

**Locating Health and Illness: A Study of Women's
Experiences in Two Contrasting Edinburgh
Neighbourhoods**

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Declaration

I certify that I am the sole author of this work.

A handwritten signature in black ink that reads "L. Airey". The signature is written in a cursive style with a large, sweeping loop at the end of the word "Airey".

Laura Airey

Abstract

This research explores the geography of health inequalities from a qualitative perspective. It considers the links between place, health and well-being by drawing on the life histories and daily routines of women in Edinburgh.

The study is based on in-depth interviews undertaken with twenty-four women aged between 45 and 59; twelve women were interviewed in each of two urban neighbourhoods. These neighbourhoods differ on some key health and socio-economic indicators - one neighbourhood is relatively affluent; the other is relatively deprived. Two interviews were conducted with each respondent. The first interview used lifegrids, which are more usually used in quantitative research, to locate health histories within the broader context of women's biographies. The second interview focused upon respondents' current daily routines, in order to consider how understandings and experiences of health and illness might be shaped by the web of resources and relationships that constitute everyday lives within particular geographical and social spaces.

The research prioritises the contribution of lay perspectives to understandings of health inequalities. Interviews were designed to tap into lay understandings of the meaning of inequality and to explore the psycho-social dimensions of health. This has two key implications for the research findings. First, the data testify to people's resistance to separating out 'health' and 'illness' from other dimensions of life experiences. Second, positive well-being emerges as a central theme within people's conceptualisations of health.

By combining a lifecourse perspective with a focus upon current experience, the research is able to situate women's experiences of both good health and illness within a web of health-relevant (health enhancing and depleting) resources. The study investigates a number of these resources: money, employment, features of the physical and social environment, and personal relationships. The findings indicate that access to such resources is influenced by social position. Furthermore, social position is also shown to have shaped women's trajectories into the neighbourhoods in which they now live. Thus, the analysis suggests how dimensions of individual

biographies interact with experiences of particular places in ways which are relevant for health.

The thesis as a whole draws on lay perspectives and experiences to elaborate current understandings of the processes which underpin geographies of health inequalities. Theoretically, it confirms the importance of psycho-social pathways linking life experiences with health. Conceptually it contributes to the debate on contextual and compositional factors accounting for geographical patterns of health and illness. Overall, it points to the priority that well-being has in people's lives and the extent to which this is mediated by experiences of social inequality.

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Chapter 1: Starting Points

1.1 Introduction

In affluent developed societies such as Britain, length of life and the risk of becoming ill are neither evenly nor randomly distributed amongst the population. Rather, there is a wealth of evidence which demonstrates that mortality and morbidity rates are clearly socially patterned according to socio-economic gradients. More affluent members of society, including those engaged in non-manual occupations, live longer and experience far better health than people in manual occupations with low incomes. The aim of this thesis is to contribute to understandings of why and how health risks are systematically patterned both socially (along a socio-economic gradient) and spatially (according to geographical areas). To that end, this thesis explores not only the processes through which relatively low socio-economic status might serve to undermine health and well-being, but also seeks to illuminate some of the mechanisms and pathways through which relatively high socio-economic status might promote good health and well-being.

The research which forms the basis of the thesis was designed to address some issues which lie at the heart of current debates over how health inequalities are generated and sustained. In this chapter I offer an overview of developments within the health inequalities literature in recent years, in order to provide a context within which to situate my own research project. I discuss the theoretical perspectives and empirical findings which shaped the design of my research. I also highlight some gaps within the literature and I show how my project is an attempt to start filling in these missing links.

1.2 The Black Report

The Black Report, first published in 1980, drew on British data which demonstrated a strong inverse relationship between occupational social class (as measured by the Registrar General's Classification of Occupations) and mortality and morbidity rates (Townsend & Davidson, 1988). For example, the report stated

that in the early 1970s, death rates for men and women in social class V were 2.5 times higher than for men and women in social class I (1988: 43). The report offered evidence of class gradients for various causes of death, including respiratory diseases, circulatory diseases, malignant neoplasms (cancer), diseases of the digestive system, and accidents, poisoning and violence. The authors of the report asserted that the excess mortality experienced by low-income groups is potentially preventable, and that social variations in health status are therefore more appropriately termed health inequalities. As well as identifying social class inequalities in health, the Black Report also documented regional differences in mortality and morbidity rates, noting poorer health in Northern regions of the country, compared to Southern regions (1988: 49-50).

As well as presenting conclusive evidence about health inequalities, the Black Report also considered four possible explanations for their existence. In the light of the tremendous influence that the Black Report has had upon subsequent research in the health inequalities field, it is useful briefly to review these explanatory approaches. Firstly, the authors considered the **artefact** explanation—that apparent inequalities in mortality rates between social classes are in fact artificially generated due to the inaccurate calculation of social class status. This explanation was discounted in the report; subsequently, several other studies have also demonstrated a consistently firm link between socio-economic status and health, regardless of the classificatory system used to determine the class position of individuals (Shaw et al, 1999; Vagero & Illsley, 1995). Secondly, the working group considered the possibility that health inequalities may be accounted for by **social selection**, whereby healthier members of the population tend to be upwardly socially mobile, whilst those with poorer health tend to move down the social scale – perhaps due to illness-related unemployment or the inability to secure a mortgage for health-related reasons. The authors argued that whilst there is some evidence of social selection occurring, it is insufficient to account for the magnitude of social variations in health.

The third and fourth explanations for health inequalities considered in the Black report are based on the notion that social circumstances may influence health; however, they differ significantly in emphasis. The **cultural/behavioural**

explanation is based upon evidence that more affluent social groups tend to adopt behaviours that are health-promoting, whereas poorer socio-economic groups are more likely to engage in behaviours that are health-damaging. The authors rejected the argument that the social class gradient in health may be explained solely by the health-related behaviours of individuals within different social classes. However, the report recognised the need to explore why health-related behaviours are structured by social class; in other words, what it is about people's socio-economic circumstances that may either constrain or enable the adoption of healthy lifestyle behaviours.

The authors of the Black Report concluded that the most plausible explanations for the existence of health inequalities are those which are rooted in a **materialist/structural** perspective, and which focus upon:

The role of economic and associated socio-structural factors in the distribution of health and well-being.
(1988: 106)

According to this explanation, inequalities in income and wealth (which reflect the occupational class structure) give rise to social gradients in mortality and morbidity. The working group identified a number of pathways through which structural factors may shape the social patterning of health. For example, they recognised that poverty and deprivation may pose material risks to the health of poorer social groups, via aspects of their living circumstances such as poor quality housing or inadequate heating. However, they also identified a range of other health-related dimensions associated with occupational class position, which are not necessarily physical in nature:

Occupational class is multifaceted in ‘advanced’ societies, and apart from the variables most readily associated with socio-economic position – income, savings, property and housing – there are many other dimensions which can be expected to exert an active causal influence on health. People at work for instance, encounter different material conditions and amenities, levels of danger and risk, degree of security and stability, association with other workers, levels of job satisfaction and physical and mental strain. These other dimensions of material inequality are also closely associated with another determinant of health – education. (Townsend and Davidson, 1988: 109)

The working group’s verdict, that the causes of health inequalities are best understood with reference to the materialist/structural explanatory model, had important implications for health inequalities research throughout the 1980s and 1990s (Bartley et al, 1998; Macintyre, 1997). However, health inequalities research in the past two decades has also been influenced by the political response to the Black Report, and by the direction of health policy under both Conservative and Labour administrations.

1.2.1 Responses to the Black Report – the policy context

The findings of the report were dismissed by the Conservative government of the time and preventive health policy in Britain throughout the 1980s and 1990s was dominated by an emphasis upon individual responsibility for health maintenance and protection, and an explicit emphasis upon the significance of lifestyle and behaviour in disease prevention (Allsop and Freeman, in Mills, 1993; Townsend, Davidson and Whitehead, 1988). This approach was a strong theme in policy documents such as *Promoting Better Health* (DHSS, 1987) and *The Health of the Nation* (DHS, 1992).

Since the Labour party came to power in 1997, there has been a significant shift in policy approaches to inequalities. The government instigated an Independent Inquiry into Inequalities in Health, chaired by Sir Donald Acheson, in 1997. The Acheson report was published in 1998, and it re-iterated the findings of the Black Report – that health inequalities are rooted in the social structure (Independent Inquiry into Inequalities in Health, 1998). The Inquiry made 39 main recommendations for action to reduce inequalities in health. In response, the government published a White Paper in July 1999 entitled “Saving lives: Our

healthier nation”, in which it acknowledged the need to tackle health inequalities. In Scotland, a White Paper entitled “Towards a Healthier Scotland” was published in February 1999 (SODH); this identified the need to reduce health inequalities in Scotland as an overarching policy aim (1999:7). In contrast to the previous Conservative administrations, the government has recognised the need to address inequalities in the structural determinants of health, such as living standards, rather than focusing solely on individual behaviours (Graham, 2000). This reorientation of the public health agenda has generally been welcomed by the research community, although there is some debate as to whether the government has taken enough action to ameliorate the root causes of health inequalities (Graham, 1999; Shaw et al, 1999a).

1.2.2 Responses to the Black Report – the research context

Despite the Conservative administration’s denial of the suggestion that social variations in health are rooted in socio-economic inequality, numerous follow-up studies have confirmed the existence, and indeed widening, of health inequalities in the two decades since the report’s publication (Carroll and Davey Smith, 1997; Davey Smith et al, 1990; Drever, Whitehead & Roden, 1996; Marmot & McDowall, 1986; Whitehead, 1988). The findings of the Black Report stimulated a considerable body of research, which was primarily quantitative in nature, and which sought to account for the empirically demonstrable links between social class and health. The health inequalities literature since the early 1980s has been characterised by a series of polarised debates concerning the relative explanatory power of the categories identified in the Black report. These debates have been comprehensively reviewed elsewhere, and so will not be rehearsed here (Bartley et al, 1998; Benzeval et al, 1995; Davey Smith et al, 1990; Macintyre, 1997; Vagero & Illsley, 1995). However, an important point to emerge from these reviews is that, despite the authors of the Black Report concluding that materialist factors are the most plausible explanations for health inequalities, relatively little research has been carried out to investigate precisely how these factors shape population health. Rather, debates in the literature have centred upon efforts to disprove the three alternative categories of explanation identified in the Black report (Blane et al, 1993; Macintyre, 1997; West, 1998). My

thesis, in contrast, sets out to identify how a *range* of health-relevant events, environments and relationships interact in people's lives at different times and in different places.

The field of health inequalities research is enormous, and as a result, it is necessary to be highly selective in terms of the research findings and theoretical perspectives which are included in the present discussion. In the following sections I therefore focus upon those themes within the literature which have particularly inspired the design of this research.

1.3 Empirical and theoretical inspirations

1.3.1 Step-wise gradients in health

In recent years, researchers have refined and developed their analyses of large scale survey data; more sophisticated measures of socio-economic status have been developed, and several longitudinal studies have traced associations between socio-economic position and health in specific individuals over time. It has become apparent that differences in health status exist between people in every layer in the social hierarchy, and not simply between the richest and poorest in society. In Britain, for example, the Whitehall studies of British civil servants have played a key role in exposing socio-economic gradients in health (Marmot et al, 1984; Marmot et al, 1991). In the original Whitehall study, which started in 1967, aetiological risk factors for CHD mortality were investigated in 18,403 male civil servants in London. The findings demonstrated a clear gradient in mortality risk between occupational grades, with employees in the lowest grades experiencing mortality risks that were almost three times as high as the most senior administrative grade (Carroll et al, 1996) . The second study, Whitehall II, was designed to investigate potential explanations for the observed health gradient. It is a longitudinal study of 10,308 male and female civil servants, and it focuses upon morbidity as well as mortality (Marmot & Davey Smith, 1997). Findings from Whitehall II indicate that every grade has worse health than the one above; Marmot et al assert that the data indicate:

...a social gradient that runs right across the whole population: the lower the social status the greater the physical and mental ill health and the worse the psychological well-being. (1997:906).

The data gathered in the Whitehall studies indicate that the finely grained association between socio-economic status and mortality and morbidity risks cannot be explained with reference to a 'threshold' relationship between income and health. The fact that the studies have been undertaken with a sample of workers in white-collar occupations means that 'material deprivation' cannot account for the greater health risks faced by the lowest grade employees. Evidence from the studies also clearly demonstrates that the effects of social selection and of health-related behaviours such as smoking are of insufficient magnitude to explain the observed social gradient in health.

In seeking alternative explanations, the authors of the Whitehall studies have raised the possibility that amongst civil service employees, it is their *relative* position within the socio-economic hierarchy that has more important implications for their health, rather than their absolute level of income. The researchers have hypothesised that the relationship between relative socio-economic position and health status may be mediated by psychosocial influences which are related to features of the work environment and to social circumstances outside work. Factors such as a low degree of control at work, low job variety and skill use, and low job satisfaction, have all been demonstrated to increase with each successive step down the employment hierarchy; such factors are associated with poor psychological health and overall health status (Marmot et al, 1997).

The identification of a linear relationship between income and health has prompted considerable interest in the role of psycho-social mediators between relative deprivation and health status; the next section offers an overview of the theoretical foundations of what has become known as the 'psycho-social perspective'.

1.3.2 The psycho-social perspective

In the mid 1990s, findings from various research projects, such as the Whitehall studies, offered clear evidence that the explanatory categories advanced in the Black Report were inadequate for explaining the step-wise gradient in health in Britain and other affluent developed societies. In the search for more adequate explanations for the causes of health inequalities, attention has increasingly focused upon the possibility of psycho-social mediators between socio-economic position and health. The emergence of the psycho-social perspective is closely associated with the work of Richard Wilkinson. In a series of publications Wilkinson has outlined his thesis that in advanced developed societies, health inequalities are related more to the distribution of income and wealth amongst the population than they are to absolute levels of individual income (Wilkinson, 1992; 1994, 1996).

Wilkinson's starting point is a comparison of mortality statistics between affluent, developed countries. This reveals that once countries have passed through the epidemiological transition (when chronic, degenerative diseases replace infectious diseases as a major cause of death), life expectancy is not related to overall levels of income and wealth within these societies, but rather to the extent of income inequality experienced between social groups. This means that increased wealth in these countries does not necessarily translate into better population health, if these material gains are not fairly distributed amongst the population. Wilkinson presents a range of data which indicate that those countries with wide inequalities in income and wealth have lower life expectancies than more egalitarian societies (Wilkinson, 1996). Britain is a country with wide inequalities in income and wealth. Shaw et al report that:

In Britain the income gap between the worst off and the best off has been widening over the past 20 years ... after housing costs, the richest 10% of the population have 27% of total income, whereas the poorest 10% have only 2.2% of total income in 1994/5. This compares to 21% and 4%, respectively, in 1979.
(Shaw et al, 1999a: 145)

Wilkinson's concern is that inequality affects the health chances of the whole population, and not simply those of the poorest social groups. This is demonstrated

by the step-wise gradients in mortality and morbidity for numerous diseases; every layer of the social hierarchy lives longer and experiences better health than the one below. Wilkinson argues that this gradient in mortality and morbidity, coupled with the fact that the poorest social groups die of the same diseases as the rest of the population (and not from 'diseases of poverty'), together indicate that health in advanced affluent societies is strongly related to relative, and not absolute, levels of income and wealth.

Having established that, in countries such as Britain, health chances are primarily determined by relative position in the social hierarchy, rather than access to absolute levels of resources, Wilkinson has attempted to explain how social inequality, relative deprivation, and health inequalities are connected. The crux of his thesis is that the relationship between income inequality and population health is mediated by psycho-social processes. He argues that social inequalities undermine the social cohesiveness of societies, which manifests in a breakdown of social relations; this weakening of the social fabric generates psycho-social stress. This stress is not an individual phenomenon, but is socially structured, and is associated with the subjective experience of relative deprivation. The further down the social scale individuals are situated, the greater the psycho-social stress that they are exposed to. Wilkinson's notion that psycho-social stress is socially patterned is supported by research findings within the stress and health literature (McDonough et al, 2002; Pearlin, 1989; Taylor and Repetti, 1997; Turner et al, 1995; Whelan, 1993). This work has highlighted structural determinants which shape exposure to stressful life events and situations. Whilst all social groups are exposed to stress throughout their lives, evidence indicates that:

The structural contexts of people's lives are not extraneous to the stress process but are fundamental to that process. They are the sources of hardship and privilege, threat and security, conflict and harmony.
(Pearlin, 1989: 242)

Wilkinson draws on a range of studies which demonstrate that the experience of stress weakens the immune system, increasing susceptibility to a range of chronic

and infectious diseases (although it is chronic diseases which are most significant here, as they are the major causes of death in developed societies).

Findings within the stress literature indicate that relatively deprived social groups are also those with the fewest resources to counteract the negative consequences of stress (Taylor and Seeman, 1999). Wilkinson points to the indirect role of stress upon health with reference to social gradients in health-related behaviours; on the whole, poorer social groups are more likely to engage in health-damaging behaviours compared to more affluent social groups. He argues that this may be partly understood as a response to psycho-social stressors engendered by the social environment. Wilkinson also refers to the supposedly less adequate psycho-social resources of poorer social groups; in particular, to the concept of 'personal control', and its role in influencing individual responses to stress. Within the stress literature, it is argued that the greater the degree of control that individuals perceive themselves to have over their lives, the better able they are to respond to stressful situations, in terms of coping ability, decision making, and maintaining self-esteem. For example, Syme comments that:

The lower down one is in the socio-economic status hierarchy, the less control one has over the factors that affect life and living circumstances.
(Syme, 1989: 4)

It is argued that those with the least money, power and status in society are not only likely to be exposed to a greater number of psycho-social stressors than the better-off, but that they are also least likely to possess the resources to respond to such stressors effectively, due to their more limited control over their life situation (Siegrist and Matschinger, 1989).

Wilkinson concludes that health inequalities may be explained by the disproportionate burden of psycho-social stress experienced by those at the 'wrong end' of the social ladder, which serves to weaken their immune systems, increasing their vulnerability to illness, and ultimately, premature death:

The social consequences of people's differing circumstances in terms of stress, self-esteem and social relations may now be one of the most important influences on health.
(Wilkinson, 1992:168)

Psycho-social explanations for health inequalities have been widely debated in the literature (Elstad, 1998; Forbes & Wainwright, 2001; Lynch and Kaplan, 1997; Syme, 1996; Tarlov, 1996;). These debates have been limited by two key problems. Firstly, psycho-social stress is hard to identify and measure and is often referred to by proxy measures of social cohesion, even though the precise pathways through which income inequality and social cohesion may be related are not clearly understood (Baum, 1999; Muntaner and Lynch, 1999; Wilkinson, 1999). Secondly, there is little consensus within the literature regarding the conceptualisation and measurement of social cohesion (and of social capital, a related psycho-social construct), or the appropriate spatial scale at which these constructs should be investigated (Boyle et al, 1999; Lochner et al, 1999; Lynch and Kaplan, 1997; Veenstra, 2000; Wilkinson, 1999). Additionally, within these debates, there have been calls more recently to refocus research efforts upon material circumstances as the most significant underlying cause of health inequalities (Carroll et al, 1996; Shaw et al, 1999; Muntaner et al, 2001). A striking feature of all strands of this debate is the almost exclusive use of extensive survey data to explore the antecedents of health inequalities. The difficulties arise because quantitative surveys are extremely limited in their ability to trace out how psycho-social mechanisms might operate in the context of people's lives, just as they are unable to show how stressors themselves impact upon the immune system to undermine health status. Whether, how, and to what extent psycho-social stress has a bearing on people's health experiences has still to be established. This thesis is one step along this route.

1.3.3 Health over the lifecourse

So far, life history contributions to the study of inequalities in health show that health is a lifelong development for the individual.
(Wadsworth, 1997:867)

The authors of the Black Report noted that different causal influences upon the social patterning of health might operate at different stages in life (1988: 115).

The past decade has seen a resurgence of interest in the question of *when* health inequalities are generated. A number of researchers have begun to explore the idea that adult health status is likely to have roots in foetal development and early life experience; some have also raised the possibility that health experience may be affected by events and life situations stretching even further back in time, to maternal foetal development. Barker (1991; 1994) has been one such researcher, introducing the concept of ‘biological programming’. This concept suggests that foetal development in utero and in infancy may determine an individual’s biological parameters later in life, and that therefore biological risk may be established very early on in life. There is evidence to show that the social and economic conditions that a pregnant woman is exposed to may affect the development of her unborn child. Women located within poorer socio-economic groups tend to be exposed to a greater number of health risks than more advantaged women – poorer women tend to live in worse housing conditions, be more likely to be inadequately nourished, and are more likely to engage in health damaging behaviours such as smoking (Graham, 1993; Wilkinson, 1996). Barker’s studies have demonstrated that babies born to women in the poorest social groups are of lower birth weight than those born to middle class women. He argues that not only does this reflect the effect that poverty and deprivation has upon foetal development, but that low birthweight can also be directly linked to the experience of ischaemic heart disease later in life (Barker 1994).

Whilst Barker has conducted numerous studies to test his thesis, other writers have displayed scepticism at his approach. Vagero and Illsley (1995) have questioned the validity of Barker’s data, and also contest the plausibility of the idea that low birth weight can be directly linked to heart disease some fifty years later, without considering the mediating influence of other factors in the intervening time period. Vagero & Illsley also advocate a lifecourse approach to the study of health inequalities, but consider the concept of ‘social programming’ to be more plausible than to Barker’s ‘biological programming’. They summarise social programming in the following way:

...the effects of the early social environment on later health are mediated through the social conditions of upbringing, educational experience and achievement, entry into work, and the living conditions and lifestyle that these bring with them.
(Vagero & Illsley, 1995: 231)

Other researchers have sought to bridge these polarities in explanatory approach, by acknowledging the possibility that biological risk may well be established early on in life, but by widening the focus of their research to consider the dynamic social processes operating throughout life that may also contribute to adult health status, and thus to the generation of health inequalities. Many of these researchers have undertaken studies with longitudinal datasets (Davey Smith, 1997; Kuh et al, 1997; Lynch et al, 1997; Mheen et al, 1998; Power et al 1996, 1998; Wadsworth, 1996, 1997). Findings from these studies have led to an enriched understanding of the importance of adopting a lifecourse perspective in order to understand the social patterning of health and illness. Bartley and colleagues (1997), have conceptualised the lifecourse in the following way:

...the lifecourse may be regarded as combining biological and social elements which interact with each other. Individuals' biological development takes place within a social context which structures their life chances, so that advantages and disadvantages tend to cluster sectionally and accumulate longitudinally.
(Bartley, Blane & Montgomery, 1997: 1194)

Wadsworth (1996; 1997) has suggested some social pathways through which health may be moulded across the lifecourse. For example, throughout childhood and early adulthood, individuals are exposed to a number of factors and situations that may either be health protective or health damaging, and which will thus either contribute to or deplete the stock of 'health capital' possessed by the individual. Childhood socio-economic and family circumstances to a large extent shape the pathways to good or poor health; adverse childhood conditions such as poverty have been demonstrated to have deleterious effects upon childhood health. This in turn may have damaging consequences, not only for educational attainment and thus future socio-economic position, but it could also increase susceptibility to illness in adulthood. Mheen et al (1998), using data from their longitudinal study of socio-economic health differences in the Netherlands, found that the risk of adult health

problems was twice as high amongst adults who reported health problems in childhood compared to those who did not. The findings of Mheen and colleagues support Wadsworth's proposition that health selection may operate as a result of childhood illness, although it is less clear whether adult ill health has health selective effects to the same extent. What Mheen did point out was that childhood socio-economic conditions do indeed impact upon adult *health* status, regardless of whether or not they also affect adult socio-economic status.

Lynch et al, focusing on adult health behaviours adopt a similar stance, arguing that a lifecourse approach is necessary to understand why people adopt health damaging behaviours:

...the patterns of adult health behaviours and psycho-social characteristics show remarkably consistent associations with the childhood, educational and occupational stages of the socio-economic lifecourse and are supportive of the notion that adult health behaviours and psycho-social characteristics have SES roots early in life.

(Lynch et al, 1997: 817)

It ought to be noted that the lifecourse perspective does not offer a complete explanation for health inequalities. For example, social class gradients in health do not appear to widen with age, when the notion of the accumulation of health risk over time suggests that this would be the case (West, 1998). However, notwithstanding unresolved issues, it is clear that the lifecourse perspective has been very useful for demonstrating that cumulative exposure to health risks over the lifecourse is systematically structured by social class.

The lifecourse perspective in health inequalities research offers us 'snapshots' of influences upon health at different points in time, mainly through the use of survey data, which, although useful, do not fully capture the dynamic nature of health development over time. Furthermore, whilst these data inform us of exposures to health risks throughout the lifecourse, they do not shed light on how these exposures might actually be *experienced*. Thus, these data have limited potential to uncover psycho-social health risks which may operate over the lifecourse. Another limitation of survey data is that health tends to be conceptualised in terms of episodes of

sickness, rather than using more positive concepts of health. Understandings of how health is shaped over the lifecourse may be complemented by qualitative research which focuses on lay accounts of experience over the lifecourse.

In recent years, there has been a shift within sociological thinking, away from the concept of the life cycle, which implies a fixity in the life stages that all individuals pass through, towards a more open-ended and fluid conception of the lifecourse (Backett & Davison, 1995; Bury, 2000). Backett and Davison (1995) argue that the concept of the lifecourse is bound up with the interaction between individual biographies and the socio-cultural contexts in which people live. Their research indicates that stages in the lifecourse are denoted by a variety of demographic, social, psychological and biological markers. Stages in the lifecourse also have cultural meanings attached to them, which may influence the ways in which lay people interpret their health and illness experiences at particular times in their lives. In her work on class, time and biography, Blaxter (2000) also highlights the way in which individuals make sense of health and illness by reconstructing their own biographies. In accounting for their health, individuals do not necessarily refer to calendar time; rather, time is constructed subjectively with reference to periods of life associated with particular social roles, set within the wider social context. In the qualitative study of health inequalities, these sociological insights may provide a theoretical approach for understanding lay accounts of health over the lifecourse.

1.4 The geography of health inequalities

In Section 1.2 it was mentioned that the authors of the Black Report identified regional variations in mortality and morbidity. Since the publication of the Black Report, much work has been undertaken to map geographical inequalities in health, which have been documented on a range of spatial scales. In recent years, research has pointed to the widening of geographical health inequalities over time (Dorling et al, 2000; Shaw et al, 1999a). For example, in a Scottish context, McLoone & Boddy (1994) conducted research which compared death rates between over 1000 different postcode sectors. Their results showed that in the time period

1990-1992, death rates from heart disease in the least two affluent postcode sectors were 130% higher than death rates in the two most affluent postcode sectors.

That there are geographical variations in health is clear; however, there is some debate in the literature as to what accounts for these empirically demonstrable links between place and health. Describing and accounting for the geography of health inequalities has been a key theme within health inequalities research (Curtis & Jones, 1998; Shaw et al 1999a). As with the literature on social inequalities in health, the literature on geographical inequalities in health has been characterised by debates; in this case, as to the relative influence of compositional factors - the aggregated characteristics of individuals living in specific areas, and contextual factors - the physical and social features of particular places (Duncan & Jones, 1995; Jones & Moon, 1993; Kearns & Joseph, 1993; Macintyre et al, 1993; Shouls et al, 1996; Sloggett & Joshi, 1994). In common with health inequalities research more generally, quantitative approaches have dominated the field. Generally, research findings suggest that compositional factors account for most of the statistical variations in mortality and morbidity between different geographical areas (Shouls et al, 1996; Sloggett and Joshi, 1994). However, it is acknowledged that contextual factors do matter as well (Stafford et al, 2001; Joshi et al, 2000). Pickett and Pearl (2001) have recently reviewed over two dozen studies undertaken before 1998, which investigated geographical variations in mortality and morbidity; they reported that almost all of these studies have found, “a statistically significant association between at least one neighbourhood measure of socio-economic status and health, controlling for individual socio-economic status” (Pickett and Pearl, 2001: 119).

Whilst much of the research effort has been directed at exploring the independent effect of either individual or area factors upon health, the ways in which these factors might interact to shape health outcomes remain poorly understood. Curtis and Jones have recently argued that the nature of the relationships between place and health remain under-theorised (Curtis and Jones, 1998: 89). However, there have been some important theoretical developments in the geographical literature throughout the 1990s. A significant theme to emerge in recent geographical research is the re-working of the concepts of ‘place’ and ‘space’, in

order to explore the role of specific locales in the production of geographical variations in health (Gatrell, 1997; Jones & Moon, 1993; Kearns, 1993; Kearns & Joseph, 1993; Moon & Jones, 1994). Traditionally, health inequalities research has tended to regard specific places merely as ‘containers’ within which populations are located, reducing the notion of place to that of a unit of analysis – for example, quantitative studies that have compared mortality and morbidity rates between electoral wards. As a result:

...seldom...does location itself play a real part in the analysis; it is the canvas on which events happen but the nature of the locality and its role in structuring health status and health related behaviour is neglected.

(Jones & Moon, 1993:515)

Geographers have contributed to the understanding of spatial variations in health through a critical engagement with the role of place itself in the social production of health inequalities. The influence of humanistic perspectives within Geography has led to the concept of ‘space’ being broadened beyond notions of geometric space, to encompass a notion of space as something which is socially constructed – the medium and outcome of social relations (Kearns and Joseph, 1993). Individuals interact with social and economic processes in and through space; these social relations are constructed within particular geographical settings. Within social space, processes of political and socio-economic change are mediated by the agency of individuals possessing particular socio-economic characteristics. This contributes to locally specific modifications to the physical and social environment – the places in which people live out their lives:

...space is...a medium through which the character of places is reproduced, both in the tangible landscape and in the consciousness of individual residents.

(Kearns & Joseph, 1993:715)

Kearns and Joseph assert that both social position *and* places themselves, shape the life experiences of individuals:

...a person's socio-economic status helps shape their experience of places at the same time as place of residence influences opportunities for activity and experience.
(Kearns & Joseph, 1993: 716)

Macintyre et al (1993) have developed a theoretical framework for investigating the ways in which different places shape opportunities for health. They have suggested that the physical, environmental, socio-economic and cultural characteristics of specific localities exert an influence upon the health of residents, by serving as mediating factors between socio-economic position and health. In other words, they argue that places exert contextual effects upon health, which are distinct from the compositional effects of an aggregation of individuals with particular (health-influencing) characteristics, such as low income:

Whatever one's personal characteristics, the opportunity structures in the poorer area are less conducive to health or health promoting activities than in the better off area. These local disadvantages are magnified when combined with the less adequate personal resources of those living in the poorer area.
(Macintyre et al, 1993:223)

These researchers and other commentators have called for research that engages more thoroughly with the socio-economic processes and socio-environmental features that operate in specific places – research which attempts to further understandings of how these processes and features interact with individuals and influence their health.

It has been suggested that the psychological impact of living in a particular place may exert either health - depleting or health - enhancing influences upon residents, perhaps because of the influence that living in a certain area has upon people's perceptions of their "place in the world" (Kearns, 1993). This is illustrated by Gatrell:

Individuals living in small localities or neighbourhoods will build up cognitive social maps of the environmental quality and socio-economic status of nearby neighbourhoods. Their awareness of disparities may well trigger the kind of biological response that Tarlov proposes and Brunner (1996) describes in detail (Gatrell, 1997:149)

These comments suggest that there may be psycho-social pathways linking health experience and the social meanings attached to living in a particular area of residence. However, few studies have undertaken empirical exploration of this potential relationship. Sooman and Macintyre (1995) investigated lay perceptions of the local environment in socially contrasting neighbourhoods in Glasgow in order to ascertain whether these were related to individual health. They concluded that systematic variations in perceptions were related to self-reported health; residents of poorer districts had the most negative perceptions of their environment, and reported worse health than more affluent respondents. More recently, Gatrell and colleagues (2000) have undertaken a project in which they have combined quantitative and qualitative methods in order to explore how health experience is influenced by people's subjective experiences of, and feelings about the neighbourhoods in which they live.

The policy implication of both the theoretical and empirical work that has been undertaken on the geography of health inequalities is that place matters when seeking to tackle health inequalities. Thus a focus purely on individuals and their behaviours, without taking into account their socio-spatial context may well be misguided. Macintyre et al (1993) suggest an alternative direction for health policy:

A large proportion (of public health policies) seem to be based on the principle that if working class people could become more like middle class people, then their rates of illness and premature death would become more like those of middle class people. An alternative approach would be to try making working class areas more like middle class areas by improving the social and physical environment.

(Macintyre et al, 1993:229-230)

1.5 Understanding complexity: the need for new theoretical and methodological approaches

So far in this chapter, I have discussed a range of theoretical perspectives associated with particular strands of research into social and spatial inequalities in health. The psycho-social perspective, a lifecourse perspective, and debates about compositional and contextual features of places are all theoretical approaches which have informed the design of this study. In this section, however, I consider calls within the literature for research that recognises the complexity of the processes which shape health inequalities. Firstly, I discuss a prominent theme within the literature, which relates to the necessity of scrutinising inequalities in women's health separately to inequalities in men's health. I then move on to outline critiques of health inequalities research which have emerged in the literature since the late 1990s, including the identification of various limitations associated with quantitative techniques. Finally, I review findings from qualitative studies of health and illness, which suggest that focusing on lay perspectives may provide a fruitful opportunity to further unravel the complex relationships between socio-economic position and health.

1.5.1 Inequalities in women's health

In recent years, there has been a growing recognition within the literature that gender, as an axis of social stratification, structures men and women's lives in ways that have implications for their experiences of health and illness (Moss, 2002). As such, researchers have increasingly recognised the need to consider the social patterning of women's health separately to that of men's health. Arber (1990, 1991) has identified several conceptual problems associated with health inequalities research which, she argues, hinders understandings of inequalities in health between

women. She points out that whilst inequalities in men's health have been considered on the basis of occupational class, inequalities in women's health have been examined in relation to their roles within the family. Within this conceptual framework, paid employment has been regarded as an additional role, rather than as a structural variable. This has led to debates over whether role accumulation leads to health benefits via the effect of paid employment on self-esteem and social contacts, or whether employment leads to role overload, with harmful consequences for women's health. Arber's critique of existing research has highlighted the need to integrate a focus on role analysis within structural approaches to the study of health inequalities.

