've got Yarm, Eaglescliffe and Hartburn, and you start coming towards Stockton North and Bishopsgarth is in Stockton South but it's on the border. The difference in what people have got, and the struggle, they just don't appreciate it. And it seems to me they have really bought into this 'they must all be scroungers, they must all be on benefits, all these people must be here.* (Kelly, Wave I)

The inequality within Stockton discussed by respondents mirrors national income and wealth inequality trends, whereby levels not witnessed since the 1930s are returning. The share of GDP going to the top 1% of earners has more than doubled since 1979, and was 14.5% as of 2013 (Hirsch, 2013). As Dorling (2015) has stated, when income inequality of this level exists, social inequality also prevails. The effect is particularly stark for those at the bottom 10% of the income spectrum, where financial, social, economic and sometimes cultural exclusion is felt more acutely (McKenzie, 2015: 104).

High levels of inequality and a stratified class system endured in spite of the New Labour rhetoric of 'social mobility', and have intensified with the Conservative 'shirker' austerity narrative. These are leading to a misidentification in places like Stockton of the 'causes' of relative inequality or prosperity. Those in Stockton South who have done well cannot see the wider context of their prosperity, and those in Stockton North who struggle blame 'foreigners' or even other 'benefit scroungers'. The main cause of the wide health inequalities we see in Stockton are not explained by one dominant causal factor. Rather, as Navarro (2000) and Doyal (1995) have argued, it is a combination of multiple factors, underpinned by a structural political and economic system which stratified groups, along gendered, racialised and classed lines (Navarro, 2009: 423).

4.3.3   *Placing poor health*

> *If a baby is born in a poorer area, damp house, bad food, grew up and worked in steel works, got a good job and moved to better area but gave all his money to his kids, got old and sick and had to move back to poorer area, he would die at 65. A bloke born in the richer area (Wynyard), nice house, easy life, good opportunities and wealth, would die at 80.* (Fieldnotes 07/05/2016)

People I met during fieldwork expressed a reflective understanding of the causes of health inequalities, rooted in their experiences. They understood that the social environments, material and economic resources in different areas in Stockton had a huge bearing on the health of people living there. Cummins et al. (2007) conceptualised the 'relational' ways place impacts health – 'through complex relational spatial interdependencies which exist between people and places' (2007: 1835) and this resonated with the testimonies respondents gave about their perceptions of health inequalities in Stockton. Place is significant when understanding and critiquing austerity; the effects of austerity and responses to it vary from place to place. The economic, health and spatial facets of this are significant. The role of place is understood by health

geographers and social scientists (Pearce, 2012; Pearce et al. 2016; Macintyre et al. 1993) to play a large role in influencing health.

As has been discussed, health and social inequalities in Stockton are wide. That these inequalities exist in areas in close proximity to each other is embedded in the historical, economic and political context of Stockton as a place and Teesside as a region – experiences which are mirrored in other post-industrial regions (Bush et al., 2001; Kelaher et al., 2010; Thomas, 2016). Places have experienced differing levels of service provision and cuts, infrastructure development, labour market changes and local council service provision (Dunatchick et al., 2015). This in turn plays a part in shaping the experiences and practices of individuals, such as mothers, who live in different places and use spaces in them.

4.3.4   Austerity and the erosion of 'community'

Findings suggest that austerity was altering the relationship respondents had with their communities and with each other. One of the ways this was played out was by focussing on individualised negative behaviours in specific parts of Stockton. This masked the wider political economic facets of austerity and the wider class politics at play. Wright (2015) argued that the decline in neighbourhood level community cohesion does not inherently indicate a lack of a sense of duty towards others, or the inevitability of antisocial behaviour – 'antisocial individualism' (Mooney, 2010: 2). Rather, findings indicated that the kinds of 'frequent and intense interaction' (Bauman, 2001:48) which historically underpinned the experience and meaning of community are not as strong as they once were.

Mutual support mechanisms historically emerged to some extent from necessity and a sense of interdependency and commonality amongst local residents – resonating with the experiences of other neighbourhoods described in the literature (Bott, 2003; Damer, 1989; Lupton, 2003; Wilmott and Young, 1957). But this is becoming less prevalent. As people experience increasing stresses in daily life they have less energy to engage in communal activities and feel that their engagement with other community members has lessened. As a result, the sense of Stockton as a place of home and community has deteriorated, leading to a denudation of the networks between people through which communal bonds are established and preserved. This in turn increases the perceived disintegration of a community feeling.

As Wright (2015) has argued, meanings and experiences of community emerge from everyday activities and interactions and forms of social solidarity are shaped by the broader socioeconomic context. Her analysis suggests that the apparent trend towards social fragmentation on neighbourhood levels reflects the deterritorialisation of contemporary patterns of work, housing, leisure and relationships. This challenges behavioural explanations of the decline of place-based community, and highlights the constraints people experience on their capacity and inclination to develop relationships with others. In particular, key modes of stratification and inequality and the associated stigmatisation of particular groups would seem to have important effects on the forms that social solidarity takes. Both the Marmot Review (2010) and Due North report (2014), important reports on health inequalities, advocate for 'community empowerment' and

increased autonomy as a means of alleviating health inequalities. Due North argues that some of the key drivers for health inequalities are issues relating to power, resources and wealth – the power the public has over the allocation of resources in their communities can empower and indirectly improve health (2014: 27). While there were a lot of community resources in the more affluent parts of Stockton, where health is also better, there was a lack, and expectation of closure, of many community resources in less affluent areas. This may be affect the different experiences in places across the borough, and be a contributing factor to the health gap in Stockton-on-Tees.

Conclusion

This chapter described how austerity was shaping respondents' perspectives on place, community, and processes of austerity. Different places presented respondents with possibilities and opportunities, or risks, sometimes devoid of opportunity. Living and being in certain spaces provided circumstances for respondents to flourish, or conversely increased their vulnerability to certain aspects of austerity measures. I discussed the need for the regeneration of spaces that enable participation and facilitate flourishing within the community. Childcare centres were given as an important example of this. Respondents articulated various ways in which different spaces in Stockton were impacted by austerity measures, and that these processes were making unequal places more uneven. I argued that a nostalgic focus on the past as an 'idealised form of social solidarity', as the Big Society rhetoric has done, risks masking the reasons behind the 'decline' of local community. This is most stark in myth-making of 'proletarian bonhomie in the face of hardship' (Wallace, 2010: 57).

The UK is experiencing a period of social upheaval – in the aftermath of the Brexit vote, political views and experiences of everyday life are ever-polarised. The gap between younger and older generations (Pottinger et al., 2017) and richer and poorer communities (Hartmann and Leug, 2017) is widening. The implementation of austerity within the deepening of the neoliberal state (Peck, 2009) and the fragmentation of communities is changing the environment in which mothers live, care for their children, families and communities, and how they perceive the places in which they live. There has been a withdrawal of many publically funded services, caused some service provides to engage the help of volunteers, and privatised other core services. Significance aspects of this turn have intensified inequalities and amplified the expectation that individuals and groups will be self-reliant and autonomous.

Understanding these changes can help us to understand how Stockton, places like it, and different types of people at different points across the life course, are being impacted by these processes. In this sense, it is of increasing important to directly examine the relationship between personal life and public political engagement. As Holmes et al. (2017) note, 'some theorists have assumed a zero-sum opposition between deep intimacy in personal life and investment in 'community' or friendliness towards strangers'. As they state, we need more research into the interplay between cultural discourse and the material conditions of everyday life and relationships. It is important for geographers to focus on the spatially uneven impact of austerity both on experiences of everyday life as well as on measurable inequalities. Through this, we can conceptualise how

people in different places are affected by structural forces in uneven ways, and mount a challenge to the latent risks in particular locations.

5. Findings II: Perspectives on the Social Determinants of Health and Women's Invisible Inequalities in Stockton - 'I'm Not in Good Health, But I Try Me Best'

Introduction

This chapter illuminates the ways respondents articulated their health in relation to the 'social determinants of health' in an age of austerity, as well as their perspectives on health inequalities in Stockton and their socio-economic and gendered roots. Findings indicated that there was a socio-economic gradient whereby those living on lower incomes and with fewer socio-economic resources, more generally expressed that their overall health was worse than those with more money, better housing, and living in more affluent neighbourhoods. The chapter is structured as follows – the first section explores the experiences and impacts of the social determinants of health in Stockton. Specific attention is paid to the role of material determinants – housing, money and community centres as the uneven socio-spatial distribution of resources contributes to poorer health (Pearce et al., 2010). Mattheys et al. (2016) found these material factors, as well as psychosocial factors (the feelings of connectedness and belonging these factors facilitate) to be driving the wide health gap in Stockton.

The next section presents a discussion of the mental health issues many respondents discussed. Experiences of post-natal depression, anxiety, and depression were commonly cited, while more extreme manifestations of poor mental health, such as suicidal tendencies and self-harm were also discussed. The mental health issues respondents reported are discussed in relation to the literature on the politics of women's health (Doyal, 1995). Recent research has reported increased experiences of mental ill health are one of the consequences of ongoing austerity (Mattheys, 2015) and the narratives presented provide telling insight into the stressors being encountered by mothers in particular. Section three illustrates the experiences of mothers in Stockton through the concept of 'invisible inequalities'. This is linked to the intersectionality of inequality they experience, which includes factors such as gender and class. Class narratives of austerity, reforms to the social security system and everyday life in Stockton are presented through a discussion of the social gradient of health and social class within the region. Accounts of 'everyday life' are presented to demonstrate this. There is an emphasis on insights into health and changes in material circumstances collected during 18 months of fieldwork. In this section an intersectional understanding of health inequality is emphasised.

5.1.1 Everyday life, health and austerity in Stockton

> *Austerity has had a massive impact, for sure. It's hard because, people, they're dealing with that many things in their everyday life already. It is getting worse. We meet with people and they were already living in poverty and then it's literally just that next step further.* (Jill, employee at Thrive, Wave I)

This section discusses everyday life and health in a period of enduring austerity, and the inequalities respondents experiencing unequal life circumstances reported. As has been discussed throughout, Stockton is

a place of wide and localised health inequalities. Recent research has indicated that austerity will contribute to widening health inequalities (Bambra, 2016; Stuckler and Basu, 2013), particularly in the North East (Bambra and Garthwaite, 2015; Bhandari et al., 2017; Mattheys et al., 2016). Respondents cited poor quality housing in their areas, the closure of community services and increasing financial insecurity as having an impact on their wellbeing. These factors constitute what Jones and McCormack (2016) have referred to as 'socio-structural violence'. These are economic, political and cultural mechanisms, structures and normative practices which foster the conditions in which health inequalities proliferate (2016: 239) and generate inequalities.

5.2 The social determinants of health

5.2.1 Housing

Having a positive experience of home is important for health (Gibson et al., 2011). There was a common experience by those living on lower incomes of living in housing that was deemed unsatisfactory, through recurring damp problems, unaffordability, and proximity to anti-social behaviour. Most respondents lived in socially rented housing, but some lived in private rental accommodation and three had mortgages.

Figure 7. Row of terraced housing in town centre

Pat had a poor experience of her family's housing association housing. The family had constant colds and her daughter used an inhaler which she attributed to the damp.

> *The one we're in, it's very damp. It's always cold…Me plugs gone in the wash house, the tiles are lifting up and the toilet's broken. But you can't get in touch with them* [the housing office] *unless you walk to* [another area] *cos we used to have councils on* [our estate] *but they're all shut now.* (Pat, Wave I)

Trish lived on the same estate, although they don't know each other, and had the same experience. Her family, especially her young daughter, had a lot of colds and chest infections because their house was 'full of damp'.

> *Wash it with bleach'. I did that. I went to the Environmental Health about it cos they were just completely ignoring me, just repeating 'wash it with bleach'. So they come out, took all me kitchen up, I had to move out, lived in another house for three month. They took my kitchen floor up and when I moved in I've got the damp in again and it's worse than ever.* (Trish, Wave II)

Respondents living in rented homes recounted at times feeling frustrated, disempowered, angry or stressed out by their housing situation. Kelly had lived in a private rental home and had also experienced the health effects of living in a damp, cold house:

> *It's better than what we were living in before. We were living in a two bedroom bungalow that was cold, it had damp, I had a bad chest the whole time we lived there. We're lucky we've managed to move on.* (Kelly, Wave I)

Respondents reported numerous times that local council providers and housing associations were not apologetic about services being cut or repairs on houses not being carried out in a timely fashion. Individuals had reported during fieldwork being taken to court over 'priority debts' such as unpaid rent or council tax, charged hefty court fees and fined as the collection of their debt was passed on to a private collection agency which compounded their anger and debt.

Brenda was put in touch with me by Emily, who gave Brenda welfare rights advice. Brenda is re-married. Her first husband wouldn't let her work outside the home and was abusive. Brenda has two children, one lives with them and is working towards becoming a manager at a fast food restaurant. Her son lives in Newcastle, where they lived for many years and is a homeless drug addict. Brenda has multiple disabilities; she suffers from very poor mental health, and is struggling to deal with issues from her past, including abuse as a child. Brenda loves talking – both times I interviewed her I stayed two hours.

Brenda (Wave II) discussed the messiness of moving house and having benefits shifted to their new address. She stated:

> *We're waiting for new housing benefit. I was having money taken off my benefits every fortnight for rent arrears. Obviously we knew we were getting paid and the social are now saying we have rent arrears of £1400-odd. I was told when I moved the money for my old place would stop and I'd have to make an arrangement for it to be taken out again. Yet I got a letter yesterday morning to say they're still taking the money off! I'm still waiting for me new water card, I've got to pay me water card or I'll be in arrears with everything. I don't know if I've got to pay council tax or anything.*

There were examples of individuals being met with hostility, bureaucracy and unwillingness to accommodate for unexpected difficulties such as sudden changes in financial circumstances or benefit delays, however no one reported being evicted. These experiences are reflective of research conducted by Kirwin (2017) into everyday indebtedness in an age of austerity. Individuals were uncertain about what their debt really meant for their financial futures, and advice is unclear and often contradictory. Some respondents used doorstep lenders and had extensive high-cost debt. Many had a history of making costly financial decisions due to life on a low income. Some respondents stated they would not go to the CAB as they mistrusted it, seeing it as an apparatus of the state. These factors might combine to generate negative consequences in the future.

Recent benefit changes have had a cumulative effect on many households across Stockton – housing benefit had not increased since 2010 and other changes, such as the Bedroom Tax (or 'under-occupancy penalty') were affecting those who had children living with them on a shared basis or had other housing needs, such as those with a disability who could not share a bedroom with a partner. Both the location of the poor-quality housing some respondents lived in, on specific estates in specific parts of the borough, and the houses themselves, reinforce a set of inequalities for those living in them. Slater (2017: 117) has noted that 'the sense of social indignity that has come to enshroud certain urban districts…has implications for residents in terms of employment prospects, educational attainment, and receipt of social assistance'. These mechanisms place those in poorer areas at a disadvantage.

5.2.2   Community services and amenities

A frequent theme in interviews, and during fieldwork, was the essential role of services within the local community. Using the children's centres for nursery or adult literacy classes, going to the community centre café for a cheap cup of coffee, conducting job searches on the library computer, or availing of welfare advice within walking distance were all important to respondents. These community-based services were a large part of the lives of mothers with young children, jobseekers, mothers working in the home, carers, refugees, and those on very low incomes. Community services were administered largely by local councils, libraries, community centres, leisure centres or by charities, in the case of some refugee support services, disability outreach services and women's services. There was an overwhelming feeling that these services were fading away through gradually reduced opening hours, replacing paid staff with volunteers and then closing entirely without advance warning. Kelly discussed the loss of services for those with educational and support needs, such as for her two boys who have autism. She stated that:

> The council got rid of the autism outreach service because of cuts to the budget. So we can't get them to observe or come out to the home because they've gone. It's really difficult to get an appointment with CAMHS [Child and Adolescent Mental Health Services] but my oldest needs them so I'm trying. (Kelly, Wave I)

Lucy had also noticed cutbacks to children's services:

> I always get the feeling that Stockton is trying, and the council do have its best interests at heart. What's cut back, I've noticed, are the Sure Starts groups. And I know things like breast feeding support has been really patchy. There used to be a breast feeding café at the Sure Start that you'd go to and you got your lunch and then that was cut back…and equally on the other hand there's always a big push to bring breast feeding rates up but then they cut the café out, and there were two sort of professional peer supporters that used to go around and support women and I'm fairly sure their jobs don't exist anymore. (Lucy, Wave I)

Lucy lives in Stockton South in a privately owned home with her husband and two children. She has extended family all over the country and has lived abroad. Lucy thinks Stockton is a great place to live and raise children. During our interviews Lucy was calm and positive with a self-deprecating sense of humour. She and her husband are doing well with their careers and the children are healthy and happy. A theme which

surfaced in our second interview was her worries for the future: both her parents and her husband will require care as they get older, and she worries about how the care will be funded. Talk of houses being sold led to discussion of inheritance and worries for her own pension entitlements.

Carol spoke of her work with refugee and asylum seeker communities in the North East at risk of female genital mutilation. This was at a time when there were large amounts of refugees in the Teesside area – relative to the population some of the highest rates in England (Bates, 2017), and the need for services to support them was greater than ever:

> There's not much funding going on now. And that's putting people's lives in danger. Especially with women's services. Services that used to support women, now they're no more. The cuts have stopped services that are vital and that's a big problem. With the North East Refugee Service, they've been doing such fantastic work supporting asylum seekers, since all the cuts, it's closed. In a sense. It's there, but it's not there. You only have volunteers there now, no paid staff, they can't do all the work that they used to do. We see now, asylum seekers and refugees, you see a lot of people suffering as a result of that, because that service is not there anymore. (Carol, Wave I)

Carol was a journalist in Africa, but left because she was in danger, and sought asylum in the UK. She met her husband in Stockton and they have two children. They live in the city centre. She is an outspoken advocate of female genital mutilation awareness and runs training on the issue. Before she got Leave to Remain she did this voluntarily, and is now trying to start a business. Her husband is in training and hoping to start work soon. He needs to prove that he was claiming asylum during the period he was, which is proving difficult as he is registered under his wife's name. He was sanctioned in the past for failing to look for enough jobs, and they really struggled to make ends meet then. She works hard and wants to work hard in the future to provide for her children.

Many third sector organisations were running on reduced funding, leading to staffing cuts and a rollback of services offered. Local government had to make a huge amount of cuts, as the responsibility for carrying them out had been transferred from central government by HM Treasury, and then budget allocations had been reduced. In Stockton, there has been a local council budget reduction of 20% 2009-2017 (Brown and Hood, 2016). As an example, Stockton's spending on children's centres had fallen from £404 million to £276 million between 2011 and 2014 (ONS, 2016). In England, local authorities were forecast to spend 11.8% less on children's centres in 2016/17 than in 2015/16, down from £763.9m to £673.9m (Department for Education, 2016).

Community services were seen as very important in providing a space to come together or to acquire new skills. The use of community centres has positive mental health outcomes (Wells et al., 2013, Renton et al., 2012, Cyril et al., 2015). The closure of these services represents a real, practical and emotional loss for low-

income communities. At the annual Social Policy Association conference in July 2017, Thrive Teesside presented their recommendations on a bottom-up vision of a 'good society'. One recommendation focussed on the need to bring back community centres as, in their experience, they provided an array of services for the community run by the community – services such as housing advice, childcare, job clubs and cafes (Thrive Teesside, 2017).

5.2.3   Financial insecurity

> *We had a long discussion about how the representations of people on benefits are not accurate – Anne says the only difference between 'us and them' is that they get their credit from a credit card and the bank, whereas she has to go to doorstop and payday lenders. The only difference between us is the rate of interest we pay.* (Fieldnotes, 12/04/2016)

A number of points were particularly relevant in relation to financial insecurity. There was a lack of affordable credit available alongside a prevalent experience of being in debt. There was the experience of a low-pay, no-pay cycle where the majority of work available was low paid and insecure. These factors were compounded by the gendered experiences women felt, whereby the unequal dynamics within households meant they did the majority of the budgeting and managing of the household in an everyday sense. These intersecting inequalities compounded the experiences of poor mental health lower income respondents had felt.

Respondents discussed how they were finding it harder to make ends meet. This is discussed in relation to the financial experiences of respondents as women, and then the intersectionality of their inequality as women and in relation to their socio-economic experience. Kelly described how she was responsible for managing all of the family's money. When they were both working her ex-partner got into debt, and this was something she had to manage on an ongoing basis:

> *It's always been me* [handling the money at home]. *We tried to have it when we were both working so it was separate. But he kept getting into lots of debt. So all the bills started coming out of my bank account just to make sure they were getting paid. As the years went by it became that anything he was getting came into my bank account. Which totally altered the whole dynamic of our relationship. Because I became like a mother giving pocket money. Luckily I have these reserves from my son. I know I'll be alright, cos I'm good at money management now. Especially cos I can't get into any debt. But it was always me…* (Kelly, Wave II)

Their quotes illustrate how life was structured to a large extent by the caring responsibilities of having children and of running a home. Experiences of lacking money, time and support, were frequently recounted by those on low income. Most of the mothers had most of the responsibility for the bills, so the burden of household management rested with them, as Pat's quote illustrates:

> *I pay the bills. They hand me the money and I go 'thank you' and it's gone out. I do it all. The money goes into his account but I've got control of it. Then it's rent, gas, electric, Virgin, pay all of them and then what I have left I pay the shopping. Never save nowt.* (Pat, Wave II)

By way of contrast, Lucy and Emily, both from more affluent areas, paid all their household bills by direct debit and Lucy did her food shopping online. This contrasted with the experiences of other respondents such

as Trish and Pat who used prepay meters for their gas and electricity. Here, Emily discussed their household bills:

> *Because we just have a little system where we have a separate account where the bills come out of, and we just pay a set amount into that every month. We do have a look and we look when the annual bills come in and he said the other day 'did you know the gas and electric's gone up by £50 every month? That's a lot' and I agreed and I said 'I don't know why.* (Wave II)

Carol described how she had, in her head, what bills needed to be paid and if there was anything left over they could use it to buy other things:

> *I will say that we share, but I am like the one who is more in control. I am the one who knows exactly what needs to be done. I can just tell him 'oh we need this' but left to his own devices he won't remember. I remember everything. And because we're not working now, we know tomorrow if we're getting our joint support as a couple, we'll know that we have to pay council tax, water, so we know when we get that money, which goes in his account, the first thing that's going to happen is we need to sort out all the bills and what's left, that's what we use.* (Carol, Wave II)

The intersections of socio-economic and class experience in conjunction with gender were apparent. Those on low incomes had to rely on alternative sources of credit from those available to middle-income households. In Stockton, the organisation Five Lamps and lenders like Provident ('Provvie'), provide loans at very high interest rates – 89.9% APR for Five Lamps, Provident 535.5% (Five Lamps, 2017; Provident, 2018). As well as this, pawning goods, for example by selling to cash converters, was not unheard of. The Glasgow Centre for Population Health have argued that being in debt, especially to high cost lenders, represents a public health risk (GCPH, 2016) as it can lead to increased stress levels and mental health issues.

It is important to note that it was not just respondents on low incomes who were financially impacted by austerity, although the materiality of these experiences was often different. Emily lost her job with the council and had taken up a lower paying job as a result:

> *I was made redundant by the council three years ago. They started the first round of cuts and when the cuts to local funding came in, my job was deleted. I took voluntary redundancy so I took a payoff, a small payoff; it was tiny, not enough to live off for a year even. So I decided to take a low paid job while I decide what to do next, and I'm still in that low paid job now because I'm now a student as well. Less than a year later my husband became redundant because, this is all the effects of austerity, he was working for an outsourced company which just folded suddenly. We went through a lot of anxiety going through those redundancies in a short space of time, so we were fortunate that we both found jobs within a short space of time, and didn't have to claim benefits.* (Emily, Wave I)

There was a prevalence of low-paid, insecure work in the area which made it hard for mothers to get decent-paying jobs. *'Low paid jobs, that's all there is. You can walk into a job, and its social caring, cleaning houses, in nursing homes'* (Anne, Wave II). This was part of the experience of the low-pay, no-pay cycle (Shildrick et al., 2010). Pat perceived that her ability to re-enter the labour market was hindered by a lack of skills. She also saw herself as primarily a mother and homemaker, and thus not keen to engage in waged labour. She expected further

struggles in the future through the reduction of her benefits under welfare reform, and as she no longer had dependent children to enhance the value of the family's benefit payments.

> *I'm just managing. When the kids were kids we were getting about £300-400* [a week]. *We could afford to go away ourselves. We always went away. Might have been when the kids should have been at school, they only missed a week, but it was cheaper then. But now, last holiday I had were about 17 year ago. We can't do that nowadays. We had a car. We had to give it up cos we couldn't afford the petrol and the tax and insurance. Too cold to put your coat off. And if you can't pay your bill they just cut you off. Don't give you a chance.* (Pat, Wave II)

Pat, discusses a set of circumstances – rent going up as well as a funeral increasing their financial vulnerability:

> *We got that phone call yesterday that the rent had increased and on top of that his sister* [the death of her sister-in-law] *and you're just thinking 'Oh God, give us a day, one day'. Nowt changes. We normally pay £58 a fortnight, and now it's £89. I won't be going out shopping, capping the gas, capping the electric, cos I won't know what to do.* (Pat, Wave II).

She also discussed the stress of the family affording the unexpected costs of a funeral. Pat's family, many of whom also lived in a low income, might be at risk of experiencing 'funeral poverty'. This 'funeral poverty' has been highlighted by Church Action on Poverty, and occurs when the death of a loved one plunges a family into serious and long-term debt (Purcell and Cooper, 2015).

> *Never have a chance to save anything. Because for example his sister has just passed away. We don't even know if she's got insurance. We did help out last time, with my husband's mother. We all had to give a donation for the headstone. It's not just, it's like, I need a pair of shoes for the funeral. You can guarantee, they always end up in a pub. There'll be sandwiches, soup in the pub after, we'll have to pay towards that. Nothing left after that.* (Pat, Wave II)

Personal over-indebtedness and financial vulnerability can have a huge impact on physical and mental health (GCPH, 2016). It can also generate knock-on consequences for families and exacerbate levels of exclusion. These testimonies indicated how everyday experiences of indebtedness and financial insecurity differed greatly for participants, with austerity adding to a situation indicative of a great deal of insecurity.

Carol's husband was keen to find work but due to his refugee status needed documents from the Home Office which they were being slow to provide, resulting in him losing out on opportunities. They had also had their family benefits sanctioned as he was not spending enough time seeking work – the rules of which he had not been familiar with.

> *He was sanctioned for a whole month, so we stayed a whole month without any money. They said he wasn't looking for enough work, and that was something we didn't know anything about, but they said no, he wasn't looking for enough work.* (Wave I)

In regards to health, and similar to other studies of women's lives (Cunningham-Burley et al. 2006; Graham 1984; Hartley et al., 1992) respondents indicated that their daily lives could be associated with much physical and emotional stress over a period of many years. Cunningham-Burley et al. noted how 'many spoke

graphically of the effect of this stress on their wellbeing and some felt that it was, at times, responsible for episodes of ill health' (2006: 392). Women often combine the work of balancing the household finances and struggle to make the budget work, with low-paid employment in insecure jobs, and to fit these in alongside caring work. Women also report more instances of mental health issues as they juggle multiple roles and responsibilities (Jones and Daykin, 2015). This is discussed in the following section.

5.3 Women's mental health and austerity

Mental health issues emerged as a major recurring theme in the research. Mental wellbeing was being affected through increased feelings of insecurity and disempowerment, struggling with money and decreasing social supports, as community capacities to manage were undermined. Many respondents lived in areas with multiple and complex issues of deprivation. Most respondents had experienced depression and anxiety, and many had taken medication or attended counselling for these issues. Kelly had *'…been seeing a psychologist for a year. I went to the doctors to get some medication for depression, and at the time I'd been eating a lot whenever the boys were stressing me out'* (Kelly, Wave I). There were socio-economic and spatial dimensions at play, in combination with the social determinants of health to produce an 'intersectionality of inequality' which I discuss in the third section (Greer Murphy, 2016; Hill, 2016). Kelly's experience, for example, was related to a stressful relationship, not having enough money, having two children with autism and managing their care and education, as well as managing her own mental wellbeing.

Descriptions of perinatal mental health issues were common. In our first interview, Becky discussed the circumstances around the birth of her daughter:

> *It was straightforward for the first bit, but she was in breach so we had to go to the doctor. I had extra scans to see, they did this procedure and everyone was going 'that was brave' but it didn't hurt. They gave me gas and I didn't even use it. Had an epidural. I had a section and I was up and about in two days. Refused painkillers, because I was solely responsible for her so I didn't want to blur my mind with the painkillers. And I had to get over my fear of needles. I didn't want to but I had to get over it for her.* (Becky, Wave I)

She described feeling depressed and crying for 'no reason'. As the sole carer of her child, she has a huge amount of responsibility and only occasional help from her partner. Her daughter was three at the time of our interviews:

> *I have suffered from depression. I still have it, I think. I do still sometimes sit there and just burst out crying, for no reason. And I think…it's from when I had her. I think it was that we don't live together, and so all of the pressure's on me. Everything's on me.* (Wave II)

Becky's mental health was also compromised by living in an area with anti-social behaviour taking place. It made day-to-day life that bit more challenging, especially with a young child. Becky said on her estate *'most people will keep to themselves. There's some dealing going on. There's about three or four drug dealers in one block of flats. It's very hard from that sense because I don't want* [her daughter] *to go outside'* (Becky, Wave I). Caring for her child in this environment made her feel stressed out.

Kelly discussed her experience of post-natal depression during a period of upheaval – her father was dying, there were money troubles and her son, as she would later find out, had autism.