A related theoretical issue that Arber has identified concerns the need for a more detailed examination of women's socio-economic position; an issue that has also been raised by other researchers (Arber, 1997; Bartley et al, 1999). It has been shown that the existing measures of class used routinely in health surveys do not adequately capture the social position of women. For example, measures of household material circumstances as a marker of social class obscure women's own employment situations, which in themselves may have a direct effect upon their health. However, classifying women according to their own current or last occupation does not take into account their marital status or their actual labour market position. Furthermore, occupational class categories have been constructed from men's occupations, and may be inadequate for classifying the nature of employment that women engage in. In her analysis of British survey data collected in the early 1990s, Arber demonstrated the necessity of using a variety of indicators to capture different dimensions of women's socio-economic status:

Women's limiting long-standing illness can be explained solely by their own labour market characteristics, whereas self-assessed health relates to wider aspects of a woman's everyday life. It is better captured by a range of variables, including women's educational qualifications and occupational class, her husband's class and his employment status (if married), and the material conditions in which the household lives.

(Arber, 1997: 785)

In recent years, analyses of women's health have emerged which have adopted the more sophisticated theoretical approach advocated by Arber and others. Studies based on survey data increasingly take into account several dimensions of women's social circumstances when considering structural influences upon women's health (Arber, 1991, 1997; Bartley et al, 1992; Denton and Walters, 1999). Findings from these studies expose complex interactions between women's material circumstances, the nature of their paid and unpaid employment, their marital status, and their experiences of health and illness (Bartley et al, 1999; Hunt and Annandale, 1993). For example, although there is broad agreement between different studies that, on the whole, women's engagement in paid work enhances their health, this is not true for all women. Lone parents engaged in full time work tend to report worse health than women in other family circumstances (Bartley et al, 1992; Denton and Walters, 1999; Macran et al, 1996). The patterning of women's health also varies according to the dimension of health under consideration; Bartley et al (1992) and Denton and Walters (1999) have found that women working either part-time or full-time in professional occupations report poorer physical and mental health than might be expected.

Although these studies using large-scale survey data highlight complex statistical associations between different aspects of women's social circumstances and various dimensions of their health experiences, they are limited in their ability to explain the meanings associated with different role combinations in particular social contexts. In other words, they tell us little about *why* and *how* women's social roles and circumstances shape their health. As Bartley et al comment:

Information on role occupancy tells us only a limited amount about women's experiences of 'role strain or role enhancement'.
(Bartley et al, 1999: 110)

The need for more detailed understanding is articulated by Denton and Walters:

Our analysis suggests that the complex links between the public spheres of work and the private sphere of the family needs fuller investigation.
(Denton and Walters, 1999: 1233)

The limitations of survey-based studies is a theme that is considered in relation to health inequalities research more generally in the following section.

1.5.2 Critiques of existing research

Section 1.2.2 referred to the fact that much of the health inequalities literature has been characterised by polarised debates concerning the salience of different explanatory models – for example, lifestyle versus material circumstances, and material circumstances versus psycho-social pathways. Recently, this polarisation of opinion has been critiqued by a number of researchers (Macintyre; 1997; Marmot et al, 1997; West, 1998). These researchers have argued that it is unlikely that there is a unitary explanation for health inequalities, and that efforts to 'prove' the primacy of one explanation over another obscures the likelihood that there may be several different mechanisms linking socio-economic position and health. Different mechanisms operate at different points in the social hierarchy, and multiple influences upon health might interact with each other in a variety of ways, in different places and at different times. Macintyre (1997) has argued that in order to explain the finely graded differences in mortality and morbidity between every layer in the social strata, researchers need to develop theoretical and methodological approaches which integrate different strands of explanation. She comments:

Such binary oppositions may help to generate hypotheses and stimulate empirical research, but we also need more fine grained micro-level research exploring not only their relative importance in different social contexts but also their possible interactions or additive effects.

(Macintyre, 1997: 740)

Since the late 1990s, a small but growing number of researchers in the health inequalities field have begun to draw attention to the limitations associated with using analyses of large scale survey data as a means of trying to understand the processes through which health inequalities are generated and maintained. A key theme within this critique of existing health inequalities research is that quantitative approaches are not able to engage with the inherent complexities underlying the relationships between socio-economic status and health. Popay and colleagues (Popay et al, 1998) have highlighted the limitations of risk factor epidemiology, pointing out that excess mortality in poorer social groups cannot be wholly explained by the cumulative effect of individual risk factors. Furthermore, they argue that a focus on risk factors has tended to neglect the social contexts in which individuals are situated; thus, little attention has been paid to the processes through which these factors might actually shape the health of different social groups. They argue:

...today, a great deal of epidemiology and social survey work remains profoundly non-social – in the sense that it does not explore the complex interactive relationship between individual experience, social action and the way in which societies are organised at the macro level.

(Popay et al, 1998: 68).

Both Macintyre (1997) and Popay et al (1998) point to the need to engage more closely with the *social contexts* which shape individuals' experiences of health and illness. Popay and colleagues also highlight the need to develop more sophisticated understandings of how individuals actually *experience* structures of inequality, and the ways in which this relates to health outcomes. Research undertaken from a psycho-social perspective suggests that social inequalities are translated into health inequalities via psycho-social stress engendered by the

subjective experience of relative deprivation. However, somewhat surprisingly, there has been remarkably little research undertaken to investigate psycho-social dimensions of the experience of inequality from the point of view of individuals themselves (Forbes and Wainwright, 2001; Popay et al, 1998). If Wilkinson's thesis is correct, then there is something very important about the *meanings* associated with relative deprivation; however, quantitative techniques are ill-suited to this type of analysis (Gatrell et al, 2000).

A further limitation of existing health inequalities research relates to the conceptualisation and measurement of health. So far, most studies have primarily focused upon what makes people ill, and upon why relatively deprived social groups are likely to experience more illness, and die sooner, than more affluent social groups. In other words, the term 'health' has been predominantly constructed in the inequalities literature in terms of mortality and morbidity. However, it has long been recognised that health is in fact a multi-dimensional concept – as far back as 1947, the World Health Organisation defined health as “ a state of complete physical, social and mental well-being and not merely the absence of disease or infirmity” (WHO, 1947). Despite this, the dominant biomedical model of health as 'the absence of disease' has shaped the nature of the information commonly gathered in large-scale surveys (Baum, 1995; Macintyre, 1997: 733). Although some quantitative studies have analysed associations between socio-economic position and self-reported physical and mental health (Macintyre and Ellaway, 1995; Macran et al, 1996), negative measures of health, such as chronic illness, reported symptoms, and measures of restricted activity, still prevail (Macintyre, 1997: 733). Forbes and Wainwright have highlighted this imbalance within the literature:

It is also important to consider health inequalities in relation to positive health indicators and quality of life measures.
(Forbes and Wainwright, 2001: 813)

Current understandings of health inequalities could be enriched by applying the theoretical approaches from the lifecourse and the psycho-social perspectives to the study of positive aspects of health. For example, research investigating psycho-social processes has predominantly focused upon how the experience of relative

deprivation causes psycho-social stress, which has a negative effect upon mental health, and in turn is associated with poor physical health. However, little work has been undertaken which explores how occupying a relatively privileged socio-economic position might enhance well-being and/or promote good physical health. This may be because more positive dimensions of health experience, particularly those relating to mental and emotional health, are relatively difficult to define and measure; as such, they are not easily captured through survey research.

1.5.3 How qualitative research may contribute to understanding health inequalities

It is at this juncture that qualitative approaches may be particularly fruitful in enhancing understandings of how health inequalities are generated and sustained (Chamberlain, 1997). Qualitative research is designed to gain a detailed understanding of processes and relationships within the social world – “interpreting phenomena in terms of the meanings people bring to them” (Denzin and Lincoln, 1998:3). Baum (1995) details three main ways in which qualitative research is useful within the field of health research. Firstly, it can help explain the economic, social, political and cultural factors which influence health and disease. Secondly, through qualitative research, we may gain an understanding of individuals within particular communities interpret health and illness. Thirdly, qualitative research enables the study of interactions between various players who are relevant to any given health issue. Baum summarises the utility of qualitative health methods by reproducing a quote from Bryman:

The sine qua non [of qualitative research] is a commitment to seeing the social world from the point of view of the actor....there is a simultaneous expression of preference for a contextual understanding so that behaviour is to be understood in the context of meaning systems employed by a particular group or society.
(Bryman [1984], in Baum, 1995: 463)

Whilst few qualitative studies have been undertaken as yet to explore the adequacy of psycho-social explanations for health inequalities, there is a substantial body of qualitative research undertaken within medical sociology which investigates the social construction of health and illness from lay perspectives. Studies in this

field have illuminated the fact that lay views and experiences are constructed within particular socio-cultural contexts. These studies demonstrate that in order to understand how individuals interpret their experiences of health and illness, it is necessary to take into account broader aspects of their life circumstances; these insights may usefully be applied to the qualitative study of health inequalities.

An important strand of qualitative research into health and illness is comprised of studies which have investigated lay concepts of health. Herzlich (1973) conducted a pioneering study in France, in which she investigated the concepts of health offered by 80 middle class, middle aged respondents, the majority of whom lived in Paris. She argued that people's personal definitions of health and illness are drawn from shared cultural understandings, and her analysis suggests that the concepts of health that people hold are connected to their wider relationship with society. Herzlich identified three conceptions of health within lay definitions. The first is 'health in a vacuum'. Here, health is conceptualised negatively - that is, health is defined as the absence of illness. This concept of health implies that health is not noticed until the experience of illness alerts the individual that something (i.e. health) has been 'lost'. The second concept of health is 'health as reserve'. This is a characteristic of the individual and refers to one's 'stock' of good health, which enables the individual to resist disease and illness. This reserve may be built up or depleted over time. 'Health as equilibrium' is the third concept of health identified by Herzlich. This refers to a state of positive emotional well-being and the freedom to do what one wants. Conceived of in this way, health is dependent upon events and situations in the individual's life, and as such it is something that can be gained or lost; it is regarded as a norm against which one can compare oneself.

Herzlich's findings demonstrate that, according to lay perspectives, health is not understood to be merely the opposite of illness. Health is conceptualised independently of illness, which indicates that the study of 'health' is a legitimate research topic in its own right. Nor is health a fixed, simple entity; many of the respondents in Herzlich's study offered complex definitions of health which encompassed more than one of the concepts outlined above. By highlighting lay

concepts of 'health as reserve', and 'health as equilibrium', Herzlich demonstrated how health is understood to be interwoven with other aspects of daily living.

Findings from other qualitative studies support Herzlich's conclusions that health may be conceptualised in a variety of ways. Williams (1983) studied lay concepts of health amongst a sample of elderly Aberdonians from all social classes, and found that these respondents had similar concepts of health to those of Herzlich's respondents, as did Pill and Stott's (1982) working class female respondents in Wales. Blaxter and Paterson (1982) studied two generations of working class Scottish women, and found that they only conceptualised health in negative terms. Together, these studies identified three distinct ways in which health may be defined by lay people: health as the absence of illness, health as the functional ability to carry out everyday activities, and health as fitness and well-being (Blaxter, 1990: 14). More recently, further support for these findings has been offered by Litva and Eyles (1994).

The studies which have been highlighted so far have demonstrated the complexity of lay understandings of health and illness. There is some uncertainty within the literature as to whether lay concepts of health vary according to social class. D'Houtard and Field (1984) conducted a large scale survey in France which clearly indicated associations between social class and concepts of health, with middle class respondents offering more positive concepts of health, and working class respondents defining health in negative terms. However, subsequent research has indicated that apparent social class differences in concepts of health may be a product of an interview setting in which respondents are asked to define health in an abstract context. It has been suggested that middle class respondents may feel more at ease articulating their views compared to working class respondents, and this may account for the apparently more elaborate, and positive definitions of health which are thought to be held by middle class people (Blaxter, 1990; Calnan, 1987). Backett (1989), commenting on the inconclusive nature of existing work, argued that:

much more comparative data grounded in the everyday lives and concerns of different groups in the population are required before firmer conclusions can be drawn about variations between them. (Backett 1989: 42)

In addition to research on concepts of health, other studies have examined how people's social contexts shape the ways in which they negotiate issues related to health and illness in the course of their everyday lives (Backett, 1992; Backett and Davison, 1992; Backett and Davison, 1995; Calnan and Williams, 1991; Charles and Walters, 1998; Stainton Rogers, 1991; Walters and Charles, 1997). For example, Backett and Davison (1992; 1995) have carried out research with a variety of social groups, exploring lay views of the meaning associated with 'lifestyle', and the salience of so-called healthy behaviours. They argued that lay views about health and health maintenance are strongly shaped by cultural, structural and social expectations (1992: 58). They have identified lifecourse stage as a key structural influence upon people's experience of the social world; they draw attention to the importance of incorporating a conceptual focus upon the lifecourse within research on lay understandings of health.

Within geography, a number of qualitative studies have investigated the role of place in the social construction of health and illness (see reviews in Jones and Moon, 1993; Kearns and Joseph, 1993; Curtis and Taket, 1996). Dyck (1999), in her review of qualitative research within medical geography, comments on the contribution that these studies make to understandings of the relationships between place and health:

Certainly interpretive analyses of the contextual embeddedness of individual perceptions, experiences, and actions emphasize the centrality of human agency in negotiating the meaning of health and illness in particular places.

(Dyck, 1999: 247)

Qualitative research processes allow the examination of variations in the construction of ideas about health, illness, and health care over time and place which unsettle taken-for-granted social categories and expose relations and distributions of power that are involved in the constitution of subjectivities and experiences of being healthy, sick, or disabled.

(Dyck, 1999: 250)

However, there have been surprisingly few qualitative studies which have given equal emphasis to a focus on specific places along with the study of various social processes which underpin health inequalities. A notable exception to this is the ethnographic research undertaken by Cornwell (1984) in a neighbourhood in London's East-End, in which she studied how individuals' constructions of health and illness were shaped by their living and working conditions. More recently, the Salford and Lancaster study, conducted by Popay, Gatrell and colleagues, has combined quantitative and qualitative methods in order to investigate the implications for individual health and well-being of people's biographical experiences within specific neighbourhoods (Popay et al, 1998; Gatrell et al, 2000).

In combination, findings from qualitative research undertaken within medical sociology and geography, suggest that qualitative approaches may be extremely fruitful in furthering understandings of how geographical inequalities in health are generated and maintained. Forbes and Wainwright have recently argued that:

We must start seeing the questions about health inequalities in the context of the lives of the people most impacted by them.

(Forbes and Wainwright, 2001: 813)

Qualitative research which engages with lay biographical accounts has the potential to explore how those 'risk factors' identified by quantitative studies are actually experienced by individuals living in different socio-spatial contexts. Qualitative approaches also seem to be particularly relevant to the empirical investigation of psycho-social influences upon health which may operate in

particular places. Research methods such as in-depth interviews are able to tap into people's own understandings of their experiences of social inequality, and whether and how they perceive this to relate to their experiences of health and illness. In this way, health-relevant psycho-social dimensions of socio-economic status *and* of the experience of place may be uncovered.

1.6 This research

...individuals (and their ill-health) cannot be understood solely by looking inside their bodies and brains; one must also look inside their communities, their networks, their workplaces, their families and even the trajectories of their life.

(Lomas, 1998: 1182)

This research is a qualitative investigation of some of the social processes which contribute to the geography of health inequalities. The study draws together various theoretical strands within the literatures on social and geographical inequalities in health, and applies these perspectives within a qualitative research context. The study was designed to investigate lay accounts of both good health and illness over the lifecourse; and to contextualise these health and illness experiences within people's broader accounts of their everyday lives in specific places. By investigating biographical experiences, the research aimed to explore continuities and changes in individuals' life circumstances, and to consider people's own understandings of whether and how these circumstances might be related to their health. Thus, this research encompasses a focus upon dynamic processes which contribute to geographical health inequalities.

A key aim of this research was to investigate how a variety of socially structured influences upon health might operate over the course of people's lives. The literature points to a multiplicity of health determinants – material, behavioural, and psycho-social in origin. Individual 'risk factors' do not shape health independently from each other; rather, different facets of people's lives are interdependent (Marmot and Davey Smith, 1997: 294); the research design was informed by this recognition. Having acknowledged the complex interlinkings between different influences upon health at the outset of the PhD project, a research

design was needed that would allow for an appreciation of these interconnections, whilst also enabling individual factors to be investigated separately (Smith et al, forthcoming).

In attempting to capture the dynamic interplay between various health-related dimensions of individuals' lives, I have found it useful to work with the conceptually innovative notion of a multi-dimensional '**web of resources**', within which health and illness experiences are constituted. Reference to a web is intended to convey the idea that influences over health are separate, yet connected – like nodes in a spiders' web. Smith et al (forthcoming) have worked with a similar concept, that of a health resource network. As Smith and colleagues write, the advantage of conceptualising influences upon health in terms of a network or a web is that:

...it encourages us to recognise that no individual social or environmental predictor of health works on its own ... [it is] an approach which allows particular nodes ... to be scrutinised separately (housing, employment, lifestyle and so on) yet which forces analysts to be mindful of the extent to which these are tied together.

(Smith et al, forthcoming)

Throughout the course of the research, I have drawn on the image of a web of resources as a conceptual tool which has both guided the design of the study, and has facilitated my analysis of lay accounts of influences upon health and illness. It is not intended to be a highly-developed theoretical framework for explaining health inequalities; rather, it is a helpful way of incorporating a variety of theoretical perspectives, identified in the literature, into one study. Thus, material, behavioural and psychosocial explanations for health inequalities are considered alongside insights from the lifecourse literature; the potential influence of contextual features of place upon health is also acknowledged.

The concept of 'resources' for health is one that has been used before in qualitative research projects (Cowley, 1995; Cowley and Billings, 1999; Gabe and Thorogood, 1986; Smith et al, forthcoming). Cowley and Billings, in their research on lay views about health maintenance, identified a wide range of health-relevant material, social, environmental, cultural, personal and emotional factors within

respondents' accounts of their everyday lives. These factors were embedded within the circumstances of individuals' lives. Cowley and Billings conceptualise 'health' as a dynamic process rather than a static state, which is consistent with the wider lifecourse literature (Kuh and Ben-Shlomo, 1997; Wadsworth, 1997). Their analysis suggests that these factors may be experienced by individuals either positively – in which case they may be considered to be resources for health creation, or negatively – in which case, they may be considered to be stressful drains on individuals' health resources, likely to deplete health. Ideas about health as a process, and about resources for health affords an opportunity to widen the focus of research beyond pathways to poor health, to encompass an exploration of salutogenic processes - how good health is produced and maintained (Antonovsky, 1987; Charlton, 1996; Charlton and White, 1995; Mackenbach et al, 1994).

Williams and Popay (1998) argue that the concept of 'resources' is theoretically useful, as it allows for an exploration of the connections between social structures and individual agency. They regard this conceptual approach as a fruitful one because it views individuals as:

...creative agents operating within a system of risks and opportunities, complexly structured by economic, social and cultural dynamics, in which their welfare outcomes are negotiated through their access to, and management of resources.
(Williams and Popay, 1998: 164)

Williams and Popay's discussion of resources is set within the context of developments in welfare research; however, in my opinion, the concept may also be usefully applied to the study of health inequalities – by substituting the phrase “welfare outcomes” for “health outcomes” in the quotation presented above. The notion of a web of resources conveys the idea that risks and opportunities for health are spatially uneven and vary over time; it also allows for interactions between individuals and their environments by recognising individual agency.

In order to apply the conceptual approach derived from the idea of a 'web of resources' to the study of processes which contribute to geographical inequalities in health, a methodological approach was required that combined a focus upon both the

past and the present of individuals' lives. I felt that it was not sufficient to explore how individuals' current health and well-being is sustained or undermined by their current everyday experiences within particular geographical and social spaces. Rather, in recognition of the fact that health status develops over the lifecourse, I considered it necessary also to trace individuals' experiences of health and illness over the course of their lives, in the context of their trajectories through particular socio-spatial contexts.

The decision to focus upon how health is constituted over time and through place within a web of health-relevant resources required a research design that would enable the construction of detailed, in-depth lay accounts. Given the intended depth and complexity of the data, the study needed to be small-scale and limited in scope in order to be manageable. Therefore, the study was designed to compare the health and illness experiences of twenty-four women who live in Edinburgh; twelve women in each of two neighbourhoods, which have contrasting socio-economic and health profiles. One neighbourhood is relatively affluent, with a population who have better than average health (compared to Edinburgh as a whole); the other neighbourhood is relatively disadvantaged, with a population who have worse than average health. Thus, the study is rooted in a geography of health inequalities.

I wanted to explore women's accounts of health and illness throughout their lives, set within broader accounts of their lifecourse trajectories through particular social-economic, spatial and cultural hierarchies/contexts. Recognising that people's biographies are bound up with particular places (Gatrell et al 2000), I wished to explore the pathways through which specific individuals came to be living in these two particular neighbourhoods. I also wanted to explore interactions between women's experiences within specific geographical and social spaces and their experiences of good health and illness, both past and present - and to consider the implications of these experiences for their future health prospects (Easterlow et al, 2000). Through a comparison of accounts from women living in two contrasting neighbourhoods, the project was designed to shed light upon the processes through which compositional and contextual features of places interact in health relevant ways - from a lay perspective.

As alluded to earlier, the study was limited to an investigation of women's experiences of health and illness. The discussion in Section 1.5.2 highlighted the fact that women's inequalities in health are relatively under-researched, compared to those of men. Focusing upon the processes through which women's health inequalities are perpetuated was a response to gaps identified within the literature. However, the decision to focus solely upon women was also a pragmatic one. Researching both men and women would have introduced further complexity to the data, in terms of the need to incorporate a comparative analysis of the role of gender in the social construction of health and illness.

It is recognised within the literature that age is a structural variable which shapes views and experiences of health and illness (Macintyre, 1994). Again, in order to simplify the parameters of the research, the study focused upon women at mid-life, in the age range 45-59 years. Women at mid-life are an under-researched social group, yet mid-life is a significant period in the lifecourse. It is a time in which women may experience profound changes in relation to their positions within both the labour market and the family. Mid-life has also been identified as a time when the experience of chronic health problems may become more prevalent; as such, inequalities in health between socio-economic groups also become particularly apparent (Blaxter, 1990: 235). Thus, studying individuals at mid-life provides a good opportunity for exploring how health may be built up and worn down over the lifecourse.

1.7 Structure of the thesis

In this chapter I have introduced the research, outlining those areas of the literature which have influenced the design of the study, and offering a descriptive overview of the research methodology. Chapter Two elaborates upon the methodological approach taken in the research. I discuss details of the research design and the methods used for data collection and analysis. Chapters Three to Seven discuss empirical findings of the research. In Chapter Three, I set the scene for the rest of the thesis, by comparing the self-reported health status of the respondents in each sample group. I discuss the concepts of health offered by respondents, and consider the significance of psycho-social dimensions of health within the data. The data presented in Chapter Three confirms the importance of considering dimensions of health such as psycho-social well-being, alongside physical aspects of health.

In Chapter Four, I discuss respondents' accounts of how access to financial resources has shaped opportunities for good health over the lifecourse. The chapter demonstrates how relative affluence and relative poverty may accumulate over the lifecourse, and I explore material, behavioural and psycho-social links between money and health. Chapter Five moves on to consider an aspect of respondents' lives that is related to their financial circumstances – namely their participation in the labour market. The chapter traces respondents' employment trajectories, from leaving school through to the present day, and the discussion explores ways in which relationships between good health, illness and employment may be socially patterned. Chapter Six considers women's social roles and relationships within the family. I explore how gender, as an axis of social inequality, interrelates with socio-economic position in health-relevant ways.

Chapters Four, Five and Six all focus upon separate yet interrelated dimensions of respondents' social circumstances, which were identified by respondents' themselves as influencing their experiences of health and illness over the lifecourse. Through exposing similarities and differences in the reported experiences of the two sample groups, I suggest processes through which health inequalities may be generated.

These chapters also consider ways in which access to financial resources, employment trajectories, and family relationships have shaped the respondents' trajectories into their respective neighbourhoods. In Chapter Seven, I engage explicitly with ideas about how contextual features of particular neighbourhoods might influence the health and illness experiences of the people living within them. The chapter compares accounts of the socio-environmental aspects of the two neighbourhoods, and I discuss ways in which the neighbourhoods themselves are considered by respondents to exert a bearing upon their health and well-being. In Chapter Eight, I draw together the substantive findings presented throughout the thesis, and I highlight some interconnections between the different thematic topics which are explored in Chapters Three to Seven.

Chapter 2: Methodology

2.1 Introduction

In Chapter One, I presented a rationale for the adoption of a qualitative methodology for this research. At the outset of the project, the aim of the research was to explore some of the processes through which geographical health inequalities are generated and sustained. My research questions were related to investigating how people's experiences of health and illness in particular geographical and social spaces might be shaped both by compositional and contextual influences, but I wanted to explore these issues from the point of view of lay people themselves. Mason defines qualitative research as being "concerned with how the social world is interpreted, understood, experienced or produced" (1996:4). Therefore, adopting a qualitative approach to investigate lay understandings is a valid means of generating knowledge about the social world (Mason, 1996).

This chapter provides an overview of the methodological approach which underpins this research. The chapter is structured around discussion of each stage in the research process: the research design, respondent recruitment, and the construction and analysis of data. I also reflect upon the process of conducting the fieldwork, and the limitations associated with the methods of data collection that were used.

2.2 Research design and methods

2.2.1 Sensitising work

The broad research questions that this study was designed to explore were formulated in response to a familiarisation with the health inequalities literature, as outlined in Chapter One. However, before actually undertaking the fieldwork, some sensitising work was required to inform of specific aspects of the study design - such as defining the sampling frame, deciding upon the most appropriate research methods, and developing a list of themes to be explored in the research (Cunningham-Burley and Milburn, 1995; Rice and Ezzy, 1999).

This sensitising work comprised a series of six focus group interviews, which were undertaken with members of a variety of different community organisations in Edinburgh. Bedford and Burgess (2001) have identified focus group research as a useful way of comparing the 'world-views' of different social groups. These group interviews enabled me to explore lay views and experiences of health and illness as they relate to people's everyday lives. Conducting several of these interviews allowed me to consider how lay understandings of issues relating to health and illness might be constructed differently according to dimensions of individuals' social circumstances, such as age, gender, socio-economic position, employment status, and neighbourhood of residence.

These groups were recruited via publicity information about the groups, available from CapInfo, a computerised database maintained by the City of Edinburgh Council. I telephoned the organiser of each group to explain the project, and to ask them if it would be possible to arrange access to the group in order to carry out an informal interview. If the group organisers agreed to ask group members if they wished to take part in an interview, they then recruited volunteers and arranged an interview time on my behalf. Normally these interviews took place at times when the groups were meeting anyway.

The group interviews that I conducted generally lasted between 45 minutes and an hour and a half. The interviews were loosely structured around topics that I thought I might wish to incorporate into my study, based on my reading of the health inequalities literature: lay concepts of health and the determinants of health; lay understandings of 'lifestyle' in relation to health; concepts and experiences of stress; and the potential influences of 'place' upon health. These interviews were tape-recorded, but were not transcribed; at this stage I thought that it was sufficient to take notes from the tapes about emergent themes and issues that seemed particularly interesting or important.

Despite the diversity of personal circumstances in the groups of people interviewed, particular themes emerged from all of the interviews. In people's accounts of both their general concepts of health and their own personal experiences

of health, health tended to be discussed in a way that suggests that lay actors experience and understand 'health' as being rather like a thread, in that it is interwoven with various other threads which make up the 'fabric' of life. Thus, in order to understand people's accounts of their health and illness experiences, it is necessary to engage with the 'fabric' of their lives as a whole, both past and present – in other words, to explore health within the wider contexts in which individuals see their lives as being situated. This is consistent with the existing literature relating to the study of lay views of health (Backett, 1992; Calnan and Williams, 1991). This theme within the group interviews also supported the adoption of a lifecourse perspective in the research, focusing upon life circumstances and trajectories over time, as well as on people's current day-to-day lives.

Analysis of the group interviews also indicated that issues of social inequality are relevant in people's understandings of the determinants of health, as are issues related to neighbourhood-based influences upon health. The fact that members of all of the groups seemed able to relate to these topics, in terms of talking at length about them, encouraged me that it would be feasible to explore these issues in the main phase of the fieldwork.

2.2.2 Research methods

On the basis of the themes which emerged from the group discussion interviews (and in light of previous research on similar topics), in-depth, semi-structured interviews with individuals were chosen as the most appropriate method of apprehending the depth and complexity of the social contexts within which people's experiences of health and illness are constructed (Backett, 1992; Denton and Walters, 1999; Lofland and Lofland, 1995; Miller and Glassner, 1997). Semi-structured interviews, using a topic guide, allow flexibility in eliciting accounts from individuals about various aspects of their lives, whilst still allowing for consistency in terms of the topic areas discussed with each respondent (Mason, 1996).

One of the aims of the research was to explore the processes through which health may be built up and worn down over the lifecourse, in different socio-spatial contexts. Thus, as well as studying individuals' current health and illness

experiences within particular geographical and social spaces, I wanted to be able to access accounts of earlier life events and experiences. This required two separate approaches to data generation – one based upon the construction of retrospective biographical accounts; the other based upon exploring current everyday experiences within particular geographical areas, and whether and how these might relate to health issues. These methodological considerations led to the decision to conduct two interviews with each respondent.

The first interview was designed around the re-construction of life histories (Anderson and Jack, 1998). The advantages of a life history approach are described in the following way by Gerson and Horowitz:

People experience their lives, not as a set of factors or variables, but rather as the unfolding of events, perceptions and feelings over time. Chronologically ordered questions thus provide a structure for recounting a coherent narrative and for remembering potentially important, but easily overlooked events and experiences. When the interview moves through a series of experiences, from past to present to imagined future, people are able to recall the unfolding of a specified set of occurrences (for example, family, work or relationship histories) and to place these histories in a social and perceptual context ... It becomes possible to uncover the social, structural, and cultural bases of choices and actions that might appear natural or predetermined.
(Gerson and Horowitz, 2002:206)

The second interview was designed around current life experiences – an approach commonly used in studies of lay perspectives on health and illness (Backett, 1992; Calnan and Williams, 1991). The structure and format of these interviews will be considered in Section 2.4.

In addition to enabling the construction of two different types of data (biographical and current life experiences), there are other methodological advantages associated with repeat interviewing. The importance of establishing rapport with research participants is a widespread notion within the qualitative literature (Backett, 1992; Miller and Glassner, 1997; Oakley, 1981). Repeat interviewing offers on-going opportunities for the development of trust between the interviewer and interviewee, and this is regarded as vital in interview situations

where sensitive or personal topics may be explored (Booth and Booth, 1994; Gerson and Horowitz, 2002). It has been noted that in one-off interviews, research participants tend to construct 'public' accounts that they believe to be culturally acceptable, reflecting 'what everyone knows' (Backett, 1989; Cornwell, 1984). By contrast, in repeat interview situations, individuals are more likely to draw upon their own experiences, constructing 'private accounts' (Cornwell, 1984; Rice and Ezzy, 1999). There is some acknowledgement in the literature that the distinction between public and private accounts is complex; however, conducting repeat interviews at least allows for the exploration of themes arising from the first interview (Backett, 1992; Blaxter, 1990).

In practical terms, a further justification for conducting repeat interviews in this research relates to the breadth and depth of the interview topics. Interviewing is recognised as a time consuming and emotionally demanding social interaction (Rice and Ezzy, 1999); I felt that it would be impractical to attempt to cover all of the research topics in one interview.

2.2.3 Selecting a sampling frame

Study neighbourhoods

Consistent with the research aim of exploring processes which contribute to geographical inequalities in health, the study was designed to compare people's experiences of health and illness within two socially contrasting neighbourhoods; one relatively affluent neighbourhood, with a relatively well population, and one relatively deprived neighbourhood, with a relatively sick population. Study neighbourhoods were selected on the basis of ward-level information gathered in the 1991 census. These data sets relate to characteristics of the population such as housing tenure, car ownership, employment status and reported long term limiting illness. I was aware that there may be considerable heterogeneity within wards, in terms of the nature of particular places as social spaces (Gatrell et al, 2000). I was also mindful that ward boundaries are constructed for political and administrative purposes, and do not necessarily 'map' onto commonly held lay understandings of neighbourhood boundaries (Wiggins et al, 2002). Nevertheless, the ward data were

useful for identifying socially contrasting localities. Key socio-economic and health indicators for the selected wards are presented in Table 2.1.

In order to protect respondents' anonymity, the neighbourhoods have been given pseudonyms: **'Braemore'** is the relatively affluent study neighbourhood, and **'Kirkhead'** is the relatively deprived study neighbourhood.

Table 2.1 Socio-economic indices derived from ward level census data:

Table 2.1 a) Social class (Households): % of households with economically active head

Social Class Category	Braemore	Kirkhead	City of Edinburgh as a whole
	<i>%</i>	<i>%</i>	<i>%</i>
Class I	21.6	2.7	11.5
Class II	52.1	18.8	33.9
Class IIN	14.7	18.8	17.9
Class IIM	7.4	26.9	19.6
Class IV	1.1	12.9	10.2
Others (armed forces, Govt. Scheme, not stated)	2.1	8.6	2.0

Table 2.1 b) Housing tenure categories: % of households

Tenure category	Braemore	Kirkhead	City of Edinburgh as a whole
	<i>%</i>	<i>%</i>	<i>%</i>
Owner-occupier	90.0	51.4	66.4
Private rented	7.3	5.1	8.6
Rented with job	0.5	6.3	1.1
Housing association rent	0.8	1.3	4.0
Local Authority rent	1.3	32.9	19.1
Scottish Homes rent	0.0	3.0	0.8

Table 2.1 c) Car availability: % of households

Households with:	Braemore	Kirkhead	City of Edinburgh as a whole
	%	%	%
No car	24.8	56.0	46.5
One car	52.6	37.4	40.0
Two cars	20.0	5.9	11.9
Three cars	2.6	0.7	1.6

Table 2.1 d) Limiting Long-term Illness rates in 45-59 age group

Braemore			Kirkhead			City of Edinburgh as a whole		
%			%			%		
Males	Females	Persons	Males	Females	Persons	Males	Females	Persons
11.6	6.3	8.6	18.1	12.0	14.7	13.4	12.7	13.1

Source: Edinburgh District Council Planning Department; Derived from 1991 Census Small Area Statistics

Braemore was chosen as the relatively affluent study neighbourhood, partly on the basis of census data, and partly because it was mentioned several times as being a ‘posh’ area, in the course of the initial group interviews that I carried out. Given the emergence of ‘neighbourhood reputation’ as a potential contextually based psycho-social influence upon health (Macintyre et al, 1993), I was interested to explore the views and experiences of individuals living within an neighbourhood that has a reputation for being affluent.

Kirkhead was selected as the relatively deprived study neighbourhood. Again, this decision was based partly on census data for the ward within which Kirkhead is situated. However, another reason for selecting this neighbourhood is that it is contiguous with Braemore. As mentioned in Chapter One (Section 1.4), Gatrell (1997) has suggested that there may be psycho-social implications for health and well-being associated with individuals comparing features of their own neighbourhoods with those nearby. The selection of two socially contrasting yet contiguous neighbourhoods provided an opportunity for an empirical investigation of this theoretical idea. It should be noted that Kirkhead is not one of the most severely deprived neighbourhoods in Edinburgh, and this is one of the reasons why it was

selected as a study neighbourhood. Researchers have become increasingly aware of the need for a fine-grained approach to the study of health inequalities (Macintyre, 1997; Wilkinson, 1996). Therefore it is appropriate to focus attention on health-relevant processes operating not only within extremely affluent and extremely deprived neighbourhoods, but also within neighbourhoods that occupy a more intermediate position on the wealth/health continuum.

Sample groups

Decisions about the characteristics of the social groups to be included in the study were made with reference to intellectual as well as practical considerations (Mason, 1996). I chose to undertake the research with women in mid-life (between the ages of 45 and 59 years). There are some important and complex differences between men and women in terms of their health and illness experiences across the lifecourse (Macintyre et al, 1996). To incorporate a comparative focus upon gender-related determinants of health as well as seeking to draw contrasts between respondents based upon their neighbourhood of residence seemed too ambitious for the scope of a PhD project. Narrowing the focus of research to women at midlife is justified by the fact that as a subset of the general population, women in this age group are a relatively under-researched social group, particularly in relation to health inequalities research (Arber, 1997; Roberts, 1992). The choice to study women also reflected a pragmatic consideration - although I had been very interested in the accounts offered by the groups of men in my initial fieldwork, I felt uncomfortable about the prospect of undertaking lengthy interviews as a lone female, with unfamiliar men, particularly if I ended up conducting research in respondents' homes. Thus, my decision to focus upon women was made for practical as well as theoretical reasons - an influence upon research design acknowledged by Lofland and Lofland (1995).

The literature on health inequalities suggests that mid-life is a stage in the lifecourse when health inequalities between socio-economic groups start to become more apparent, as the incidence of chronic health problems and premature death become increasingly common (Blaxter, 1990). By investigating the experiences of different women within this age group, my intention was to explore some of the

processes through which health inequalities are generated over the lifecourse. Thus, a focus on health-relevant experiences at earlier stages of life would not be excluded from the study, but rather considered in the context of a longer lifecourse. I wanted to research the ways in which life events and socio-economic circumstances may interact with experiences of health and illness. A focus upon women in the middle years meant that respondents would be old enough to have experienced a range of structurally shaped life events and situations, such as entry to, and pathways through the housing market; entry to, pathways through, and even exit from the labour market; family formation and possible breakdown (Bartley et al, 1997).

2.2.4 Recruitment of respondents

Having chosen the sampling frame – women between the ages of 45-59, living in Braemore or Kirkhead, I began the process of recruiting respondents into the study in November 1999. Twelve women were recruited into each neighbourhood sample group. In light of the detailed nature of the data that I intended to collect, and the fact that this would involve conducting two interviews with each respondent, I felt that recruiting a total of twenty-four respondents would yield a manageable volume of data, given the time constraints of the study.

The parameters that I had set for the study meant that purposive sampling techniques were the most appropriate ways of recruiting respondents (Mason, 1996; Silverman, 2000). The only criteria for inclusion in the study were that women were of the appropriate age and lived in the appropriate neighbourhoods. I decided not to recruit on the basis of self-reported health, or through GP medical records, because I was interested in exploring women's accounts of experiences of both good health and illness, whatever their actual current state of health. I was not looking for a 'representative' sample of women from whose accounts I could make statistical generalisations. Rather, in keeping with the epistemological assumptions which underpin qualitative research, I was concerned with exploring subjective understandings of experiences of health and illness (Limb and Dwyer, 2001; Mason, 1996; Rice and Ezzy, 1999).

Gaining access to respondents is acknowledged within the literature as a potentially difficult stage of the research process (Lofland and Lofland, 1995; Mason, 1996). In order to recruit the required number of respondents into each sample group, I was obliged to engage in a variety of recruitment strategies, some of which proved to be more effective than others. For example, snowballing – where an initial respondent is asked to suggest other people who may be willing to participate in the research, proved to be particularly fruitful in Braemore although less so in Kirkhead, for reasons which are unclear (Lofland and Lofland, 1995; Rice and Ezzy, 1999). The first recruit into the Braemore sample was the mother of an acquaintance – she in turn introduced me to two of her neighbours. In total, six respondents in the Braemore sample, and two in the Kirkhead sample were recruited through personal contacts and snowballing.

At the same time as using snowballing as a way of recruiting respondents, I placed an advert in the local paper, which yielded responses from four women in Braemore and two women in Kirkhead, all of whom were recruited into the study. I also designed flyers and posters advertising the study, which I distributed in local shops and meeting places, such as cafes, churches, community centres, schools and doctors surgeries. These had a very limited response – only two respondents were recruited into the study in this way, both into the Braemore sample group. The lack of response generated by these flyers perhaps illustrates the point made by Lofland and Lofland, that successfully accessing research respondents often depends upon personal contacts (1995: 37).

It turned out to be much easier to recruit respondents into the Braemore sample than it was to recruit respondents into the Kirkhead sample, although the reasons for this are unclear. Several weeks after having advertised the study in Kirkhead through flyers, posters, and an advert in the local press, I still had not recruited any women from Kirkhead, although I had recruited several women for the Braemore sample. On the advice of other researchers at The University of Edinburgh, I approached the university personnel department to ask for permission to write a letter of invitation to the study to all female employees who met the sampling criteria. This is a strategy that has successfully been pursued in other research

(Backett-Milburn et al, 2000). I made it clear that I did not require access to any employee records as such, but just a list of appropriate names and addresses. I submitted a draft copy of the proposed letter to the personnel department for approval prior to receiving a list of names and addresses. Seven women in total fitted the criteria for the study, and I wrote to all of them. I received one reply, from a woman who agreed to participate in the study.

The approach which proved most fruitful in recruiting respondents for the Kirkhead sample was through accessing patient records from a General Practice in the neighbourhood, in order to send letters of invitation to the study to those patients who fitted the criteria for the study. I had informally approached one practice in Kirkhead who had verbally agreed to allow me access to patient names and addresses, provided that the project was awarded ethical approval by Lothian Primary Care Ethics Committee. An application for ethical approval was successfully submitted; however, I then discovered that the GP surgery in question had decided against allowing me access to their records. This was a frustrating setback. Fortunately, I was able to gain access to another GP surgery in Kirkhead, through an acquaintance who had recently started working there as a GP locum. Through this personal connection, I was permitted access to a list of the names and addresses of female patients born between 1941 and 1955, who lived within the relevant neighbourhood. A GP partner removed from the list those women that she felt it would be inappropriate to invite to take part in the study – for example, women who were seriously ill, or who had been recently bereaved. After these names had been withdrawn, there remained 240 names on the list.

A random sample of 120 patients were sent letters introducing the study, signed by the GP and written on surgery-headed paper. Enclosed with the letter was an information sheet about the study, and a reply slip with a freepost envelope that could be returned to me, if the women wished to express an interest in the study. The letter and information sheet are reproduced in Appendix One. At this stage of the research, I had managed to recruit six women into the sample, and so only needed to recruit six women from Kirkhead into the study. To send letters to over a hundred women might seem a little excessive. However, I was concerned about not being

able to recruit enough respondents in the fast-disappearing time that I had scheduled for fieldwork. Having found it so difficult to recruit the first six women into the Kirkhead sample, I decided that the more women I contacted, the greater chance there was of recruiting the requisite number of respondents.

Twenty women responded to this letter, to indicate that they were interested in taking part in the study. I attempted to contact all of the women who responded to the letter from the GP. Because the only criteria for inclusion in the study were that respondents lived in the neighbourhood and were the appropriate age, I recruited respondents into the study in the order that they replied to the letter. However, I contacted those women who replied after I had finished recruiting respondents, in order to thank them for responding and explain that I had already recruited enough respondents into the study. The fruitfulness of this recruitment strategy may partly be related to the gatekeeping role played by the GP. The fact that the letter of introduction was signed by the GP may have lent the study an air of respectability or trustworthiness; alternatively, women may have responded out of a sense of obligation to the GP. Whatever the reason for the positive response to this strategy, it served to highlight the usefulness of gaining access to potential respondents through gatekeepers and other intermediaries with personal contacts (Walsh,1998).

2.2.5 Contacting respondents and obtaining consent

I initially established contact with potential research participants by telephoning those women who had indicated that they were interested in taking part in the study by sending me their contact details. The purpose of this call was to introduce myself, explain the research in general terms, and to give women the opportunity to ask any questions they had about the research before deciding whether or not to participate. The research was framed as a study of the health and illness experiences of women living in different parts of Edinburgh, and about other general aspects of their lives. I emphasised that I was interested in hearing women's own stories and opinions about the sorts of things (both good and bad) that had influenced their past and present health. I offered a brief outline of the two interviews, along with an estimate of the likely time commitment required, if women chose to participate (between 90-120 minutes per interview).

During this initial telephone call I explained that if women chose to participate in the study, their anonymity would be protected through the use of pseudonyms. I also informed the women that I planned to tape-record and transcribe interviews (with their permission), so they could take this into account when deciding whether or not to participate. Having explained the study and answered any questions, I told all of the women that I would be happy to phone again if they wanted some time to consider whether or not to take part; however, every woman that I contacted agreed to participate in the study during the course of the initial telephone conversation. All of the participants opted to be interviewed in their own homes, and mutually convenient times were arranged for the first interview.

Gaining consent is a crucial, yet potentially problematic, ethical consideration (Valentine, 2001). The complexity of gaining informed consent is acknowledged within the literature; research participants may not fully appreciate what it is they are consenting to (Mason, 1996). In an attempt to raise respondents' awareness of what giving consent means, I explained that the study formed the basis of a PhD project that would be written up, and that extracts from their interviews might potentially be published, albeit in anonymised form. Additionally, at the start of the first interview, respondents were asked to sign a consent form which stated that they agreed to take part in the research, that the interviews would be tape-recorded, that all information provided would be confidential and anonymous, and that they were entitled to withdraw from the research at any point.

2.2.6 Some comments on the sample groups

The criteria for inclusion in the study were relatively loosely defined, based on gender, age, and neighbourhood of residence. This led to considerable diversity both within and between the two sample groups, which could have shaped the findings of the study. This is not necessarily a limitation of the research, as the study was designed to explore processes through which health and illness experiences are negotiated throughout the lifecourse by individuals in a *range* of social contexts. As with research projects in general, the respondents in this study essentially self-selected into the study, in that they chose whether or not to take part (Lofland and Lofland, 1995). This has certain (but largely unspecifiable) implications in terms of

the characteristics of the women who decided to take part in the project, and in terms of the nature of the data constructed.

One striking characteristic of the total sample which is worth noting is that sixteen of the twenty-four women are, or have been employed in health-related jobs. These women may have been motivated to participate in the study through a particular interest in health-related issues. Another important feature of the sample is that ten respondents reported chronic health problems (nine in the Kirkhead sample and one in the Braemore sample). Again, these women may have been particularly interested in the study because of its focus on experiences of health and illness (although I made it clear in the recruitment process that I was interested in experiences of good, as well as poor health). All of the respondents are White; this reflects the ethnic composition of the two study neighbourhoods – data from the 1991 Census show that 98% of the population of the two areas are White. Information related to the socio-economic and family circumstances of all respondents is provided in Appendix Two.

2.3 Data Construction

Topic guides for each interview were developed on the basis of breaking down the broad research questions into separate themes. The content of each topic guide is discussed in more detail below. Three pilot interviews were undertaken with women recruited through personal contacts. These women were in the appropriate age range, although they did not live in the chosen study areas. Piloting provided an opportunity to check that the topic guides included topics that were relevant and appropriate to the women's lives, and which would yield data that were useful in terms of addressing the research questions. It also allowed me to check that questions were worded appropriately (Cunningham-Burley and Backett-Milburn, 1998). I made minor adjustments to the topic guides in response to the pilot interviews.

A key theme within the qualitative literature is the need for researchers to demonstrate a reflexive awareness of the active role they play in the process of data

construction; researchers are not neutral observers (Backett, 1992; Mason, 1996). Indeed, the notion that interviewers should remain detached from their interviewees has been strongly criticised, particularly within the feminist literature (Oakley, 1981; England, 1994). Throughout the interview process, and especially upon meeting respondents for the first time, I made active efforts to establish rapport and trust with research participants (an issue that was raised in Section 2.2.2). I wanted respondents to feel at ease during the interview process, and so I deliberately engaged in small talk at the beginning (and end) of interviews. I interviewed respondents in their own homes, and in almost all cases, building rapport with respondents was facilitated by the fact that respondents themselves seemed keen to appear welcoming, for example by offering me a drink. As a woman in my early twenties, I was of a similar age to many of the respondents' children, and I think that this, combined with the fact that I presented myself as a student (rather than as a 'researcher') contributed to being able to present myself in a non-threatening way (Lofland and Lofland, 1995). I also responded to any questions that respondents had about the study, or about me personally.

At the start of each interview, I explained the general purpose of the study, and the specific purpose of that particular interview. I consciously shifted back and forth between the roles of a 'competent individual' – able to clearly explain what the study was about and why I was doing it, and a 'naïve learner' - keen to hear about experiences and views that the respondents themselves considered to be important (Lofland and Lofland, 1995).

2.3.1 The first interview – introducing the lifegrid

On the basis of the literature and sensitising pilot work I aimed to elicit accounts from respondents about their lifecourse experiences of both good health and illness, within the context of accounts about their wider life circumstances. In addition to an interest in how good or poor health might accumulate over the lifecourse, I was interested in the associations and connections that respondents themselves might make between particular life events or situations, and their experiences of health and illness. I was aware of debates within the literature about the accuracy of retrospective data and so I wanted to use a method of data collection

which would facilitate the construction of reliable data. These issues are discussed within Parry et al (1999).

After discussions with Dr. Odette Parry and Carolyn Thomson at the Research Unit for Health and Behavioural Change at The University of Edinburgh, I decided to use a modified lifegrid approach to facilitate the collection of detailed lifecourse data. Parry and colleagues had recently used the lifegrid in a qualitative study of smoking behaviour over the lifecourse (Parry et al, 1999); they in turn had received training in the lifegrid method from David Blane and colleagues, who had used the lifegrid to obtain more structured data about links between cumulative exposure to health-damaging environments and social class variations in health (Berney and Blane, 1997; Berney et al, 2000; Blane, 1996; Dorling et al, 2000).

A lifegrid comprises of one sheet of A3 graph paper, divided into a number of columns - five, in this research. A 'time line' is marked down the vertical axis of the graph paper, displaying dates at five-yearly intervals; in the case of this research, starting at 1940. The birth date of the respondent is recorded on the vertical axis, and his or her age at intervals of five years is also recorded on this axis. At the top of each of the five columns is a title relating to a broad area of life experience: family, education/work, housing, lifestyle, and health. A lifegrid is prepared for each respondent prior to the interview. During the interview, the lifegrid is operationalised through the use of an interview topic guide. Significant life events relating to the research topics under investigation are recorded chronologically on the lifegrid in the appropriate column. An example of a completed lifegrid is shown in Appendix Three.

In a paper which they wrote after completing their study, Parry et al (1999) identify five advantages to using lifegrids in the collection of retrospective qualitative data. Firstly, lifegrids facilitate recall by enabling the respondent to structure his or her account around meaningful and memorable events and situations in his or her life. Secondly, because completing a lifegrid requires a high level of engagement from the respondent, it is conducive to the development of rapport between the researcher and the respondent. Thirdly, completing a lifegrid involves

specific tasks, which provide a focus for data collection. Fourthly, the grid appears to enable the respondent to mention traumatic experiences without this necessarily being emotionally charged. Finally, using a lifegrid allows the respondents to take some control over the course of data collection and the re-construction of his or her biography. Thus, the use of lifegrids in qualitative lifecourse research is an innovative method of facilitating recall when collecting retrospective accounts. In a later section, I discuss some of my own experiences of using the lifegrid, and pick up on some of the points raised by Parry and her colleagues.

At the start of each interview I explained the concept of the lifegrid to the respondent, emphasising that I wanted us to view filling in the lifegrid as a mutual task. I explained that I was interested not only in her health and illness experiences over the course of her life, but also in other aspects of her life that she considered to be significant and/or health relevant. I explained that I had a topic guide to aid our discussion, but that the lifegrid did not have to be completed in any particular order. Therefore, if the respondent was in the middle of telling me about an event or situation that could be recorded in one of the columns and this triggered a memory of a relevant event or situation that could be recorded in another column, it would be possible to move back and forth between different columns, and between different life stages. Writing down significant events on the grid allowed them to be cross-referenced with the dates of other occurrences already recorded on the grid. I emphasised that the lifegrid was not a 'scientific' tool but rather a visual aid to facilitate the reconstruction of biographies.

The lifegrid interview began by confirming the respondent's date of birth, and by asking her where she had been born. I then asked details about her family, such as whether or not she had any siblings, and what her parents did for a living when she was a child. My intention was to start off the interviews with relatively non-threatening questions that would not be too challenging for respondents to answer. Recording information on the grid about, for example, when siblings were born, and where the respondent lived as a child, also offered an opportunity to demonstrate to the respondent how the lifegrid 'works'. I then asked the respondent

various questions relating to aspects of her childhood circumstances, and about her health as a child.

In this research, use of the lifegrid was operationalised through an interview topic guide based around various life stages which have been identified by Bartley et al (1997) as being “critical life transitions”. These researchers have argued that throughout the lifecourse, individuals go through a number of socially critical periods which engender a degree of material and psycho-social uncertainty, both for the individuals concerned, and for their families. They suggest that the degree of insecurity experienced by individuals is powerfully influenced by their access to resources, which in turn is shaped by their location within the socio-economic structure. In Box 2.1 I present a list of critical periods which I focused upon in my study (derived from Bartley et al (1997) and Shaw et al (1999a)).

Box 2.1 Critical life transitions

- Transition from primary to secondary school
- School examinations
- Entry to the labour market
- Leaving parental home
- Entry to (and trajectories through) the housing market
- Establishing social and sexual relationships
- Transition to parenthood
- Job insecurity, change or loss
- Episodes of illness
- Onset of chronic illness
- Labour market exit

The lifegrid interviews were loosely structured around critical life transitions for two reasons. The first is theoretical: Bartley et al argue that at each of these critical life periods:

...social and economic disadvantage can push the individual another step down the aetiological pathway towards established chronic disease.

(Bartley, Blane & Montgomery, 1997: 1195)

Given the purported significance within the literature of these transitional periods in relation to later health outcomes, I wanted to explore whether (and in what ways) they were perceived to be significant within lay accounts of the lifecourse. The second reason is more practical: Parry and colleagues assert that:

...the identification of key life transitions and turning points can provide a framework within which socio-biographical detail can usefully be explored.

(Parry et al, 1997:2)

Thus, by using critical life transitions as a framework, I intended to construct data about various dimensions of the respondents' socio-economic circumstances at various stages throughout the lifecourse.

In addition to asking questions based upon critical life transitions, the 'housing' column of the grid facilitated the reconstruction of respondents' housing trajectories into their current homes. In particular, specific questions were asked about respondents' pathways into, and their experiences within, the study neighbourhoods, in order to explore how the women's biographical experiences have been constituted within particular geographical and social spaces (Gatrell et al, 2001). Data constructed about the social contexts of respondents' lives served as valuable contextual information - a background against which to discuss health-related lifestyle habits and experiences of health and illness over the lifecourse.

At the end of the lifecourse interview, I asked respondents a set of questions on the topic of health and healthiness. Some of these questions were abstract and general – e.g. “How would you describe being healthy?” and others were personal, relating to their perceptions of their own health – e.g. “Do you consider yourself to be a healthy person?”. This provided respondents with a further opportunity to reflect on their health throughout their lives, as well allowing for the construction of concepts of health. A copy of the lifegrid interview topic guide is in Appendix Four.

2.3.2 Reflections on using the lifegrid

In general, I found the lifegrids to be an extremely useful aid to data collection. During the lifegrid interviews, I tended to sit next to, or very near to the respondents, in a position where we could both clearly see the lifegrid. Most of the respondents engaged with the lifegrid, by looking and pointing at it during the interview, and by using the information that I recorded in particular columns on the grid to help them recall events and situations that could be recorded in other columns. It was very useful to be able to refer to information written on the grid, which often prompted me to ask particular questions. For example, if a respondent reported several significant events within a short period of time, such as moving house, having a baby, and experiencing a bereavement, I would ask whether they remembered the experience of these clustered events as being particularly stressful, or as influencing their health in any way.

However, there were some disadvantages to using the lifegrid. I made it clear to respondents that it was *their* lifegrid that we were filling in, and therefore they were to feel free to talk about significant events and situations in an order which made sense to them. However, one or two respondents did not actively engage with the lifegrid – for example, they did not look at it or express much interest in filling it in. These interviews tended to be shorter than those with other, more engaged respondents, and I found it hard to encourage these respondents to talk to me in any detail.

A more common concern was that whilst the semi-structured nature of the interviews allowed for flexibility and encouraged the construction of richly detailed data, it also meant that interviews were frequently ‘messy’, which could leave me feeling slightly uneasy and unsure of whether I had collected enough ‘relevant data’ within the overall mass (Mason, 1996). This is perhaps related to the fact that the ‘logic’ of the grid – filling in information in chronological order, is not necessarily the same as the ‘logic’ of the recall of life events and experiences. An example of the messiness of data construction is that on occasion, respondents would refer to events that were perhaps decades apart, and I sometimes struggled to follow the

thread of their accounts. At times, I felt uncomfortable interrupting the respondents' narratives in order to clarify points or to change the subject - unsure whether they had wandered off the point of our discussion, or whether, if I allowed them to continue talking, they would in fact arrive at a significant and insightful endpoint.

There were also instances where I might be talking with a respondent about, for example, significant events within the family, and I would end up re-constructing her experiences of family relationships throughout the course of her life, and then need to go right back to her teens to ask about lifestyle habits or educational qualifications. This shifting between different topics and different life stages could sometimes feel disjointed – for example, if I felt that I was changing the subject abruptly. One strategy of making sure that important research topics were covered over the course of interviews was to look over a checklist of key questions towards the end of the interview, in order to ask those questions that had not already been discussed.

Another, related issue is that it became apparent during the research, that although my questions were structured around critical life transitions, some transitions were more relevant for some respondents than for others – flexibility was required on my part to stay alert to events and experiences which the respondents indicated had been significant, meaningful and/or health relevant *for them*.

Although respondents generally indicated that the lifegrid was useful for facilitating recall, there were some instances where trying to clarify the chronological order of different life events and personal circumstances, and cross-reference them with health histories proved to be somewhat arduous. For example, there were one or two instances in interviews when I realised that I was spending so much time on trying to record the order of particular events that I was neglecting the 'bigger picture' of health and illness experiences throughout the lifecourse as a whole. In other words, my focus upon getting chronological details threatened to pre-occupy me, at the expense of actually listening to the respondents' accounts of about particular experiences. After a couple of these occasions, I reflected that I had intended the lifegrid to be a tool for facilitating data collection – a means to an end,

not an end in itself. I became less fastidious about getting respondents to remember precise dates, and tried to devote my energies to engaging more closely with the content of the respondents' accounts.

During the lifegrid interviews, I was conscious of the need to balance the breadth and the depth of the data constructed. It was a challenge to cover accounts about a broad range of topics spanning the whole lifecourse within a reasonable length of interviewing time. Most of the lifegrid interviews lasted around an hour and a half, but occasionally they extended to over two hours. If interviews approached the two hour mark without it being obvious that we had nearly completed filling in the grid, I agreed with the respondent that we would halt the interview and resume it on another occasion - I discovered that interviewing, and being interviewed can be an exhausting experience. The sheer breadth of the data that I wished to collect means that data about some topics were constructed in more depth than other topics, and this varied between individual respondents. A key point in relation to this is that the ages of the respondents ranged between 45-59 years; the oldest respondents had approximately 15 more years of life experience to report than the youngest women in the study, and so their interviews may have tended to cover a greater breadth of topics, but in less detail than those with younger respondents.

Lifegrid interviews could also be emotionally draining. Parry et al suggest that lifegrids may enable respondents to talk about traumatic experiences without the experience being emotionally charged. Whilst I agree with these authors that noting down these traumatic events on the grid seemed to be a way of granting me permission to ask about these experiences, in many cases, the women's accounts of traumatic events were emotionally charged. Although most respondents were willing to talk about traumatic events, it was not unusual for them to burst into tears in the process of recounting their experiences. In these situations, I was aware of the need for sensitivity; I asked respondents if they would like to turn the tape off, or curtail the interview altogether, and I tended to sit quietly and wait until they had regained their composure and were ready to continue. Often, I myself felt distressed by the stories that the respondents were telling me, and this tended to influence subsequent parts of the interview. For example, in the context of hearing about distressing

instances of bereavement, or marital breakdown, I often felt that certain questions relating to the same life stage, for example about eating habits, were not only fairly irrelevant but might also appear insensitive to the respondent as well. I was aware that I had an ethical obligation to respond in flexible and sensitive ways to the potentially distressing emotions that could arise in an interview situation (Kobayashi, 2001).

My discussion in this section has indicated that, although on the whole the lifegrid is a useful and innovative tool to aid the construction of retrospective accounts, the lifegrid interviews did not necessarily proceed in straightforward or unproblematic ways. However, the limitations of the data which I have identified are not necessarily connected to use of the lifegrid per se, but are perhaps issues related to qualitative research more broadly.

2.3.3 The second interview – daily routines

The lifegrid interview was designed to elicit accounts about various aspects of the respondents' lives from the time that they were children up to the present day, in order to understand respondents' trajectories into the study neighbourhoods, and to contextualise their lifecourse health and illness experiences. The second interview, termed the 'daily routines' interview, was designed to explore various aspects of the respondents' current day-to-day lives, in order to understand how 'where they are now' might be shaping their current health and future health prospects.

After each lifegrid interview I listened to the tape and took notes on important themes in that respondent's account, as a way of preparing for the daily routines interview. I also noted down issues and topics that I wished to explore further in the daily routines interview – either to clarify particular points, or because further discussion might yield important insights into how that respondent understood her experiences of health and illness.

The interview was designed to elicit accounts of everyday life, and a topic guide was developed to facilitate discussion of routine experiences and whether and how these might relate to issues of health and illness. The intention was to construct

accounts of 'a typical day', and to explore respondents' understandings of those dimensions of daily life that they perceive to be health-relevant. In particular, questions in the topic guide were informed by theoretical notions of the influence of psycho-social stress upon health, and so were designed to explore sources of stress in everyday life (Pearlin, 1989; Wilkinson, 1996).

Consistent with the aim of the interview, the interview guide covered a range of topics relating to daily life, including: eating habits, paid and unpaid work, domestic arrangements, money, social relationships, shopping habits, transport use, leisure activities, and exercise. Respondents' views and experiences of the local neighbourhood were sought, to explore perceptions of how living in particular places might be relevant for health and well-being. Questions relating to current health experiences were included in the topic guide. The topic guide for the daily routines interview is in Appendix Five. As with the lifegrid interview, I had a checklist of key questions that I referred to towards the end of the daily routines interview to ensure that particularly important topics were covered during the interview.

The daily routines interview began by feeding back to respondents' their definitions of health and healthiness that they had constructed in lifegrid interview. This provided the respondents with an opportunity to confirm, refine or extend the definition of health that they had previously constructed, and to check whether I had interpreted their accounts correctly. Starting the daily routines interview in this way also acted as a point of continuity between the two interviews. After a discussion of the respondents' views about health, I invited the respondents to tell me about a typical day, starting with when they got up in the morning. As with the lifegrid interview, the daily routines interview was semi-structured. I used a topic guide of questions, but tried to allow the respondents to lead the discussion as much as possible by asking questions in relation to relevant topics that they mentioned spontaneously as they described their everyday routines. As a result, the daily routines interviews were very flexible in structure.

At the end of the second interview, respondents were asked to complete a form, giving summary information about their household circumstances, and the

health of members of their households. The design of the form was reproduced with permission from Anne Ellaway at the MRC Social and Public Health Sciences Unit at the University of Glasgow; a copy is shown in Appendix Six. One of the questions on the form asks for details of total household income. The form is designed to allow information on household income to be stated as a weekly, monthly or yearly figure, either before or after tax. Whilst this way of collecting information was designed to allow respondents to provide information about their income in a way which was easiest for them, it also meant that it was difficult to standardise the information that was gathered. This is an aspect of the research design that could be improved, were the study to be replicated.

2.3.4 Reflections on the interview process

In-depth interviewing has frequently been heralded by feminist researchers as a technique that serves to break down the hierarchical relationships that have traditionally existed between the powerful researcher and the less powerful researched. Oakley (1981) was one of the first feminist academics to argue that it is morally indefensible for female researchers to seek to maintain 'objective' and therefore hierarchical relations with female research participants, which treat women solely as providers of data. Furthermore, Oakley maintained that seeking to collaborate with research participants and thus attempting to minimise power inequalities is the only way that researchers will access plausible understandings of the lives of interviewees. In her work, Oakley emphasised the 'sisterhood' of women, and maintained that commonalities between women facilitates an interview process that is more akin to a two-way conversation.

More recently, however, it has been increasingly acknowledged that women are not a homogenous group, but are divided along various axes of social relations, such as class, race and age (Dyck, 1997; Staeheli and Lawson, 1994). The dynamics of power relations in the interview context are complex and fluid, and it is not necessarily the researcher who wields the most power throughout the interview (Mason, 1996; Reynolds, 2002). I certainly felt on occasion that it was the respondents, and not me, who held more power and exerted more influence over the interview setting. For example, a few respondents said so little that I wondered why

they had agreed to participate; others frequently engaged in long monologues, following their own train of thought for extended periods of time, which I found hard, but wasn't sure how to respond to. There were other situations in which I felt disempowered – for example, when respondents forgot my name, or forgot that we had arranged to meet, or spent a long time talking on the telephone in the middle of the interview. Whilst these episodes were frustrating, they were also relatively rare; perhaps such occasions were an inevitable trade-off associated with the fact that research participants were doing me a huge favour by participating in the project in the first place (Lofland and Lofland, 1995; Valentine, 2001).

2.4 Data management and analysis

After I had carried out the first two or three interviews, I transcribed them and circulated the transcripts amongst my supervisors, in order to get some feedback on the quality of the interviews. I made some minor adjustments to the interview topic guides in response to their comments. Throughout the fieldwork process I reviewed the topic guides and interview techniques after every few interviews, and reflected upon themes arising in the interviews, in order that I could fine-tune my interviewing style and topic guides as appropriate.

All of the interviews were recorded onto audio tape, with the respondents' permission, with the exception of one lifegrid interview with a Braemore respondent, when I failed to press the correct buttons on the tape recorder – a trying experience, which proved to be a good learning point! I decided to transcribe the interviews myself, primarily because I did not have the resources to pay for them to be professionally transcribed. The advantage of transcribing the interviews myself is that through the process of doing it, I became extremely familiar with the data, and the iterative process of analysis continued throughout (Lofland and Lofland, 1995). The interviews were transcribed verbatim, although not all of the interviews were transcribed in full – occasionally, interviews drifted off into topics of conversation that were completely outside of the research questions; given time constraints, and the fact that I had 47 lengthy interviews to transcribe, this was a sensible approach. During the transcription process I made notes on themes within the data that I

thought were interesting or potentially important, which I revisited when I engaged more fully in data analysis.

During the early stages of data analysis, each transcript was printed and read several times, and I made notes and comments in the paper margins. Through this intensive reading, I increased my familiarity with the data, and began to develop a sense of important themes within the data. I started off by reading the lifegrid and daily routines transcripts of individual women, in order to get an overall sense of their 'life stories'. I then read the transcripts in a different way, comparing the data constructed respondents in the Braemore sample with those in the Kirkhead sample. Throughout this process, I made copious notes about themes and patterns that I was starting to discern within the data, and about how these themes might relate to my original research questions and to existing research findings reported in the literature. By moving back and forth between the data and the research questions, I slowly started to develop a coding framework (Lofland and Lofland, 1995; Mason, 1996).

Developing a coding framework was one of the hardest parts of the analysis. The study was designed with the intention of trying to take a holistic approach to the determinants of health and illness. The whole point of the research was to recognise that although it might be possible in theory to parcel out determinants of health into separate 'risk' factors, in reality these determinants are meshed together and intertwined in lived experience. However, now I was required to start 'chopping up' respondents' narratives, which by their very nature illustrated the interconnectedness of different dimensions of life experience. This issue was not confined to the question of how to code the data - for months I agonised over how I was actually going to be able to organise discussion of the data into separate chapters of the thesis without undermining what I perceived to be an important theoretical point upon which the research was based – namely, the interconnectedness of health and life circumstances.

In the end, I accepted that it was unrealistic to try and devise a 'perfect' coding framework, given the extent to which different themes within the data were interwoven. The complexity of the coding framework was magnified by the need to

code biographical data that related to past, as well as present events and experiences. After several attempts, I developed a workable, if complex, coding framework that I used with every transcript, after testing it out on a few transcripts to start with. A copy of the coding framework that I used is presented in Appendix Seven.

I used a computerised analysis package, HyperResearch, to facilitate systematic coding of the data. Within the literature, it is advocated that computer aided qualitative data analysis software (CAQDAS) should be used in a critical and reflexive way by researchers; they should not be used as a means to gain some form of 'scientific respectability' for qualitative research (Crang et al, 1997; Hinchliffe et al, 1997). The package was used to 'file' similar chunks of data from different respondents under thematic headings – a sophisticated form of cutting and pasting. Once all of the transcripts had been coded, HyperResearch was extremely useful in offering more or less instantaneous access to all of the data excerpts collated under individual codes.