> *My son came along in 2009, and it was probably one of the worst times of my life. I had post-natal depression after him, for about 6 months before I got any help. And the doctor asked if I had any support. I had my mum, but she's caring for my dad, he had just finished his chemotherapy at that time but we knew he wasn't going to get better. The doctor said 'well you're lucky, you've got more than a lot of people have' and sent me away. No medication, no help. Thank goodness I changed doctors, because it took me a long time to go to the doctor because we were really struggling with money. So the new doctors gave me some anti-depressants and sent me on my way.* (Wave I)

The experience of post-natal depression can be linked to living on a low income or in a context of economic or social insecurity. The social determinants of mental health include social, cultural, economic, political and environmental factors such as living standards, working conditions, social protection and community social supports Elliot (2016: 16). The lived experience of 'depletion through social reproduction' (when outgoing energy and resources to care for others exceeding incoming wellbeing-protecting factors) (Rai et al., 2013) had perhaps led to the stress or mental ill-health that was reported. Mental health issues such as depression, anxiety and post-natal depression were described frequently in interviews and fieldwork. Experiences of precarity and the mental health consequences they present, have been discussed by philosopher and gender theorist Judith Butler (2015: 15) who stated that:

> *The more one complies with the demand of 'responsibility' to become self-reliant, the more socially isolated one becomes and the more precarious one feels; and the more supporting social structures fall away for 'economic' reasons, the more isolated one feels in one's sense of heightened anxiety and moral failure.* (2015: 15)

Mental health is crucial for general wellbeing, and to live a happy and productive life. Psychosocial stress is of huge significance; chronic low level stress 'gets under the skin' and makes this difficult to achieve (Garthwaite and Bambra, 2017). Emily described a period of job uncertainty for her husband and how this had left her feeling incredibly anxious. In the end they hadn't lost any money due to a buffer of savings and careful financial planning, but the feeling of anxiety lasted a long time.

> *A few years ago I suffered from anxiety…I felt under pressure, because there was some financial stuff around my anxiety, because my husband lost his job very suddenly a few years ago, and although he got a new job straight away, that fear that hit me when he lost his job cos the company just went bust overnight, we didn't know if he was going to get paid. That kind of fear that hit me, it took ages to go away. And even though we didn't lose any money and we're a lot more financially secure than lots of people in a much worse position, you can't plan for the feeling of insecurity that's gonna hit you when that happens.* (Wave II)

Emily was also anxious around her daughter's health condition.

> *There's been a massive journey with her health. That's been very stressful as well. That was one of the things that made me quite anxious a couple of years ago when I suffered with anxiety. Cos I'd had a massive battle with the NHS to get treatment for her and to get to the bottom of her health.* (Wave II)

Wright et al. (2015) noted that middle-class mothers were more likely to go to great lengths to ensure 'their children's current and future health' (Wright et al., 2015) and this is indicative of Emily's experience – taking time to visit specialists, reading the literature around her daughter's health issues and tirelessly advocating on her behalf. Class is undoubtedly of great significance to understanding the causes of health inequalities. An intersectional perspective, which acknowledges not only class but also other factors such as gender or disability, can further enhance this. To understand health inequalities and the links to social position, we must focus on more than singular aspects of social identity or position (Hill, 2016: 102). The next section discusses the experiences of women in particular.

5.3.1 Gendered political economy of mental health

Stein (1997) has argued that health has been perceived as having a single, dominant determinant. To more adequately understand women's health, and mental health, it might be more sensible to view it as having multiple determinants or as 'an intricate, non-linear, tangled web of factors, some of which are socio-political' (1997: 89). This 'tangled web of factors' is complex and rooted in local, community, national, familial and structural inequalities. Denton et al. (2004) have argued that 'levels of health are determined by social structures of inequality, differences in health related behaviours and psychosocial factors including stressful life events, chronic stressors and psychological resources. But the picture is more complex than that… (these) factors are rooted in the social structures of inequality that define people's lives'.

Paula, manager of Thrive stated that mental health issues were rife among the low-income women she helped:

> *Predominantly it's anxiety, it's depression, it's stress-related…mostly it's anxiety and depression, I can't stress enough how many people won't come out of the house. A lot of people don't access other services, and it's only after a few months of meeting them that you only find out the true extent of their debt, their mental health problems, their other issues, cos they're not gonna open up on day one.* (Paula, Wave I)

Paula is the manager of a charity; she keeps it going on a daily basis. She has a husband, and was married once before. She has a daughter who has her own kids; she's very supportive of her daughter and does childcare for her. Her first husband was in the military so they moved around a lot. She has great insights and is passionate about fighting injustices. She is also very willing to speak openly about her experiences of struggling on low income, her husband's precarious employment, and her struggles with debt.

Discussions of mental health issues arose in interviews with all but one participant. Lucy, the mother with the highest income, a husband working in a professional job, and a mortgage, never mentioned struggling with mental health issues (but this is not to say she never experienced poor mental health, rather that she did not mention it in our interviews). This hints at the intrinsic inequality of being a mother in a time in which social reproduction is not valued, as she had more time and resources, expressing feelings of frustration or anxiety were not at the fore of our conversations. Oakley (1994) has stated that, 'whether we speak of paid or unpaid

work, child work or childcare is the responsibility of mothers' (Oakley, 1994). Mothers are therefore central to maintaining family life (Guendouzi, 2006) and to the wellbeing of children (Arendell, 1997).

Fischer (2009) noted in Capitalist Realism that poor mental health is now treated as a natural and inevitable experience. He argues that contemporary social theory should be politicised and work to critique this, as earlier radical theorists such as Foucault (2009, 1994) and Deleuze and Guattari (2004, 1983) in the 1960s and 1970s had critiqued extreme mental conditions such as schizophrenia as political rather than 'natural' experiences. Fischer called for the politicisation of common issues which are attributed a banal and mundane normality, such as depression, anxiety, feelings of stress. These experiences of stress and distress are so endemic in capitalist society. He argued that:

> *Instead of treating it as incumbent on individuals to resolve their own psychological distress…we need to ask: "how has it become acceptable that so many people are ill?" The 'mental health plague' in capitalist societies would suggest that…capitalism is inherently dysfunctional, and the cost of it appearing to work is very high.* (2009: 19)

This critique mirrors the work of Schrecker (2017, 2016) and Schrecker and Bambra (2015) who have written from the perspective of public health on the health risks of neoliberalism, referring to the epidemics of ill health, including the rise of mental ill health, stemming from these economic policies. While some respondents did speak out against their treatment by individual GPs, there was a lack of critique by most respondents of the underlying causes of their mental health struggles, and the political economy of health which was creating these circumstances.

5.3.2   Class and experiences of inequality

For many mothers in the study, life had 'always been' tough; austerity merely presented a new set of compounding factor. Class position plays an inextricable role in proximity to austerity's effects and likelihood of having experienced deprivation or inequality in the past. As stated at the start of this chapter, Jones and McCormack (2016) asserted that 'socio-structural violence' is the systematic political, economic and cultural practices which foster the conditions in which health inequalities proliferate (2016: 239). One of the most enduring ways this is enacted is through reinforcing social class differences, although the injustice of class inequalities in causing health inequalities has become an increasingly unpopular explanatory framework in recent decades (Collins et al., 2016: 135; Macintyre et al., 2018). There has been an increasing focus on 'lifestyle factors' over structural causes, on changing behaviour through psychological interventions, and working on behaviour and thought (Friedli, 2016: 206). This has been at the expense of arguments relating explicitly to material circumstances and rooted in class, income, wealth inequality or the political economy of health.

During the research I spoke to wealthier mothers as well as those on lower incomes. Three respondents were homeowners and considered themselves 'middle class', with varying degrees of financial security. They had all attended University and had travelled extensively. Those higher on the income spectrum, with more money

and resources, had buffers. This buffer (the presence of cultural, economic and financial capital) was really the main marker of the different health experiences of the mothers I spent time with. This included access to bank credit, labour market mobility and access to education for retraining and up-skilling. They were shielded from unpleasant and unsuitable social housing, were able to gain education to re-train to fit with a changing job market, and were not subject to stigma or assumptions about their parenting. By way of contrast, the experience for low-income mothers was more precarious in many ways.

Before our second interview, Lisa and her husband had received an unexpected tax rebate which had totally changed their outlook. As she said:

> *Since we got this money he's changed. He's planning…he's booked in work. And it's just because of that bit of money. It makes everything possible.* (Lisa, Wave II)

This point is very important – this small amount of money, which Lisa admitted was not enough to even clear their debts, represented hope, and it was a huge burden off their shoulders. Imagining what they might spend the money on brought them great satisfaction, and Lisa reported a marked improvement in her mental health after receiving this payment.

For many of the low-income mothers, state surveillance was frequently mentioned, often referred to simply as 'the social'. The following fieldwork extract illustrates the struggle Linda experienced. Linda was a one-time member of the women's group who stopped attending:

> *Linda: 26, separated from abusive alcoholic husband, with whom she has a 5 year old son. Moved home with her young son was given no support for months after moving into her home. She was sleeping on her settee for 4 months before she got a bed. No loans and no support had been offered to her even though she is struggling. For a while before she had her house she had to move in with her parents. The social workers told her the house 'wasn't prepared' for her little boy, but they didn't offer her any support or suggest any way she could get it prepared.* (Fieldnotes, 21/05/2015)

5.3.3   Talking about Class

It is not easy to measure, define or classify social class. In recent years, talking about class and quantifying it has become even more unclear, as working-class lives, experiences and opportunities continue to change drastically (Savage and Friedman, 2015). There are numerous definitions, ranging from measures of income, wealth, educational attainment, self-identification or cultural markers of accent and dress. Nancy Fraser's (2000) work is useful in this respect. For Fraser, class refers to the 'complex imbrications' of status and economic position (measured by income, wealth, occupation etc.). In this sense, 'status subordination is often linked to distributive injustice' (Hobson, 2003) and one's class position is, among other things, related to his relationship to the market. Class, for Fraser, has both dimensions of an economic category and significance as a social classifier. Some respondents identified strongly with an idea of a traditional 'working class' rooted in the industrial legacy of Stockton and Teesside. This meaning-making of identity vis-à-vis working class-ness by some respondents is in contrast to the work of some scholars, such as Skeggs (1997) who found her respondents unwilling to label themselves working class due to the negative connotations associated with it.

Brenda was keen to emphasise how austerity measures were having a huge impact on working class people in particular – both those who had become reliant on benefits and those living in social housing. In regards to accessing services, she felt working class people were 'tret [treated] as a number, not as a person, and I think that's wrong' (Wave I). As well as that, she felt working class people were being hit unfairly through low pay, the bedroom tax and a poverty premium on hire purchase household goods. For some, this was through exposure to consciousness-raising around social justice through their work at Thrive, but not exclusively so. Brenda (Wave I), who was not involved in any sort of voluntary or community-building work, stated:

> *You hear of all these people taking their lives because of the bedroom tax, so the government can make more money off the working class people. Or the Social. People who have lived off the Social and lived in their houses since they were kids, they've inherited them, council houses, and they have to move out… For that issue, the bedroom tax, there's so many issues with the government. All these things they put into place, you get with one hand and it's taken with the other. And now people are being punished for being on the Social. Some people don't ask to be on the Social.*

During ethnography, references to the working class, low-income homes and benefit-reliant families were made interchangeably. This narrative, which conflates welfare dependency with working class identity, is something which has been long used as a rhetorical device to generate ill-will towards social welfare. It also indicates the complexities of 'class' as a concept. It has been explicitly used during austerity to cut benefits (Slater, 2012) and, it has been argued, has been internalised by those living on low incomes (Roberts, 2017). Furthermore, it fits with some of Skeggs (2002, 2004) writing on class, namely where she has argued that historically, the 'working-class have been forced to 'tell' themselves in particular ways in order to prove themselves as respectable, reflexive, moral 'subjects of value' (Skeggs, 2004 cited in Allen and Taylor, 2012: 17). It is important to note that, in spite of her conflation of markers of class with the rhetoric of benefit reliance, she did so with no ill will, identifying herself as part of this ambiguous group. This indicates the internalisation for many across the class spectrum in the UK of a 'logic of welfare commonsense' (Jensen, 2014).

Class was a recurring theme throughout many of the interviews. The changing characteristics of class and work in the area was described by participants in interesting ways. For example, Kelly (Wave I) gave insight into the shifting landscape of class among the people she grew up with:

> *When I was in school, the people I went to school with, their mams and dads were teachers, they worked in shops, and they did well under a Labour government. They got tax credits, able to buy a house in Fairfield, their children have gone to University and stayed away, and now they're turning their back on all that. They seem to have become middle class people. They were working class people when I was at school, we all were. But they did well through the late 90s - early 2000s. They're not 'the other,' you were them, 20 years ago. They see them taking off the government, and don't realise because they're not taking right now, that they benefitted like that in the past.*

Respondents talking about money, income and wealth was one of the most obvious ways class was manifested through the interviews. Middle class respondents were aware of the privilege their more advantageous class position afforded them. Sam (Wave I) said that:

> *The reality with class is that you're quite significantly better off. You might think you're only a little bit better off than some of the people you're interviewing in Stockton, when in fact you're a world removed. A bus ride takes you to the centre of Stockton but you're a world away from it.*

Her experiences working and living in Stockton enhanced her belief that meritocracy did not really exist and that, for her, there was a sort of inevitable unfairness about the inequality she saw around her. She said:

> *I feel it strongly because I've worked in those communities. I feel the privilege. But you know, you work, you work hard to get all that stuff and you don't realise how other people work hard, and never get that stuff. They work really hard just to get even.* (Sam, Wave I)

Sam is a single mum from a rural village which she classes as stereotypically middle class. She has two teenage children. Her parents moved out from London when she was a kid because there was racial tension (her dad is Indian) and they didn't want her to grow up near that. She has lived around Middlesbrough most of her adult life. She works at the University and does small bits of community and advocacy work. She believes that giving up career prospects so her children could have a stable and consistent parent around, and live in a comfortable area of Stockton was worth it, although she wonders about the future. She owns her own home. She has an international extended family, and is well-travelled.

The blurred lines of what class means in contemporary society were exemplified by the experience of Lisa and her husband. She labelled herself as coming from an affluent middle class, stable home in Durham. But her life now, with her working class second husband and their shared families, was precarious. This precarious position was felt viscerally. She talked about how bad being in debt and not earning enough made her feel – sometimes physically ill, it impacted her appetite, her ability to sleep, and left her feeling worried. It also made her husband sick:

> *You don't realise sometimes, what a pressure it's putting on your life that you're listening to other people having these conversations all the time and you don't realise, they're talking about things you could never be a part of. He got really ill, had to be taken to hospital as an emergency a few weeks ago. We found out it was ulcers. And I think it's down to stress. He got ill, and that knocked him off, he couldn't earn any money and he was saying 'oh what's the point in doing photography anyway, I'm never gonna earn any money, it's too hard.* (Caroline, Wave I)

Inherent in the classed experience of those occupying less advantageous class positions is both 'maldistribution and misrecognition'. This has huge significance for health. Bambra (2011: 187) argues that work and the socio-economic class polarities it creates play a fundamental role in creating inequalities in the distribution of morbidity and mortality, via uneven exposure to physical hazards and psychosocial risks in the workplace, as well as through different experiences of the labour market and of paid work. Graham (2000: 90)

stated that social class is 'written on the body'; it is inscribed in our experiences of health and our chance of premature death. Trends across time and between societies show men and women in higher socio-economic groups enjoying better health across longer lives than those in lower socio-economic groups.

5.3.4   Everyday experiences of class and inequality

Conducting ethnographic fieldwork in Stockton afforded me insight into the lived experiences of economic inequalities. In October 2016 to coincide with the release of the Ken Loach film I, Daniel Blake (2017) (which dramatises the experience of those on out of work benefits in an area of welfare reform) Thrive organised an awareness event to highlight the impact of sanctions. As we stood outside the Jobcentre Plus, most claimants that were going in for a meeting stopped either to sign our petition or to chat, and there was a positive energy around the space. At one point a man stopped to chat to us, and returned five minutes later with a bag of stolen joints of meat from Tesco, offering to sell them to us.

> *The experiences of today resonated with me. It was very obvious that successive welfare reforms have really impacted a lot of the people we talked to. The bedroom tax, sanctions, lone parent conditionality, work capability assessments were all mentioned, as well as the general lack of good jobs. A lot of people came to talk to us, a lot more than I would have expected. There was a buzz in the air, everyone was angry, but no one was really sure what to do about it. In that moment, posing for pictures, holding placards and gathering signatures for a petition felt like the only thing we could do to make a difference.* (Fieldnotes, 21/10/2016)

There were other pertinent examples. Pat had to attend a funeral but couldn't afford suitable clothing. Linda, a member of the women's group, couldn't afford a school uniform for her son. Anne gave her some clothes her grandchildren had outgrown. These experiences drove home how restrictive life on a low income was.

By contrast, I also saw another side of Stockton within the town centre. I conducted interviews in a holistic café selling almond milk lattes and wellness-enhancing stones, beside a speciality pet shop selling gourmet dog food. One encounter stood out:

> *Two men and a woman had sat eating their breakfast, talking very loudly, with thick Teesside accents. It was obvious the staff didn't think they fit the part. When they left, the staff started exchanging knowing looks, and talking in hushed voices – totally audible as the café was deserted apart from me, waiting for my respondent. They started saying these people had been behaving badly, and one said they had paid for their breakfast using drug money.* (Fieldnotes, 09/03/2016)

This reinforced the long tradition of social distancing from a supposed 'underclass' (Macnicol, 2017) and positioned these individuals as separate from the 'normal' clientele of the café. Difference classed spaces within Stockton exist in close proximity. The fluidity with which it is possible to move from one to another speaks to the work of Closs Stephens who has argued that the atmospheres in these spaces (in this case, the town centre of Stockton) are diffuse, forming a 'constantly morphing structure, with points of intensity rather than something hierarchical and static that coalesces around a central point' (2015: 100). Not a long walk from the gourmet pet food shop, where one might spend £5 on a doggie treat. There were endless discussions at the Women's Group of how state benefits now stretched less and less towards covering costs –

the costs of servicing debt (never of clearing it, as this would be practically impossible with high interest rates), of everyday living expenses, of not being able to buy respectable clothes to attend a funeral, go to the dentist for a filling or to get a haircut.

5.4 Invisible Inequalities

5.4.1 Women's health inequalities in Stockton

> *Women are impacted upon, they've reduced the age at which mothers have to go out and find work. And they want to be a mam, and they want to stay at home and be a role model to their children in that way. But they can't cos now they're forced to look for a job. The cuts in tax credits, the benefit cap, all of these things, financially have an impact on women. And the lack of services in the local area to support women.* (Paula, Wave I)

The research methods employed in this study did not aim to substantively measure or comment on health inequalities explicitly, but were well suited to capturing the effects of the cuts on women and the impact on their lay perspectives on health in a qualitative sense. Many of the respondents described their own health as less than optimum and referred to challenges rooted in multiple aspects of their lives; poor housing, closure of community services, the lack of quality work and corresponding shortage of income. This does not extrapolate further, but gives important insight into the health of women in a way often lacking in health research (Smith et al., 2016: 5).

In the final portion of follow-on interviews, I asked respondents to reflect on their own health. This included asking what good health meant to them and how their expectations matched how they perceived their own health. As Popay et al. (1998: 636) have argued, 'lay knowledge' presented as narrative can provide insight into the links between agency and structure that underpin health (Cumins et al., 2005b; Elliot et al., 2016; Garthwaite and Bambra, 2017). I received a wide array of answers and responses generally followed a similar pattern; stating that good health amounted to healthy diet, good mental health, moderation, exercise, not being stressed out and having enough money and time. Respondents then stated that they tried to take care of themselves through small acts of 'self-care' or taking time away from their children, or by studying or working on developing their own hobbies and interests.

Many of the mothers stated that they did not have the time, resources, energy or level of freedom needed to take care of themselves and were keenly aware of the factors in their environments, histories, lives and bodies that held them back from achieving what they would consider an optimal level of health. Those with complex or chronic health issues elaborated on these throughout our interviews. Carol saw health as having an underlying root to good mental wellbeing, a feeling of happiness, as well as the absence of physical ailments.

> *It's not just about saying 'oh well, I have no physical illness so that means I'm healthy.' Sometimes I see somebody who is smiley and cheerful, but they go home and they're unhappy, so for me being healthy is not so much to say 'well I'm not sick, I'm not in hospital, that means I'm healthy.' It's about a whole lot of other things as well.* (Wave II)

Brenda found this a very difficult question to answer:

> *Tricky question. To be able to walk, to be able to go back to work. I would love to go back to work. Honestly. That was my independence. And although I love me husband and we spend 24 hours a day together, that was my break, you know. My health would be for all this to go away and me to go back to work. I want me independence back and I amn't going to get it and that's what's so hard, cos I am a really independent person and when I'm in that chair I'm like a demon. I don't realise it but I'm a horrible person.* (Wave II)

Pat lived on a low income in one of the more deprived areas of Stockton. She was honest about how she felt she wasn't in good health, but was also clear about the limits those on low incomes faced in terms of their health. Eating well on a reduced budget was difficult, which for Pat was a key indicator of good health (We discussed eating well and home-cooking a lot during our interviews). She also saw her health in terms of a functional capacity as Pill and Parry (1988) found in their research with working class mothers in South Wales. For her it was articulated as the absence of illness. She stated:

> *I'm not in good health, but I try me best. I need to be cos I'm the rock in my house. I think it's the mind. If I'm not healthy I won't be able to cope. I can't get sick. I had the flu mind, and I just had to keep going. I can't die in my house. I had to stay up, even when I had the flu. Had to keep going on. If he's [partner] got a cold he's out on the chair, coughing, you know. I have to go out and do the shopping even when I'm sick. It doesn't matter if I'm dying I still have to get up so it doesn't matter, you get used to it. It's a hard question, that. As for health, I think you just eat junk because you can't afford 'oh I'll buy fruit, I'll buy this' cos you can't afford fruit. And you just go 'I'll get the cheapest, a packet of crisps'. So you just eat the wrong stuff, and you manage. But I think as long as you got bread and water, you can manage. That's what they always say.*

As these quotes illustrate, respondents were reflexive and honest about their own health, easily admitting that they felt the picture of their health fell short of the ideal version they held for themselves. A lack of time, money, resources and support from husbands and partners coupled with caring duties taking precedent, held many back from taking care of themselves and achieving their idea of optimum good health. In particular for those on low incomes, the 'intersectionality of inequality' meant that their material circumstances were becoming strained and stress levels and feelings of insecurity were increasing.

The reduction in opportunities for communities to come together in public spaces may perpetuate gendered health inequalities. Therefore, the closure of community centres and community services which I have cited previously is highly relevant. As Dodson (2015) has argued, 'gender organises the political sphere in ways that systematically constrain the ability of women to exercise their political voice' (2015: 378). Oakley (1993) stated that for individuals within a society to have good health, a moral basis of good social relations must exist. She argued that it is 'attempting the impossible' to pursue health in a society in which one group is systematically at a disadvantage – the group in this case being women. It is through understanding the lives and experiences of mothers that we can come to understand the unique pressures women, and mothers, face, particularly under austerity. Thus, the everyday life of mothers becomes an important prism through which to view inequality. However, this is the very thing that is so absent from many accounts of health inequalities, epidemiology, public policy, and government explanations of inequality.

5.4.2 The labour of caring

Women's everyday experiences of juggling multiple roles leads to a temporal experience which is in many ways different from mens' (Jurczyk, 1998). These experiences, rooted in everyday experience, indicate an inequality in gendered experiences of time, for women. As an example, women engage in significantly more caring work leaving less time for leisure and time for oneself. This self-care time is valuable for mental wellbeing (Giallo et al., 2011) particularly for mothers of children with disabilities, lone parents, and families struggling financially. Furthermore, in the neoliberal era we are seeing the decreased legitimacy of a mothers own needs and desires, and gender equity claims regarding women's employment and child care that run contrary to women's lived reality (Wall, 2013). This gendered temporality is something which has been often marginalised in academic research (Maher, 2009). However, McKie et al.'s (2002) Caringscapes work is useful here, as it allows us to explore spatial and temporal landscapes of care, including relationships, formal and informal, emotional and material kinds of support as well as the increasingly uneven geographies of service provision and place.

The importance of temporality, therefore, enables us to think differently about vulnerability, interdependency and change in families, and to make the case for forms of flexible, long-term support based on sustained relationships rather than short-term interventions. McKie et al. proposed that the complex nature of the spatio-temporal frameworks of work and care is central to understanding its' social organisation. This spatio-temporal framework should be central to understanding the combination of care and paid work in policy and academic debate (2002: 900). An analysis of austerity must consider the unwaged work women do and multiple roles they occupy.

5.4.3 Intersectionality, gender and health

Patterns of inequality between women and men are not linear, and have changed in complex ways in recent decades, not simply for better or worse (Walby, 1997). There is a lack of insight into the intersecting nature of gendered and spatial inequalities stemming from austerity (Greer Murphy, 2016). An intersectional perspective allows us to see how categories overlap, intersect and amplify. It allows us to 'keep 'in place' a concern with intersections of class, race, gender and sexuality'. It 'forces an awareness of the social divisions that are thought of as enduring, as against those that are seen as simply old and settled' (Allen and Taylor, 2012). Many accounts of health inequalities have failed to capture the significance of the qualitative difference of different 'lifeworlds' (Schutz, 1972) and the markers of identity which set lifeworlds apart. This research found that the intersections of these inequalities both create the conditions for, and exacerbate lived experiences of, poor health, debt and multiple disadvantages.

Intersectionality is an important concept to add to the health inequalities debate as it allows us to focus on structure and the axes of different social positions (Hill, 2016: 95). As has been noted, research into gender and health inequalities emphasises the intersection between gender and other social positions such as socio-economic position and income (Denton, Prus and Walters, 2004; Hill, 2016). Kelly's experience is illustrative

of how different categories intersect to sometimes produce negative health outcomes. In her case, Kelly was suffering psychologically as a result of stress and depression and was also over-eating as a coping mechanism. As she said:

> *The more pressure you're under the worse you feel. My health and wellbeing's been pretty poor. It's never been 'how do I be the strongest for me' it's been 'what can I do for them'. What I'm learning from my psychologist is how you put yourself in the centre of things and learn how to do what's best for you. Cos when you put yourself in the centre of things you don't do things that harm yourself.* (Wave II)

Her journey through health issues was precipitated by a complex set of events. She finally got a diagnosis of autism for her two sons, which resulted in her being awarded Carer's Allowance to care for them full time. Before, she said:

> *When your children still have something different about them, you still have to look after them but you don't get Carer's Allowance. I couldn't get Job Seeker's, I couldn't get any Income Support, I could get nothing. I was being a carer, but that wasn't being recognised.* (Kelly, Wave II)

Brenda was in her late forties at the time of our interviews. She had two children and was re-married. In Brenda's childhood she was a victim of abuse, and suffered from post-traumatic stress disorder as a result. Her first marriage was conflictual. From it she had two children, a daughter who lives with her, and a son who is homeless in Newcastle and addicted to drugs. She had suffered from post-natal depression with both babies. With her second, she used to take her temper out on her eldest all the time without being able to control it. In her own words, she 'would have knocked her across the room if the bed hadn't been there'. She was glad she divulged when she did and got the help she needed (Wave II). She re-married and her husband had to give up work to be her full-time carer. Brenda suffered from osteoarthritis and at times had been confined to a wheelchair. She had bariatric surgery a few years ago. She suffered from very poor mental health, had depression, and sometimes felt suicidal. She was taking numerous pain killers, including morphine, for chronic pain. Our second interview highlighted how her mental health had deteriorated in a few short months:

> *Me health's been up and down. I had the crisis team involved with me because I'm suicidal. They said they'd contacted somebody the first time they were out in September but nobody had contacted me for counselling. But they got them out the same day for me. They referred me to a Domestic Abuse Service and I thought 'yes, I'm finally going to get some help'. Not once were any of my issues broached. I had a couple of sessions and then either, I think I cancelled one session but the last session I had to cancel was because I'd had the phone call, we had to pack. She cancelled a few of them and when I cancelled the last one she went 'well do you want us to just close your file?' and I went 'you might as well'. And I was devastated.* (Wave II)

Brenda's also had extensive debt issues, as she explained:

> *We're managing ok now, but last year, we asked for help, we went to the housing for help, all these people for help, and nobody would help us. I suffer from serious depression, so my mental state was just on the floor. All these things they put into place, you get with one hand and it's taken with the other. I hate not being mobile*

and not being able to work. I wasn't bothered by the rent and that when we were both working, d'you know what I mean? We could do that. Even though we struggled. (Brenda, Wave I)

In recent years she worked in McDonalds along with her daughter, and loved the atmosphere. She had to stop that due to her health issues, and resented both the loss of income and loss of freedom that came with going to work and getting out of the house. She had trouble claiming disability benefits, and through the help of a welfare rights advisor successfully appealed her initially denied ESA claim.

In order to fully understand the pathways to poor health that, cumulatively make health inequalities between groups so stark, it is essential to see the links between and across social categories. As Karlsen and Nazroo (2007) argued, it is crucial for researchers to collect data on multiple aspects of social life. This is why findings presented here centred on diverse topics relating to everyday life – money and household finance, food shopping, work, motherhood and social life. I wanted to explore the multiple aspects of respondents' lives and identities and through them come to understand how health is experienced and good or poor health emerges throughout life. As Hill stated, intersectionality can help us to examine 'patterns of health in relation to multiple markers of social position and to consider the heterogeneous experiences of groups defined by any one social category' (2016: 104).