Having coded the data, I focused analysis upon specific topics – for example, experiences within the labour market. By printing out all of the data relating to each topic, I was able to appreciate the range and complexity of the data. I searched the data for common themes and patterns, both within and between the two sample groups, generating ideas and interpretations of the data, and then checking whether these interpretations were actually supported by the data. In particular, I looked for negative or deviant cases which would challenge my interpretations, rather than simply looking for data which would support them. This 'constant comparative method' of inductive analysis is well documented in the literature (Denzin, 1989; Glaser and Strauss, 1967; Mason, 1996). Throughout the process of data analysis, I continue to re-read whole transcripts in addition to the coding reports, in order to maintain a sense of the contexts within which the data were constructed. In this way, I attempted to develop a sophisticated analysis of the data.

In the empirical chapters which follow, I have made efforts to be transparent in demonstrating how I arrived at my analysis and interpretation of the data. The data presented have been selected because they are illustrative of particular themes

within the data, and they express or encapsulate the points I wish to make particularly well. In many instances, more than one quotation is presented in order to illustrate an argument –this is done either to indicate that the respondents expressed a range of contrasting views on a particular topic, or conversely, to illustrate that particular opinions were commonly expressed by more than one respondent. I have attempted to convey the complexity of the data by writing about unusual or unexpected themes within the data, which have challenged my previously held ideas/theories about particular topics. Throughout the thesis, I have made efforts, when presenting data extracts, to also present information which illustrates the contexts within which the data were constructed. Through the use of these strategies, I have sought to demonstrate the rigour of the analysis presented (Mason, 1996; Rice and Ezzy, 1999). The anonymity of respondents has been preserved through the use of pseudonyms (as mentioned in Section 2.2.5). For a minority of respondents, certain identifying factual and personal details have also been changed.

2.5 Summary

In this chapter I have described the ‘natural history’ (Silverman, 2000) of the research project, explaining the processes through which the research was designed and executed. I have offered some reflections on the processes of data collection and analysis, including some thoughts on the ways in which I, as the researcher, shaped the construction as well as the interpretation of the data.

In Chapter Three I discuss respondents’ accounts of health and illness.

Chapter 3: Accounts of health and illness

3.1 Introduction

Chapter One outlined a review of sociological research on health in recent decades, highlighting the shift away from a biomedically-orientated focus upon disease and illness, and the growing recognition of the need to embrace a social model of health which encompasses more positive dimensions of health (Nettleton, 1995). An important body of work has investigated lay views about health and illness (Backett, 1992; Blaxter, 1990; Blaxter and Paterson, 1982; d'Houtard and Field, 1984; Herzlich, 1973). A key contribution of these studies is that they have demonstrated the complexity of lay understandings about health and illness. These studies also suggest that lay understandings of health and illness are shaped by the socio-cultural contexts in which people live, and as such are socially patterned. Radley states that:

...how people think about health and illness varies with their position in society, so that this discourse is itself informed by their interests in other spheres of life.
(Radley, 1993: 2)

In this chapter I start to unpack the respondents' views about and experiences of health and illness. The study of lay concepts of health, and of how lay actors perceive their own health, offers an opportunity to consider how individuals' constructions of health are influenced by their interpretations of their social contexts (Backett, 1989). This study prioritises lay perspectives in exploring processes which underpin geographical health inequalities; an important starting point is therefore to investigate whether individuals in contrasting geographical and social spaces conceptualise health in different ways. Thus, the discussion presented here serves as a vital preliminary to the following empirical chapters.

In Section 3.2 , I consider the ways in which respondents conceptualised 'health' in the interviews, comparing accounts within and between the two sample groups. In particular, I highlight the emphasis placed upon positive dimensions of health in the women's accounts.

In Section 3.3 , I introduce the notion that respondents' perceptions of their own health reflect a moral imperative to claim healthiness as part of personal identity. There are stark differences between the two sample groups in terms of reported morbidity (as shown in Section 3.1.1); in Sections 3.4 and 3.5 I consider the implications of the presence or absence of chronic health problems in terms of how respondents described their own health. I present data which indicate that respondents from both sample groups engaged in complex evaluative processes when talking about how healthy they perceive themselves to be; the data point to a moral imperative to claim healthiness as an important element of individual identity (Crawford, 1984).

In Section 3.6 I discuss respondents' accounts of the experience of stress, and their perceptions of whether and how stress influences their health. As discussed in Chapter One, proponents of psycho - social explanations for health inequalities contend that psycho-social stress mediates between the experience of relative deprivation and poor health (Elstad, 1998; Wilkinson, 1996). With this in mind, discussion of how the respondents themselves understand and experience 'stress' prepares the way for subsequent chapters, in which I explore the extent to which disparities in health reported by the two sample groups might be explained by respondents' differing experiences of socially mediated stress within contrasting geographical and social spaces.

3.1.1 Health profile of respondents

Nine respondents in the Kirkhead sample reported chronic health problems, compared to one respondent in the Braemore sample. Table 3.1 presents data on the chronic health problems reported by respondents in both sample groups.

Table 3.1 Chronic health problems reported by respondents in both sample groups

Chronic health problems reported in the Kirkhead sample group (n=9) Note: Eight of these nine respondents report more than one health problem	Chronic health problems reported in the Braemore sample group (n= 1) Note: One respondent reported four health problems
Diabetes (4 respondents) Arthritis (3 respondents) Asthma (3 respondents) Depression (3 respondents) Alcoholism (2 respondents) Multiple Sclerosis (1 respondent) Addison's Disease (1 respondent) Angina (1 respondent)	Arthritis Depression Sensory Impairment. Ulcerative Colitis

3.2 Health matters

Respondents' concepts of health were elicited in response to the question "How would you describe being healthy?". In Chapter Two (Section 2.3.3 , page 60), I explained that respondents were asked this question in both the first and the second interview, in an attempt to elicit private accounts regarding concepts of health (Cornwell, 1984; Backett, 1989). I began the second interview by reminding women of how they had previously defined being healthy, and asking if they had anything to add to their definition. In response, almost all of the respondents, whilst supporting what they had said in the first interview, also elaborated on their views about health - amplifying rather than contradicting what they had previously told me. As a result of this process, data on this topic are richly detailed, and they offer a complex picture of how individuals in contrasting circumstances conceptualise health.

There is some suggestion within the literature that lay concepts of health vary by social class (d'Houtard and Field, 1984). However, in this study, there is a large degree of overlap between the two sample groups in terms of how the majority of respondents conceptualised health. Of the 24 respondents, only 5 conceptualised health in ways which are clearly distinguishable from the other respondents.

Accounts from this small subset of respondents may be thought of as occupying extreme positions on a continuum along which all of the respondents' constructions of health are situated. What is interesting is that for these five respondents, there does appear to be some overlap between their socio-economic position, their neighbourhood of residence, their experience of health problems, and their concepts of health.

Three of these five women live in Braemore, reported no health problems, and are relatively affluent in relation to the rest of the total sample. Accounts from these three respondents are dominated by references to mental and emotional states; physical health is mentioned in passing, if at all. Their concepts of health stand in stark contrast to those of the other two respondents in this subset. These two women live in Kirkhead; both have chronic health problems and are amongst the least affluent respondents in study. These two respondents defined health in much more negative terms, focusing on the absence of illness and the ability to fulfil tasks and responsibilities. Their accounts suggest that they are unable to conceptualise health in positive terms at all (Blaxter and Paterson, 1982). These contrasting concepts of health are presented in Table 3.2.

Table 3.2 Contrasting constructions of health

Relatively affluent Braemore respondents without health problems: positive concepts of health	Relatively deprived Kirkhead respondents with health problems: negative concepts of health
<p>Diane: I suppose fundamentally I think of it as um a kind of sense of total well-being, you know that I'm generally sort of free of stress and unhappiness and so on.</p> <p>Jacqueline: I mean it's physical but it's emotional and mental and um psychological health, all these things are bound up together, so it's not just feeling physically well or whatever, cos that combines with everything else, it makes you feel better about life.</p> <p>Pam: ...there are so many aspects, uh minimally stressed, minimally worried, um reasonably fulfilled, um...and uh healthy in the way that I can get on with my life, I can do the things that I want to do...have the energy to do them I would say [...]so it's a mixture of the psychological if you like, intellectual and, and the physical element.</p>	<p>Morag: Well so long as you can get around, and you can dae most things for yourself, you shouldnae complain. There's usually folk who are worse, lots worse than theirselves sometimes. (diabetes, asthma)</p> <p>Linda: Well I think if you've got all your, you know, you've not got much wrong with you. (diabetes, mobility problems)</p>

Whereas the concepts of health offered by Linda and Morag are limited and functional, Diane, Jacqueline, and Pam constructed health in multi-dimensional terms. Their definitions of health as feeling free of stress, worry and unhappiness, and feeling fulfilled and good about life, clearly indicate that psycho-social aspects of health predominate in how these three women conceptualise health.

The concepts of health offered by this subset of five women lend some support to the suggestion that social circumstances may influence ideas about health. However, between the two extremes of the concepts offered by this subset, respondents in both sample groups tended to construct health in similar ways, which do not appear to be related in any clear way to the respondents' personal circumstances. Across both sample groups, health was conceptualised in

multidimensional terms, combining references to aspects of physical health with comments about mental/emotional states. For example the notion of health as the absence of illness or disease was commonly combined with other, more positive, dimensions of health such as being fit, having energy, feeling sociable, and experiencing positive mental and emotional health.

These mental and emotional dimensions of health may be encapsulated by the phrase ‘**well-being**’ – a term drawn from Blaxter’s analysis of lay concepts of health in the Health and Lifestyles Survey (Blaxter, 1990). Following Blaxter, the term ‘well-being’ will be used throughout this thesis in order to distinguish between psycho-social aspects of health on the one hand, and physical dimensions of health (such as the presence or absence of disease or illness, and physical fitness) on the other. The word ‘health’ is used throughout the thesis to describe aspects of physical health.

Despite broad similarities across the two sample groups in terms of the ways in which respondents conceptualised health, there are differences in the *emphasis* that individual women placed on particular dimensions of health. This seems to be related to whether or not respondents have chronic physical health problems. Respondents with chronic health problems focused primarily on aspects of physical health in conceptualising health. Their definitions of health appear to be strongly shaped by their everyday experiences of illness and circumscribed physical functioning. Six of the seven respondents with chronic physical health problems emphasised aspects of health such as the absence of illness and/or pain, not being dependent on medication, and being able to ‘get around’ or engage in ‘normal life’. In other words, it seems that these chronically ill women were inverting their own experiences of life with chronic health problems in order to construct a notion of what ‘being healthy’ would be like for them personally. However, this is not to say that more positive dimensions of health were not included at all in their accounts; almost all respondents with chronic health problems went on to articulate positive notions of health, such as ‘feeling good’.

In the concepts of health offered by respondents without health problems, the weight of emphasis is more obviously upon positive dimensions of health. Health as the absence of illness was also mentioned by these respondents, although in an abstract rather than a personalised sense.

Below, data excerpts are presented in a series of tables which are illustrative of the data set as a whole. These particular data were chosen firstly to indicate the range of different dimensions of health which the respondents incorporated into their concepts, and secondly to demonstrate that respondents in very different social circumstances, conceptualised health in similar ways.

Table 3.3 Health as the absence of pain and having energy

Braemore	Kirkhead
<p>Jean: Not having pain and being full of energy.</p> <p>(Ulcerative colitis, sensory impairment, depression)</p>	<p>Josie: Getting up and feeling well and being able to get through the day without aches and pains[...]being healthy is not having illness, not having ailments, not carrying too much weight [...]and just feeling that you've got energy.</p> <p>(Depression)</p>

Jean and Josie's circumstances differ in important ways. Jean lives in social rented housing in Braemore. She has multiple health problems which prevent her from engaging in paid employment. Josie works full time, although she is suffering from depression. She lives in Kirkhead and owns her home. Although their social contexts are quite different, Jean and Josie offered similar concepts of health; these focus predominantly on negative aspects of health - the absence of pain and illness. Neither respondent placed much emphasis on well-being, although Josie did refer to 'feeling well'. The concepts of health articulated by Jean and Josie are quite limited when compared to accounts from other respondents. This is perhaps due to their own experiences of physical and mental health problems, which may have lowered their expectations of what 'being healthy' means. However, they do also mention a more positive dimension of health – having energy.

Table 3.4 Health as the absence of illness; fitness; being able to exercise

Braemore	Kirkhead
<p>Marion : Someone with energy [...] well obviously not being sick, um being able to enjoy life to the full, be able to take advantage of what there is on offer, to be able to walk and enjoy the countryside, to be able to swim and play sports, not be encumbered by physical or mental problems.</p>	<p>LA: Thinking about health, how would you describe being healthy? Ruth: Well I suppose healthy is um when you don't have to take any medication, which I have to take loads of, eh. And I would say that um being fit uh....probably being able to do exercises and things...I mean the most I can do is aqua aerobics in the water.....uh....being full of energy must be healthy. (Diabetes, asthma)</p>

Marion and Ruth's social circumstances differ in some key aspects. Marion is relatively affluent, works in a highly skilled job and does not have any health problems. Ruth is less affluent, works in a low-skilled job and has multiple health problems. Despite these differences, their concepts of health incorporate similar dimensions- health as the absence of illness, health as fitness and the ability to participate in sport and exercise, and health as having energy. However, Ruth's account is personalised, and she draws on her experiences of chronic illness in constructing her concept of health. By contrast, Marion's concept of health is abstract and impersonal, and her account emphasises health as a resource that enables individuals to enjoy life, implying there are psycho-social dimensions to health.

Table 3.5 Health as sociability

Braemore	Kirkhead
<p>Carol: I think if you're feeling well you want to do things and you're interested in getting up in the morning and it doesn't feel like a complete drag [...] you think that when you're at work that what you're doing is worthwhile [...] if you're not well [...] you don't want to get up in the morning, you don't want to make contact with other people.</p>	<p>Fiona: I think that when you're healthy, you've got, you want to get up in the morning, you want to do things...like you can get up, do the housework, do the washing, and go out, and fit more things in, but when you're unhealthy, more or less everything seems such a task [...] and if you get asked out "oh I don't really want to come out".</p>

Carol and Fiona are similar in that neither have chronic health problems. However, as with Marion and Ruth in the previous example, there are important contrasts in Carol and Fiona’s social circumstances. Carol, a Braemore respondent, has a higher socio-economic status than Fiona, in terms of occupation, income and housing tenure. In their accounts, both Carol and Fiona portray being healthy as having a general enthusiasm for life – ‘wanting to get up in the morning’, showing interest in one’s work, and feeling sociable. At other points in their interviews, these two respondents also referred to physical dimensions of health. However, in this context, the emphasis is more upon health as a state of mind or general outlook on life; again, this suggests that well-being is an important dimension of health.

Table 3.6 Health as equilibrium between physical health and well-being

Braemore	Kirkhead
<p>Rachel: Absence of illness, plus sort of feeling good, I mean I think even if I wasn’t ill, if I didn’t have an illness, but I felt low energy [...] you know, sort of depressed, then I think I would feel as though I was ill.</p>	<p>Shona: Well I think physically and mentally you’ve got to feel...in tune with your health. I mean if you’re mentally feeling stressed or anything like that, you’re not gonna really feel particularly healthy.</p>

Rachel and Shona live in contrasting social circumstances. Whilst Rachel is divorced, has a relatively low income, and lives in privately rented accommodation, Shona is married, has a higher household income than Rachel, and is a home-owner. Neither Rachel nor Shona experience health problems. In these excerpts, Rachel and Shona both conceptualise health in terms of a balance between physical health on the one hand, and psycho-social well-being on the other. Well-being is portrayed as being as salient as physical health; both women indicate in their accounts that they would not feel healthy if they were feeling stressed or depressed. The way in which Rachel and Shona defined health has clear links to Herzlich’s notion of health as equilibrium (Herzlich, 1973).

The excerpts presented above from Rachel and Shona’s accounts are examples of a wider theme within the data, which relates to lay understandings of the complex relationships between physical health and well-being. The data clearly

indicate that well-being may be conceptualised and experienced independently from physical health; however, each aspect of health may have a bearing upon the other. The nature of the interaction between physical health and well-being is particularly salient for respondents with chronic health problems. This subset of respondents tended to indicate in their accounts that, for them, a sense of equilibrium between physical health and well-being is contingent upon their day-to-day experiences of chronic illness. For example, Ruth suggested that feeling good physically promotes an overall feeling of well-being:

LA: Can you describe what it feels like to feel well?

Ruth: Well you're on a high because you feel good, and you're not wakening up coughing and things like that, and you can plan to do things.

(Kirkhead, diabetes, asthma)

Conversely, Lizzie commented that her emotional well-being is undermined by her physical health problems:

Lizzie: You don't want to get up in the morning and feel like I'm feeling today, you want to get up and think "oh I'm feeling great, this is good, it's a lovely day, I can go out and take a walk if I want to". Well at the moment I cannae do that, so I'm feeling bleugh and it kind of depresses me a bit, you know, cos I like to get out and I like to do things, and I don't want to feel the pain, cos it drags you down.

(Kirkhead, osteo-arthritis)

Celia's account suggests that, in order to feel healthy, there needs to be a sense of harmony between her mind and body. However, her account implies that her current sense of poor well-being is undermining her ability to stay physically healthy:

Celia: I think being healthy you, you have to be um, er well both mind and body, they both have to be...at peace with one another I think, and um to get the most out of your life I think you have to...and I'm not managing this, you have to keep physically healthy but you can't do that if the mental side isn't right.

(Kirkhead, Addison's disease, alcoholism, depression)

The data that I have presented in this section demonstrate that although it is possible to distinguish between different dimensions of health which are represented in the respondents' accounts, there are no clear associations between the respondents' concepts of health and, for example, their neighbourhood of residence, their level of affluence or their health status. What is clear from the data is that 'health' matters to the respondents in the study in ways that are distinct from ideas about illness. The respondents constructed multi-dimensional concepts of health; only some of aspects of their constructions are directly related to physical health. Rather, what emerges from the respondents' accounts is that ideas about health are constructed in relation to aspects of everyday life (Backett, 1992). The concepts of health presented in this section illustrate the emergence of psycho-social dimensions of health as a strong theme within the data – well-being is a key aspect of health in lay accounts (Blaxter, 1990).

3.3 The moral imperative to claim health

In Section 3.2 I argued that there are broad similarities between the two neighbourhood samples, in terms of how respondents conceptualised health in the interviews. However, as highlighted in the introduction, there are striking differences between the two sample groups in terms of their health profiles. Many more respondents in the Kirkhead sample group reported chronic health problems than those in the Braemore sample group. In this section, I consider respondents' evaluations of their own health.

In response to a question about how healthy they perceive themselves to be, the majority of respondents in both sample groups engaged in a process of evaluating their health in relation to a range of dimensions of health. There are variations between respondents in terms of the criteria used by respondents to evaluate their own health; I will present data to indicate that these variations are associated with whether or not individual respondents suffer from chronic health problems.

The data relating to respondents' perceptions of their own health suggest that there is something elusive about the notion of health; because of its multi-

dimensional nature, being fully healthy is perhaps an unattainable ideal. Most respondents articulated perceptions that they ‘fall short’ of being fully healthy. However, at the same time, almost all of the respondents seemed keen to construct accounts of their own health in ways that enabled them to ‘claim’ some form of healthy identity. Respondents did this by attempting to minimise aspects of their lives that might be deemed ‘unhealthy’, whilst at the same time focusing on those elements of their lives around which they *are* able to construct and maintain a ‘healthy’ identity. This theme within the data reflects what Crawford has identified as “ a strong moral imperative attached to health and to the normality of health” (1984: 64). The importance of health for individual identity has been noted throughout the literature (Blaxter, 1997; Herzlich, 1973; Litva and Eyles, 1994; Radley, 1994).

Sections 3.4 and 3.5 explore how the moral imperative to claim health is expressed in the data. Firstly, I consider accounts from respondents who did not report chronic health problems. Section 3.5 moves on to discuss accounts from respondents who do have chronic health problems, but who nevertheless also strove to present themselves as healthy individuals in the interviews.

3.4 Evaluating health: respondents without chronic health problems

3.4.1 Claiming health

Eleven respondents in the Braemore sample, and three respondents in the Kirkhead sample do not have chronic health problems. Asking this subset of respondents to comment on their own ‘health’ (rather than *healthiness* in an abstract sense) prompted accounts that are overwhelmingly structured around the experience of good *physical* health, which can be ‘proved’ by the fact that these respondents have not experienced any ‘major’ or ‘real’ illnesses. Thus, whilst these women referred to both physical health *and* well-being when offering generalised concepts of health, they tended primarily to draw on the notion of health as being “the absence of illness” in the context of talking about their own health (Blaxter, 1997). This, it would seem, was in order to legitimate their claims that they consider themselves to

have experienced good health over the course of their lives. This point is illustrated by the range of quotations presented below:

LA: How would you describe your health over the course of your life, sort of on the whole?

Diane: Well I've had no, no major um, major health problems that have been sort of really debilitating, um no major surgery or accidents or anything of that kind.

(Braemore)

LA: Thinking over the last few years, how would you say your health has been? Over the last few years?

Jacqueline: Um I think really it's been pretty good, in fact it has, I've had very little um...real illness at all, in fact probably none.

(Braemore)

Shona: I mean I suppose really I've been really quite blessed, you know because I haven't even had major surgery, you know I haven't even had my tonsils out or my appendix out or anything like that, so I suppose um...I am quite a healthy person.

(Kirkhead)

Kirsty: I mean the physical illnesses that I have had have probably been straightforward ones, you know appendicitis, tonsillitis, you know these sort of things.

(Kirkhead)

In some cases, these women have in fact previously experienced episodes of acute illness or health problems that required medication or surgery. It could be argued that if one is to evaluate one's health on the basis of "the absence of illness", as these women did, then such episodes of ill health might well pose a challenge to one's construction of self as healthy. In these situations, however, the data indicate that these women tended to engage in strategies to minimise the significance of their experience of illness. These strategies seem to serve the function of allowing the respondents to present themselves as 'healthy' individuals. For example, they dismissed their experiences as 'minor' episodes, or as 'not real' illnesses. Alternatively, these respondents highlighted their good recovery from such episodes of illness, drawing on the idea of 'health as a reserve' to emphasise that their stock of good physical health has not suffered in the long term. Even in instances where this subset of respondents reported current health problems, their accounts suggest that

these health problems can be easily accommodated within an overall perception of themselves as ‘healthy’ individuals who are resilient to serious health problems. The following quotes illustrate this attitude:

Rachel: I don’t very often get ill, and I mean I have this hayfever thing, which I don’t, I mean it’s so normal for me, and I think also because it’s an allergy rather than an illness then I don’t consider it, I don’t consider myself to be unwell because of it

LA: Right, okay

Rachel: Um yeah, I mean I don’t, again I hate saying this, but I seem to miss 95% of all the um viruses, and bugs and colds and flus and things that go round a lot of the people that I know, so, I consider myself to be quite a healthy person.

(Braemore)

Esther: I’m very lucky cos I, you know, I rarely, I have lots of sore throats, lots and lots and lots of throat infections, but I think that’s from being at school, that’s my thing that I have wrong with me (yeah, yeah) but I very rarely, I mean I can’t rememberI’ve once, once been in bed with flu, many, many years ago...I’m very lucky.

(Braemore)

This apparent emphasis on physical healthiness over the course of their lives was reinforced by some of these respondents, who emphasised their healthiness by drawing on notions of ‘health as function’ (Blaxter, 1990). This is indicated by phrases such as “when I was working full time I was hardly ever off work” (Carol, Braemore), and “I’ve always held down a job and run the house” (Hattie, Braemore).

On a methodological note, it is possible that the different concepts of health that respondents drew on in different contexts is a reflection of the terminology that I used during the interviews – namely that of asking women about their ‘health’, which Blaxter and Paterson (1982) suggest tends to prompt accounts that relate to the experience of illness. Women’s accounts may have been constructed differently if I had asked them “how well they felt”, as it is recognised that individuals may perceive their short-term *health state* somewhat differently from their long-term *health* (Blaxter, 1990; Litva and Eyles, 1994). However, it is also possible that the women’s focus on physical functioning arose because the fulfilment of many social roles and obligations in day-to-day life is to a large extent dependent on good health

in a functional sense - on not being “encumbered by physical and mental problems” (Marion, Braemore). Not only are these women able to participate in activities perceived to be part of ‘normal life’ (such as paid and voluntary work, domestic tasks, and social relationships); their accounts also indicate that in general, they do not even have to think about whether they are healthy enough to live a ‘normal life’. Rather, good physical health is taken for granted. Furthermore, their accounts also hint that they hold a ‘positive mindset’ regarding their health – they consider themselves to be healthy and do not entertain the possibility that this healthiness might be undermined. The following quotes illustrate this idea:

LA: Do you think about your health on a day-to-day basis now?

Jacqueline: No I don’t, I know that I’m pretty healthy, and I don’t worry about it.
(Braemore)

LA: Yeah, and is it important to you to be healthy?

Rachel: Yes, I hate being ill [*laughter*] yeah, yeah, oh God yeah, I can’t imagine how it wouldn’t be important

LA: Yeah ...is it something that you think about?

Rachel: Um...no I mean I really do just take it for granted [...]I just assume that I will be healthy, you know I just don’t ever consider the possibility that I might not be...past experience is that I have been healthy for 51 years, you know, give or take a week here or there, so...I don’t consider the possibility that it might change.

(Braemore)

A further indication of a ‘positive mindset’ is the fact that two women claimed that it is only on those rare occasions when they do fall ill that they become conscious of their health at all; this serves to reinforce their perceptions of themselves as ‘normally healthy’:

LA: how do you generally tend to feel on a day-to-day basis?

Hattie: Och, I’m quite healthy, usually

LA: And is your health something that you think about, are you sort of conscious ?

Hattie: Not from a day-to-day thing, it’s when I’m not feeling well that I then think you know, I think it again, it’s the reverse, it’s when you’re not well, you realise that you’re normally healthy.

(Braemore)

Shona: I think that maybe you just don't appreciate your health until something happens and you don't have it, you know.

(Kirkhead)

For three women in this subset of respondents without chronic health problems, being physically healthy and able to function was overtly constructed as a matter of moral worth. These respondents commented that their opinions about health stem from their upbringing, suggesting that cultural attitudes which portray illness as weakness have been inculcated in them by their parents:

Marion: I think that to be healthy is to be able to enjoy life, I like to be able to enjoy life and um...yes I think, I think it's a sort of pride as well, I seem to, whether it's a cultural thing from my parents or whatever, you take pride in being able to cope and be healthy and manage and not take time off work, and we were always sent off to school oh you'll be fine, off you go, so perhaps that's...coming through in my attitude.

(Braemore)

Kirsty: I don't get neurotic about health, that's one thing, I think that stems back to my childhood where you weren't allowed to be ill, and I do look on illness as a weakness, I still am very conscious that it's a problem I have, that I think that illness is a weakness in people, and therefore in myself, I won't give in to illness, but I don't get neurotic about it.

(Kirkhead)

The data that I have presented so far suggest that for those respondents who do not have chronic health problems, 'health as the absence of illness' and 'health as function' are two concepts of health that are central to their evaluations of their own health. These women's accounts suggest that for them, their functional physical healthiness constitutes a kind of 'baseline' of healthiness, in that they all consider themselves to be at least 'basically healthy'. This baseline of healthiness is by and large taken for granted and I suggest that because of this, it is rendered 'invisible' in these women's day-to-day lives. This may explain why, in the context of defining health in an abstract sense, several women without health problems emphasised well-being. As one respondent commented:

Shona: I think health for me is contentment and I think that that is probably only because I haven't had a major health problem, you know I suppose that life has been good to me that way.
(Kirkhead)

3.4.2 Falling short of 'full health'

Despite data which indicate that respondents without health problems consider themselves to be 'basically healthy', there is also evidence to suggest that these women do not necessarily consider themselves to be 'fully healthy'. When I asked a direct question about whether they consider themselves to be healthy, only two of the women without chronic health problems indicated that they consider themselves to be healthy in every way. Rather, most of this subset offered accounts of their own health which suggest that they do not in fact feel that their own health necessarily matches up to the multi-dimensional concepts of health that they had previously described in response to a general, abstract question. In several instances, general concepts of what it is to be 'fully healthy' were constructed as being contingent upon a variety of circumstances and situations. The following excerpt illustrates the contingent nature of health, and it also highlights a more general sense within the data that there is something a little elusive about the idea of healthiness:

LA: I want to start off just by asking you how you would define being healthy, if I asked you to describe a healthy person, what would you say?

Pam: Ooh if I feel healthy than I have a.....gosh, I'm trying to find the right word, a reasonable, a reasonable level of, of energy, um...and with that of course a certain sense of well-being which is very, which has a very large emotional component, psychological component, so I feel, um....somehow um ah...uh there are so many aspects, uh minimally stressed, minimally worried, um...reasonably fulfilled, um...and uh healthy in the way that I can get on with my life, I can do the things that I want to do...have the energy to do them I would say [...]so it's a mixture of the psychological if you like, intellectual and, and the physical element which might include diet, exercise. Um, hopefully...creating the sort of relationships that are supportive
(Braemore)

Consequently, whilst a multi-dimensional concept of health, encompassing both good physical health and positive well-being, might be desirable, there is a sense in the respondents' accounts that this is in some ways perceived to be difficult

to attain, even if one's physical health is basically good. Women tended to evaluate their own levels of perceived healthiness against a variety of criteria in addition to 'absence of illness'. These criteria, or dimensions of health, include fitness levels, energy levels, leading a healthy lifestyle, being an appropriate weight, age-related healthiness – 'being healthy for one's age', and being able to cope with life events and situations. Almost all women, in evaluating how healthy they are on the basis of a combination of different criteria, made comments indicating that they feel that there is 'room for improvement' in their health. Table 3.7 displays a range of quotations from respondents who consider themselves to be healthy from the point of view of not having any illnesses, but less than 'fully healthy' according to other criteria.

Table 3.7 Room for improvement in health: “I am healthy, but...”

<p>...I’m overweight.”</p> <p>Sarah: I feel I’ve had pretty good health, I must admit. I’ve had no major things that I can think of [...]But obviously weight is an element there of course, so therefore I suppose being overweight and not getting maybe enough exercise in these middle years, from about 30 through you know the last 10 or 15, 20 years, I maybe haven’t. I’ve done too much sitting and standing, when I really wanted to be doing something more energetic. (Braemore)</p>
<p>...I’m a smoker.”</p> <p>Fiona: I know I’m fit because I do a lot of walking in the corridors with the patients, I am up down up down up down oh about 200 times a day (yeah) so it’s not as if I’m // LA: //Not getting any exercise But em, I know I’m wheezing through smoking, and that’s not healthy. (Kirkhead)</p>
<p>...I’m unfit.”</p> <p>LA: would you describe yourself as a healthy person? Stella: Moderately... I would say, now, at the moment, yeah...cos I certainly do feel that ...um there are things that I, that I’m not able to do, well not necessarily not able to do, I can sort of force myself to do things, but um...I’m not as fit as I was um I mean I can obviously still swim and do things like that, but um och yes, I mean I walk the dog. (Braemore)</p>
<p>...I’m tired all the time.”</p> <p>Shona: I don’t sleep that well now, and I’m constantly waking up thinking I’m as tired as when I went to my bed. (Kirkhead)</p>
<p>...my emotional health isn’t good.”</p> <p>Jacqueline: I think from a practical point of view, from a physically healthy point of view yes I am, I’m a very healthy person, um, emotionally perhaps not quite so healthy. (Braemore)</p>
<p>...I’m not as healthy as other people my age.”</p> <p>Pam: I compare myself sometimes to my twin sister, who’s got bags of energy[...]she’s got far more energy than me. Mind you she’s at a different stage in her life in that she got married in ‘68, her son was born in ‘69, so she had her family 7, 8 years I think before me. (Braemore)</p>

What is interesting is that whilst these women may have been prepared to admit that they consider aspects of their lives to be unhealthy, none of their accounts suggest that their overall perceptions of themselves as healthy are actually fundamentally challenged by these ‘unhealthy’ aspects of their lives. This has clear parallels with the women’s apparent denials that episodes of illness throughout their lives have undermined their health in the long term. The women’s accounts indicate that the areas of their lives that they consider to be unhealthy do not actually undermine their sense of ‘health as function’; these respondents are still able to do what they want to do, and thus these ‘unhealthy’ aspects of their lives do not pose a serious threat to the quality of their day-to-day lives, and thus to their identities as healthy individuals.

A strategy that six respondents in this subset used in order to reinforce their identities as healthy individuals (despite falling short of ‘full health’), was to compare their own health favourably with other people’s. This seemed to be particularly important immediately after women admitted that they are *not* as healthy as they would like to be. In other words, after comparing their health *negatively* with other people’s, it seemed to be important for these respondents to be able to identify people whose healthiness is even more in question than their own. The following quotations are illustrative of this tendency:

Hattie: I have my times of being low like everyone does, but I’m quite certain that I’m not a depressive like my mother is, thank God, and I think that I’m, I have enough knowledge that if I know that I’m having problems dealing with something, that I’ll actually take myself off and get help from a counsellor if I feel I need to.

(Braemore)

Carol: I’m certainly not anything like as physically fit as my husband, um, I would say I was moderately healthy, but um if I was comparing myself to other people that work in the office in Airdrie I’m extremely healthy, because there were 8 of us and I think 5 smoked, and um...people would get bronchitis and be off sick for quite a long time, and they would seem to be off work a lot more than I ever was.

(Braemore)

Elsbeth Graham and colleagues (2001) have suggested that engaging in social comparisons (both favourable and unfavourable) may have potential psycho-social consequences for health and well-being; this is a theme that is noted throughout the thesis.

The range of data that I have presented from the accounts of respondents who do not suffer from chronic health problems indicates that there are a variety of ways in which respondents were able to present themselves as healthy individuals, not least by focusing upon biomedically defined parameters of health. In the next section I explore how respondents with chronic health problems also evaluated their own health in ways which enabled them to present themselves as healthy individuals.