5.4.4 Invisible Inequalities

The experience of women, especially within the context of social class, warrants further investigation. Many women often do not independently earn salaries, their pension or property entitlements are often secured via their husbands, and their working lives are configured differently from men's due to their reproductive and caring work. I would argue that this could be characterised as the 'invisible inequality' of women's lives and is, to an extent, masked by a discussion of class – household income masks a lot of inequality in policy and benefit terms (Evans, 2016). It masks the inequality of resource distribution within wealthier households, and the true extent of poverty within poorer households where mothers are not earning independently. Recent work by The Runnymede Trust and Women's Budget Group (Hall et al., 2017) on intersecting inequalities, whereby BAME (black and minority ethnic) women were found to be particularly vulnerable to the consequences of austerity. There are clear implications for health inequalities research in this – some important indicators of social position, such as income or employment status, are not as relevant for women, therefore making understanding their position (and thus measuring health inequalities) more complex (Hill, 2016: 102).

Theorising the interplay between class and gender (as well as other categories) is an important component of forming a coherent opposition to the inequalities austerity is producing and forming a political and policy response that might challenge these. This interplay, as MacKinnon stated (1982), should incorporate class-based analyses (in her argument Marxist, although the debate is not necessarily limited to this particular framing) and gender-based (of which certain strands of feminist theory are useful). She noted that, as the 'organisation expropriation of the work of some for the benefit of others defines class', so the gendering of

roles creates a co-constitutive form of power and maldistribution. MacKinnon notes that through the production of gender, heterosexuality is the governing structure, gender and the family its 'congealed forms', sex roles its qualities generalised to social personal, reproduction a consequence, and control its issue' (1989: 516).

Gender roles and societal norms and values have a huge part to play in the differing health experiences of men and women. Gender is an important determinant of health because gender inequality leads to different experiences of health for women, rooted in imbalances of power and societal roles and expectations. As Walters (2004: 1) noted:

> *Recent studies of gender differences in health point to a lack of data and to the importance of understanding changing gender relations; differences in power and access to resources between women and men, and changing expectations of appropriate gender roles and behaviours. Poverty, social exclusion, unemployment, poor working conditions and unequal gender relations have a profound influence on patterns of health and illness.*

Having enough income is crucial for good health; sufficient income is needed to buy food or pay for housing, and lacking money generates psychosocial effects which can lead to worry and stress. Austerity has gradually eroded the financial capacities of those in low-income communities, as well as those working in the public sector, with children, with a disability, and those getting their income from social security payments. Respondents were keen to note that they did not perceive a lack of jobs, per se, in the area. However, there was perceived to be a prevalence of low-paid, insecure work. For women who are more likely to occupy these insecure jobs, there is greater incidence of mental health issues, as they juggle multiple roles and responsibilities such as unpaid caring work (Jones and Daykin, 2015). There is a clear classed dynamic to this. For example, the qualitatively different life experiences of Lucy, Sam and Emily, who fit into a typical 'middle class' classification, were far removed from the experiences of Pat, Brenda or Trish, who had more typically 'working class' lives.

Conclusion

This chapter emphasised the value of 'everyday' perspectives on health, everyday life and health inequalities. Quantitative approaches to health inequalities often downplay this form of knowledge production. However, the facets of life that rise to the surface in the narratives of 'everydayness' tell us a great deal. Popay et al. (1998: 363) have argued that lay knowledge provides invaluable insight into 'the dynamic relationships between human agency and wider social structures that underpin inequalities in health'. In the interviews, there was an underlying theme of 'managing' in diverse circumstances – managing the budget, the food shop, care for ageing parents, children, and benefit changes. Of fifteen women, from a wide variety of incomes, only one, the mother with the highest income and most secure family situation, did not mention experiencing mental health issues. For the women at the lower end of the income spectrum, experiences of poor mental health were common themes. Furthermore, narratives of perceived failures of medical care, of counselling services, of being offered drugs when they wanted holistic care, were common. In the wider picture of their

lives, a picture of multiple stressful life events emerges, now being made worse by austerity measures. With ongoing austerity cuts and cumulative effects, we might expect the situation in low income areas to worsen.

Participants discussed needing support from a range of services. Brenda needed to deal with her physical health and chronic pain issues, counselling for emotional issues, financial assistance and the provision of things like a mobility scooter and a new wheelchair. Kelly needed confidence in her benefits arriving on time, disability support services for her sons, and counselling to deal with emotional issues around food. With public sector services being cut and local council funding severely reduced (Hastings et al., 2015) as well as conditionality of her benefit payments, they, and others, are likely to find themselves having to make difficult decisions in her future, as the poorest places and most vulnerable people are being hardest hit (Hastings et al., 2017).

This research could not directly answer the question of why women live longer than men, but have worse mental and chronic health issues – the sample size was small and the qualitative nature could not objectively measure more than the respondents' perspectives. It did, however, do two key things that qualitative research is particularly well suited to; it presented the narratives and 'everyday life' accounts of a group of women, and revealed strategies for coping, perspectives, and meaning making that the respondents themselves utilise and demonstrate to be available, and valuable, to them. As argued earlier, women, particularly mothers, face a set of distinct risks under austerity. The narratives represented throughout the chapters illustrate the detrimental impacts of austerity for respondents, as well its intersectional nature, and the importance of establishing a gendered political economy of health.

Furthermore, the centrality of 'invisible inequalities' in the everyday lives of respondents constitute a major source of depletion which is likely a contributory factor to the gendered health inequalities mothers experience. The caring work, mental load, constant demands and daily stresses discussed in the preceding sections constitute a great burden to women. My qualitative research was well suited to shedding light on the practical aspects of everyday life that might contribute to gendered health inequalities. The chronic and mental health issues described by participants are reflective of the 'women get sick, men die' dynamic described throughout the literature on the gendered politics of health (Payne and Doyal, 2015).

6. <u>Discussion and Conclusion</u>

6.1 Summary of key aspects of the thesis

The aim of this PhD has been to draw insight into the everyday lived experience of austerity. Through empirical longitudinal and ethnographic research with mothers living in Stockton-on-Tees, it aimed to investigate the everyday impacts of austerity measures on health and wellbeing. It also aimed, through engagement with mothers in a place of wide health inequalities, to draw insight into the gendered experience of health inequalities. I talked to mothers about how they conceptualised austerity and welfare reform, their relationship to these 'macro' factors, and the impact they had on 'micro' factors – their everyday opportunities, life trajectories and hopes for the future.

The review of the literature in **Chapter Two** presented the core research relevant to the thesis, and emphasised the cross-cutting, interdisciplinary nature of the research. The literature centred around three main themes – the value of everyday life when considering the impacts of austerity; the interplay between macro and micro factors determining the political economy of health; and the intersectionality of inequality underpinning the lives of respondents.

Chapter Three outlined the methodology and methods used in the research, emphasising the relevance of combining longitudinal interviewing and ethnography in this research context. The methods used represented a distinct point of departure from most research into 'place and health' in health geography, which typically employs quantitative methods (such as Chaix, Merlo, and Chauvin, 2005; Giles-Corti and Donovan, 2003; and Sampson, Morenoff, and Gannon-Rowley, 2002). Much of the work in the health geography literature pertaining to place and health thus far is quantitative in nature. As Pearce (2013) noted in the health inequalities literature and Brown and Spencer (2014) in the field of economics, interdisciplinarity can invite new understandings and interrogations of the inequalities austerity is producing. Therefore my approach seeks to enhance the field as it utilises qualitative (ethnographical and longitudinal) methods to examine the political economy of health. Qualitative, sociological work which seeks to understand the everyday lived experience and the intangible emotions and practices of individuals is of great importance in this respect.

Chapter Four discussed how 'place' mattered as a conceptual grounding in the everyday lives of respondents. Place shaped everyday practices, habits and opportunities and, as a consequence of austerity, amplified the challenges experienced in less affluent places and widened the inequalities between places in Stockton. In this chapter, I discussed linkages between health and place and provided illustrations drawn from the ethnographic research. I demonstrated how respondents felt that those in poorer areas were more likely to have poorer health, and how living in a damp house or having a bad job could contribute to this. I also demonstrated that respondents with fewer socio-economic resources reported feeling anxious and experiencing stress and worry. Significant community resources, such as community centres and support services were being rolled back in austerity and this was cause for major concern. This chapter argued that an emphasis on individualised 'failings' (of estates, groups or individuals) overshadowed the socio-spatial

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inequality austerity is producing. It also emphasised the need for ongoing research into the intersecting harms austerity is generating, as has recently been discussed in work by Emejuju and Bassel (2017) and Hall et al. (2017).

Chapter Five centred around a discussion of respondent's experiences of health, everyday life and perspectives on the social determinants of health in the context of austerity. I emphasised the value of researching everyday life with mothers and presenting lay experiences on health. I explored the social determinants of health in Stockton and the localised impact of austerity on respondents, and how compositional determinants impacted localised inequalities on a classed and socio-economic spectrum. I then discussed the pervasiveness of mental health issues for respondents, and the different experiences of these. For respondents, being mothers within certain classed contexts limited opportunities or framed choices in certain ways. The complex intersections of gender, age, dis/ability and socio-economic status produced different lived experiences which had consequences for health in an age of austerity – increasing mental health issues for many. Finally, I argued that women face 'invisible inequalities' through a combination of financial inequality, the pressure of caring work and a lack of support services. These invisible inequalities, I argued, in the context of an intersectionality of inequality, may contribute to the experience of widening health inequalities for women.

Finally, the discussion in **Chapter Six** seeks to advance the arguments made in the preceding chapters. It does so by first drawing on a political economy of health explanation to argue that the root causes of inequality and health inequalities in Stockton are embedded in the broader political and economic structures of society. The cause of poorer health in deprived parts of Stockton are due to historical, political and economic processes which have created socially stratified experiences of everyday life leading to different health experiences. Austerity is one major factor contributing to this. Following this, I argue that an explicitly FPE perspective provides a point of departure from the conventional political economy approach which does not give due consideration to gender. The impacts of austerity are politically and economically to the detriment of less privileged groups and are gendered in both design and outcome. They do not acknowledge women's unpaid labour and deepen inequalities experienced by women. I finally argued that through a FPE critique we can fully integrate the different dimensions of society – public and private, economic and social, and the different levels on which political life operates, in order to thoroughly understand the causes and implications of austerity and mount a challenge to it.

This thesis offers an innovative contribution to the broad fields which examine the geographies of health inequalities and feminist enquiry into austerity. It occupies an intersection between a number of strands of knowledge and disciplines – drawing on geographical, sociological and health inequalities literature. Significantly, it contributes to the debate within health geography on context and composition (Bhandari et al., 2017; Cummins et al., 2007; MacIntyre et al., 2002; Marmot and Allen, 2014; Pickett and Pearl, 2001) and emphasises the need to move beyond the traditional binary of this explanation, turning instead to a political economy of health for a more complete explanation. Examining how respondents understood health

inequalities and the gendered and classed experiences of health was of great importance and represented an original contribution to the literature – as this type of work on everyday life, in the context of austerity, has not yet been done with mothers.

The empirical investigation into the contextual and compositional factors underpinning health through the lens of 'lived experience' was also an original contribution. It draws on the importance of intersectionality as a core concept – how class, income, geography, dis/ability and gender impacted and informed these experiences. This is important because much health inequalities research has taken socio-economic status as the main stratifying category, and incorporated intersecting categories in unsatisfactory ways. The utilisation of an intersectional perspective in examining health represents an important and significant step towards advancing the field of health inequalities research.

6.2 The gendered political economy of health

6.2.1 Beyond 'place matters' and 'the social determinants of health' to a wider politics of health

Place-based 'contextual' factors or individual 'compositional' factors were conventionally cited in health geography as the explanatory frameworks for understanding what causes health inequalities. Explanations for why the lives of many respondents in Stockton were becoming more difficult in the period of austerity might centre around these. A 'relational' (Cummins et al., 2007) or 'collective' – the 'socio-cultural and historical features of communities' (Macintyre, 1997; Macintyre et al., 2002) – perspective might also be employed. But none of these accounts are adequate at unpacking the structural causes of health inequalities. Pearce (2013) has articulated that contextual explanations provide only a partial account of health inequalities in a localised context. Places are fluid, the result of years and decades of accumulated social and economic change (Wacquant, 2008) as the human geography literature indicates. Compositional explanations, when not veering towards behavioural accounts or 'lifestyle drift' (Mackenbach, 2011) provide a useful way of encountering agency, choice and the practices people make in their distinct social worlds (Curtis, 2004). Place-based, individual and collective factors matter in the 'mutually reinforcing and reciprocal relationship between people and place' (Cummins et al., 2007) and therefore framing the issue as a 'relational' one is important. However, these factors impact health inequalities in ways which are not easy to unpack.

Explanations for the broad set of experiences relating to austerity and the widening of the health gap cannot be explained solely through examining the impact of austerity on places nor through understanding the experiences and perspectives of people living there, however complex. It mattered that respondents perceived anti-social behaviour to be increasing in their areas, were unable to adequately heat their homes and worried a lot more as welfare reforms hit and their benefits decreased, because these impacted their material, financial, mental and emotional wellbeing. It also mattered that Stockton had gone through iterations of similar political and economic struggles within the living memory of respondents, such as the closure of the steelworks, chemical works and the decline of the once-thriving shipping industry.

A relational conceptualisation challenges the binary of compositional and contextual factors. It understands that 'places' vary in how they are articulated through space and time and accommodates the significance of scale – how places are 'produced and maintained by the activities of 'actors', proximate or distal to a particular place, who operate individually or in concert across a wide range of geographical scales' (Conradson, 2005). However, a political economy approach and, furthermore, one which considers the gendered political economy of health is more appropriate for digging into the structural explanations for health inequalities in an age of austerity. Without this, it is possible to draw out neither the multiple, overlapping causes of inequalities and health inequalities, nor the solutions.

6.2.2   Towards a gendered political economy of health in an age of austerity

The place you are born in and live in, where you might travel to, choices you have available to you to take or not take, everyday practices and habits shape experiences of health and contribute to health inequalities. This has been articulated by Slater (2013) who argued that 'where you live affects your life chances' but that 'your life chances affect where you live' (2013: 367). These mutually reinforcing factors imply both an interrelatedness of causes, and a structural underpinning of inequality. While a relational understanding of health inequalities is an important way of explaining how inequalities are played out through everyday life, places, individuals and communities, it cannot delve deeper. The determinants of these factors are ultimately governed by political and economic forces. Therefore, these individual or localised characteristics can, and should be, subsumed under a greater understanding of political and economic structures governing society and lives (Bambra, 2016).

While it is true that, for respondents, damp housing led to having more colds, it is neither the damp housing nor the housing association that manages said housing that is really the cause of the colds, nor the feeling of unfairness this situation created. Rather, it is the circumstances in which poor quality social housing are allowed to endure within an overall context of inequality that matters. The housing market is one cause of this, but so too are the social security landscape, the job market, regional and geographical inequality and class hierarchies of power and maldistribution. The political economy of health perspective provides a way of understanding how places, lives and practices are shaped by political decisions, public policy and economic rationale in a national and globalised sense. It provides an analysis which considers the political causes and consequences of the widening health gap.