3.5 Evaluating health: respondents with chronic health problems

3.5.1 Chronic health problems –a barrier to claiming health

An important difference between the self-evaluated healthiness of those respondents who don't have chronic health problems, compared with those who do, is that whilst the first group of respondents were able to 'claim healthiness' by citing their good physical health, this strategy was not available to respondents with chronic health problems. Indeed, many respondents with health problems defined themselves as unhealthy according to criteria relating to physical healthiness. For example, Ellen, a Kirkhead respondent with Multiple Sclerosis responded in the following way to a question about whether she thinks of herself as a healthy person:

Ellen: Today? Now? No...well, it's all tied in with the MS, you know, I'm in constant pain, I'm never free of pain.

(Kirkhead)

In the following similar interview excerpt, Morag, another Kirkhead respondent, explains why she doesn't think of herself as being healthy:

LA: Do you think of yourself as a healthy person?

Morag: I was, but now I'm not

LA: Right, why don't you think of yourself as being healthy now?

Morag: Well, I've got asthma, I've got eczema, I've got diabetes, I've got anaemia...that's about it, but that's enough I think.

(Kirkhead)

Whereas women without chronic health problems talked about being able to fulfil their social roles and obligations without needing to actively consider their state of health, the accounts of women with health problems indicate that participation in activities commonly portrayed as 'normal' is, at best, something that cannot be taken for granted and, at worst, something that is impossible. There is a sense in the data that for this subset of respondents, the topic of their own (poor) health is something that is very much 'present' in their day-to-day lives. These respondents often referred to the fact that the unpredictability and varying intensity of their symptoms means that their ability to undertake day-to-day activities is often limited. Furthermore, these women also suggested that it is difficult for them to make social arrangements as they have to evaluate how they feel physically on a day-to-day basis – as indicated by the following quotations:

Mary: There are days when I feel bloody awful, you know for no apparent reason and I put it down to the diabetes or whatever, mainly the diabetes, because diabetes is such a funny disease, you can waken up in the morning and just feel awful.

(Kirkhead)

Lizzie: That's how I feel, that you should be able to go out, do the things you want to do, and that's being healthy[...] I can't go all day. Like I did it yesterday, I went to the CAB and I did my wee bit of reception work, and then instead of going straight home I decided to go to the bingo, and half way through the bingo I was thinking "this is stupid, I should be in bed lying down or something", and I got in and I was exhausted and all I wanted to do was sleep.

(Kirkhead)

Linda: I mean there's obviously times where you feel a lot better than others you know, even days you know, every day is a different day you know, um....on some days your bones are achey you know, more than another day you know, so therefore that doesn't make you feel very, you know....you just sort of got to take each day you know.

(Kirkhead)

These data suggest that having a chronic health problem significantly limits the extent to which these women feel that they are able to lead a 'normal life', and thus limits the extent to which they consider themselves to be healthy, given that the ability to participate in everyday activities is to a large extent predicated on good physical health.

The role of social comparisons in evaluating health was mentioned in the previous section. In contrast to respondents who do not have health problems, several women with chronic health problems compared their health unfavourably to that of their peers, which seems to reinforce their sense of being unhealthy. For example, Ruth commented:

Ruth: I suppose that's what makes you feel unhealthy, when you're slow at doing things, you feel instead of being nearly 50 you feel like 70, you know. But um...I would say probably unhealthy compared to my brothers and sisters.

(Kirkhead)

This sense of not being as healthy as one should be for one's age is echoed by Morag:

Morag: Well at the moment, I cannae rush or hurry, cos with the anaemia and the asthma, you get breathless. With the anaemia you feel tired as well, so therefore it takes you longer to do things that you would if you were okay.

LA: Yeah, yeah...so it sounds like it's had quite an effect on your day-to-day life

Morag: It does, it means that you cannae get around as quick as you should for your age.

LA: Yeah, yeah...and if you look at other women about your sort of age, how healthy would you say that you are compared to them?

Morag: Well most folk that I know round about my own age, most of them are okay, they've not got anything wrong with them.

(Kirkhead)

3.5.2 Claiming health despite health problems

Despite talking at length about the ways in which their health problems impinge upon and restrict their daily lives, this subset of respondents generally appeared reluctant to construct themselves as wholly 'unhealthy' or 'sick'. This may be interpreted as a response to the moral imperative to be healthy in an increasingly 'healthist' culture (Crawford, 1984). It is possible to identify a number of strategies whereby women with chronic illnesses endeavoured to portray themselves as healthy in at least some respects, even if they could not present themselves as being completely physically healthy. These strategies involved constructing healthiness around categories other than 'absence of disease'. One strategy was to minimise the severity of the health problem by claiming that "apart from having X health problem" the respondent is in good health. This strategy represents illness as an 'alien invader' (Herzlich, 1973) that is 'outside' the self.

A second strategy that several women engaged in was to highlight the importance of 'responding healthily' to their health problems. Thus, respondents indicated that they feel that they can in fact be considered healthy due to the way that they cope with their health problems. However, the notion of responding healthily was not necessarily constructed in the same way by different women. For two respondents, an important aspect of being able to maintain a healthy identity is the fact that they are able to hold down paid employment. Other women suggested that

an appropriate response to their health problems is to adapt their routines so that they do not 'over-do' things physically. Conversely, the healthy thing to do could be defined as not 'giving in' to illness.

Again, engaging in social comparisons emerges as a theme within the data; in this context, respondents attempted to 'claim' healthiness by favourably comparing their own response to illness to the responses of other people. Another important function of comparisons is that they enabled women to claim a form of healthiness by stating that at least their health problems are not as bad as other people's. Here, there is a sense in these respondents' accounts that they feel their health could be worse, and that therefore they ought to be grateful for the level of health (however limited) that they are able to enjoy. Table 3.8 gives examples of all of these strategies for constructing and claiming healthiness.

Table 3.8 Strategies for claiming healthiness: “I may have health problems, but...”

<p>... my health problems are separate to my ‘self’.”</p> <p>Ellen: I don’t think I’m unhealthy (no) I think I’m generally a healthy person, apart from my MS, it’s the MS that’s holding me back, but what can you do? Yeah, I consider myself fairly healthy. (Multiple Sclerosis)</p>
<p>...I can participate in the labour market.”</p> <p>Ruth: I’ve always worked, I’ve never been out of work, I’ve had a steady job and I love my work, which I think balances things up. (Diabetes; asthma)</p>
<p>...I respond healthily by not ‘overdoing it’.”</p> <p>Mary: I feel that I’m well because uh I’m able to um cope with the problems that I’ve got, I really don’t let them stop me from doing things that I want to do , I think , I think I realise my own limitations and um I think I would say “no” if I thought something was going to be impossible for me to do. (Diabetes; angina; chronic back pain)</p>
<p>...I respond healthily by not ‘giving in’.”</p> <p>LA: How do you see yourself? Lizzie: I normally think that I feel okay, that I’m quite a healthy person, cos I’m not, I’m not ill all the time, I just have days where I’m not so good, like I am today, I just have days when I’m ... LA: Not so good Lizzie: Not so good, but I mean even that is healthier than some people lying in their beds, I mean to me , an unhealthy person lies in their bed all day and doesnae make an effort to go out, but if you’re making an effort, I mean you might not be exactly full of health, but there’s something that you can do, you know, you’re no as bad as some people LA: Do you think that some of it is to do with your mental attitude? Lizzie: I suppose so, cos you won’t give in to it (Osteo-arthritis)</p>
<p>...at least I am better off than other people.”</p> <p>Linda: I should be lucky and thankful that I’ve not had you know big problems , um...maybe some people would say....um....I’ve had you know, not had big illnesses or not had to...I mean diabetes is thingummy, but so many people have got it ,you know, more and more you know , um...but I’ve not had anything you know like cancer , or breast or anything like that and I think there’s worse people (Diabetes, mobility problems)</p>

In summary, the data suggest that due to the many potential dimensions of health, all respondents perceive being fully healthy as a state that is somewhat elusive. Nevertheless it seemed important for respondents to be able to claim a healthy identity, irrespective of whether or not they have health problems. The data suggest that how respondents evaluated their health in the interviews was shaped not only to the experience (or not) of chronic illness, but also to the specific contexts of their lives.

The respondents' actual experiences of health and illness clearly vary according to the neighbourhoods that they live in. The task of this thesis is to explore the processes through which these health differences between the two sample groups may have been generated. In the next section I introduce the idea that the respondents' differential exposure to stress over the course of their lives may contribute to these health differences.

3.6 Stress, health and well-being

Psycho-social explanations for health inequalities suggest that stress is linked to poor health, and that the experience of stress is socially patterned. Research evidence indicates that individuals in poorer social groups are exposed to more chronic stress than individuals in more affluent groups (McDonough et al, 2002; Pearlin, 1989, Turner et al, 1995; Wilkinson, 1996). Furthermore, it is argued that the experience of stress is more health-damaging for poorer social groups than it is for more affluent groups, because poorer individuals have access to fewer material, social and personal resources to help buffer the negative effects of stress (Taylor and Seeman, 1999). One of the central themes of this thesis is whether the better health reported by respondents in Braemore compared to that of respondents in Kirkhead might be explained by socially structured experiences of stress. However, in order to do this, it is important first to explore whether respondents actually recognise 'stress' as part of their lived experiences, and if so, whether and how this relates to their understandings of health and illness.

The data that have been presented so far in this chapter point to the salience of well-being in women's overall understandings of what it is to be healthy. In contrast to biomedical discourses of health, the respondents' accounts of health (both in terms of abstract definitions and in their personal experiences) indicate that many respondents in both sample groups understand there to be some form of relationship between mind and body (although the perceived nature of this relationship varies between different women). This is further illustrated by data concerning the respondent's views about stress and experiences of situations which they defined as being 'stressful'. Although some researchers question whether such a thing as 'stress' exists at all (Pollock, 1988; Radley, 1993), the concept of stress is a theme that is present in the majority of the accounts from respondents from both sample groups. Data on the topic of stress were constructed in a variety of contexts throughout the lifegrid and the daily routines interviews. In the lifegrid interviews respondents were invited to offer accounts about their lives at particular stages; in this situation, respondents tended spontaneously to refer to events and situations during particular periods in their lives which they described as being 'stressful'. Again, asking respondents to tell me about different aspects of their daily lives tended to elicit spontaneous comments which reveal the respondents' perceptions of the relative stressfulness of their current life circumstances.

In addition to these spontaneous accounts, I also asked respondents specific questions about 'stress': how they would describe being stressed; whether they believe that stress can have an influence upon health; the kinds of situations and events that they find stressful; how they cope with stress; and how stressful they feel their day-to-day lives are.

Almost all of the women in both sample groups were able to offer descriptions of what the experience of 'being stressed' feels like; this suggests that the notion of 'stress' is widespread within lay understandings. The actual experience of 'being' or 'feeling' stressed is described in a variety of ways by respondents, and these descriptions tend to incorporate both physical and mental/emotional dimensions.

A range of physical symptoms were offered by the respondents as being related to the experience of stress. In the women's accounts, there seem to be two types of physical symptoms that are connected to the experience of stress. The first type serve as 'warning signals', bodily cues that 'alert' the respondents to the fact that they are stressed. For example, five respondents talked about how being stressed can provoke muscle tension and a feeling of 'tightness', as illustrated below by the comments of two of these women:

LA: And what do you feel is going on inside your head?

Ellen: I don't know, I just feel all tight and tense, you know I just can't sort of, like I'm all sort of tight up, tense, I just can't cope with it.

(Kirkhead)

Josie: I can't seem to get it out of my mind and think about other things. You know my mind just seems to be just focusing on that one issue and physically I just feel tight and tense and not able to sort of, I just feel that I'm uptight, and it goes on and on.

(Kirkhead)

Other physical indicators of stress that respondents identified are tiredness (sometimes linked to not being able to sleep), stomach pains and indigestion, headaches, palpitations, breathing difficulties, and loss of appetite. In many cases, the respondents described experiencing more than one bodily cue:

Marion: I remember experiencing stress for the first time, our marriage was breaking up and I had palpitations and the butterflies in the stomach and not being able to swallow, you know those physical signs, and um...the clenched fists when you're tired, you know you're sitting there and you think why is that fist clenching and you try and relax it, and you can be sitting watching something you're enjoying on the television and you find it's, that, I used to do that all the time....um tension in your neck..

(Braemore)

Celia: You feel sick [...] and you start to feel a bit um, your breathing gets difficult, no doubt about it, um, and nervous, afraid.

(Kirkhead)

The second type of physical symptom associated with stress is the experience of a specific illness or condition. In the accounts of five women within the Braemore sample and two women in the Kirkhead sample, acute episodes of medically defined

conditions such as eczema, migraine and sciatica, or the worsening of existing health problems such as Multiple Sclerosis, were identified as being triggered by the experience of stress. In other words, these conditions are considered to be general *consequences* of experiencing stress rather than being bodily indicators of stress. The following excerpts illustrate this notion that experiencing stress tends to prompt the onset of episodes of particular health problems:

Hattie: My family history, my mum's got asthma, we've sort of got eczema lingering, which comes up, like if I'm stressed I get eczema.

(Braemore)

Jacqueline: I was very stressed last week [...]and then at the end of last week I had a migraine.

(Braemore)

LA: Does stress affect your health, other than the irritable bowel syndrome? Have you ever felt that stress has affected your health in other ways?

Pam: It's, it's um brought on a mild re-occurrence of my sciatica, definitely. If I'm stressed I tend to be tense, and the tension, there's some slight lack of alignment in my spine I think and because my muscles tense up it seems to increase the um mal-alignment and put pressure on my sciatic nerve, um... it'll affect my sleep pattern and therefore have a knock-on effect, um...to some extent it will affect my appetite, so yes, I mean it can potentially have quite significant effects.

(Braemore)

Ellen: If I get stressed it makes my MS ten times worse. I tell everybody that as well, I say don't stress me out, I can't cope [...] I feel more tired in my limbs. I'm in constant pain anyway but the pain seems to get sorer than what it normally does, and I'm thinking I just honestly can't cope.

(Kirkhead)

So far, discussion has focused primarily on women's accounts of physical (or bodily) signs of and responses to stress. Equally, stress is perceived by respondents to impinge upon mental and emotional well-being. Several respondents within both sample groups talked about being unable to 'switch off' mentally when they are stressed, due to worrying about the stressful situation which they are experiencing. This affects their ability to relax, and can prevent them from sleeping properly. The

following three quotations are from respondents describing stress in terms of something that they experience 'in their heads':

Rachel: It feels like this sort of committee that can't agree on anything sitting in my head, and I just wish they'd all shut up and get out [*laughter*], and you know stuff like not sleeping at night because it's all going, and it's completely um unproductive.

(Braemore)

Esther: If I'm not coping then I'll feel all jangly in my head, and I just feel as if you know screws have come out.

(Braemore)

Josie: Once there's something in my head niggling away, I can't switch off from it at all, it's just there and there until it's resolved

LA: Right, and would you describe that as stress?

Josie: Yeah, yeah...I would yeah.

(Kirkhead)

Other respondents referred to how stress undermines their emotional well-being, leaving them feeling low in mood, tearful or irritable. In a few accounts, respondents indicated that they view the concept of stress as being closely linked to that of depression:

Hattie: I think if you're stressed you become depressed so it's probably more a depressive sort of thing.

(Braemore)

Shona: When I'm feeling stressed I can't really be bothered with the same things that I would take an interest in. And that's the time that I cannae be bothered speaking, you know and instead of phoning them to say I'm really stressed, you know um, and have a moan, I'm not that type, um so I tend to withdraw a bit.

(Kirkhead)

LA: Can you tell me what it actually feels like when you're stressed? How would you describe it?

Linda: Very tearful....and that you know, weep very easily, get upset, I think that's part of the stress, well to me anyway it is.

(Kirkhead)

It is evident from the data presented in this section that feeling or being stressed can encompass a range of mental, emotional and physical symptoms or sensations; the data clearly indicate that the experience of stress involves complex

and variable interactions between mind and body. Thus, the experience of stress may be understood as having the potential to undermine health and well-being in a variety of ways. As will be explored later on in the thesis, the data indicate that, in lay understandings, there is a complex relationship between the experience of stress, notions of time, and illness causality.

In the chapters which follow I explore how structural forces have served to shape the respondents' locations both within the social structure and within geographical and social space, and how these locations have in turn shaped the respondents' exposure to potentially stressful situations in different spheres of life. I present data which suggest that the respondents locate their own lifecourse experiences of good health and illness within the myriad of life events, social structures, social roles and personal relationships that together constitute the everyday contexts within which the women's lives have been, and still are embedded. In other words, I argue that the respondents' individual health and illness experiences throughout their lives have been constituted within a socially structured 'web of resources' - resources which have been more or less health-promoting or health-damaging.

I discuss data which suggest that on the whole, more affluent respondents in Braemore have been exposed to fewer stressors than more deprived respondents within the Kirkhead sample. I also present data which indicate that the respondents' access to resources which act as 'buffers' against the health-damaging impact of stress is also socially patterned. These themes are explored through discussion of various dimensions of the respondents' social and spatial locations over the course of their lives.

In Chapter Four I consider accounts of the interaction between health and access to financial resources over the lifecourse.

Chapter 4: Resources for health and well-being (i): Money and Wealth

4.1 Introduction

In Chapter Three, I presented data which indicate that respondents in the Braemore sample experience better health (in terms of the absence of chronic health problems) than respondents in the Kirkhead sample. In this chapter, the main issue that I seek to address is how the respondents' access to financial resources throughout their lives has shaped their opportunities for good health and well-being. By exploring this topic, I take a first step towards illuminating ways in which the differing health profiles of the two sample groups may have their roots in dimensions of the social structure.

As reported in Chapter One, there is overwhelming evidence within the wider literature that money and wealth are key determinants of health (Shaw et al, 1999a). The aim of this chapter is to unpack the associations between financial resources and health, through an analysis of lay perspectives on ways in which access to financial resources shapes the quality and meaning of everyday life in health-relevant ways.

This chapter considers first of all the pathways through which respondents' access to financial resources has been structured over the lifecourse. In Section 4.2 I offer an overview of the respondents' access to financial resources at the time of interviewing, in order to illustrate current variations in income and wealth both within and between the two sample groups. Then, in Section 4.3, I present data collected in the lifegrid interviews to demonstrate that the respondents' current financial situations do not simply reflect current income, but also reflect the level of wealth that respondents have accrued over the course of their lives since childhood. This section highlights some of the dynamic social processes through which socio-economic advantage or disadvantage may accumulate over the lifecourse.

In Section 4.4 I draw on data from respondents in both sample groups to discuss the health implications of absolute levels of income and wealth. The data offer some clear indications of how material resources can shape exposure to various

health risks on the one hand, and influence access to health-promoting resources on the other. I discuss the respondents' own understandings of the ways in which their access to financial resources either enables or constrains their opportunities for good health. Section 4.5 considers the salience of access to financial resources in the respondents' contextualised accounts of their engagement in health-related behaviours.

Section 4.6 moves beyond a focus on material pathways which may link financial resources and health. Here, I explore possible psycho-social mediators between financial resources and well-being. There is evidence in the data that respondents' perceptions of their financial circumstances (and, consequently, their 'place' in the social hierarchy) are shaped by notions of relative as well as absolute wealth. I argue that the respondents' subjective interpretations of their own financial situations may have psycho-social implications for their sense of well-being.

Throughout both the first and the second interviews, I asked a range of questions designed to elicit accounts of how access to financial resources throughout the lifecourse has structured respondents' lives in health-relevant ways. Some of these questions were directly related to financial resources. For example, I asked respondents if they have ever worried about money, or had to do without things that they need or want due to a lack of money; items of expenditure they would cut back on if their income was reduced; and what they would buy if their income increased. Questions of this nature were designed to find out about respondents' perceptions of their own financial position, and to identify their priorities regarding financial expenditure. They also provided an opportunity to explore the distribution of resources within respondents' households (Pahl, 1989).

Data were also constructed more spontaneously in the course of respondents talking about their lives. For example, accounts of day-to-day routines offer an indication of the ways in which access to financial resources may constrain or enable the scope of activities that respondents engage in on a regular basis. Together, data which relate both directly and indirectly to the topic of money and wealth, offer an

insight into whether and how respondents perceive their access to financial resources to influence their health and well-being.

4.2 Respondents' financial circumstances: current income

There is considerable variation in the current income levels reported by the respondents, particularly between the incomes of the most affluent and least affluent respondents in the study. Written information on current income was provided by the respondents at the end of the last interview that I conducted with each woman, as detailed in Chapter Two. This information proved to be difficult to standardise, because of the range of ways in which respondents provided this information (see Section 2.3.4 page 62). However, at the extremes of income distribution within the study, the fact that incomes are stated in different forms has little impact upon the magnitude of income differentials. For example, according to the written information provided by the respondents, current household incomes range between £240 (net) per month, which is the income support received by a Kirkhead respondent and her husband, and £50,000 (gross) per year – the combined earnings of a Braemore respondent and her husband. These polarities in income are striking; however, the incomes of most of the respondents are not clustered around these extremes, but rather are spread along what might be thought of as an 'income continuum'. Given the nature of the information I gathered, it has been more difficult to rank respondents accurately according to their income. It is nevertheless possible to divide the respondents into three broad income categories: high, low and middle – these are represented in Table 4.1.

Table 4.1 Income categories

Household income per month (net)	Employment status of adults in household
<p>Low: less than £800 8 respondents in total: 6 in Kirkhead sample 2 in Braemore sample</p>	<p>Kirkhead respondents: 3 divorced/widowed respondents on state benefits 2 married respondents: both partners on state benefits¹ 1 separated respondent in paid work Braemore respondents: 1 divorced respondent on state benefits 1 divorced respondent in paid work</p>
<p>Middle: between £800-1,600 8 respondents in total: 6 in Kirkhead sample 2 in Braemore sample</p>	<p>Kirkhead respondents: 4 married respondents: both partners in paid work 2 divorced respondents in paid work Braemore respondents: 1 divorced respondent in paid employment 1 married respondent: both partners in paid work</p>
<p>High: over £1,600 8 respondents in total: all in Braemore sample</p>	<p>Braemore respondents: 4 married respondents: both partners in paid work 3 married respondents in unpaid work ; partners in paid work 1 divorced respondent in paid work</p>

An important point to note is that there are no Kirkhead respondents within the high income category, but there are a small number of Braemore respondents within the middle and low income categories. The Kirkhead respondents are evenly split between the middle and low income categories; this hints at considerable heterogeneity amongst this sample group – something that reflects the general differences in income between those respondents in receipt of state benefits, and those in paid work. The diversity in the incomes of the Kirkhead sample group is

¹ The household income of one of these respondents falls within the middle income category. However, it is derived from state benefits to three adults; therefore it is more appropriately categorised as low income.

also reflected in their accounts of the relationships between financial circumstances, health and well-being.

The information presented in the table shows that within each broad income category, respondents differ in terms of their marital and employment status. The range of social contexts within which the respondents' household incomes are generated means that, even within each income category, there are important differences in the total household resources, as well as the individual resources available to respondents. This has implications for the ways in which respondents understand their access to financial resources to interact with their experiences of health and illness. Thus, although it is possible to divide the respondents into three income groups, this runs the risk of masking important distinctions between different women in terms of how their experiences of daily life are actually shaped by their level of income.

4.3 Respondents' financial circumstances: accumulation of wealth over the lifecourse

A clear theme to emerge from the respondents' accounts is that almost all of the women take into consideration a range of different forms of wealth in addition to current income in their accounts of whether and how their financial position has influenced their lives in health-relevant ways. During the interviews I did not ask specific questions about forms of wealth such as inheritances, savings, pensions and financial support from family members, and thus I do not have systematic data on these topics. However, respondents in both sample groups made spontaneous references to whether or not they have access to these forms of wealth. I did ask about whether or not respondents own their own homes, and whether they have a car; home ownership is a topic that will be explored later in this section.

Overall, the data suggest that respondents in the Braemore sample have accumulated much higher levels of wealth over the lifecourse than respondents in the Kirkhead sample. For example, the eight Braemore respondents in the 'high' income group are all home owners, and almost all of them reported having savings or inherited capital. These women were also more likely than Kirkhead respondents to

report having pension provision other than that offered by the state, thus ensuring that they will continue to have a degree of financial security in the future. However, the data gathered both directly and indirectly about various forms of wealth indicate a rather more complex picture of the respondents' financial circumstances than would be the case if the data on financial resources were restricted to current income. In particular, it is interesting to note the variations in wealth reported by the eight respondents in the 'low' income category. In Table 4.2, data are presented on the reported assets of respondents in the low income category. Obviously, these data are limited in their utility because they were not collected systematically; nevertheless, they point to the need for a fine-grained approach when considering the influence of financial resources upon health.

Table 4.2 Reported assets of respondents in the lowest income category

Kirkhead respondents in the low income category (n=6)			
Name	Source of income	Tenure category	Other assets
Mary	Benefits	Owner Occupier (RTB*)	£1000 shares, £8000 insurance policy
Linda	Benefits	Owner occupier	None
Morag	Benefits	Owner occupier (RTB*)	None
Celia	Benefits	Owner occupier	Recently received an inheritance– used to pay off debts and buy a car
Lizzie	Benefits	Social renter	Occupational pension
Fiona	Paid work	Social renter	None
Braemore respondents in the low income category (n=2)			
Jean	Benefits	Social renter	Shares (no value given)
Rachel	Paid work	Private renter	None

***RTB: Owner occupation accessed through Right to Buy sales of Local Authority housing**

From the information presented in Table 4.2, it is apparent that there are considerable differences in wealth between different respondents in the low income category. Differences between respondents in this subset, in terms of their financial circumstances are confirmed by their accounts of how their life experiences have been shaped by their access to financial resources.

This table also highlights the variation in housing tenure amongst respondents in the low income category. One of the major forms of wealth in British society is home ownership, and housing tenure has been identified as a key mediator of health inequalities (Easterlow et al, 2000; Macintyre et al, 2000). Home ownership is a prominent topic within the interview data, partly because a focus upon housing trajectories was an integral part of the research design. Currently, ten respondents in Braemore, and nine in Kirkhead live in owner-occupied properties. This commonality of housing tenure between the two sample groups masks wide variations in the amount of housing wealth that respondents actually have access to. In Sections 4.3.1 and 4.3.2 , I present data from respondents in all income groups, to show how their opportunities to acquire wealth through owner occupation have been structured by various dimensions of their social position - in ways which have favoured the Braemore respondents.

4.3.1 Home ownership in Braemore

On the whole, housing in Braemore is larger, in better condition, more socially desirable and consequently much higher in financial value than housing in Kirkhead. In Braemore, eight of the ten respondents who are owner occupiers are from middle class backgrounds. Educationally advantaged, they generally reported high qualifications, as did the other two respondents in this subset who were originally from working class families. Accounts from this subset of ten respondents indicate that their level of qualifications subsequently enabled them to occupy relatively advantaged positions in the labour market. Moreover, all of this subset of respondents are, or have been, married to men in professional and managerial occupations. The data indicate that the high socio-economic status of the men that they married served to consolidate and reinforce these women's already advantaged socio-economic positions.

As a result of this cumulative social advantage in early adulthood, this subset reported that they found it relatively easy to access owner-occupation. High household incomes enabled these women and their partners to obtain a mortgage and save money for a deposit on a property. Furthermore, four of the ten respondents reported receiving financial help from their families in order to purchase property.

Five of the ten respondents bought first homes that were large enough to accommodate children born in later years. These women are still living in these houses approximately thirty years on, and have amassed a large stock of housing wealth through house price appreciation in one of Edinburgh's most popular residential areas. The other five respondents in this subset have moved up the housing ladder over the years, again acquiring housing wealth in successive moves. The data presented in Table 4.3 illustrate some of the processes through which Braemore respondents in the high income group have accrued housing wealth.

Table 4.3 Acquisition of wealth through the housing market: Braemore respondents

<p>Links between high educational attainment, income, and ability to save for deposit</p> <p>Hattie : When I first went into nursing my dad had suggested that it was quite a good idea to have a standing order once a month off your salary going into a building society as a way of saving [...]when we got married I had enough saved up in this account for the deposit for our flat.</p> <p>Esther: I always saved money [...] my husband saved £1000 for the deposit and I saved the £1000 to do it all up [...] when I started teaching my salary was £875.</p>
<p>Financial help from family for a deposit</p> <p>Pam: In fact it was my husband who had financial help when he was in Bristol to buy um, it was one of those twin flats[...] and when he sold that we had some capital therefore to start.</p> <p>Carol: My cousin gave us some money [...] it was quite a large sum in those days, I think it was about £3000 or something, she said that was for our deposit for our house.</p>
<p>Ability to get a mortgage because of high household income</p> <p>Stella: He was working for an insurance company so we got a nice cheap mortgage.</p> <p>Esther: I can't recall any difficulty getting a mortgage whatsoever.</p>
<p>Moving up the housing ladder....</p> <p>Stella: We definitely made money on houses [...] we bought for about 8000 and sold it for 15 [...] the housing is cheaper in Glasgow and we were able to get you know a 5 bedroom house.</p> <p>Hattie: My husband said that he thought that we should move because we were earning more than our mortgage justified if you know what I mean, just to keep going up the market.</p>
<p>Housing as a significant source of wealth</p> <p>Sarah: We do know that at the end of the day we could sell this house and buy a cottage you know in some cheap part of the country and live very comfortably for the rest of our lives.</p> <p>Marion: I suppose looking to the future as well, it's maybe money for your care when you have to see it to pay for our care when you're an old lady.</p>

4.3.2 Home ownership in Kirkhead

Compared to the owner-occupiers in the Braemore sample, the ten respondents in Kirkhead who own their homes have accrued much lower levels of housing wealth due to the nature of the housing that they live in. Their trajectories into home ownership were markedly different from those reported by the Braemore sample group, and they reflect the experience of relative socio-economic disadvantage over the lifecourse. On the whole, respondents in the Kirkhead sample left school with few or no qualifications and they married men from lower socio-economic groups. Their relatively low household incomes over the lifecourse means that respondents in Kirkhead have had fewer financial resources to invest in housing, compared to owner-occupiers in Braemore. Four respondents in this subset live in homes that they originally rented from the local authority, and which they have subsequently bought at discounted rates under the Right to Buy policy. Right to Buy has enabled these respondents to access owner-occupation despite not necessarily having high household incomes or money saved for a deposit. One of these respondents pointed out the financial advantages of buying her home from the local authority, compared to renting:

Tania: Nowadays a council, a rent for this house is nearly £250 a month. Now I bought this for 11 [*thousand pounds*], my mortgage is only £110 [...] now to me that makes sense, rather than pay £250 a month for something that's never going to be yours [...] I think it's a very good idea to buy a house, especially with the council now.

There are indications within the data that those respondents in Kirkhead who have bought their homes under the Right to Buy policy consider it to be a good form of investment. For example, Ruth comments on how she and her husband have paid off their mortgage and now consider themselves to be relatively well-off:

LA: Was it important to you to own your own house?

Ruth: It was important to me because I had a step-family and because I was younger than George [*husband*], I wanted something for security[...] it's the best thing we've ever done, because no mortgage or anything and life's been good to us cos we can go all these holidays, because we're financially better off.

(Kirkhead)

Another respondent, Mary, explains how her home has multiplied in value since she bought it from the council in the early 1980s:

Mary: I think it's nice to own your own home, but the good thing about this is I will have made a good profit on this house, cos this was my mum's house, it was a council house, and it might not be very good quality but um the house in 1984 was valued at £18,000 and my mother got this house for £9000, and Gerry [neighbour] sold her flat just the other week there for £45,000, so I bought this for £9000 and if I get £45,000 for this it's all mine, you know, so okay, I've put in central heating and double glazing and a new kitchen, all these years ago, but I mean I'll get my money back.

(Kirkhead)

This increase in housing wealth over the time that Mary has owned her flat is significant. However, the value of the homes owned by Braemore respondents is, on average, well over £150,000, compared to the £45-50,000 reported by Kirkhead respondents. Moreover, as indicated in the previous section, women in the Braemore sample were far more likely than those in the Kirkhead sample to report additional forms of wealth such as savings.

In this section I have presented data which highlight the cumulative social processes through which Braemore respondents have been able to acquire greater stocks of housing wealth compared to Kirkhead respondents. In combination, the data presented so far in this chapter show that on the whole, the Braemore respondents have access to considerably higher levels of financial resources than the Kirkhead respondents. In the sections which follow, I discuss possible pathways through which these disparities between the two sample groups, in terms of their income and wealth across the lifecourse, may be related to the contrasting health and illness experiences reported by the respondents.

4.4 What money can buy: material pathways between financial resources and health

Almost every respondent made some form of reference to how financial resources shape material living standards in health-relevant ways, either in relation to their own lives, or when talking about people generally. In my analysis of the data, the concept of ‘choice’ emerged as a central theme in respondents’ understandings of the influence of money upon health. Five respondents in the Braemore sample, and two in the Kirkhead sample explicitly referred to how financial resources may either enable or constrain individual choice in terms of the ability to secure particular health-relevant goods and services and living standards. The notion of choice as a mediator between financial resources and health is a theme that is also woven into the personal accounts of a further twelve respondents, from both sample groups, albeit in a more indirect and implicit manner. Thus, the majority of the respondents either directly or indirectly expressed the opinion that the greater the level of financial resources that individuals have access to, the greater their freedom of choice in securing health-promoting material conditions.

The importance ascribed to ‘having choices’ by the respondents is evident both in data constructed in response to generalised questions about how money might affect health and well-being, and in the respondents’ personal accounts of everyday life. In the following selection of quotations, respondents in each of the income categories articulate their understanding of the relationship between access to financial resources and the ability to make health-relevant choices in relation to material living standards. These accounts were prompted by direct, general questions:

LA: Do you think that income, a family's income can influence their health?

Pam: oh yes, undoubtedly, tremendously. Income affects the house you're going to buy, the area you live in, the food you eat. whether you can heat your er house enough, whether you can clothe yourselves properly, um whether you can buy er for instance homeopathic medicines or maybe additional supplements, um, even paying for advice about these things, having a holiday, having domestic help, um....oh I mean it just affects everything, everything to a tremendous degree. Your children's education, freedom of choice in all these spheres.

(Braemore, high income)

LA: Do you think that the level of income or wealth that somebody has can influence their health chances?

Jacqueline: Yes [...] um, you have more choices when you're better off, so you can opt to go abroad in the winter more easily, or to have a holiday two or three times a year or whatever, um and I think those things are important because it's the quality of the time that you spend with family and friends and things, which is also a contributor to health, um....and aspects of leisure are easier to tap into.