Austerity is leading to depressed wages, a weakening of social protection, reduction of public social expenditures, privatisation of public services such as medical care, education, and social services and a weakening of collective bargaining and trade unions (Navarro, 2013). The structures and policies governing what is possible and what is not are at the root of explaining differences in experiences of inequalities and health inequalities. The solutions to the inequalities austerity is perpetuating lie not specifically in campaigning for more social housing units, campaigns to raise awareness of mental health issues, or affordable sources of credit for low income households. Isolated or specific policy solutions and targeted interventions can only

ameliorate in small-scale circumstances. Gideon (2014) has developed a framework which captures the 'multi-determinants of health and well-being' alongside the organisational and institutional structure of these.

However, the political economy of health perspective is subject to the critique that it is too often gender-blind or that it differentiates between the normative categories of 'men' and 'women' while ignoring the complexities of these roles (Krieger and Fee, 1994). To give one example, unpaid care work provides a central function in health care provision and health outcomes, something which is overlooked in many quantitative studies on the political economy of health (Gideon, 2014: 24). For this reason it is important to reemphasise the gender dimension of this field.

6.2.3   *A feminist political economy of health*

Women and men have different health experiences – to put it simply, women live longer than men but have worse health. The adage 'women get sick, men die' (Doyal, 1995) has summed this up. In countries where gender equality is greater, the health of both men and women also tends to be better (Stanistreet et al., 2005). In order to interrogate the gendered inequalities of health, we need to examine the 'base of privilege and power within society' (Kapilashrami et al. 2015: 22). The earlier literature from the 1970s, the most well-cited example being Doyal and Pennell (1979) critiqued women's burden of ill health, stating that women, particularly working class women, engage in a double burden which impacts their health negatively. This double burden or 'second shift' (Hochschild, 1989) – wage labour and household duties, resulted in women who were 'over-worked and physically and mentally exhausted'. They were less likely to join trade unions and campaign for better conditions (Panikar, 1980), were under-paid and had greater job insecurity. They also performed emotional labour (Hochschild, 1983) to a greater degree than their male counterparts.

Academics writing in this field (Hibbard and Pope 1983, Gove and Hughes 1979, Verbrugge 1985) took the stance that 'the differential risks acquired by the social roles, life styles and health behaviours that men and women engage in and, therefore, that women's higher morbidity is 'real' and firmly rooted in life circumstances and experiences' (Annandale and Hunt, 1990: 25) and that it had a psychosocial component (Nathanson 1977). This earlier work occupied an important intersection between theory and praxis – its aim was to help foster a healthier society. Moving towards the present day, the field began to be influenced by, on the one hand, liberal feminism's concern with the 'health enhancing effects of access to social roles and statuses hitherto defined as male' and radical feminism's emphasis on 'the primacy of gender over other statuses in the production of inequality' (Annandale 1998a). Annandale and Hunt in their 2000 text which reinvigorated the field put forth a number of valid questions – 'to what extent should the ongoing social change in men and women's lives in the worlds of work, household and the family, leisure and consumption in western societies be understood in terms of greater equality or greater inequality?' and 'How are we to understand the new social relations of gender in this context – has patriarchy been superseded, or has it taken on new forms that no longer rely upon a binary division of gender?' (2000: 2).

This thesis acknowledges the importance of this older work which critiqued patriarchal society and work from the 1990s. The application of a gendered political economy of health in this thesis acknowledges the importance of examining access to healthcare and the political and economic implications for health of unequal society. The questions posed in the earlier eras and the research agenda set out are of renewed relevance in the era of austerity, when health inequalities are widening. When I emphasise the importance of the gendered focus on the political economy of health, I do so not to reify the different categories of 'men' and 'women' but rather to emphasise that under austerity people are operating in ever-more gendered spheres which have great implications for their health and, in the specific case of this thesis, the health of mothers and women. A growing interest in intersectionality as a framework (Hill, 2016) provides a new opportunity for understanding how different roles intersect and overlap to produce inequality, although this aspect of the discipline is not yet well developed. My contribution represents an attempt to advance this important aspect of the health inequalities field.

6.2.4   The need for a feminist political economy of austerity

A feminist political economy perspective is, I argue, the best way to advance the discussion of the political economy of austerity and provides unique points on which to challenge austerity (Bakker, 2007). A major emphasis of this perspective, one which is not accounted for in other theoretical frameworks, is social provisioning, or how societies organise to provide for the sustaining and flourishing of life (Nelson, 2005: 6) and how power is exerted by one group over another. Marilyn Waring, author of influential text 'If Women Counted', has argued that we must refute the 'partiality of political economy' and that 'feminist scholarship cannot engage in the disciplinary fragmentation which current pervades social science' (1989: 10). By utilising an intersectional lens, one which acknowledges the centrality of social class and capitalist relations (Anthias 2012; Emejulu and Bassel, 2015) we can enhance our understanding of how the enduring crisis of austerity is an issue of FPE.

Within a contemporary neoliberal economic understanding of the economy and society, there is a supremacy of accounts of rational economic behaviour (Nelson 1995). Individuals are framed as self-serving and efficiency-seeking. The FPE framework directly challenges this perspective, arguing that equality, compassion, altruism, fairness and care, factors deemed to belong to the non-market sector and private sphere, should also be considered as motivating factors in human behaviour. Furthermore, in private spaces, such as the family, the work of caring and acting compassionately has traditionally been assigned to women (Beneria et al., 2003: 68). This further muddles the underlying motivations of the capacity to behave as a 'rational actor' – to what extent do women act freely? As Ferber and Nelson (1993: 6) note, 'models of free individual choice are not adequate to analyse behaviour fraught with issues of dependence, interdependence, tradition, and power'.

The location and concentration of caring in private spaces is not inherently 'natural' but a product of capitalist society. The separation of these realms creates an inherent imbalance in society which does not benefit the majority. Fraser has argued that 'Capitalism's economic subsystem depends on social reproductive activities external to it' (2016b: 101). Not only does the prevalent economic system rely upon social reproduction to

sustain it, but creates the circumstances for a crisis to flourish when capital's 'drive to expanded accumulation becomes unmoored from its social bases and turns against them' (2016b: 103). This current period of austerity is one such instance and required a feminist lens to adequately critique.

6.2.5 A feminist political economy of health and austerity in Stockton

The mothers I interviewed for this thesis experienced a set of circumstances which were disadvantageous to their economic and mental wellbeing. With children, many of whom were of pre-school age, they could not simply go out to work. Therefore, they were reliant on partners, husbands or the state for income. In an age of welfare state retrenchment and declining wage growth, this represents a point of struggle. Many women juggle housework and caring for their children alongside ongoing mental health and sometimes physical health (such as chronic pain) issues and pressure from the state to enter paid work. This set of circumstances encompasses the invisible inequalities of women's lives – unable to work due to caring duties, the often-invisible mental health issues from the strains and stresses of caring work that never ends (depletion through social reproduction), chronic pain that goes untreated owing to lack of time and resources, and a partner who fails to value the contribution she. It also illustrates the limitations of conventional perspectives on redistributive justice centred around money alone. As Adkins (2015: 31) has articulated in noting the limitations of having 'faith in money as an injustice-remedying substance in a crisis-ridden and (still thoroughly) financialised reality' (Adkins, 2015: 31).

In this section I advance the argument regarding the importance of conceptualising austerity through the feminist political economy [FPE] lens. The argument is set out as thus – firstly, that social reproduction [SR] is a hugely time-consuming facet of many women's lives but that it constitutes an invisible inequality that sustains a fundamentally unequal system through the time and resource drain and social depletion it places on women. The artificial obscuring of the importance and value of SR places women in a difficult situation – they are expected to be immersed in both the public and private spheres, simultaneously, without adequate background support. Secondly, this factor, and the specific configuration of austerity reforms, means that austerity is thoroughly gendered. Under austerity, for example, many of the mechanisms through which women engaging in SR might access a reasonable standard of living – through benefits, being exempt from welfare conditionality and access to services that bolster and support their work, have been gradually withdrawn. Finally, a solution to the harm of austerity must go beyond arguments for redistribution, and acknowledge women's invisible inequalities.

6.2.6 The invisibility of social reproduction constitutes the primary mechanism of women's 'invisible inequality'

It was apparent when conducting research that social reproduction – childrearing, caring and household work, and the 'invisible inequalities' it created – generated time binds for respondents, and in some instances respondents linked this to increased mental ill health. This may represent the process of 'depletion through social reproduction' – 'the level at which the resource outflows exceed inflows in carrying out social

reproductive work over a threshold of sustainability, making it harmful for those engaged in this unvalued work' (Rai et al., 2013: 3). These were not incidental, but prevalent themes within the data. The enduring nature of these factors was immersed in a deeper, entrenched logic of a value system which does not acknowledge the worth or contribution of these forms of labour to reproducing the national economy and society. Economic and financial activities 'free-ride' on social reproduction, in the sense that the latter are a prerequisite for the former (Fraser, 2016). These 'background' activities are separate from economic activities, 'structurally subordinating' it to wage work (Fraser, 21016: 102). Throughout history, for every society and culture, social reproductive processes are and must continue to operate prior to economic processes. Their artificial separation into different spheres from at least the industrial era onwards (de Vries 1993; Sharpe, 1995) represents an obscuring of the importance and value of social reproduction. Goldschmidt-Clermont, in 'Unpaid Work and the Household' argued that:

> *'the border line between production and consumption, as drawn in economics, is only a conventional line, convenient for distinguishing between relatively easy to measure monetary transactions on the one hand, and nonmonetary production for exchange or self-consumption on the other'* (1982: 1).

Aspects of the neoliberal turn have intensified these invisible inequalities. They include the 'simultaneous erosion and intensification of gender' whereby gender and the differing needs of women, are erased from policy considerations, and the 'simultaneous demands for autonomisation and responsibilisation' (Bakker, 2007). This takes place through the progressive detachment of individuals from social networks and supports, while at the same time, responsibility for systemic problems is handed to the individual (Bakker, 2007; Brodie, 2003). Gender structures place different levels of value on 'masculinised and feminised identities, desires, expectations, knowledge, skills, labour, wages, activities and experiences' (Spike Petersen, 2005).

The value of unwaged labour, such as care and reproductive labour is often overlooked in relation to the measurement of productivity and economic worth (Bezanson and Luxton, 2006: 37; Beneria et al., 2003: 43 Riley, 2008). Contrary to this erasure, I argue that work cannot be understood without examining how gender is embedded in all social relations (Dickinson and Schaeffer 2001). Public and private spheres are intimately connected. The public world of politics, of social institutions and businesses and productivity cannot exist within the private, of homes and reproduction, of care work and domestic labour. As I will argue in the following sections, when this is not acknowledged it leads to increasing 'social depletion' which affects everyone in society (Rai et al., 2013). In the context of austerity and other 'crises' this risk is great.

6.2.7 *Austerity is implicitly gendered*

Gender is central to ongoing economic and welfare reforms in the UK – cuts and reforms have had explicit consequences for gender equality (Hall et al., 2017). Austerity is creating the circumstances to embed inequalities within men and women's experiences of everyday life and entrench the invisibility of private care work and other forms of social reproduction. Under austerity we have seen the culmination of a focal point of 'crisis' – a shift away from a family wage to the absorption of women into the labour market, increasingly retrenched state support for women, and an explicitly shrinking value attributed to social reproduction. In

recent years, different iterations of the 'family wage' have helped to stabilise capitalism (Fraser, 2013) shifting from a male breadwinner to dual earner model. The distinct social experiences of the sexes are a crucial means of analysing equality in society (MacKinnon 1982: 518).

Making women empirically visible is essential, as it exposes the different ways men and women engage with and are affected by political economy (Spike Petersen, 2005: 502). The political and economic implications of hardening social attitudes towards those reliant on benefits and those on low incomes (Jensen and Tyler, 2015) impact women in specific ways. Recent policies such as the Two Child Limit reflect this and harm women and their children explicitly. The Two Child Limit (gov.uk, 2017) caps the payment of certain benefits to families with more than two children. This is highly regressive, as a more families with three or more children live in poverty than families with two or fewer children (Bradshaw, 2017). The exceptions on the grounds of rape or other violence, which women must prove, has been condemned by numerous women's groups (Hall et al., 2017).

Tracey Jensen has recently provided insight into the moral economy of 'bad parenting', and how it is directly linked to the idea of 'Broken Britain' (Jensen, 2018). Negative stereotyping of poorer families as morally and socially deficient is used to further justify welfare cuts and programmes such as the Troubled Families programme, which entrench the economic and social inequality of growing numbers of families. Montgomerie and Tepe-Belfrage (2016) have highlighted the 'moral political economy' of austerity whereby the moralising language of the 'undeserving poor' has been directed in particular at women. They found firstly that familial debt is framed through a lack of 'financial literacy' and secondly that poorer women's morality is called into question in relation to the practices of social reproduction in everyday life. Instances of 'lacking' are framed through individualised and gendered failure and obscure the root political and economic causes. These examples illustrate how policy is deliberately obscured (Crouch, 2011; Hay, 2013), as politicians and policy-makers continue a project of austerity which generates uneven consequences for households and families while failing to address the structural problems of unfettered financialised growth. As feminist economists have noted, 'economic growth' acts as a framing device whereby the positive presentation of national economic performance obscures and silences those who might challenge it (such as heterodox economists or political opponents of austerity), and silencing those who are affected by these practices, in this case, women (Montgonerie and Tepe-Belfrage, 2016; Ferber and Nelson, 1993; Roberts et al., 2011).

6.2.8   Challenging austerity through feminist political economy

Findings from this research indicated that austerity measures were having distinct consequences for the everyday lives of mothers, as combining caring work and the additional pressures austerity was creating were contributing to mounting debt, a feeling of the deteriorating in the quality of community life and worsening mental health, referred to as social depletion (Rai et al., 2013). Through engaging with a FPE perspective we can generate substantive challenge to the gendered nature of austerity, and widening health inequalities. FPE can address these issues which, at their root, are about the political, economic and cultural expectations placed upon 'women' as social actors (Collins, 2015). Austerity, as a continuation of the neoliberal state, is a political

strategy through which the economy of debt and the operation of money as a commodity is extended, exposing women in particular to the operations of that very commodity and placing them at a disadvantage (Adkins, 2015). Some examples of this include financialisation and labour market expansion and deregulation. The IMF, one of the main institutions promoting austerity measures globally, has now acknowledged that austerity has stifled economic growth and widened inequality (Ostry et al., 2016). Their choice of phrasing – 'fiscal consolidation' gets to the heart of the issue. Austerity must be understood as more-than economic to get to the heart of the consequences it has had.