(Braemore, middle income)

LA: We've talked quite a lot about money. Do you think that the amount of money or wealth//

Lizzie: // yeah, I think, I think money has a lot to do with it. If you've got money you can do a lot of things. Uh....like you can buy the right things that you want to eat. You could have somebody cooking for you, you could have, you're able to go where you want to, when you want to, you know you can just pay for it.

(Kirkhead, low income)

In these accounts, the respondents suggest that access to financial resources influences health via the choices individuals are able to make about the conditions of their lives. They identify material health determinants such as housing and heating; they also refer to health-relevant ways in which money may shape quality of life more broadly – as Lizzie indicates, having money gives people the choice to ‘do a lot of things’. This is an important theme within the respondents’ accounts about their own lives - respondents perceive their access to financial resources as either enabling or constraining their level of choice with regard to participation in a range of activities. These activities are not necessarily directly health-related in terms of

physical health, but they are nevertheless identified as contributing to quality of life and well-being. Access to transport (both private and public), being able to afford a holiday, trips to the cinema or the theatre, eating out, buying clothing, and participating in social activities were talked about by a majority of respondents in both sample groups as being dimensions of social life that contribute to quality of life and well-being – not only in a general context, but also in relation to their own lives. The data suggest that there may also be psycho-social implications associated with whether or not the respondents can afford to participate in particular social activities – this is a theme that will be discussed in more detail in a later section of the chapter.

The data suggest that one important way in which respondents' access to resources may shape their health relates to whether or not they are able to choose to access semi-privatised health services such as going to the dentist and optician; to access 'alternative' therapies such as homeopathy and chiropractice; and to pay for 'treats' such as massage. Affluent respondents within the Braemore sample tended to acknowledge that their relative wealth offers them choices in terms of looking after their health. The accounts of these respondents clearly contrast with the experiences described by less affluent women in the study, whose accounts show that they perceive the health-benefits of particular health care services, but whose choices about caring for their health in particular ways are restricted by their inability to pay for such services. The contrasts between the experiences of more and less affluent respondents are illustrated in Table 4.4.

Table 4.4 How financial resources influences the ways in which respondents are able to look after their health

More affluent respondents	Less affluent respondents
<p>Diane: I still fork out a great deal of money to go to the dentist from time to time and if we were strapped for cash I certainly wouldn't go to the dentist unless I could find a National Health dentisteven so, it would be expensive...even things like getting your eyes checked and so on, all these things are a luxury for many people..... yeah, um, when I get sore shoulders and muscles I go and pay a physio to massage me, which you know is a luxury , um.... So I'm very aware of being very privileged that way, to have quite a lot of choices open to me. (Braemore, high income)</p>	<p>Jacqueline: I haven't been to the dentist in years until about 2 weeks ago when I broke a tooth and had to go , and he was very sweet, he said when did you last go to the dentist and I just muttered laughter but that was one of the things when money was very very tight I gave up because I thought well you know I can't do it. (Braemore, middle income)</p> <p>Mary: I want to just be able to say "right I need a new pair of glasses, I'm just going to go and get a new pair of glasses" without having to worry about the expense. (Kirkhead, low income)</p>
<p>Marion: I'm a great believer in reflexology and adjuncts to things like massage and whatever LA: And so how frequently would you go and have a massage or whatever? Marion: Maybe once a month ...once again that's down to money, cos that costs about £25-30 a session, so not everybody can go and treat themselves in such a way. (Braemore, high income)</p>	<p>Jean: My blood pressure was very high by then, um, but I was, I went to a chiropracter and they got that down a bit, so// LA: //And was that chiropracter recommended to you? Jean: Yes, and it also helped all the aches and pains all over my body too, which was quite nice. But it was expensive and I couldn't do it for very long. (Braemore, low income)</p>

4.5 Interactions between financial resources and health-related behaviours

In Section 4.4 I presented data which indicate that, in the context of answering abstract questions about the relationship between money and health, and also when talking about their own everyday lives, respondents articulated understandings that access to financial resources may either enable or constrain opportunities for good health. However, when respondents were asked for their

general views on the determinants of health, personal responsibility in the maintenance of good health and the avoidance of illness emerged as a dominant theme in accounts from respondents in both sample groups. Personal responsibility was most often expressed with reference to the health-related lifestyle behaviours of eating, drinking, smoking and exercise. In some respects, the dominance of behavioural discourses within the women's accounts is hardly surprising, given the health policy context over the past two decades, which has focused upon lifestyle behaviours as the key to health improvement (DHSS, 1987; DoH, 1992; SODH, 1992; SODH, 1996).

The policy focus on health-related behaviours is at odds with research findings which indicate that the contribution of health-related behaviours to inequalities in health is relatively minor, accounting for between 10-30 per cent of the socio-economic gradient in health (Graham, 2000; Rose and Marmot, 1981; Wilkinson, 1996). Furthermore, studies have indicated that the health-relevance of particular lifestyle behaviours must be considered in specific social contexts – the significance of their influence upon health varies between social groups. Nevertheless, discussion of health-related behaviours is relevant here, because of the prominence of this theme within the data.

4.5.1 Perceived links between lifestyle and health

Regardless of their socio-economic position, almost all of the women in the study demonstrated in their accounts that they have a great deal of knowledge concerning health-related behaviours. For example, respondents in both neighbourhoods frequently mentioned the importance of having a healthy diet and taking exercise in promoting and maintaining good health, as well as talking about the health-damaging effects of smoking and excessive drinking. The following quotations illustrate that respondents in varying socio-economic positions are able to demonstrate an awareness of health education messages:

Hattie: A lot of it can come from you, I mean people can be unhealthy because they are smoking, they're doing drugs, they're not eating properly, so there are different aspects of health rather than just being ill with an illness.

(Braemore, high income category)

Shona: I think you have to be conscious and look after your health you know. If you smoke then you're damaging your health, um if you get too stressed out you're actually damaging your health, drink too much, if you're not aware of those things there's nothing that anybody can really do to help you, um....everybody's in charge of their own health.

(Kirkhead, middle income category)

LA: is there anything else that you think is important [for staying healthy]?

Morag: Um, that you do some exercise of some kind, as well as diet.

(Kirkhead, low income category)

Women in both groups commented that information about health-related behaviours is widely disseminated, and many women's accounts suggested that they have internalised health education discourses of personal responsibility for health. This is illustrated by the following comment:

Ruth: I think uh everybody's geared into thinking about weight and health now, it's a big issue, um in the media and everything all the time, so I suppose it's in your mind.

(Kirkhead, middle income category)

Overall within the data, diet is the lifestyle habit that respondents linked most explicitly to their health. Most women within both sample groups indicated in their accounts that they consider their diet to be relatively healthy; the majority of respondents also claimed that a concern for health influences what they choose to eat. For example, respondents in Braemore tended to talk about their perceptions of diet as a means of preventing the onset of health problems. Furthermore, accounts from married respondents in the Braemore sample suggest that they often act as 'gatekeepers' for their husbands' health, through the use of food as a health-promoting resource, particularly if they reported their husbands as having health problems. These data echo the findings of other studies (e.g. Backett, 1990; Calnan

& Williams, 1991). The following quotations illustrate the 'gatekeeping' role of this subset of Braemore respondents:

LA: And you mentioned sort of fat content influencing food, and is that to do with your own weight and how you feel about//

Diane: Yes, yes, weight but also just health generally actually to be honest, um, sort of being aware of cholesterol levels and Bill [*husband*] as well you know, what's healthy for him

LA: Right, and is that a recent thing, that you have become of that?

Diane: Um, I would say that I am more aware of it now, yes...I think that just because I'm at a stage where I am less active as part of my normal life[...] you know I'm aware that it wouldn't be good news to build up cholesterol too much.

(Braemore, high income)

LA: And have your eating habits changed over the years?

Christina: Well we're eating more ready made meals, you heat up in the microwave and the oven, just because there's two of us and you get portions for two people

LA: Yeah...aside from that, have you changed in any other way?

Christina: Eating much less red meat and more chicken, um

LA: Why's that?

Christina: Cos it's healthier...eating less salt overall, cos my husband's [*high blood pressure*]...I suppose it does me good as well.

(Braemore, middle income)

By contrast, those respondents in Kirkhead who are most concerned with healthy eating tend to be women who have changed their diet in recent years in response to having been diagnosed with chronic illnesses:

Lizzie: When I was very very bad with the arthritis and it was pulling me down I went on it [*special diet*] [...]

LA: So how did your diet change?

Lizzie: It took the pain away actually, cos you went off...it's mostly vegetables, soya beans, nutty things, cabbages, all really healthy foods and brown rice, brown bread, and you're cutting out all red meat [...]

LA: And so how different, when you changed your diet, how different was it to what you had been eating before?

Lizzie: Well stodge...I mean it was potatoes, sausages, all fat in them, animal fat, mince, well mince has got a lot of fat in it too.

(Kirkhead, low income)

LA: How does the diabetes affect day-to-day life for you?

Ruth: I don't actually think about it as much as...like I used to love having a bar of chocolate, or pigging out when there was tea parties at work, but now I'm very aware of like the carbohydrates that I eat, starchy things rather than sweet things if I can, and um...low cal juice and things like that, Diet Coke and things, um...I just think I don't want, I wouldn't want to end up with bad eyesight or losing limbs through diabetes.

(Kirkhead, middle income)

From the data which I have presented so far in this section, I have argued that respondents in both sample groups indicated a perception that lifestyle behaviours may influence health. Within their accounts, diet is portrayed as having a prominent role in health maintenance and the prevention of disease. It is clear from their accounts that respondents in all of the income groups are aware of health education messages. However, in the next subsection, I argue that the data strongly suggest that respondents' actual engagement in particular lifestyle behaviours is mediated by their level of income.

4.5.2 How financial resources shape engagement in health-related lifestyle behaviours

The influence of income upon health-related behaviours is most apparent in relation to respondents' reported dietary habits. Data suggest that respondents perceive their ability to eat a healthy diet as being shaped by their access to financial resources. More affluent respondents indicated in their accounts that their level of financial resources enables them a degree of choice over where they shop and the types of foodstuffs that they buy, and thus it is relatively easy for them to prioritise healthy eating when purchasing food. By contrast, accounts offered by less affluent respondents suggest that for them, eating a healthy diet may require them to engage in budgeting strategies that can take time and effort to undertake – for example, travelling to cheap supermarkets some distance from their homes, and preparing home-made food every day. These respondents also tended to indicate that they feel restricted in their choice of foodstuffs. Overall, less affluent respondents indicated in their accounts that their opportunities to eat healthily are more limited than those of more affluent respondents; furthermore, their experiences of these limitations are portrayed by some relatively deprived respondents as being quite stressful.

Data indicating the reported influence of financial resources upon diet are presented in Table 4.5, and illustrates contrasts between the accounts of high income Braemore respondents and low income Kirkhead respondents.

Table 4.5 How access to financial resources may influence food purchase and consumption

Braemore respondents (high income)	Kirkhead respondents (low income)
<i>Financial resources may determine where respondents buy food</i>	
<p>Esther: I like to shop for convenience and I don't, it doesn't bother me if something's cheaper elsewhere, it's not, it's not worth my time to drive you know, somewhere else to get bargains, you get enough bargains at Safeways.</p> <p>LA: Why do you shop there [at Marks and Spencer]rather than anywhere else?</p> <p>Marion: Because it's good quality and I can park outside and I find it good for meals for one [...]I love their fruit and vegetables, it is more expensive but...I just like their stuff.</p>	<p>Morag: Well at Asda you get more for your money than you do, there's a Safeways there, and there's a Tesco, and both of them are dear, they're okay if you're working, but wi the two of us no being able to work, Asda's quite, they're quite reasonable with their stuff, you can get quite a lot of things that cost you mair at Safeways that doesnae cost you there. So that's why we go to Asda. And then Iceland, they're quite good as well, because quite often they have buy one, get one free, and depends on what they've got on offer, but usually they've got quite good offers on.</p>
<i>Financial resources may influence the range of foods respondents buy</i>	
<p>Hattie: I mean if I'm going to the supermarket and I've thought I'm gonna make something and it's got a red pepper in it, in the summer you can get them 56p a pound and in the winter they're sometimes £2.70, I mean I've got enough money that I don't have to worry about that, if I want a red pepper I'll just buy one, so I'm, you know I'm lucky that way, and I'm probably not...totally aware of prices of things because of that.</p>	<p>Celia: This is something that the doctor doesn't understand, she said oh but there's lots of cheap foods, you know, when you're on the dole, but you see when you're on the dole for a long time you have to eat those foods all the time, it's unremitting.</p> <p>Mary: I don't eat a lot of red meat, that's not so much from...a health point of view, it's really financial, well it started off as financial anyway, cos red meat was so expensive compared to chicken.</p>
<i>Financial resources may influence ability to buy "healthy" food</i>	
<p>Diane: I have noticed that, that I'm more, less frugal in terms of spending the money if it's in the interests of better health (right) but then, you know I'm at a certain stage of life when I can afford to decide to do that.</p>	<p>Morag: Sometimes if folk have not got much money, especially if you're on special diets and that, you just have not got the money to buy what they're telling you to eat, you have to buy something different that you can afford.</p>

These data indicate that the respondents' reported desire to promote good health through diet seems to be mediated by their access to financial resources

(Marshall et al, 1995; Sooman et al, 1993). These data are important, but they need to be interpreted alongside other themes within the data, which suggest that the eating habits of respondents in both sample groups are complexly related to the socio-cultural contexts of the women's everyday lives. Within accounts of everyday life, neither a concern for health nor budgetary constraints were necessarily articulated as priorities which influence respondents' eating habits. Various influences upon diet were identified, such as weight control, time constraints and family preferences. Table 4.6 presents data which illustrate that respondents in both sample groups account for their eating habits by referring to a range of priorities which relate to the contexts of their everyday lives.

Table 4.6 Influences over diet which are grounded in the context of everyday life

<i>Time constraints</i>
<p>Kirsty: I'm a wee bit of an erratic eater in that respect and I think the shifts determine that a wee bit as well [...]by the time I've locked up and got away and everything it's quarter past, twenty past 8 sort of thing, and that's when maybe the toastie is the easier option, cos I'm hungry and I want something quick. (Kirkhead, middle income)</p> <p>LA: And what would you say influences you choice of food that you buy? Carol: well um partly not wanting to spend vast amounts of time cooking if it's just the two of us. (Braemore, high income)</p>
<i>Family preferences</i>
<p>Tania: I love fish, I like steak, I like salads, but Alistair [<i>husband</i>] is the opposite and I only cook what he likes. He likes all the fast foods, but I don't like it. He likes sausage, egg and chips, that's alright for a one-off. He likes pies and that. I mean I like braised steak, and mince and things, but he doesn't like anything like that. (Kirkhead, middle income)</p> <p>Diane: If there are other people, and obviously that includes Bill [<i>husband</i>] to some extent, I'll try and please them by doing things that they like. (Braemore, high income)</p>
<i>Weight control</i>
<p>Stella: I mean I would say I was certainly thinking about trying to get enough calories into Gordon [<i>son</i>], uh whilst not having too many calories in myself. (Braemore, high income)</p> <p>Josie: I get to a stage where I think "enough", and I go back to being aware of what I'm eating, making sure I'm using skimmed milk, not using fats or butters, you know just being aware if I'm shopping I buy fruits and vegetables and if I'm buying puddings I always check how much fat is in them. (Kirkhead, middle income)</p>

In the excerpts presented in Table 4.6, access to financial resources is not explicitly mentioned. However, my interpretation of these data is that the various influences upon diet identified by respondents are nevertheless related to the socio-economic contexts of their lives (Backett, 1992; Calnan and Williams, 1991; Marshall et al, 1995). For example, a certain level of income is necessary in order to be able to buy food that is quick to prepare. Similarly, financial resources may also

determine the extent to which respondents are able to purchase foods which are low in fat, or to structure meals around family preferences. There are no quotations from respondents in the lowest income category in Table 4.6, and this reflects the dominance in their accounts of budgetary constraints upon food purchase.

The data about the respondents' reported eating habits offer an insight into the complexities associated with influences upon health-related behaviours, and reinforce the need to explore the social contexts in which people engage in particular behaviours, in order to understand the nature of the relationship between social position, lifestyle and health. This is further supported by the data regarding other health-related lifestyle habits. As would be expected from the wider literature, the more affluent respondents in the study generally reported engaging in 'healthy' behaviours more often than the relatively deprived respondents (Blaxter, 1990). A total of six respondents identify themselves as smokers. All of these women are in the lowest or the middle income bracket; four live in Kirkhead and two in Braemore. In terms of alcohol consumption, most women in both samples regard themselves as light drinkers. However, two Kirkhead respondents identify themselves as alcoholics. Respondents in the Braemore sample are far more likely to mention taking regular exercise than those in the Kirkhead sample.

In their accounts of all these behaviours, however, respondents rarely explicitly referred to access to financial resources as a factor influencing their behaviour. Nor did health concerns seem to be necessarily uppermost in women's minds as they talked about whether or not they smoke, drink or take exercise on a regular basis. Rather, as with accounts of dietary habits, accounts of these lifestyle behaviours were situated within the context of life circumstances more generally. For example, cigarette smoking was described by most of the smokers as a means of coping with stress but was not directly linked to the constraints of living on a relatively low income:

LA: How many do you tend to smoke in a week?

Jean: 100...which is certainly more than it was

LA: Right...why do you think you are smoking more now?

Jean: Because of Richard [*son*]...it's my, my inability to deal with Richard

LA: Would you say it helps you cope with stress?

Jean: I suppose it is, it's not a good way is it...it's a way of allowing myself to sit down when I have a cup of tea and just take 10 minutes to be calmer.

(Braemore, low income)

Josie: Just beginning of this year I was going through a stressful time, my mum had had cataract operation on her eye and she was really, sounds really cruel, but she was really making heavy weather of it, I mean she is old and she is a bit frail, but I mean you would have thought she had had major transplant surgery [...] I had no time to myself and I found I was smoking you know in the morning, during the day at work, cos I just wanted a cigarette, um...

LA: And did it help you cope?

Josie: It did help me a bit.

(Kirkhead, middle income)

Although in these quotations respondents do not make explicit associations between their financial circumstances and their smoking, their accounts do suggest that for them, smoking offers an opportunity for relaxation that is both affordable and can be slotted into brief moments of the day. Graham (1987; 1993) has conducted several influential studies that expose how women on low incomes use cigarette smoking as a resource for maintaining well-being in constrained socio-economic circumstances. The theme of smoking as a 'symbolic act' is one that is represented by the quotation below:

Rachel: I started smoking after she [*daughter*] had gone to bed at night, because it was like "pew...peace", you know and it was a little symbolic act somehow, you know that then I could have my cigarette.

(Braemore, low income)

The data suggest ways in which respondents' socio-economic circumstances might influence their attitudes to exercise. For example, for relatively affluent women, keeping fit through various sports and activities tended to be described as

not only something that is important for promoting health and well-being, but also as a leisure pursuit:

Diane: I love walking, I love walking so I tend to use walking as a way of seeing my friends rather than sitting having coffee, that kind of thing.

(Braemore, high income)

Marion: I go to the gym with friends on a Sunday

LA: So is that a regular thing?

Marion: Yes, every Sunday

LA: And what is the motivation for doing that ?

Marion: To get fit, keep fit rather, yes, fitness[...] it's nice to go with someone as well, and it's quite pleasurable, they have a nice sauna afterwards, and uh, it's lovely.

(Braemore, high income)

LA: So how many hours a week would you say you're involved in the tennis club?

Christina: Well I play two mornings a week and that's about an hour and a half each morning, play at night for another hour and a half, and I often play on a Saturday afternoon [...] if it's a nice day, there's people available, make an arrangement and see friends and have an hour and a half.

(Braemore, middle income)

I interpret these respondents' accounts as examples of how financial resources enable participation in these particular forms of exercise. In Diane's case, the fact that she is in a financial position where she does not have to work means that she has time to go walking with friends; Marion can afford to pay for gym membership; Christina has the time and the money to actively participate in the local tennis club.

These accounts contrast with those of less affluent respondents in Kirkhead, who were less likely to report engaging in exercise on a regular basis, and who rarely mentioned exercise as a form of social activity. Again, it was rare for respondents to directly link their exercise habits to their financial circumstances. However, a minority of respondents made reference to the fact that they regard the time required to maintain their health through exercise as being incompatible with the demands of their work and family commitments:

Josie: I know that you can just do ordinary exercises at home, but doing regular swimming or going to the gym or that, I just don't have the time to do it, I can't fit it in amongst everything else.
(Kirkhead, middle income)

Fiona: Well I've got a lot of friends go to a gym and they keep themselves healthy, you know they make an effort, but the people I'm talking about have no family, they're single females in their 30s, so em, they're more aware of what they're doing in their lives, they're paying a mortgage, they're working, but when they've finished work they'll go to a gym or they'll go swimming, they're more health-conscious but they haven't got the, they haven't got the same lifestyle as the rest of us who's got a family and just have to get on with it, it would be really nice to go to a gym and say "I'm feeling great today", but we just can't do it.
(Kirkhead, low income)

At a different point in her interview Fiona maintained that she gets sufficient exercise in her job; this opinion is echoed by Ruth:

Ruth: Although I'm big, I'm quite active, and I'm on the go, if you see me at work I'm on the go the whole time, and I can run, if I had to run for a bus I can run, I'm not stiff or anything, I'm quite agile. But I'm not into keep fit or anything like that.
(Kirkhead, middle income)

These findings are supported by other studies of lay accounts of health behaviours (Backett, 1992; Backett and Davison, 1992; Calnan and Williams, 1991; Mullen, 1992; Saltonstall, 1993).

The discussion presented in this section has raised a number of important points. Discourses about the role of lifestyle behaviours are dominant within the respondents' general accounts about how people can maintain good health. I have argued that respondents in both sample groups, regardless of their access to financial resources, demonstrate an awareness of health-education messages about lifestyle habits. However, data indicate that the respondents' actual engagement in health-related behaviours is socially structured, with affluent respondents more likely to report engaging in 'healthier' behaviours.

In terms of accounting for their own experiences, respondents described their engagement in particular behaviours as being shaped by the constraints and

circumstances of their everyday lives. Although financial resources are obviously a central feature of the respondents' circumstances, this is a theme that tended to remain implicit within women's accounts. I have shown that it is only in the case of food purchase and consumption that respondents explicitly referred to money as a factor which influences their actions. Nevertheless, analysis of data demonstrates that it is the relatively deprived respondents who are least likely to engage in healthy behaviours. Thus, without over-generalising, the data offer clues about how dimensions of social position, including access to financial resources, may influence a range of health-related behaviours (Shaw et al, 1999b).

4.6 Psycho-social pathways between financial resources, health and well-being.

In Chapter One I reviewed psycho-social explanations for health inequalities. The core assumptions of research undertaken within the psycho-social perspective are that income inequalities within society serve to undermine the quality of social relations, as trust and co-operation between individuals and social groups are eroded. It is argued that this weakening in the quality of the social fabric engenders psycho-social stress, which is disproportionately experienced by relatively deprived social groups. Such psycho-social stress has been shown to have deleterious consequences both for well-being and for physical health for *all* groups in society; however, the threats to health and well-being are thought to increase with each step down the social scale (Elstad, 1998; Marmot & Davey Smith, 1997; Wilkinson, 1996). Thus, it is argued that the relationship between income, wealth and health is not confined to absolute levels of financial resources – relative differences between social groups are held to be of central importance. In this section I draw on a range of data to suggest that there may be psycho-social links between the respondents' access to financial resources (in both absolute and relative terms) and their experiences of health and well-being. I interpret these data in the light of the existing literature on psycho-social explanations for health inequalities.

4.6.1 Absolute income, financial (in)security, health and well-being

The data indicate stark contrasts between the material standards of living enjoyed by relatively affluent respondents in the Braemore sample group compared to the most deprived respondents in the Kirkhead sample. In previous sections, I have considered ways in which respondents' absolute levels of income and wealth might influence their health via material and behavioural pathways. Whilst the literature tends to suggest that it is subjective interpretations of *relative* income that have consequences for health, there is evidence within the data to suggest that there are also psycho-social dimensions associated with subjective appraisals of *absolute* income.

The notion of financial security is a key theme within the data and it is frequently expressed in terms of whether or not financial issues are a source of worry or stress in the respondents' day-to-day lives. In this respect there are very clear distinctions between the accounts of the most affluent respondents, all of whom are in the Braemore sample group, and those of the most deprived respondents in the Kirkhead sample group. Braemore respondents in the high income category tended readily to acknowledge that their high levels of income and wealth mean that they do not have to worry about money, either in the short-term, day-to-day context, or in the context of facing unexpected bills or expenses. The quotations presented below, from Braemore respondents in the high income group, illustrate this theme:

LA: Has money ever been a worry for you, sort of looking back?

Hattie: [...]it's not been an issue really [...] we've got our pensions set up, we've got savingsif the roof caves in tomorrow we've actually got enough money to pay for it because it's the way that we've learnt to live and we play safe.

(Braemore)

LA: And do you ever worry about money ?

Diane: No, I don't worry about money at all, to be honest we don't need to worry about it, because we have quite a bit of capital from our families behind us, but we don't tend to live off it, we live within our income I suppose.

(Braemore)

Esther: I'm always aware that I'm comfortable now, I don't have to worry.

(Braemore)

Stella: I'm not worried about not having enough money.

(Braemore)

The influence of absolute levels of income upon well-being is perhaps more clearly evident in the accounts of the six respondents in the study who derive their income from state benefits; their experiences stand in sharp contrast to those of the most affluent respondents. These relatively deprived women offer powerful examples of the ways in which the financial worries that arise from living on a low income can not only shape access to material resources for health, but also engender a sense of financial insecurity (Lynch, 2000). Their accounts indicate that this insecurity is stressful, and has the potential to undermine well-being. Data from this subset of respondents suggests that financial insecurity is stressful for a number of reasons. Firstly, several of these women made reference to the chronic stressfulness of worrying about whether there will be enough money to cover day-to-day necessities:

Celia: You have to budget all the time and the constant, constant stress of paying the bills is just impossible, you think oh, I can't do anymore, I can't do it.

(Kirkhead, low income)

LA: How much does a concern for money affect your day-to-day decisions?

Mary: Well I, I think about money every day, I worry about money every day, and what I say is I'm a very good money manager, but you can only manage money if you've got money to manage.

(Kirkhead, low income)

Unlike more affluent respondents in the study, the six respondents living on benefits are obliged to stick to a very tight budget in order to manage financially. Their interviews show that having very limited financial resources means that these respondents are prevented from being able to plan ahead financially – instead they reported that they have no option but to live from week to week and from month to month:

Lizzie: I mean if you're needing a pair of shoes and you cannae afford it that month, you don't get it, you just say well I have to wait, and so you wait, and then uh...and that's sum and total of it, you don't get yourself running up all these debts and everything, I just say no, I'm not going to do that, well I don't...

LA: And how does it make you feel when you, for example need a pair of shoes and you can't get them?

Lizzie: I suppose it depresses you at the time.

(Kirkhead, low income)

Celia: When you have no money you can't actually have a routine, uh, you have to, you are ruled very much by when you get your giro.

(Kirkhead, low income)

Furthermore, these women indicated in their accounts that building up any savings is virtually impossible, as there is very little spare money left over at the end of the month. The lack of a financial 'safety net' is a further health-relevant dimension of financial insecurity that serves to exacerbate the material health risks experienced by these respondents. For example, unexpected financial outlay, even if the actual monetary value involved is relatively small, may have serious consequences for their other household expenditure. As such, this can be an acutely stressful experience:

Jean: And we've had like 6 bus fares this week, now that's £3, £4.20 or something, yeah £4.20...so I found this screwed up £5 note and sent him off to the bank to get change. But that was touch and go, I would normally not have had that £5 note at all.

(Braemore, low income)

LA: Coming back to think about money a bit more, do you ever worry about money?

Morag: Sometimes, especially when the blooming council, we were paying £18 council tax, we got a letter last week and we have to start paying, we have to make one payment of £67 and 5 payments of £65

[...] **LA: Right, so what will you do, how will you pay it?**

Morag: Well I'll just need to scrimp the money together and pay it, cos if you dinnae pay it they'll take you to court for it and then you're a damn sight worse off [...] Gus [*husband*] said to them "am I supposed to give you £67 and I'm left with about £7 to feed my wife and son?"

(Kirkhead, low income)

A theme running through the accounts of respondents who live on benefits is that the difficulties and stresses of living on a low income are compounded by the insecurity that comes from periodic changes to benefit entitlement, particularly in the case of benefits such as Disability Living Allowance:

Lizzie: I've been kind of short of money, getting that knock back with the money has knocked me down a bit, so I'm like onto £270 completely, whereas I had £270 plus £148, which was my mobility allowance, which helped. It also helped pay for my bus pass, and if I needed a taxi I could get a taxi. Now I just couldn't afford a taxi, being quite truthful, and I've still not heard, I got a letter saying that it would be 11 weeks before they would re-look at the DLA, but I don't think I'm gonna get it, so I'm just starting to base myself back on this £270.

(Kirkhead, low income)

Jean: The financial things over the last couple of months have been very stressful too.

LA: Right, what's been happening?

Jean: Well with Richard [son] leaving school and not getting into college, that means that I lost the child benefit, the one parent benefit, some of my incapacity benefit, and Nick [ex-husband] is no longer legally bound to give us anything.

(Braemore, low income)

The data presented so far indicate that, for several respondents, living on a low income engenders a sense of financial insecurity. Not only does this insecurity expose them directly to health risks located in the material environment, but it is also experienced as being stressful. In their accounts, respondents both implicitly and explicitly suggested that the stress of financial insecurity undermines their sense of well-being. Furthermore, two of these women also made connections between the stress of financial insecurity and their physical state of health:

LA: Do you think things happening with your health have ever been connected to other things that were going on in different parts, areas of your life at the same time?

Mary: Yeah, I think um...for example, when I was worrying about money, right at the beginning I think that made my back worse, because you're so tensed up, so obviously your back's going to go into spasm isn't it.

(Kirkhead, low income)

Celia: You're constantly worrying [about money] and that brings you down both mentally and physically

LA: **And do you feel with him [husband] that his health has been affected by the situation?**

Celia: Terribly, yes, uh...very much so and being physically ill makes you depressed anyway and of course it's a vicious circle because um...you're so worried about your future.

(Kirkhead, low income)

In this section I have contrasted the accounts of the most and least affluent respondents, and illustrated how the theme of 'money worries' is used by respondents to indicate whether or not they feel financially secure. The perceived impact upon well-being of feeling financially secure is not explicit within the data from the affluent respondents in the Braemore sample. However, data constructed by relatively deprived respondents in the Kirkhead sample offer much more obvious indications of psycho-social processes through which low income and poor well-being may be linked. The data suggest that low income engenders a sense of financial insecurity, which is experienced as being stressful, with potentially deleterious consequences for well-being and even physical health (Pearlin, 1989; Walters, 1993; Wilkinson, 1996). In the next section, I move on to consider the notion that a sense of financial security is not necessarily related solely to absolute income level, but that perceptions of relative access to financial resources may also be relevant.

4.6.2 Relative income, financial (in)security and health

Adopting a lifecourse perspective for this research means that it has been possible to elicit accounts of the dynamic 'financial pathways' through which the respondents have 'arrived' at their current financial circumstances. Data gathered on this topic indicate that respondents' current levels of income and wealth reflect particular processes of accumulation and depletion of financial resources over the course of their lives. This is important because the respondents' accounts suggest that their perceptions of their current financial situations are related to their socio-economic circumstances over the course of their lives - both in childhood and throughout adulthood. In this section, I assert that respondents' perceptions of the

relative state of their current financial circumstances may have psycho-social implications for their health and well-being.

There are indications within the data that those respondents who reported feeling financially secure tend to be women whose financial resources match both the financial demands that they face and the expectations that they have with regard to their standard of living. These expectations may be understood to be rooted in the women's experiences of particular socio-economic circumstances in childhood and over the lifecourse, and thus are derived more from relative and contingent understandings of affluence and poverty than from absolute notions of poverty and wealth. For example, those respondents who were brought up in middle class, affluent families tend to have higher expectations regarding the standard of living they feel they should currently enjoy, compared to respondents who were brought up in relatively deprived families. Thus, even respondents whose actual incomes and/or assets are relatively low may claim to feel financially secure, if their standard of living meets their expectations. Conversely, more affluent respondents might perceive themselves to be financially insecure if there is a 'gap' between their standard of living expectations on the one hand, and their financial resources on the other; this sense of insecurity may serve to undermine their sense of well-being (Boyle et al, 1999).

Dissonance between the respondents' expectations and the reality of their financial circumstances may have been engendered by particular life events which have resulted in changes in respondents' financial circumstances (for better or worse). These events include marriage, divorce, job loss, illness and moving house; they represent key points in the lifecourse when financial resources may be accumulated or depleted. Those respondents who reported that particular life events have had a negative impact upon their financial circumstances also tended, regardless of their absolute levels of current income and wealth, to indicate in their accounts that they now feel relatively financially insecure. On the other hand, those respondents whose financial circumstances have improved as a result of particular life events, tended to indicate that they currently feel financially secure, even if their

incomes are not very high. These data point to the importance of the respondents' perceptions of their own relative wealth over the lifecourse.

The notion that financial security is contextualised, contingent and subjective in nature is further supported by data indicating that respondents on similar incomes may perceive their level of financial security very differently. Below, I present a series of vignettes which relate the stories of four respondents, all of whom are in the 'middle' income category. The vignettes trace these women's lifecourse financial trajectories, and present data which indicate how they perceive their current financial situations.

Vignette 4.1 Ellen's story of upward social mobility

- *Ellen, a Kirkhead respondent, was brought up in a working class family, in which money was tight:*

They [*parents*] weren't sort of rich, you know, I think they struggled basically

- *Ellen is married; she and her husband both work full time. She explained how she views their financial circumstances:*

I think we're quite comfortable, but obviously we don't have the added worry of having children and things like that, you know . The only unexpected bills I have at any time is the cats, if one of them has to go to the vet [...] but the money would be there to pay for it, it wouldn't be a worry.

Vignette 4.2 Jacqueline's story of downward social mobility

- *Jacqueline, a Braemore respondent, was brought up in a relatively affluent family.*
- *She married a man in a professional occupation. However, they divorced shortly after their first child was born. She has combined working and parenting for the past 20 years. She commented:*

I'm certainly not living now at a level that I would have expected to have lived at if I'd been married, for instance if I'd remarried or if I'd married somebody else.