To challenge austerity and propose solutions I argue that we should go beyond arguments based on redistribution alone. While political economists such as Blyth (2013) have advocated for a solution to austerity through taxation as redistribution, feminists such as Fraser (1995, 1997, 2013) and Adkins (2015) take a different line. Adkins, for example, has argued that 'remedies to injustices constituted by unequally distributed resources, especially socio-economic resources such as property, wealth and money, are sought via strategies of the redistribution of those resources' (Adkins, 2015: 35). Viewing money as redistribution, without acknowledge women's invisible labour and invisible inequalities, cannot provide a clear solution to the inequalities austerity has produced. Placing the role of redistribution, through wages, benefits or other mechanisms, as a remedy to inequality, without acknowledging the centrality of social reproduction to society, is incomplete.

At stake is the deteriorating mental health mentioned previously, impacting women on low incomes in particular. This could have substantial consequences for women in the UK. The mechanisms of inequality austerity utilises can be expected to exacerbate the gendered political economy of health and entrench women's inequality further. The important tool of feminist praxis has often been an asset to feminist theory, using empirical and academic work to inform activism, community organising and aim to bring about social change, and must be reinvigorated. This challenge based upon the principles of FPE (acknowledging the centrality of social reproduction but its absence in policy) be it in economic geography, health geography or sociology (Werner et al., 2017) must be central to our critique of austerity.

6.3 Main emerging themes

6.3.1   *Austerity's embeddedness in everyday life*

The research findings from this PhD suggested that austerity policies introduced since 2010 were having a negative impact on the everyday lives of most respondents in Stockton-on-Tees. The austerity measures outlined in the literature review and findings chapters (cuts to public sector services and job losses, labour market deregulation, local authority cuts and welfare reforms) were having an impact and are contributing to already-wide inequalities for communities living in more deprived areas and for individuals across the borough.

Findings indicated that the impact on localities were significant. Localised and socio-economic inequalities impacted respondents in different ways. Those in more affluent areas were more likely to feel the effect of the

cuts through, public sector cuts which generated job losses, loss of income, and the anxiety of being unemployed and without income. They also felt the loss of services such as breastfeeding support and cutbacks in the NHS. The experience of those from more deprived areas was more negative in multiple ways. Their sources of income were being diminished through benefit cuts, and a lack of quality work. These were taking place in a context in which many in poorer communities in Stockton were already living on a low income, in poor quality housing, and struggling to find well-paid and secure work. These issues were generating worry, anxiety and, for some respondents, depression. Fewer resources and a void left by service cuts had a cumulative effect on mental health. Local council cuts generated a number of challenges. Services which were once run by trained staff have volunteers making up the shortfall, were running on reduced capacity, or had ceased operation. The closure of community centres was particularly felt as a loss. Respondents felt local council were doing their best with devolved responsibility and reduced budgets, but that it wasn't enough.

Austerity was also becoming embedded in everyday life through mounting financial insecurity for many respondents. There was a feeling that there was little money left over after keeping afloat of the basic necessities with which to take part in leisure activities, take a holiday, run a car or pay for unexpected expenses. Occasional needs like a new pair of glasses or contributions to funeral expenses generated worry and anxiety. Welfare conditionality, the future switch to Universal Credit and anticipated future cuts to benefit were adding to this. Many respondents were impacted by a 'poverty premium' by relying on prepaid gas and electricity meters as well as overdrafts. They were aware of this financial penalty but felt powerless to avoid it. Many respondents had little access to credit and financial resources and had debt, so further cuts could be expected to affect them significantly.

6.3.2   *Mental health has been affected by cuts, reforms and austerity measures*

All respondents experiencing mental health issues had spoken to their GPs about it. Respondents consistently stated their preference would be for a holistic approach that included counselling or other therapies rather than be offered just medication. Many respondents took or had taken anti-depressants. Those with the most difficult mental health issues felt let down by the healthcare system and unsupported. Respondents saw cuts to the NHS as playing a part in their mental health issues – they felt it was more difficult to get a doctor's appointment, to get time with a doctor to talk through all emotional issues (especially when there were also physical issues at play) and that referrals to support services would take a long time.

All respondents but one discussed enduring and prevalent feelings of mental ill-health in their everyday lives. Discussions of mental health ranged from depression, postnatal depression, anxiety and worry to suicidal thoughts and self-harm. Mental wellbeing was being affected through feelings of insecurity and disempowerment. Stress and worry was increasing with money struggles stemming from being in debt and managing a budget on an ever-decreasing and insecure income. There was a general consensus among respondents that feeling depressed or anxious was a normal and expected experience. They also

acknowledged that their mental health issues were embedded in their roles as mothers and they would like more support from their partners and communities.

6.3.3 Mothers need more space, time and resources to care

Many respondents articulated the desire to care for their children and families free from the effects of welfare conditionality or the pressure to engage in low-wage work from their partners. Respondents felt that social and public policy, media narratives and popular discourse devalued their work as mothers and carers – work which, they felt, continued through their whole lives and which was an important part of their identity formation. There was an overall agreement that mothers caring for children and older relatives should have the right to choose when they would engage in paid work, and that this caring work should be afforded a higher value in society.

Those on low incomes noted that their ability to be a long-term stay-at-home-mother was really not an option for them and other low-income families – they would still need to supplement the family income with low-paid and casual work. This full-time mother role was seen as a possibility only for middle-class mothers. However, if and when they worked should be a choice they made rather than 'actively seeking work' being a precondition for state support. Respondents reported undertaking the majority of the unpaid household tasks, management of the bills and household finance as well as care work of children and parents. Those from middle class households were more likely to report sharing domestic work. All respondents reported experiencing a time bind, and that public policies associated with austerity were to varying degrees amplifying this. They also felt that community resources such as community centres, youth clubs for their children to attend and other support services, were crucial in supporting their caring work, and regrettably noted their retreat under austerity.

6.3.4 Inequalities intersect

Respondents, as women and mothers, experienced a set of circumstances which generated distinct experiences, some of which placed them at a disadvantage in society. These experiences related to their reproductive and caring work, which generated a time bind and depleted their capacity to cope, which made it challenging to engage in full time paid work, education or to manage the ensuing mental strain. Some were financially vulnerable and this, coupled with the future expectations of further welfare cuts, increased their need for resilience in order to manage. There was a general lack of opportunities for quality and secure work in the area and childcare was expensive. their localities, diminishing financial and community-based resources due to austerity were felt through the closure of services, community centres and cuts to local council-provided amenities and services.

These context-specific factors listed above intersected with the structural barriers women in general face across the life course to produce an intersectionality of inequality. These structural factors include inadequate representation in public life and in policy making, gender-based discrimination in the workplace and unequal gender roles. These further intersect with factors such as socio-economic status and social class, race and

disability to create 'invisible inequalities' which impede opportunities for individual women and prevent the collective mobilisation of women.

6.4 Addressing research questions and aims

Aims:

- To understand the everyday effects that austerity measures, specifically welfare reform, public service cuts, and labour market reforms, were having on mothers in Stockton-on-Tees.
- To examine how these experiences varied across class, income, and geographical contexts and the intersectionality of these.

Questions:
- How did mothers in Stockton-on-Tees talk about and conceptualise austerity, welfare reform, and their position in relation to these?
- How was austerity impacting the lives of mothers from different socio-economic contexts in Stockton-on-Tees?
- How can engaging with mothers enhance our understanding of gendered health inequalities?

This thesis sought to understand the everyday lived experience of austerity for mothers living in Stockton-on-Tees and how mothers talked about austerity and welfare reform in relation to their own subjectivities. To do this I asked questions about specific aspects of austerity – welfare reform, cuts to public sector services and jobs, and labour market reforms. It was not easy, in the course of interviews and fieldwork discussions, to separate the general experience of inequality that was felt in Stockton prior to austerity from aspects of life which were made difficult as a direct result of austerity. The rhetoric underlying austerity's welfare reform includes ideas about 'making work pay', the demonisation of those on out-of-work benefits and a 'deserving/undeserving' dichotomy (Patrick, 2017) through the 'machine of welfare common-sense' (Jensen, 2014). Inequality has been able to prevail through privatisation and welfare retrenchment which have taken place gradually and successively, are multi-modal and are frequently attributed to individual failings.

Throughout the interviews, I tried to draw out the varying impacts of austerity by making reference to specific policy measures (such as the bedroom tax or sanctions) and other effects which were more ambiguous and psychological such as increased intervention from the Job Centre or social services and asked if and how they had impacted respondents. I did this through asking open-ended questions, being clear to not lead with my intent (for example, 'have you felt affected by welfare reform, could you describe which aspects etc.?'). I found that there was a divide in how respondents talked about the impacts of austerity. Some clearly identified austerity and welfare reform as the root cause of their deepening experience of inequality. These were generally, but not wholly, respondents who were involved in community organising or were politically active. Others gave examples of how life was getting harder, knowing people who had to use foodbanks and a reduction in their income as a result of benefit cuts, but didn't explicitly identify a causal pathway from austerity measures.

These respondents conceptualised their position in relation to austerity in a non-causal way. I argue that their perspectives are shaped by the private way that their experiences as mothers are felt. Dodson (2015) contends that 'gender organises the political sphere in ways that systematically constrain the ability of women to exercise their political voice' (2015: 378). The decline in the availability of public spaces to experience 'community' and the increasing extent to which lives are lived indoors, privately, might be exacerbating this. There was also a tendency to articulate one's distance from the experience of poverty (Shildrick and MacDonald, 2013). This finding reflects research which indicates that, as working-class solidarity declines, those in low-income and marginalised communities are less likely to identify the socio-structural causes of this (Shildrick and MacDonald, 2013).

Interviewing women of different ages, socio-economic groups and women from the BAME community informed the research and this was important, as I wanted to examine the subtle differences in experience for respondents from different backgrounds and experiences. The majority of respondents were white, born in the locality and living on a low income. This is a widely represented demographic in the borough (Stockton-on-Tees Borough Council, 2011). There was also diversity to the sample in the sense that women of non-white ethnicities were interviewed, and the insights of one respondent who was a refugee were recorded. There were also women from more affluent areas whose insights were important in demonstrating how not just low income mothers are impacted by austerity (Holloway and Pimlott-Wilson, 2016). Interrogating the consequences of austerity on different socio-economic contexts revealed the multi-faceted political and economic consequences of austerity and neoliberalism (Peck, 2009). It allowed me to gain insight into how structure and agency interact and how policies can 'support – or undermine – the resilience of those at the sharp end of class and gender inequality' (Graham and McDermott, 2006) Capturing this diversity of experience demonstrated two points. Firstly, it illustrated how austerity enacted through welfare reform, labour market reforms and local council and service changes are impacting many different groups in diverse, intersecting and complex ways. Secondly, it illustrated the complexities of understanding class experience in the UK (Savage and Friedman, 2015).

There was great fluidity in the classed experience of many respondents as, throughout their lives, they moved from one context or lived situation to another. This subtle shift created complexities to their classed subjectivities, they might see themselves, or their upbringing might indicate belonging to one class group, but their income, job or accent indicate belonging to a different class category. This is consistent with Savage and Friedman's (2015) work on the changing nature of class. They have highlighted the fracture which makes it difficult to differentiate clearly between middle and working class, 'fuzziness in the middle reaches of the social structure' (2015: 172) owing to the precaritisation of the middle class, and a general shift in values and habits. They also highlight that class cannot be separated in the axes of inequality from gender or ethnicity (2015: 173).

The research methods employed in this study could not substantively measure or comment on the causes of health inequalities explicitly, but were suited to capturing the effects of the cuts on women and the impact on

their health in a qualitative sense. The research was also able to examine the interplay between structure and agency which Popay et al. (1998) have identified as a key contribution that qualitative research can make. It was in this way that it could contribute to our understanding of gendered experiences of health inequalities. Many respondents felt their health was less-than optimum and referred to challenges rooted in multiple aspects of their lives; poor housing, the lack of quality work and shortage of income, and the stress and strain of simply being a mother. These findings give important insight into the health of women in a way often lacking.

Graham and McDermott (2005) have highlighted the way in which qualitative research can be excluded from informing policy on the grounds that it is not generalisable. However, it has merit through its insight into the lay experience. The research emphasised the difficulty in discussing health inequalities in a concrete sense with individuals who are themselves directly affected by wide health inequalities. Asking individuals to reflect on a situation in which their health was personally implicated was difficult and elicited complex layers of opinion ranging from individualised to more nuanced explanations (Garthwaite and Bambra, 2017). The research gained insight into how beliefs and behaviours which may have implications for health are part of the fabric of everyday life (Backett, 1992: 257) and how respondents' behaviours and everyday lives were shaped by their experiences as mothers.

6.5 Areas for further research

This project highlighted the importance of conducting research with women and mothers, particularly in the context of recent austerity and ongoing changes in public policy and social life. There is an ongoing need to focus explicitly on the experiences, everyday lives and perspectives of women, embedded in the work of social reproduction. This should take the form of qualitative methods which emphasise lay experience and subjectivities. Participatory methods such as Participatory Action Research (Banks, Herrington and Carter, 2017; Banks et al., 2013) are one such way of ensuring participants are involved in all processes of the research, including the writing up of findings. A good example of this is the co-produced creative work done by Researcher Ruth Patrick, ATD Fourth World, Thrive Teesside and the Dole Animators highlighting the impacts of welfare reform (Poverty to Solutions, 2018). The voices of mothers are not explicitly heard within policy, nor are their needs and perspectives addressed by policy makers in general. Voicing their concerns and perspectives to inform policy that affects their lives and their families is therefore paramount.

Ongoing research into gendered experiences of health inequalities, particularly through qualitative research, is important. While there is a lot of focus on the health inequalities of men and at population level, qualitative work with women might invite new perspectives and understandings on the 'hows and whys' of people's lives that give rise to health inequalities. Work on intersectionality, such as that being undertaken by Hill (2016) is particularly important, as it highlights how gender intersects with other factors such as ethnicity. Further work should be undertaken to emphasise the 'invisible inequalities' of women's lives. Findings illustrated that women undertake a huge amount of unpaid work, have the burden of managing the household budget, and are increasingly compelled to engage in paid work. The role of social reproduction and the strain it puts

women under, specifically in a context of wide inequality warrant further investigation. Particularly relevant to this is work examining the mental health consequences of this juggling – from the experiences of stress, of shouldering multiple burdens, of chronic illness and the effect of community conditions and localised contexts on these.

The timing of this research overlapped with the build-up to the EU referendum Brexit vote for the UK to leave the European Union, resurgence in populist politics across the EU, the popularity of UKIP, and the election of Jeremy Corbyn to the Labour Party who campaigned on a left-wing platform. It would therefore be worthwhile to build on current research being undertaken into this shifting political landscape (Dorling, 2016; Pottinger et al., 2017) from the perspective of women. This could highlight the implications of this political turn for those living in an area of inequalities, and interrogate how women conceptualise their participation in public, political acts (Craddock, 2017). Trying to understand the feelings of disenfranchisement which led many to vote to leave the EU and the causes of Brexit is significant to understand the evolution of social and political life in the UK.