- *Jacqueline's income now falls within the "middle" category. She described her current financial situation in the following way:*

I think the bottom line is if I had a little bit more I would be comfortable, I wouldn't have to worry to the extent that I do now, but I don't worry to any great extent and I certainly don't worry as much as some, and um if things are tight there's always somebody to share it with, you know so it's not, it's not desperate, and when you look at it on paper, I've just been remaking my will, and looking at it on paper, it's actually not bad really, it's not hopeless, which it might have been. I get nervous about it sometimes, but not very often now

Vignette 4.3 Ruth's story of upward social mobility

- *Ruth, a Kirkhead respondent, was brought up in a working class family and she says this about her childhood circumstances:*

We didn't have a lot of money as in to have fancy things, but we always had good food and we always were dressed, we maybe only had 2 or 3 outfits, but we always had a Sunday outfit, for going to church.

- *Ruth is now married, and she and her husband both work full time. She describes her current financial circumstances in the following way.*

Since I've been married I've never had to do without anything, I've been very very lucky, um[...] I mean like I could go and buy a top or a dress, if I was going out this weekend, if I went down town today I could buy a top and not feel guilty, or worry about the money.

Vignette 4.4 Kirsty's story of downward social mobility

- *Kirsty was brought up in a comfortable, middle class family. She described her childhood in the following way:*

We would be considered upper middle class in that we were you know comfortably off [...] we had a car and we had a television [...] and you know a washing machine and that kind of thing.

- *Following divorce, Kirsty's access to financial resources decreased. She moved into Kirkhead because the housing was affordable. Thus, her stock of housing wealth is lower than when she was married:*

It's unfortunate that my life has always been down, down, down, I haven't quite reached the stage, people normally go up, up, up with properties, you know.

- *Kirsty works full time and her income falls within the middle category. She described her current financial situation in the following way:*

I'm very bad at maybe extravagances and um...you know liking a nice standard of life [...] I should maybe have savings put away for the day that maybe you know, but I feel that I have insurances, my salary is covered if I'm off work for a year or something full pay and six months half pay, something like that . And because I have this illusion that I'm not going to be ill and I'm going to be alright, I don't think ahead too often on that score. Every so often it does hit me and I panic a wee bit inside... I think it's only natural because I'm on my own.

Jacqueline and Kirsty's experiences of downward social mobility, and their subsequent feelings of financial insecurity contrast with the experiences related by Ruth and Ellen, who have experienced upward social mobility over their lifetimes, and now feel financially secure. Taken together, the vignettes suggest that a sense of financial security is shaped by relative as well as absolute ideas about living standards (Boyle et al, 1999; Tarlov, 1996).

In summary, the data presented in this section suggest that financial security may contribute to well-being, whilst financial insecurity may serve to undermine well-being via the stress which insecurity engenders. Respondents' accounts indicate that there is not necessarily a linear relationship between income levels and a sense of security, although absolute income levels seem to be the biggest influence upon

financial security for the very poorest respondents. What the data do suggest is that individuals judge themselves to be financially secure or insecure on the basis of subjective perceptions of social relativities. These findings help to illuminate some of the psycho-social processes through which relative income may be linked to health and well-being.

4.6.3 Relative income, social participation, and well-being

In Section 4.4 I discussed the influence of absolute income levels upon the choices that respondents are able to make with regard to their material standards of living. In that discussion, I commented that respondents perceive that their access to financial resources either enables or constrains their level of choice in terms of participation in social practices; for example, going on holiday, going on nights out, and buying particular sorts of food. These practices are perceived by respondents as having an intrinsically enhancing influence upon quality of life and well-being. Here, I suggest that there may also be psycho-social implications attached to whether or not one can afford to participate in such activities. These activities are outward markers of one's ability to participate in the perceived norms of one's social group, and those of wider society as a whole. Whereas relatively affluent respondents can afford to engage in particular activities and thus demonstrate their 'belonging' to a dominant social group, relatively deprived respondents lack the financial resources required to engage in activities which are designated as part of 'everyday life' according to prevailing social discourses. In other words, they experience social exclusion (Shaw et al, 1999b).

The psycho-social dimensions associated with social inclusion/exclusion are more evident in the accounts of respondents who perceive themselves to be relatively deprived, rather than those of more affluent respondents. Less affluent respondents demonstrated a keen awareness of the ways in which their perceived relative deprivation prevents their participation in social life. Their accounts suggest that this sense of being relatively deprived or marginalised has deleterious effects upon their well-being. For example, the following quotation is an account from Jacqueline that was prompted by a general question about whether she thinks that money can

influence health. The first part of Jacqueline's answer (not shown) was offered in generalised, abstract terms. She then went on to say the following:

LA: Do you think that the level of income or wealth that somebody has can influence their health chances?

Jacqueline: [...]For example, I've had to be very careful about um going to the theatre or some sort of cultural event, very often I've had to say no because I couldn't afford it, um now I'm not saying that my health would have been better if I'd gone, but it's having choices, and maybe it takes a lot of pressure off if you know you have those choices [...]and if you feel that you are marginalised or different from others around you, that can be quite difficult too.

(Braemore, middle income)

Jacqueline's comments about feeling marginalised are echoed by accounts from respondents from the Kirkhead sample, whose incomes are low:

Linda: I do [*think*] you know "why, why do they [*other people*]...not maybe sail through life, but why are they able to live a good, have a nice house, go holidays and the like, not have to worry about..."

LA: So it doesn't seem fair sometimes

Linda: Yes, sometimes I think it's very unfair, but....who are we to, who am I to....judge you know.

(Kirkhead, middle income)

Fiona: I've never had a car, I see people with cars and I think I am a bit selfish that way because I think to myself, oh wouldn't it be nice to drive, then I could go up to my mum and say "right mum I think I'll take you away down to North Berwick the day and sit on the beach", just to get away from it all, but I can't drive when I've not got a car, so I think well I haven't got it and that's it....but they kind of things set in, I think.

(Kirkhead, low income)

Celia: You feel so envious and sick at heart with what everybody else has, is able to buy in their trolleys.

(Kirkhead, low income)

Comments from these women, about things seeming "very unfair", about the experience of inequality "setting in", and about feeling "sick at heart", are clear and poignant examples of how well-being might be bound up with the experience of relative deprivation. These subjective responses to being at the 'wrong end' of the

social hierarchy seem to reflect the core of Wilkinson's arguments about the deleterious consequences of social inequalities (Wilkinson, 1996).

Analysis of these data suggests that there may be two overlapping mechanisms or pathways through which the connections between financial resources, 'choice' and well-being may be understood. Firstly, I suggest that living on a low income restricts the freedom of individuals to participate in a range of social activities that, in and of themselves, are perceived by these individuals to offer opportunities for the promotion of well-being – for example, going on holiday or engaging in a hobby that requires some financial resources. Thus, poorer people have fewer opportunities to engage in activities which would promote a sense of well-being. Secondly, individuals' restricted opportunities for the promotion of well-being do not exist in a vacuum; the women's accounts clearly indicate that they are acutely aware of social inequalities in access to material resources. For less affluent individuals and social groups within society, the process of comparing one's own situation with wealthier individuals and social groups may serve to reinforce a sense a personal disadvantage; this may be stressful and consequently may undermine well-being. The data presented here confirm the importance of considering psycho-social dimensions associated with the experience of social inequalities in the study of health inequalities. As Macran et al comment:

...the low morale and psychological debilitation attending social deprivation is as much a precursor of premature death as is physical sickness, not only as a health problem of itself but as a stage from which people never recover.
(Macran et al, 1996: 1214)

The analysis presented in this section suggests that there are psycho-social mechanisms linking the experience of relative deprivation with poor health. In the next section I draw on data to argue that it is necessary to be mindful that the psycho-social links between relative income, health and well-being are not necessarily straightforward.

4.7 The complexity of lay understandings of the links between money, health and well-being

Data presented in Section 4.6 indicate that relative income may shape health and well-being via psycho-social process; being relatively affluent may enhance well-being, whereas the experience of relative deprivation may deplete well-being. However, there is also evidence in the data that the psycho-social dimensions of the relationship between relative income and well-being are complex, and may operate in unexpected ways. This is vividly illustrated by Sarah, one of the Braemore respondents whose income falls within the ‘high’ category. In the following statement, she suggests that having a high income brings its own psycho-social pressures and insecurities:

Sarah: I think that working class people don’t realise the pressures that middle class people are under [...] we’re lucky because we have choices, I mean that is the thing we have, I think in some ways we have too many choices, in some ways that itself causes problems. Certainly if you live in a council house you don’t have to worry about you know things like insurance, you don’t have to worry about there being dry rot in the roof, you don’t have to worry about you know which...should you stay in the house you’ve got and send your children to a private school or should you move on and send them to the local school, just 101 things like that that you get, you have so many insurances you know, if you’re in a well – paid job you then have to take out insurances because you’ve got so many, a big mortgage that you’ve got to cover in case you lose your job and all that sort of sickness insurance and injury, you know whatever, covering this, that and the other, so you are paying so many things that they don’t ever have to think of, because you are middle class and you have to sort of keep your, maintain your standard of living.

(Braemore, high income)

Here, Sarah acknowledges the material benefits that relative wealth brings, in terms of the choices available to her. However, she also hints at the financial and psycho-social pressures that may result from feeling obliged to ‘keep up’ with the practices and cultural norms associated with a ‘middle class lifestyle’, such as sending children to private school, paying a large mortgage, and paying for insurance policies to safeguard future income. Sarah’s account is a rare, but illuminating

example in the data of how there may be psycho-social dimensions to the experience of relative affluence that threaten to undermine, rather than enhance, well-being.

Further examples of the complex ways in which socio-economic position is actually experienced are found in the accounts of the least affluent respondents in the study. Section 4.6 presented data which illustrate how limited access to financial resources may generate psycho-social stress, which in turn may be understood to undermine well-being. However, there are tensions and contradictions in the data. Another theme running through the accounts of the least affluent respondents is a denial that their financial circumstances actually have any significant bearing on their state of health and well-being. These sentiments were usually articulated in the context of directly asking the respondents about their financial concerns and priorities. In this context, respondents tended to draw more explicitly on absolute notions of poverty. Over half of the respondents in the lowest income category implied in their accounts that they do not ‘really’ worry about money, because they can afford to pay for essentials such as housing, food and fuel bills:

LA: It seems like what you’re saying is that it [money] affects your quality of life

Lizzie: Yeah, I suppose it does, cos if you’ve no got the money you cannae do things, but it’s not as I say the be all and end all of everything. If you’ve got something to live on, you’ve got enough money to get you food, a roof over your head, and you can get out and about...I think health’s more um...thingummy than money, it’s more important than money. Cos if you’ve no got your health, you cannae do anything.

(Kirkhead, low income)

LA: Have there been particular situations where it’s been worse than others?

Jean: Yes, but ...we've never been destitute, we've never, we've always had a roof over our heads and we've always been able to eat, even if it has been really bad stuff.

(Braemore, low income)

There is a sense in some of these women’s accounts that, over time, they have become used to living on a low income; therefore, money issues have ceased to be a major source of stress. Respondents tended to express this attitude by saying that they don’t worry about money because their current expectations regarding their

standard of living are realistically in line with their financial resources. The range of quotations presented below illustrate these respondents' active denial that living on a low income is a significant source of worry in their lives:

Rachel: I don't miss that sort of purchasing power because I've never had it and I'm not that fussed really, I mean as long as I've got enough to pay my fuel bills and I'm not, as long as I'm not cold ...you know, if I was actually not being able to afford to put the heating on and I was being cold in my home, or hungry you know or whatever, um...I don't, I'm not too bothered.

(Braemore, low income)

LA: And if you had more money, say double the amount of money that you have, what would you choose to spend that on, do you think?

Morag: ...I dunno...that used to having no very much that it doesnae bother...oh if we were both working we would be able to get things that we cannae afford to get now.

LA: Yeah, what kind of things?

Morag: ...well we used to have a car and there's no way that we can afford to have a car now.

(Kirkhead, low income)

LA: Do you feel that a concern for money affects your day to day decisions?

Fiona: At one time in my life it did because if I didn't have enough money to pay things I would get quite upset, I would start to say "well next month maybe I should do it this way and that way" and that affects how you feel, cos if you've got a worry problem, it revolves around everything.

LA: Yeah...do you ever worry about money now?

Fiona: No, because I know what I'm capable of doing at work, I know what I've got to pay out, I pay everything out and as long as I've paid my rent and my community charge and buy food and get by, I'm fine (**yeah, yeah**) I don't go out and buy a lot of clothes and I don't go holidays, it'd be nice to have a wee bit extra but I just haven't got it, so my kind of day is, everything's paid when I get paid, I'm happy. Anything I've got extra is just for you know things we need.

(Kirkhead, low income)

Within accounts from this subset of respondents, the apparent denial that their restricted access to financial resources may have implications for their health and well-being may be interpreted in different ways. Realistically, these respondents are not able to afford much more than housing, food and fuel costs, and so it could well

be that as long as they have managed to pay for these essentials, they genuinely do not worry about other, more peripheral expenditure.

However, these comments may also be understood as active attempts by respondents' to construct their identities as 'not poor'. The concept of absolute poverty implies a threshold of basic material living standards, above which individuals are not considered to be poor. By focusing on their ability to afford housing, fuel and food, these respondents may be engaged in active strategies to resist portraying themselves as being poor, although in other contexts they may nevertheless acknowledge their relative disadvantage to a certain extent. Given that poverty is a stigmatised and stigmatising condition, it may be of psycho-social importance to these respondents to be able to construct an identity through which they can distance themselves from socially stigmatised 'others' – i.e. 'the poor'. To describe themselves as poor would be to threaten their social identity (Blaxter, 1997). Thus, emphasising their ability to buy food and keep a roof over their heads might be understood as an active process through which these respondents exert their agency in order to protect their psycho-social well-being (Gatrell et al, 2000).

These data suggest that it is potentially important that these respondents are able to compare themselves favourably against social groups even worse-off than themselves. This is a theme that I explore again in Chapter Seven, where I suggest that respondents in Kirkhead engage in similar processes of identity construction in the context of talking about their experiences within their (relatively stigmatised) local neighbourhood.

4.8 Conclusions

In this chapter I have explored some of the ways in which respondents understand their access to financial resources to interact with their experiences of health and well-being. I have presented data on the respondents' reported current income, which indicate that the most affluent respondents in the study live in Braemore, whilst generally, the least affluent respondents in the study live in Kirkhead. The importance of considering forms of wealth other than income when investigating the relationship between financial resources and health has been highlighted. Data presented in the chapter have also illustrated how the adoption of a lifecourse perspective, which sheds light on the dynamic nature of access to financial resources over time, may enrich interpretations of lay accounts of the links between money, health and well-being.

The discussion presented in this chapter has explored three main themes within the data which relate to links between access to financial resources, health and well-being. Firstly, I have considered what money can buy - material pathways between money and health. Secondly, I have presented data which indicate that engagement in health-related behaviours is shaped by the respondents' socio-economic contexts. Thirdly, I have explored psycho-social mechanisms through which relative income may influence well-being, highlighting that psycho-social dimensions associated with the experience of relative affluence or deprivation are complex in nature. Overall, discussion of all three of these themes has illuminated how the contrasting health profiles of the two sample groups may be related to their unequal access to financial resources.

Chapter 5: Resources for health and well-being (ii): Work

5.1 Introduction

Paid employment (or the lack of it), is widely acknowledged as a significant feature of the social context of individuals and communities, and one which is strongly related to health outcomes (Blane et al, 1996; Marmot et al, 1999). Employment status is closely linked to the income of individuals and households, and many measures of social class are derived from occupational categorisation (Bartley et al, 2000; Emslie et al, 1999). As a result, understandings of health inequalities may be enriched through the study of the social patterning of employment experiences. In recent years, a considerable literature has accumulated concerning the implications of a variety of employment situations (paid/unpaid work, domestic labour, unemployment, insecure employment) for both physical health and psycho-social well-being. Numerous studies have indicated that both employment status and working conditions exert powerful influences upon health and well-being (Karasek & Theorell, 1990; Marmot et al, 1991; Marmot et al, 1997). Whilst the relationships between gender, work and health have been problematised and explored, this literature is not as extensive; many aspects of the health implications of women's work experiences remain to be investigated and understood (Bartley et al 1992; Emslie et al, 1999; Hunt & Annandale, 1993; Walters et al, 1997).

Quantitative research based on survey data has revealed statistical associations between, for example, employment status and self-reported health (Arber, 1991; 1997). However, these studies reveal little about how particular employment statuses are actually experienced within the context of individuals' day-to-day lives, or about whether and how lay actors understand their working conditions to influence their health and well-being. In a similar vein, although longitudinal studies such as the Whitehall I and II studies give a strong indication of how employment status and working conditions may influence mortality and morbidity over time, they are nevertheless designed to offer 'snapshots' at different points in time (Marmot et al, 1991; Marmot and Davey Smith, 1997). Thus, they do

not fully capture the dynamic nature of employment trajectories throughout the lifecourse, and offer little insight into how such trajectories are actually experienced by individuals as influencing their health and well-being (although an exception is Marmot et al (2001)).

The aim of this chapter is to discuss respondents' accounts of their lifecourse experiences in relation to the labour market, and to explore interactions between their experiences of paid work and their experiences of good health and illness. In so doing, my intention is to consider the significance of employment situations as socially structured contexts through which health inequalities might be generated and/or sustained. Discussion of the data is divided into four sections.

In Section 5.2 I present a brief overview of the respondents' current employment situations. This illustrates the outcome so far of respondents' employment trajectories over the lifecourse – trajectories that are linked in complex ways to the women's socio-economic contexts, their experiences of various life events, and their health and well-being over time. I then go on in Section 5.3 to discuss their retrospective accounts of their entry to the labour market – the starting point of these trajectories. This is important in the light of previous research findings which suggest that health inequalities between social groups in different occupational classes are generated at an early age, and may persist over the lifecourse (Blane, 1999; Wadsworth, 1997).

Section 5.4 introduces a central theme within the data; namely the influence of paid employment upon respondents' health and well-being throughout the lifecourse. In Section 5.5 I consider of working conditions on physical health; in Sections 5.6 and 5.7 I focus upon accounts of the influence of paid work upon well-being. I then move on to explore in Sections 5.8 and 5.9 how episodes of acute and chronic illness have had different consequences for individuals' employment trajectories according to their location within the labour market.

Many of the analytical points presented in this chapter draw on data from a relatively small number of respondents. There are four respondents in particular

whose accounts feature throughout the chapter: Lizzie and Josie, from the Kirkhead sample group, and Hattie and Jacqueline, from the Braemore sample group. Accounts from this subset indicate that there have been several points throughout their lives when their experiences in the labour market have intersected with their experiences of health and (more usually) illness, in ways which they themselves view as significant. The experiences reported by these women are not widely represented throughout the rest of the data. However, they are important because they illuminate interactions between health and labour market experiences which may operate on a larger scale.

Throughout the chapter, I attempt to demonstrate that in order to understand the relative importance of 'work' as a dimension of the respondents' lives that has contributed to the building up and wearing down of their health over the lifecourse, it is necessary to consider the respondents' work experiences in the context of the wider 'web of resources' in which their lives have been embedded. In other words, it is important to consider the ways in which the respondents' experiences of paid and unpaid work have been linked into wider networks of health-relevant events and situations over the lifecourse.

5.2 Current employment status

In total, eighteen out of the twenty-four respondents are currently engaged in paid employment. Of these, eleven respondents are in the Braemore sample, and seven are in the Kirkhead sample. Amongst the Braemore sample in paid employment, eight women described their jobs as part-time (although the number of hours worked per week varies considerably amongst these respondents), and three described themselves as working full time. The one respondent in the Braemore who does not have a paid job explained that this is because she suffers from chronic illness – in other words she described her employment status as 'permanently sick'.

Of the seven respondents in the Kirkhead sample who have paid employment, five work full time, and two work part time. Five women in the Kirkhead sample do not have paid employment. When asked to choose from a list of options regarding

how they would describe their employment situation, three of these five women described themselves as unpaid domestic workers, one described herself as permanently sick, and one described herself as both permanently sick and a part-time voluntary worker. It is interesting to note that all five of these women suffer from chronic illnesses which limit their day-to-day activities; however, only two women chose to describe themselves as 'permanently sick' with regard to their employment status. Table 5.1 presents the range of current occupations reported in each sample group.

Table 5.1 Respondents' current occupations

Braemore (n in paid work=11)		Kirkhead (n in paid work= 7)	
Full time	Part time	Full time	Part time
Nursing sister Personal Assistant (2 respondents)	Pharmacist Secondary school teacher Charity development worker Counsellor/proof reader Childminder Staff nurse Voluntary children's worker Cleaner/carer	Library officer University lab technician Auxiliary nurse (2) State enrolled nurse	Receptionist Pub landlady

Given the small size of the sample groups, it would be unwise to attach too much significance to the number of respondents who reported particular employment situations. However, it is possible to point to general similarities and differences both within and between the two sample groups. For example, nursing is the most common occupation within the sample group as a whole. However, the two respondents within the Braemore sample who are currently employed as nurses are more highly qualified and work at higher grades (staff nurse and sister) than the three nurses in the Kirkhead sample (two of whom are auxiliary nurses, and one who is a state enrolled nurse). On the whole, respondents in the Braemore sample work in higher status and higher paid jobs than those in Kirkhead.

However, there is some diversity within each sample group in terms of the respondents' occupations. Not all of the respondents in Braemore work in high status or highly paid occupations; for example, one respondent is a cleaner, and another respondent works part-time for a charity and earns less than £40 per week. Similarly, not all of the respondents in Kirkhead work in low status occupations; one respondent is a library officer, and another owns several pubs in Edinburgh.

In order to understand the processes through which respondents have 'arrived' at their current positions in the labour market, and how this may relate to their lifecourse experiences of health, illness and well-being, it is illuminating to trace key elements of their trajectories through the labour market from the time that they left school.

5.3 Leaving school and entering the labour market

A number of studies have highlighted the significance of educational attainment for future socio-economic status (Arber, 1997; Wadsworth, 1997). Children who stay on at school beyond the minimum leaving age are more likely to go on to tertiary education and to secure higher occupational class positions than children who leave school at the minimum leaving age with few or no educational qualifications. The data gathered in this study appear to be consistent with these research findings. The contrasts between the two sample groups in terms of their current occupational status seems to reflect the different positions of the two groups of women within the labour market from the time that they left school. Table 5.2 shows the school leaving destinations of respondents in both sample groups.

Table 5.2 School leaving destinations

Braemore respondents			Kirkhead respondents		
Name	School leaving age	First post-school occupation	Name	School leaving age	First post-school occupation
Jacqueline	16	Domestic science college	Morag	15	Printing factory
Rachel	16	Trained as a hairdresser	Lizzie	15	Assistant in a chemist shop
Jean	16	Shop assistant	Tania	15	Home help
Hattie	16	Nursing training	Ellen	16	Nursing training (did not complete)
Marion	17	Nursing training	Ruth	16	Office junior
Sarah	17	Nursing training	Shona	16	Office junior
Christina	17	Trained as an orthoptist	Fiona	16	Printing apprenticeship
Carol	18	University	Linda	16	Shop assistant
Esther	18	University	Mary	16	Nursing training
Diane	18	University	Josie	16	Clerical assistant in civil service
Pam	18	Trained as an occupational therapist	Celia	16	Beautician training
Stella	18	Trained as a pharmacist	Kirsty	18	Library service

Table 5.2 indicates that, on the whole, respondents within the Braemore sample group - most of whom now occupy relatively high socio-economic positions, left school later, and with higher qualifications, than respondents in the Kirkhead sample. They were also more likely than respondents in the Kirkhead sample to enter higher education or professional training. For example, four of the women in the Braemore sample acquired sufficient qualifications to go to university after

leaving school. A further three women in the sample obtained enough Highers or O-levels to enter nursing training from school, and two women trained in allied medical professions after leaving school, both of which required Highers or A-levels. By contrast, the majority of respondents in the Kirkhead sample left school at the minimum leaving age without formal qualifications; only two of the women within the Kirkhead sample obtained at least one Higher or equivalent. Now, Kirkhead respondents are likely to be employed in relatively low-skilled and low-paid jobs, if they are currently in paid employment at all.

5.3.1 Socio-cultural influences upon entrance to the labour market

The respondents' accounts of leaving school suggest that the educational and employment opportunities available to them were shaped by a variety of socio-cultural influences associated with their life circumstances at the time. For example, respondents in both sample groups indicated in their accounts that their school-leaving destinations were strongly influenced by other people's expectations, a factor that I interpret as being part of the prevailing socio-cultural contexts in which the respondents grew up. In Table 5.3, quotations are presented which suggest how cultural expectations rooted in the respondents' childhood socio-economic circumstances may have influenced the occupational sectors that they joined upon entering the labour market.

Table 5.3 Socio-cultural influences upon the respondents' entrance to the labour market

Braemore respondents	Kirkhead respondents
<p>Diane: There was an assumption that I would go to university but I don't remember much beyond that being thought through, you know, or talked about.</p> <p>Esther: It was decided when I was at Newcastle in the grammar school that I was going to be a mathematician, as I was very very good at Maths and they decided that I was the best mathematician that they had ever [had], they actually wanted me to go to Cambridge to do Maths [...]because I hadn't known what I wanted to do, the decisions were made for me and that was it.</p> <p>Hattie: When I left school I wasn't old enough to start nursing, and I went to college...I didn't want to stay at school because I didn't like school, and so I asked my parents if I could do something else, and they said "well you go and investigate and you find out what's available, discuss it with us and if it's something that we think is appropriate we'll consider it.</p>	<p>Celia: One of the English teachers asked my father if she could put me forward for a red brick university, they were just coming on the market then, Esher University. He said no, he didn't believe in girls being educated, he believed in them taking girly jobs like uh you could be a hairdresser, you could be a nurse, but they couldn't go on to anything academic.</p> <p>LA: And how did that make you feel? Celia: Awful, I could cry.</p> <p>Fiona: The last day of my school holidays I took the afternoon off, and I went to Slateford and I knew there was a printing firm there [...]I got interviewed with my boss, and he said you've got the qualifications to start in the clerical side, I says no, I'd prefer to take a trade. In they days if you took a trade you had three years training but the money at the end of that was better than the typing skills , so I went for a three years trade and I started that Monday.</p> <p>Shona: I think it was considered in our street if you went into an office you know you were really special.</p>

The accounts from these six women reveal the importance of parental attitudes to education and employment. Diane, from a middle class background, talked about there being 'an assumption' that she would go to university. In a similar way, Hattie reported discussing her educational options with her parents, and being encouraged by them to find a course that she would like to do. These accounts suggest that cultural attitudes within the family are important in shaping labour market position. This theme is supported by Esther's account. Her family were working class, but they placed a high value on education. Esther's account also

indicates that her teachers played a significant role in determining her entry to university.

By contrast, Celia, from a working class background, reported being forbidden by her father to pursue university entrance, even though this was what she wanted to do. Shona and Fiona are also from working class families. Their accounts do not refer directly to their parents; however, they hint at prevailing cultural assumptions about the sort of work that would be appropriate for young women at the time. Shona referred to cultural norms in her neighbourhood when she describes the social cachet associated with working in an office, whereas Fiona related how she was offered a clerical job in a printing firm, although her intention was to serve an apprenticeship.

Together, these data suggest the importance of childhood socio-cultural circumstances in shaping the respondents' entrance into the labour market. This is of potential relevance to the respondents' health and illness experiences in adulthood, given that occupational position is a key predictor of health status (Sweeting and West, 1995).

In the next sub-section, I consider accounts from a minority of women whose experiences of illness as young women were portrayed as having disrupted their entrance to the labour market.

5.3.2 Intersections between illness and entry to the labour market

In their retrospective accounts of their entry into the labour market, the respondents rarely, if ever, drew attention to the role that good health might play in securing employment. However, a small number of respondents referred to illnesses that they experienced as young women, which they put forward as a reason why their entry into the labour market was disrupted. Their accounts highlight the role played by structural factors in shaping the impact that the respondents' experiences of illness have had upon their employment status, even at the start of their working lives. Respondents in the Braemore sample, having generally obtained higher qualifications than those in the Kirkhead sample, were more likely to have entered

the labour market into occupations that offered job security in times of sickness. By contrast, less qualified respondents, most of whom are in the Kirkhead sample, tended to enter the labour market into poorly paid and relatively insecure jobs. Their accounts indicate that illness undermined their position in the labour market.

For example, three women in the Braemore sample took several weeks off work due to health problems, whilst they were training for professional jobs. None of these women indicated in their accounts that this had any negative repercussions in terms of their jobs, and they all completed their training. The following quotations are from two of these three respondents:

Esther: It was total nervous debility, I had manic depression, but it was just I mean it was like a clockwork toy being over-wound you know[...]it took me a long time to really recover...I mean I went back to teaching, my teaching course after 6 weeks.

(Braemore)

Hattie: I had been accepted to start nursing in April 68 but because of my glandular fever, my GP strongly advised me not to go into nursing in the April, he said that he didn't think that I would cope and that he thought I would end up leaving, so I did a mother's help job again [...] and then I started September 68 doing my nursing.

(Braemore)

By contrast, one woman in the Kirkhead sample recounted how she had lost her first job when she contracted TB and was admitted to hospital:

Lizzie: I actually got the job in the chemist shop [...]I left school on the Friday and I started there on the Monday[...] but 6 weeks into that, that was all disposed of, because I landed in hospital with the TB [...] I was really broken hearted when I lost the job in the chemist shop, but I had to go into hospital and I didn't know how long I was gonna be, and I was in for 3 months, so I lost the job altogether.

(Kirkhead)

Another example of how illness may disrupt entry to the labour market is provided by Jean, a Braemore respondent. Jean's account is unusual compared to other respondents in the Braemore sample group – she is the only respondent who reported suffering from chronic illness, and she is the only Braemore respondent who is currently not employed (due to her health problems). Jean's account indicates that

the health problems that she has suffered from since childhood have impinged upon the entirety of her working life. Her account indicates that her education (at a private school) was disrupted due to illness. She left school at 16 with one O-grade qualification. After two short-term jobs, working in a shop, she went to secretarial college. In the excerpt below, she describes how her training was disrupted by illness:

Jean: Dr C__ had said go be a secretary, so I thought well I'll go and give it a shot, 'cos he'll have to employ me! So I did, but I was ill.

LA: And this was still the colitis?

Jean: Yes, and then I went back and tried to do it the next year.

LA: Oh, were you not able to complete the year? And did you manage to complete it the second time?

Jean: No, no...that was 1973, the year I started, and 74 that I was um...halfway through the year I had to go back into hospital [...] I had the surgery then.

LA: And what did that involve?

Jean: That was removal of the large intestine, complete removal, and I have an ileostomy.

(Braemore)

In summary, these data offer an insight into how the impact of illness episodes upon respondents' entrance to the labour market were mediated by the nature of the occupational sector that they joined. This, in turn, was shaped by respondents' educational qualifications, which, as we have seen, was influenced by their family circumstances.

5.3.3 Summary

In this section, I have presented data which indicate that the respondents' current positions within the labour market, in terms of their occupations, are broadly similar to the positions which they occupied at the time of their entrance to the labour market. This suggests that current differences in socio-economic status between the two sample groups, as represented by the respondents' occupations, are at least partially rooted in circumstances and experiences that occurred at an earlier stage of the respondents' lifecourse. I have also offered examples of the interactions between illness and labour market entry. These demonstrate that even at the start of their

working lives, it was those respondents who were most socially advantaged in childhood who were in a better position to maintain their labour market position during episodes of illness. In Section 5.4 I discuss respondents' accounts of their experiences of interactions between work, health and well-being throughout the lifecourse.

5.4 The influence of work upon health and well-being

In Sections 5.5 – 5.7, I present data relating to different aspects of respondents' past and present jobs, which they report as having influenced their health and well-being. The data indicate three general differences between the two groups of women. Firstly, women in the Kirkhead sample have tended to work in employment sectors in which they have been exposed to greater threats to their physical health and well-being than respondents in the Braemore sample. Secondly, on the whole, respondents in Braemore have had access to a greater level of financial, personal and social resources over the course of their lives than respondents in the Kirkhead sample; these resources might be thought of as 'buffers' which have served to minimise the potentially health-damaging consequences of particular employment situations. Thirdly, respondents in Braemore are more likely to have been employed in jobs that they perceive to have enhanced their sense of well-being.

5.5 How working conditions may undermine physical health

There are relatively few instances in the data of respondents offering accounts of working conditions which they perceive to have posed a threat to their physical health. However, as might be expected, those respondents who did report such experiences were more likely to be from the Kirkhead sample, and they described working in physically demanding and poorly paid jobs. For example, in response to a general question about influences upon her health, one respondent in the Kirkhead sample referred to the impact that her working conditions throughout her life have had upon her health:

LA: Would you say that your health has been affected by things that have been happening in other parts of your life?

Lizzie: I was bothered with cystitis for a long time, off and on, and I reckon it was because I was working in the, in a canteen, where you were hot all the time and you were coming out and getting chilled, you know you were coming out for air, you were roasting and sweating and you were coming out and freezing outside, you were running about mad when you were in there as well. Catering is a very busy life [...] I think it's a hard working job and it takes its toll on you.

(Kirkhead)

Another respondent in the Kirkhead sample told a story of a situation where her physical health was put at risk due to her working conditions:

Morag: I was left with this woman and she wanted the toilet so I had no other option but to lift her myself. And she was much heavier and taller than myself and I hurt my back. And my husband said "right that's it, if she'll no' employ staff, that's it" [...] I had a bad back for ages, for about 3, 4 months, so they said that I would have to give up, that I would have to do that

LA: And did you get any kind of compensation?

Morag: No, she wouldnae pay you, she wouldnae pay you a penny more than she had to, and of course there was no industrial tribunals or anything like that then.

(Kirkhead)

Morag, in her account of working as a care assistant, portrayed herself as a victim of employer negligence - an understaffed nursing home proved to be a physically demanding (and hazardous) working environment. Furthermore, Morag's comments suggest that she perceives herself to have occupied a relatively powerless position in the labour market - she claimed that she was forced to leave her job, without legal protection or the opportunity for compensation.