Finally, as this was a longitudinal research project, one highly valid avenue of future research would be reconnecting with participants to conduct future waves of interviews. As austerity cuts will progress and roll out in the coming years, their perspectives and everyday practices may change further. It would also be valuable to see if their children's experiences of school, work and entering childhood, adolescence or adult life are being shaped by austerity measures and how they conceptualise this. These potential projects highlight the valuable and rich insights longitudinal research can provide, and their importance in this age of ongoing austerity.

6.6 Policy recommendations

In this section I make three policy recommendations based on the core findings of this thesis – that austerity generates challenges for women and contributes to the health gap, that increasing mental health issues are symptomatic of that, and that the often-invisible nature of women's caring work is central to welfare reforms and to the mental health challenges women face. These policy recommendations broadly follow Rai, Hoskyns and Thomas' (2013) work on depletion through social reproduction, in which they outline that in order to reverse this depletion processes of mitigation, replenishment and transformation are required.

Recommendation One: Mitigating the effects of austerity on individuals and communities – Addressing the uneven impact of reforms

This research has examined austerity's impact on depleted community resources, the lack of quality work and the impacts of welfare reforms on households and individuals. The United Nations Committee on Economic, Social and Cultural Rights (2016) has called for an end to austerity measures in the UK, stating that welfare payments should guarantee a level of income commensurate with a decent standard of living. Pervasive welfare reforms have negatively impacted the mental health of many, increased financial vulnerability and widened health and socio economic inequalities. The progressive redistribution of wealth within the UK is

ever-decreasing (Dorling, 2015). Regressive austerity policies need to be abandoned, and to be replaced by increased investment in cross-cutting facets of the state such as public sector services, social security provision and the NHS. Income and wealth inequality need to be addressed by a progressive and redistributive taxation system and welfare system, and labour market reforms should be brought into place which benefit workers, such as ending precarious labour practices. Specifically important is bolstering the capacity of regional government, such as in the North East, to adequately provide for their inhabitants by reinvigorating the budgets of local councils which have been so unevenly impacted under welfare reform (Gray and Barford, 2018).

Recommendation Two: Replenishment through addressing crisis in mental health

A key outcome of this research is the clear need for a concerted effort to tackle mental health issues among women. Fischer (2009) noted that poor mental health is now treated as a natural and inevitable experience and that contemporary social theory should be politicised to critique this as a political rather than 'natural' experience. Neoliberal globalisation reduces the emotional, cultural and material resources necessary for the wellbeing of most women and families (Spike Petersen, 2005: 511). In order to alleviate the prevalence of mental health issues being experienced in the UK, there must be a shift to seeing mental health as not an individual but as a collective issue. A set of policies which tackle the social determinants of mental health issues should be introduced as a point of priority. The application of Mental Health in All Policies (MHiAP) is one such tool which could be utilised (Botezat et al., 2015). This recognises the broad-scale and multi-modal approach to tackling mental health issues that would be required. It involves both strengthening protective factors and reducing risk factors throughout the life course.

Recommendation Three: Transformation through making caring work visible and acknowledged

It is essential that the role of social reproduction is afforded central value in society and policy-making needs to reflect this. This should be done by firstly providing universal childcare, publically funded through general taxation. High-quality and affordable childcare, alongside comprehensive parental leave policies facilitate high levels of maternal and female employment, widens the tax base for redistribution and generates social mobility (Moss, 2013). Countries such as Iceland and Sweden are examples of effective and flexible systems of childcare provision (Ben-Galim, 2014). The potential benefits of systematic and universal early childhood services could be utilised as a mechanism for creating an inclusive society which celebrates diversity. Secondly, the social security system should be decommodified and defamilialised, defined as the decoupling of the capacity for a socially acceptable standard of living from dependence on either wage work or from a family member (Lister, 1997:37). This would place women's capacity for financial autonomy outside of dependence on wage labour or on a partner.

Conclusion: Rethinking possibilities

This chapter argued for the need to move beyond researching the significance of place or individual practices in contributing to health inequalities, integrating them both into a relational perspective on how places and the people living in those places are mutually co-existing and co-constructive. I further argued that a political economy perspective is essential to critique how austerity has influenced both places and their contexts, and the social determinants of health and the lives of individuals. It allows us to dig deeper than superficial explanations for inequality which rely on individualised justifications for an issue which is, at its root, political and economic. The superstructures which govern our lives in a globalised sense facilitate the making of certain choices, and make some choices impossible to some. The mixed reaction to the recent publication on 'Rethinking Poverty' by Knight (2017) has indicated that there is a great variation of opinion on how to tackle poverty and inequality, and on the historical legacies we can learn from. While Knight argued that efforts to end poverty have failed and strategies need to be rethought, others have retaliated that there have been considerable gains in the past and that it is only by redistributing wealth and resources, not a new concept, that poverty can be alleviated (Green, 2017).

There has been a gradual shift in recent decades towards individualisation and individualism in society. One such manifestation has been that poverty, health inequalities, institutional racism and gender inequality are viewed, not as structural and systemic issues with a cause and solution lying beyond individual action, but as rooted in the failings and practices of individual people. The focus in policy and political debates is largely concerned with blaming individuals for their faults, hailing successes as indicative of hard work and meritocracy. It is more important than ever to build positive solutions and to foster a deep sense of agency which connects individuals to their wider communities and to society on a whole, through multiple channels.

Finally, I argue that a FPE perspective accounts for the invisible labour women engage in. When it comes to seeking out solutions to move beyond austerity and neoliberalism, we must do so while holding gender and gender norms central to the resolutions. The FPE approach which I have argued should be employed in critiques of austerity places gender and the uncounted work of social reproduction as central to finding a solution for austerity. For too long, women have been excluded and perpetuated their own exclusion from full participation in public life. The result has been an economic, political and social world which marginalises the needs of women, and causes harm to many. When they have participated, it has too often been to 'Lean In' (Sandberg, 2013), to adopt a liberal feminist attitude of working hard and holding up as positive role models those who excel in business. Fraser (2016) has highlighted that this success is often predicated upon 'leaning on' others, reproducing patriarchal hierarchies and ignoring the sacrifice that another (often poorer) woman must do to uphold caring responsibilities and is not concerned with universal emancipation or redistribution.

In order to participate in public life, it is important that women be able to bring their caring work into the public domain, where possible. We must open up the black box of the home, bring women, and their social reproductive work into the light of day. This should not be the case solely for a particularly brave or belligerent woman, but of all women. If women can mobilise collectively, drawing on the multitude of lifeworlds experienced across the spectrum of womanhood, they may realise their potential as a hugely powerful group. The emotional, mental and physical toll from failing to act collectively is too great. To close, I will quote renowned philosopher John Holloway (2014: 1070) who wrote in response to the economic crisis that:

> *To learn hope is to see the force in the present of a world that does not yet exist but could do: the strength here and now of that which does not fit, of that which screams, however silently, 'No, we do not accept, we shall create another world.*

Figure 8. Flowers blooming in a front garden in the town centre

7. <u>Appendices</u>

Appendix A: Outputs from PhD

Peer reviewed publications

Journal article

Greer Murphy, A. 2017. Austerity in the United Kingdom: the Intersections of Spatial and Gendered Inequalities. Area, 49: 122–124.

Book chapter

Bambra, C., Garthwaite, K., Greer Murphy, A. 2018. Geo-political Aspects of Health and Wellbeing. In Bonner, A. Social Determinants of Health: An Interdisciplinary Approach to Social Inequality and Wellbeing. Policy Press, Bristol.

Conference presentations

Durham University, July 2017. Social Policy Association annual conference.
Title: Health inequalities and Austerity in Stockton-on-Tees: the Experiences of Mothers and Their Families.

Stockholm University, June 2017. Nordic Geographers Meeting. Title: Health inequalities and Austerity in Stockton-on-Tees: the Experiences of Mothers and Their Families.

Sheffield Hallam University. September, 2016. People, Place and Policy conference.
Title: Lives Changed Under Austerity? Insights into the Experience of Mothers in Stockton-on-Tees.

Royal Geographical Society, London. August, 2016. Royal Geographical Association International Conference. Title: Health Inequalities and Austerity in Stockton-on-Tees: the Everyday Experiences of Mothers.

Sheffield Political Economy Research Institute, Sheffield. July, 2016. SPERI Conference.
Title: Mothers in Stockton-on-Tees: Deepening Inequality in a Period of Austerity.

Durham University, June 2016. Fuse – North East England Health Summit: Inequalities-related Stress.
Title: Stress and Mental Health: Narratives of Mothers in Stockton.

Catalyst Stockton, October 2015. Challenging inequality: promoting social justice conference.
Title: Austerity, Health and Motherhood in Stockton.

University of Kent, June 2015. Austerity, Gender and Household Finances Conference.
Title: The health effects of austerity, and lived experiences of austerity in the North East of England.

Appendix B: Fieldwork Documentation

Information Sheet

Motherhood, wellbeing and austerity in Stockton-on-Tees

This research project is being carried out by a PhD student at Durham University between 2015 and 2016. The aim is to understand the experience of mothers and their families, how they have been impacted by welfare cuts, and their health and wellbeing. The project is interested in the experiences of mothers from all around the borough.

Key themes for discussion:

- Everyday life
- Health and wellbeing
- Recession, austerity and cuts
- Motherhood and family life
- The benefits system and the job market
- Housing, childcare, and transport in the community

Interviews will be carried out with mothers from Stockton-on-Tees who are willing to share their experiences.

- The interview will last approximately 1 hour, is friendly and informal, and it can take place in a location that is convenient to you.
- Over the year 2015-2016, respondents will be contacted for interview at least once more.
- Everything you say is treated with complete confidence. Your information will be anonymous - after the taped interview is typed up, all identifying details are removed, and the recording is destroyed.
- The anonymised version of your interview then goes into secure storage, and no one will ever be able to tell it was you.
- Your participation in this project is entirely voluntary and you can decide to opt out at any time.
- Before agreeing to take part, your rights will be explained and you will be asked to sign a consent form. This asks your permission to record the interview and include the information you give in a report and other publications.
- All participating households will receive a £10 high street shopping voucher to thank them for their time and help.

"Local Health Inequalities in an Age of Austerity: The Stockton-on-Tees Study" is a research project funded by the Leverhulme Trust, run by the Wolfson Research Institute for Health and Wellbeing at Durham University (https://www.dur.ac.uk/health.inequalities/).

If you would like any further information, please get in touch with me – my contact details:

Amy Greer Murphy Email: a.a.greer-murphy@durham.ac.uk

Consent form Phase 1 Interviews

Gender motherhood and health in austerity

Consent form one-to-one interview

Please read the information sheet, and then read the points below.

Please sign below if you agree with them. Feel free to ask questions.

- This is Stage 1 of the research. It involves taking part in a one-to-one interview.
- Your contribution will be in complete confidence – your name or identifying information will never be used.
- A series of open-ended questions will be asked. If you don't want to answer any question, that is fine.
- The interview will be audio recorded. With findings from other interviews, your comments may go into a report and other publications.
- In the coming months I will be in touch to arrange a follow-up interview. If you agree to participate, your consent will be sought again.

Signed: _____ (Name, researcher)

I understand the points above, and agree to take part in this research project.

Name:_____

Signed: _____   **Date:** _____

Contact information:

Telephone number:_____

Address: _____

Preferred method of contact (please circle one):   Telephone   Letter

Consent Form Phase 2 Interviews

Gender motherhood and health in austerity

Consent form one-to-one interview

Please read the information sheet, and then read the points below.

Please sign below if you agree with them. Feel free to ask questions.

- This is Stage 2 of the research. It involves taking part in a one-to-one interview.
- Your contribution will be in complete confidence – your name or identifying information will never be used.
- A series of open-ended questions will be asked. If you don't want to answer any question, that is fine.
- The interview will be audio recorded. With findings from other interviews, your comments may go into a report and other publications.
- I may seek one more interview with you. This could take place over the phone or by email, if you prefer. If you agree to participate, your consent will be sought again.

Signed: _____ (Name, researcher)

I understand the points above, and agree to take part in this research project.

Name:_____

Signed: _____ **Date: _____**

Contact information:

Telephone number:_____

Address: _____

Preferred method of contact (please circle one):   Telephone   Letter

Interview guide

Interview Questions

Interview One

- Introduce self and project
- Background of participant
    - Could you tell me a little bit about your family – number of children, partner/husband, age of kids, are they at home, in school, working.
    - Where do you live? Could you describe your house, street, and area. What do you like or not like about where you live?
    - Where did you grow up? Could you describe it?
    - Do people you grew up with still live around here?
    - How has Stockton changed since you grew up?
- Work
    - How would you say the type of jobs around Stockton have changed in recent years?
    - What kind of jobs do you think are available to people around here?
    - Tell me a bit about the work you've done in your life.
    - Do you do paid work now? Could you tell me a bit about it?
- Discussion of welfare reform
    - Were you aware of the cuts that have come in since 2010?
    - How did you feel about it then? How do you feel about it now?
    - Have issues like bedroom tax, food bank use, sanctions touched your life in any way?
    - Have they affected people around you?
- Day in the life
    - What would a typical 'day in the life' for you look like?
    - Do you think being a mum now is different to in the past?
- Life in Stockton
    - Do you think the sense of community in Stockton is strong? Do people look out for each other?
    - If you could imagine some positive ways Stockton could change what would they look like?
- Is there anything else you want to talk about?

Interview Two

- Recap
    - Since we last spoke, how has life been? Any changes to living situation, work, kids etc.?
- Shopping and food
    - Could you tell me a bit about your food shopping – where do you shop, do you make a list, do you budget for the shop beforehand, do you routinely use vouchers? What time of day do you do your shop? Do you pay with cash? Do you ever shop online?
    - Could you tell me a bit about the food you eat at home – do you plan meals in advance, do you eat together as a family, do you batch cook, use ready meals?
- Money
    - Could you tell me about how you manage money in your house? Do you have a joint bank account? Who pays the bills? Who keeps track of what needs to be spent on what?

- o Do you or can you save? Do you have access to credit (doorstop lenders, payday loans, bank, credit union)? Who in the household is in charge of finance?
  - o If you were short of money what would you cut? How do you prioritise or do you budget?
- Health
  - o What does good health mean to you?
  - o Do you think about your own health much?
  - o How do you take care of yourself?
- Any other questions?

Interview Schedule

Participant	Wave I	Wave II
Pat	September 2015	March 2016
Dee	September 2015	March 2016
Kelly	September 2015	March 2016
Jill	December 2015	March 2016
Lucy	December 2015	September 2016
Lisa	November 2015	April 2016
Trish	November 2015	March 2016
Jodi	November 2015	April 2016
Becky	November 2015	April 2016
Emily	December 2015	May 2016
Sam	December 2015	April 2016
Paula	December 2015	September 2016
Brenda	February 2016	April 2016
Carol	February 2016	May 2016
Anne	March 2016	September 2016

Fieldwork Notes Template

Name of researcher	
Date	
Location	
Individuals present	

Field notes:

Reflections:

Ethical Considerations:

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