On the rare occasions when Braemore respondents identified situations in which their working conditions have posed a threat to their physical health, they were more likely to report being able to take action to mitigate the effects of health risks at work. For example, Hattie reported that when she started to suffer from chronic back pain - an occupational hazard related to her job as a staff nurse, she had sufficient financial resources to be able to access a range of private health treatments.

which helped to alleviate her symptoms and allowed her to maintain her employment:

Hattie: I've tried chiropractic, I tried osteopathy, I tried physio [which] was the one that eventually gave me the most relief, because they were giving me exercises to maintain it myself. um, so I usually keep it under control, but I mean I was, again it was the sort of situation where I didn't realise how bad it was until it stopped, I didn't realise how chronic it had become, um, but I was having bother at work with it for a while.

(Braemore)

Hattie's account demonstrates how the impact of an occupational health problem upon employment status may be influenced by the wider social circumstances of an individual's life.

5.6 How psycho-social work environments may deplete health and well-being

Only a very small minority of respondents reported that the conditions and demands of their work have influenced their physical health. In contrast, several respondents in both sample groups offered accounts of jobs in which aspects of the psycho-social work environment have had an influence upon their well-being (and in some cases, upon their physical health as well). I first of all discuss accounts of psycho-social stress arising from experiences in the workplace. From the accounts, it seems that the ability, or otherwise, of respondents to protect themselves from the deleterious consequences of workplace-based psycho-social stress has been related to their labour market position, and to their access to a range of other health-relevant resources.

Respondents' accounts suggest that stressful experiences at work may be due to a number of factors. One of these is having a poor relationship with work colleagues, particularly with those in authority. The following two excerpts are examples of respondents making connections between stressful experiences with colleagues in higher grades, and physical health problems:

LA: I'm interested when you were talking about the kind of things that triggered the migraines off, bottling things up. What kind of situations would that be?

Lizzie: Um....things that happened in the work place when I was working and people just annoying me so much and usually it was people that was higher than me that I couldnae really say exactly what you wanted to say

LA: Mm, and how did that make you feel, when you couldn't//

Lizzie: //It used to make me feel very tense

LA: And what was actually happening physically when you felt tense?

Lizzie: I felt like hitting people actually, but I'm not a violent person, but um that is basically, you'll building it all up inside, you get tense, you get sore, your neck gets stiff, your arms get stiff, because I think you're holding yourself rigid, er you don't realise it at the time, but looking back on it now I can see why it happened.

(Kirkhead)

Hattie: The XX job was not a happy ward, that's my most unhappy nursing that I've ever done in my life, it was very much //

LA: Was it your shift-work?

Hattie: No, no it was very much the atmosphere in the ward it was actually the sister that was the problem[...] in fact I got so unhappy at one point that my husband said I should leave[...] it actually really affected my self-confidence, I began to think it was me, and it wasn't until I had left that I actually realised how bad it had got

[...] **LA:** Yeah, and did you feel like that stress actually affected your health at all?

Hattie: Um, I'm sure it did, it wasn't necessarily obvious, um, certainly I had several bad throat infections while I was working there[...] I wouldn't be surprised if that were to do with the situation there.

(Braemore)

In Hattie's account she indicates that she left her job as a result of the stress that she experienced in relation to her work colleague. Another respondent in the Braemore sample, Jacqueline, also gave an account of a stressful relationship with a senior colleague that led her resign from her job. Although she did not connect the stress that she experienced to her physical health, Jacqueline described how her emotional well-being was undermined by her experience of harassment at work, as follows:

LA: And how had that made you feel, that harassment?

Jacqueline: It made me feel very um insecure, it made me feel very stupid, it made me feel very angry that nobody did anything to support me, um it made me feel that I was wrong, that I was doing things wrong.

(Braemore)

Like Hattie, Jacqueline decided to change jobs rather than continue to work in a stressful environment:

Jacqueline: I remember thinking one day well stuff it, I'm not going to stand for this, so I just walked, I just went, and I was very lucky because there was a job going in XX and I got that, so I just went from one job to another.

(Braemore)

The fact that both Hattie and Jacqueline were able to respond to their stressful working situations (and thus perhaps protect their health) by leaving their jobs, apparently without a break in employment, is an indication of the relatively strong position within the labour market that both of these women have experienced over the course of their lives.

Being able to change jobs is one way in which respondents in the Braemore sample have been able to protect themselves from the potentially harmful influence of stressful workplace relationships. Furthermore, four relatively affluent respondents in the Braemore sample indicated that their husbands earn sufficient income that it has not been financially necessary for these women to work. This household financial security means that these respondents have been able to leave stressful jobs without the pressure of needing to find alternative employment. For example, Pam explains how she chose to leave a job when she was unable to resolve a stressful relationship with a colleague:

Pam: My relationship with this colleague wasn't good, she very early on within a week or so of my starting she began to ignore me, um...I found it extremely difficult to work with her and I stuck it out, tried to sort it out with her initially, with my boss, and uh I left finally because there was just no movement to speak of.

(Braemore, care worker)

At another point in her interview, when I asked Pam a general question about her views on the determinants of health, she made reference to this same work situation:

Pam: I think that I've been very fortunate in that I haven't had to work, um...that I could choose what kind of work that I wanted to do, and if I discovered, as I did at XX [previous employer] that it wasn't for me after 15 months, I was able to back down without er having to struggle in a stressful situation, so I think um that definitely would have affected my health.

(Braemore)

One of the central arguments presented in Chapter Four is that the respondents' access to financial resources throughout their lives has served to either constrain or enable the choices that they have been able to make about their lives. As Pam made clear in her account, her relatively privileged financial position has allowed her the freedom to make what she has considered to be health-protective choices in her working life. Another respondent in the Braemore sample who reported being able to make a similar health-protective choice is Stella, a locum pharmacist. Stella is married to a man who works in a professional occupation, and their overall household income is high. Stella reported that she reached a point in her life when she found travelling to work stressful; as she didn't need the money, she decided to cut back on her work commitments, and only agree to take on work if she wanted to. As with Pam, Stella's secure financial position has enabled her to avoid work-related stress through choosing not to work:

Stella: I found I was doing quite a lot in Glasgow and it just builds up and builds up, and I had sort of decided when I moved back to Edinburgh that I was going to step it down a bit [...] when I was doing it in Glasgow it was a bind, you had all the rush hour and all this carry on, and I thought "do I need this?", you know, and if you don't really need the money, you think "why am I doing this?".

(Braemore, locum pharmacist)

The experiences of these relatively privileged respondents contrast with the account offered by Josie, a respondent in the Kirkhead sample. Josie talked about her difficulty in maintaining her employment as a state enrolled nurse at a time in her life when she was suffering from prolonged anxiety attacks. When she was moved

from a ward she enjoyed working in to one which she strongly disliked, she believed that the stress of her job exacerbated these debilitating attacks to the point where she felt unable to continue working:

Josie: I had countless numbers of appointments at Cardiology at the Royal Infirmary, had 24 hour cardiac tape monitoring and they couldn't find anything physically wrong with my heart, they said it was just anxiety, just tension and anxiety was causing it. And when I moved down to XX ward, I mean that was just the icing on the cake, absolutely hated it, absolutely hated it. Um, I was taking time off work cos I wasn't well, I was feeling guilty because I was taking time off work, and I think one thing just exacerbated the other, and I ended up in the February, February 92 I think or thereabout, I handed my notice in, I said I just can't do this anymore, I can't do this job feeling the way I feel.

(Kirkhead)

As a single parent, Josie did not have the financial security of having a partner in paid employment, and she also had to find work that fitted around her caring obligations. As a consequence of leaving her job and taking on two part-time and relatively poorly paid jobs, Josie's financial situation worsened, as she explains in the quotation below:

Josie: When I stopped working in '92, and gave up the nursing obviously I took a great drop in salary, even though I had the two wee jobs that I liked, um...you know I was only just scraping by to make ends meet.

(Kirkhead)

Josie's account suggests that although she took action to alleviate one source of stress in her life - her job, this change in her employment resulted in financial hardship - another source of stress which threatened to undermine Josie's health and well-being.

My interpretation of these data is that the extent to which respondents' experiences of stressful situations at work may have impinged upon their health and well-being is interconnected with aspects of their wider life circumstances, such as their overall household financial situation, and their position in the labour market (Arber, 1997). These data are further supported by two contrasting accounts relating

to the experiences of job insecurity, which has been identified within the literature as a phase in the lifecourse which may pose risks to health and well-being (Ferrie et al. 1998; Marmot et al, 2001). The first account is from Carol, a careers advisor in the Braemore sample group. She described the effect that being paid off had upon her sense of well-being:

Carol: I think that being paid off um affected my mental health

LA: In what sort of ways?

Carol: Well I think that it was alright to begin with for the first couple of weeks, but after a while you start to lose your motivation for looking for employment, once you've tried and you've not been able to get a job, you start to wonder if you can do it, you know, so yeah, and I think self-esteem drops.

(Braemore)

Carol intimated that the stressfulness of the situation was exacerbated by a lack of social support:

Carol: One of my main friends was at that time working full time herself, and ...that, that was, from my point of view that was a shame, because I couldn't see her.

LA: Mmm, yeah, and did you feel like you could get support from your family?

Carol: [...] I didn't have either of my children at home, and so it was just my husband, and he is supportive, but um, not there during the day, and my mother certainly didn't understand I don't think.

(Braemore)

However, Carol's account also suggests that the potentially health-threatening material consequences of losing her job were mitigated by the fact that she and her husband have a high overall household income, with added financial support from her husband's parents. These favourable financial circumstances cushioned the impact of Carol losing her job:

LA: I just wanted to go back to this time when you were laid off work, did that affect your family's financial situation?

Carol: Um well it would obviously affect it, but it wasn't to the, it wasn't particularly detrimental because the um, from the point of view of my children and their university education, we had help from my parents-in-law, but that was, that was in place before I was getting paid off, so none of it was, it wouldn't have made much difference.

(Braemore)

Carol's account indicates that she perceives her experience of job insecurity to have undermined her sense of well-being, but without long term consequences for her health.

By contrast, Ruth, an auxiliary nurse in the Kirkhead sample group, made explicit links in her account between the stress engendered by the closure of the ward she worked on, and a series of subsequent health problems. Shortly after hearing of the ward closure, Ruth was diagnosed with diabetes, and her account implies that job insecurity may have been a contributing factor to the onset of the disease:

Ruth: ...we didn't know whether it had been brought on by the shock of the job or the fact that part and parcel of diabetes is that when you're on steroids it catches up with you.

(Kirkhead)

Ruth went on holiday not long after the ward closure had been announced, and the week that she returned, she suffered from a full facial palsy. She was admitted to hospital, and in the following excerpt, she describes her experiences:

Ruth: So when I came back I had the palsy and I went to ENT and when I went to ENT they admitted me, cos the diabetes had flared because of it all, and I was really at an all time low and they were really worried about me, but what I didnae know was that everything had went, blood pressure, chest, everything wasn't right. [...] I was off work for like um 6 months.

LA: Goodness me.

Ruth: But actually I think it was like a breakdown as well, because mentally I had been seeing to everybody else, but I hadn't realised myself that I was needing another job and things were changing, and all my signs had just, everything had just happened at the one time, and the palsy was the warning that everything wasn't right. So it took me about 6 months to get over that

LA: And do you feel it was all triggered by the job?

Ruth: Yes, definitely. I should have actually put a claim in for stress, because they caused it by not doing procedures right, which at the time I wasn't thinking like that, but I should have done it.

(Kirkhead)

Ruth's account clearly illustrates her belief that the stress caused by her experience of job insecurity triggered a range of health problems. Bartley, Blane and Montgomery (1997) have identified times of job insecurity as being critical periods in human development. They argue that the extent to which such times of potential adversity pose risks to health and well-being may be shaped by the social and material contexts within which individuals experience these critical periods. Ruth's biographical account suggests that she has experienced relative disadvantage throughout her life; she is from a working class, relatively deprived family, left school at 16 with few qualifications, and she has worked in a relatively unskilled and poorly paid job for the majority of her working life. The nature and scope of qualitative data means that it is impossible to establish causality between Ruth's experience of job insecurity and the health problems that she subsequently suffered. However, from the data available, it is appropriate to speculate that Ruth has accumulated biological and social health risks over the course of her life, which rendered her susceptible to serious illness when she experienced an acutely stressful event at work.

Ruth eventually returned to work in the same hospital department, and she is one of five respondents currently employed as nurses within the NHS. All of these five respondents described their working conditions as very poor, due to a chronic

shortage of adequately trained staff, which makes their work very stressful. However, these respondents also reported having good relationships with their colleagues; two explicitly referred to the support of their colleagues as something which enables them to cope with the stress engendered by their working environment:

LA: How do you get on with the people you work with?

Josie: As a team we all get on really really well, I mean I think that's one of the things that keeps us all going there is the fact that we've got a good team, we get on well [...]that's what makes it tolerable really, it's a hard job.

(Kirkhead, state enrolled nurse)

LA: How well do you get on with your colleagues?

Marion: Very well, uhumgood working relationship, we are very happy in it, I think sometimes very very busy units are, a Dunkirk spirit or something

(Braemore, nurse sister)

These data suggest that social support at work is a potentially important dimension of the respondents' work environment, which may act as a 'buffer' against the stress engendered by their working conditions (Stansfeld, 1999).

5.7 How psycho-social work environments may enhance health and well-being

There are some suggestions within the data of ways in which experiences at work may promote well-being. Most of these data relate to respondents' accounts of their current employment; this reflects the centrality of paid work within the respondents' accounts of their everyday lives. Thirteen of the eighteen respondents who are currently in paid work suggest in their accounts that work enhances their well-being. This subset of thirteen respondents includes nine respondents from the Braemore sample and four respondents from the Kirkhead sample. These women portrayed their jobs in positive terms, and talked about deriving enjoyment and satisfaction from their work.

In many cases, those respondents who portrayed their jobs in positive terms linked their job satisfaction to the large amount of autonomy that they have over their

work. This autonomy may be related to being able to choose the tasks that they do, being able to plan their working days, or having a certain level of responsibility within the job. These findings are supported by the wider literature. For example, Karasek and Theorell argue that jobs which are demanding, but which also offer individuals a high degree of control over their work, are most likely to promote mental well-being (Karasek & Theorell, 1990). This proposition is supported by findings from the Whitehall II studies (Marmot & Feeney, 1996). The following quotation illustrates how a sense of having control over aspects of one's work may contribute to a sense of enjoyment of the job:

LA: What is it about your job that you enjoy?

Jacqueline: Oh the responsibility, the feeling that I'm able to set tasks for myself and for others, that I've got goals, um and that I'm being given the wherewithal I suppose to achieve those goals, I've never had that before in any of my working life, it's always been do that now, and do that next, and that kind of thing, um, not to a huge extent, but I've never had this kind of autonomy of my own to such an extent before.

(Braemore, PA/office manager)

Several of the women in this subset of respondents indicated that they perceive their jobs to be very rewarding, and they explained this by referring to both the demanding nature of the job, combined with having a high level of control. This finding supports existing research findings (Marmot & Feeney, 1996) For example, in the data excerpt below, Marion, a Braemore respondent, talks about how her senior position as a nurse sister in a hospital unit means that she has a high level of control over her work; although in practice the very nature of her job means that she has little control over what actually happens within a working day:

LA: Do you have any control over how you organise your working day?

Marion: Oh yes, I have absolute control really, but it really is determined by the patients and how busy the ward is, so when I say yes I mean no as well [laughter] I have control because I am in control of what goes on, but I have no control over what will actually happen because someone can arrest and um you're busy resuscitating someone and everything just goes pear shaped and over that you've got no control but at the same time you're in control over that situation cos you're the sort of team leader along with one of the registrars.

(Braemore)

Despite the pressures associated with her job, Marion finds her job very satisfying, as the following comment indicates:

Marion: It's a very big part of my life, I still get a tremendous buzz out of it, it's really exciting.

(Braemore, nursing sister)

In a similar vein to Marion, Esther, a secondary school teacher, also talked about the 'buzz' that she gets from her job, despite her heavy workload:

LA: Are you enjoying this job?

Esther: I love it, mmm...if I didn't get a buzz in the classroom then I wouldn't do it.

(Braemore, secondary school teacher)

These accounts contrast with those offered by two other women in the Braemore sample, who indicated that what they find appealing about their job is the fact that is *undemanding*. For example, Diane, who does proof-reading part-time, says this about her job:

Diane: I really enjoy the fact that I can do it at home, and can do it in an odd hour here or there, rather than sitting down and go on for ages, and that means that I can do it when I'm feeling at peak you know, able to concentrate, and I just like the fact that it's peaceful and flexible.

(Braemore, proof reader)

Rachel explains why she enjoys her cleaning job:

Rachel: I like cleaning because it leaves your brain free, I like mindless tasks that I can just get on with and, and my brain has time to sort of wander around, and I get a, definitely a sense of satisfaction as well...it's much better doing somebody else's cleaning because you know you leave it spotless and you don't see the process of it getting messed up again, you don't know that ten minutes after you've gone out the place is chaos again (*[laughter]*) so yeah I do, I quite enjoy it.

(Braemore, cleaner)

Rachel's comments indicate that she enjoys her job, and that it promotes her sense of well-being. Statistically, Rachel's job means that she is accorded a low occupational class, which may be predictive of premature mortality. This is reinforced by the fact that she is divorced – one of the consequences of which is that her overall household income is not boosted by the presence of a partner in paid employment. However, her subjective understanding of her job is that it enhances her quality of life. These data are interesting because they highlight the way in which qualitative research into lay understandings may reveal potentially health-relevant dimensions of experiences within the labour market that would otherwise remain hidden.

Siegrist and colleagues (1990) frame the relationship between work and well-being in terms of the balance between effort and reward (as measured by money, esteem and status, and job security). For some respondents, particularly those in public sector jobs, the satisfaction that they report from knowing that they have helped other people in the course of their work may be interpreted as a non-financial 'reward', which serves to enhance their well-being. For example, in the following excerpt Kirsty, a library officer in the Kirkhead sample, describes the satisfaction that she derives from her job, and spontaneously links this to her sense of well-being:

Kirsty: You walk out feeling good, thinking "right, I feel I've achieved something today", you know, a class visit or the elderly people coming in and just the fact that they've been pleased, or you've been to visit somebody in their home, and you come away thinking that you've done something good for them[...]the job gives me a lot of um, that helps this well-being feeling, it does give me a sense of satisfaction at times, which is important to me.

(Kirkhead, library officer)

Fiona's comments, which are presented below, suggest that she derives meaning and purpose from the knowledge that she is helping people in the course of her job:

LA: How important would you say your job is to you?

Fiona: It is important cos um, I've met a lot of good friends, and I like helping people, I like the people, the eh people that you get in, they need a lot of attention and care, and a bit of love, you know, and eh, once they've gone to nursing homes and all that, their families, their families are pleased with how they've been treated, it's given their families a rest in between worrying cos the hospital's taken over that role.

(Kirkhead, auxiliary nurse)

Fiona also mentioned that she has made a lot of good friends through her work. Accounts from other respondents also suggest that having good relationships with work colleagues is an important aspect of the work environment which contributes to positive overall perceptions of the job. The following quotations highlight the importance of good relationships with colleagues:

LA: And how would you describe your relationship with your colleagues?

Kirsty: Good, very good [...] it's a nice feeling of getting on well together, and that's good, and that makes your work, because it's a big part of one's life, a big part of the day.

(Kirkhead, Library officer)

LA: And you mentioned right at the start about health being influenced by the working environment that you're in. How positive a working environment would you say you're in at the moment, in terms of//

Jacqueline:// Oh very, I don't think I've ever been in a better environment actually, um despite the difficulties and the challenges I think it's a lovely place to work [...] there's a lot of camaraderie and it's very supportive.

(Braemore, PA/office manager)

These data indicate that the existence of supportive relationships at work is a key element of whether or not respondents perceive their jobs positively. It seems that the existence of supportive relationships in a work context may have intrinsic benefits for well-being, in addition to enabling respondents to cope with work-based stress.

The data which have been presented in this section illustrate ways in which respondents perceive work to influence their well-being. In themselves, the data may seem relatively insignificant in terms of contributing to explanations for health inequalities. However, it is important to recognise the importance of work as a health-relevant dimension of everyday life which intersects with a range of other health-relevant resources that constitute the contexts of individuals' everyday lives. Although individual resources, when considered separately, may have only a minor influence upon health and well-being, together they may have a significant cumulative effect upon health and well-being.

5.8 Interactions between illness and employment trajectories

The data suggest that illness may interact with employment trajectories in a variety of ways. The respondents' accounts indicate that the extent to which they perceive their employment situations to have been disrupted as a result of their experience of illness is related not only to the nature and severity of their health problems, but also to the nature of employment that they were engaged in at the time of suffering from particular health problems. Cross-sample comparison of data regarding the impact of illness upon employment trajectories reveals some striking differences between the experiences of the two groups of women.

To recap on the respondents' reported health histories - on the whole, respondents in the Braemore sample have experienced much better health over the course of their lives than respondents in the Kirkhead sample. Nine women in the Kirkhead sample currently suffer from chronic illness, and the accounts of respondents in this sample also reveal a high level of acute illness throughout these women's lives. By contrast, only one woman in the Braemore sample currently suffers from chronic illness. However, approximately half of the Braemore respondents reported experiencing at least one episode of acute illness over the course of their lives.

Analysis of the data highlights the role played by structural factors in shaping the impact that the respondents' experiences of illness have had upon their

employment status. A common theme running through the respondents' accounts of illness is that women in the Braemore sample are more likely to have been engaged in occupations that offer job security in times of sickness, compared to women in the Kirkhead sample. Amongst the Braemore sample, almost all of those women who reported having suffered from acute illness at some point in their lives were able to take paid sick leave from their jobs for several weeks or even months, and none of them suggested in their accounts that they felt that their job security had been threatened. However, respondents in the Kirkhead sample, who have tended to work in more insecure and poorly paid jobs, were more likely to offer accounts regarding instances where the experience of both acute and chronic illness has in some way disrupted their employment situation.

Within the data, the role of occupational conditions in mediating the perceived impact of illness upon the respondents' employment trajectories is revealed to have operated throughout the lifecourse, and not simply at the time of entry to the labour market (as mentioned in Section 5.3.1). The data suggest that the employment situations of respondents in more highly qualified and better paid occupations (generally, respondents in the Braemore sample) are unlikely to have been disrupted or threatened by health problems, even in cases where these respondents have experienced more than one episode of serious illness over the course of their lives. By contrast, for those respondents in more casual and poorly paid occupations (most of whom are in the Kirkhead sample), the experience of illness is more likely to have posed a threat to job security and these women's positions within the labour market. For example, two women in the Braemore sample have experienced episodes of illness that required them to take several months off work. They were both able to take paid sickness absence, and thus sustain their position within the labour market. Their accounts differ markedly from the experiences reported by two Kirkhead respondents who ended up leaving their jobs as a result of health problems. The contrasting accounts from these four women are presented in Table 5.4.

Table 5.4 The effect of illness upon employment status

Braemore respondents - jobs protected throughout health problems	Kirkhead respondents – jobs lost during health problems
<p>Hattie: In 91 I had a bowel re-section done [...] it turned out there was actually something mechanically wrong with my bowel[...] so what they had to do was cut out that bit and stitch it together again [...]</p> <p>LA: Right, so did you have to take time off from work?</p> <p>Hattie: Oh yeah, I was off for about 4 months</p> <p>LA: Right, okay</p> <p>Hattie: I would have been off for, for 3 months anyway, because it was a major abdominal operation and you're not meant to lift after that , um, but in fact I was off for longer than that because of the diarrhoea (right) so I think it was 4 months in the end.</p> <p>(Abdominal surgery)</p> <p>Jacqueline: I just folded, and um I had 6 months off work, and then I went back to this job, they were super to me actually, they were very good, and as they had to be, of course, and I mean it was all on full salary in those days, you wouldn't get it now.</p> <p>(Nervous breakdown)</p>	<p>Josie: The only reason that I left the health shop was when I left to have my hysterectomy and I didn't know I would be back to work so soon, otherwise I would have said to Mel [employer] "I'm gonna be back in 6 weeks time so do you want to get somebody to fit in for me"</p> <p>(Hysterectomy)</p> <p>Lizzie: I'd worked for this company 16 years, 15 years and they were treating me like a piece of dirt, like, oh, she's finished, she's on the scrap heap, they werenae even trying to look for something that they could accommodate me....if they had wanted to, they could have given me a seat at the till and I could have gone back to work ...um, but they wouldn't, or even said "well you cannae do the cashiering, but we'll get you into the office and train you up on something else", but they just didnae want to go round that.</p> <p>(Osteo-arthritis)</p>

These data point to the role of structural factors in mediating the impact of illness upon employment trajectories. For Hattie and Jacqueline, their incomes and their jobs were protected by occupational welfare policies, which meant that the impact of illness upon their employment trajectories was minimised. In her account, Hattie doesn't mention having to negotiate time off work with her employer which suggests that, for her, paid sickness absence is perhaps a 'taken for granted' condition of employment. By contrast Josie, as a casual shop worker, was not entitled to sickness leave, and she ended up resigning from her job when she went into hospital to have a hysterectomy. What is potentially significant about Josie's

experience is that this was the second time that she had given up a job because of health problems (the first time is described in Section 5.6). This suggests that Josie occupies a relatively marginal and insecure position in the labour market.

Lizzie's account highlights how employer attitudes may determine whether or not individuals with health problems are able to sustain employment. After a fall aggravated osteo-arthritis in Lizzie's knee, she was unable to stand for long periods of time. She was effectively sacked from her job as a catering assistant when her unsympathetic employer refused to make the minor adaptations to her working conditions which would have enabled her to carry out her work duties. Lizzie left her job in November 1996, only a month before the Disability Discrimination Act came into force, which would have made it unlawful for her employers to discriminate against her because of her disability. She commented:

Lizzie: Uh they paid me off in the November and the new disability law came into um force on the 1st of December. It was like they knew they had...if I had fought them long enough, they would have had to have provided me with a seat because it was the law, you couldn't discriminate against a person who had been working for you and was not disabled

LA: Right, and had you known that that law was coming in?

Lizzie: I hadn't know that the law was coming into force, it wasn't until after [...]but by that time they had put everything into action [...] if I had fought them for a wee it longer they would have had to have...but as the doctor says, do you honestly want to work for somebody that doesnae really want you there?

(Kirkhead)

Accounts from these four respondents suggest that it is not illness itself that necessarily disrupts participation within the labour market. Lizzie and Josie are clear in their accounts that it was not an inability or an unwillingness to work after experiencing illness that resulted in them leaving their jobs. Rather, structural factors as expressed through the practices of specific employers, and through characteristics of particular occupational sectors more generally, serve to shape the extent to which individuals can sustain paid employment in the light of health problems (Pinder, 1999). This argument is further strengthened by the narratives of two respondents in the Kirkhead sample, both of whom suffer from chronic health

problems. Both women are in full-time employment for public sector employers, in the same jobs that they held before their health problems were diagnosed. Although neither of them work in particularly highly skilled or highly paid occupations, they both work for employers who offer paid sick leave and who accommodate their health problems, as the following quotations illustrate:

LA: Yeah, and how secure do you feel your job is?

Ellen: I feel it, yeah I feel it's secure, well, the university do have a policy like for employing disabled people, and I don't look on myself as being disabled, and though I go off work sick with it, I'm not off as much as some people are, so yeah I feel my job is secure.

(Lab technician, Multiple Sclerosis)

Ruth: If I'm having a bad day I'll say I need some help. And I do get it sometimes, but the occupational health doctor, I keep going every 6 months to her, so that she can keep a tab on it and she can write letters to management saying you're not following procedure.

(Auxiliary nurse, Diabetes, Asthma)

Ellen and Ruth's experiences demonstrate that chronic health problems do not necessarily have to result in the loss of paid employment, provided that some flexibility is offered by the employer regarding working conditions. However, at least four respondents indicated that their experience of chronic health problems precipitated their exit from the labour market. This health selection out of paid employment will be considered in the next section.

5.9 Health selection out of employment

Out of a total of twenty-four respondents in the study, six are currently without paid employment; five in the Kirkhead sample, and one in the Braemore sample. All of these women suffer from chronic health problems. Accounts from four of these women suggest that their non-employment is related to their health problems. What is interesting is the lifestages at which these respondents exited the labour market.

Three respondents within this subset of six women gave up work upon having children, and did not return to paid work due to the subsequent development or worsening of chronic health problems. For example, Jean, a Braemore respondent,

reported suffering from ulcerative colitis *before* the birth of her first child. Despite her health problems, Jean had been able to secure continuous employment for roughly three years up until the time she had her baby. However, her health deteriorated in the years after her child was born, and consequently she did not return to paid employment. Jean had worked in a relatively low-skilled and low-paid job before the birth of her child. She implied in her account that not only is she physically unable to work, but that she is now unlikely to be able to earn enough money to off-set the loss of her sickness benefit that taking a job would entail:

LA: Since stopping working to take care of Richard [son] have you ever been back into a paid job?

Jean: No[...]I really can't afford to do that, I would lose everything, all my benefits, um....and I got onto the benefits when they were still earnings related, so I can't really complain about what I do get....but no...I'm too exhausted to work [...] I do have to take it quite easy.

(Braemore)

Two women in the Kirkhead sample also left the labour market when they had children, and subsequently did not return, due to chronic health problems. The following quotation reveals one respondent's perception of how her health problems have reduced the likelihood of her being able to re-enter paid employment as an auxiliary nurse:

Morag: Well now that I've got all the different things wrong with me nobody wouldnursing-wise nobody would take me. Whenever you said you had high blood pressure, taboowell you're more risky, with having the diabetes and the blood pressure, you're more risky of taking heart trouble, so they dinnae want to know if that's what's wrong with you

LA: So did you ever think of going back?

Morag: I would have had my health been okay.

(Kirkhead)

These data indicate that for a small minority of respondents, their exit from the labour market due to childbirth was perpetuated by the onset and development of chronic health problems. This suggests that for women, health selection back into the labour market may operate when women take childbirth-related breaks in employment. This finding seems to contradict those of large-scale health surveys.

which suggest that, in the case of women with young children, exclusion from the labour market is not associated with poor health (Arber, 1991; Macran et al, 1996). Clearly, more research is needed to understand the significance of chronic health problems within the wider context of processes which shape women's (non) return to the labour market after childbirth.

The remaining three respondents in this subset have given up paid employment much more recently. Accounts from two of these three respondents, Mary and Lizzie, portray their exit from the labour market in the mid 1990s as a major life event which precipitated a series of other health-relevant life changes. In the previous section, I presented data from Lizzie's interview, in which she describes how she was forced to leave her job as a catering assistant when she developed osteo-arthritis in her knee. At this point, Lizzie actually left the labour market altogether. Mary chose to give up her work as a staff nurse on the advice of her doctor, several years after having been diagnosed with diabetes, angina and other chronic health problems. Both Mary and Lizzie are divorced and live alone. In Table 5.5, data are presented which illustrate the impact that leaving the labour market had upon these women's life circumstances, and upon their sense of well-being.

Table 5.5 The impact of health selection out of the labour market

<p>The initial impact upon well-being...</p> <p>LA: How did you feel? Mary: Terrible. I mean everybody dreams of winning the lottery and living the life of Riley, but to be forced to give up your work...I was practically suicidal.</p> <p>LA: Yeah....and did that have any effect on your health?...you know// Lizzie: //I was depressed but I wouldnae take tablets...I mean I went through black periods where I just felt what was the good of having worked all these years to get treated like this, and to be really...yeah, I think it did, I think it affected me a bit.</p>
<p>...was compounded by the stress of adjusting to the loss of income</p> <p>Mary: My income went from about £2-300 a week, cos with doing my agency work I could earn quite a lot, to getting £47.50 a week, it was horrendous.</p> <p>Lizzie: I was in arrears with my rent, arrears with this, so all the money had to go, most of the money had to go towards my bills [...] I just kept going into overdraft[...] I was practically living on my £100 overdraft all the time, paying off my bills.</p>
<p>Their financial situations were exacerbated by wrangles with the Benefits Agency</p> <p>Mary: I got a letter back saying that I was not eligible for DLA [...]it makes you feel that you're a fraud [...]they were not only questioning my integrity, they were questioning the integrity of all these consultants that I'd seen, and I think that's a disgrace.</p> <p>Lizzie: I think it was January before I finally got a decent payment from the DHSS, but even that I had to fight for that, I had to fight all the way for any money that I got, and yet I had worked all my life, and I'd paid income tax and insurance and all the rest of it, and I just felt that I had been shoved on the scrap heap...and I really, it really disheartened me.</p>
<p>Mary's financial situation was eased slightly by her savings</p> <p>Mary: Thankfully I had a wee bit of money put aside [...]I'd had the insight years ago when my husband and I separated, to every couple of years take out a new policy, now it might only have been for a couple of thousand pounds, but I knew that this was always coming up, about 4 or 5 times in a row you see, I was having another couple of thousand pounds, but I was very tempted of course to cash them in.</p>

These data illustrate the deleterious consequences that exit from the labour market may have upon both material circumstances and upon well-being. Thankfully, both Lizzie and Mary reported that in the last few years, they have

adjusted to their change in circumstances. Both women said that they have come to terms with their disabilities; this has been achieved partly through their participation in various training courses offered at further education colleges through local support organisations. What is remarkable about the accounts of these two women is that they both said that they now have a greater sense of well-being than they ever had during previous stages in their lives:

LA: Do you consider yourself to be a healthy person?

Lizzie: Yeah, not bad ...I don't have as many attacks of um asthma, I've not had many attacks of bronchitis lately. Since I stopped working, I would say that my life has changed a bit. Maybe I'm more calmer now than what I ever was, so I don't get the headaches, I don't get the tension. I mean when I come home here at night, I can just flop out on the couch and watch the telly or put the radio on, or listen to my CDs, and if I want to go out with somebody I can go out with somebody and if I dinnae want to go out, I dinnae have to go out you know I can do what I like basically.

LA: Right, does that make you feel better?

Lizzie: Yeah, it makes me feel like I'm a person...a wee while ago I thought that I was like living in a limbo, like I wasnae even feeling what I was....I wasnae even thinking what I was feeling, I was just living and getting on with it. But lately I've found that I think a lot of things that I'm actually feeling, that I'm sensing things and I'm knowing what I'm doing and I'm happy with what I'm doing.

(Kirkhead)

Mary: Despite what I've got, I think probably this is the best that I've been, um, because I've got the chance to do it, you know I've got the chance now to look after myself, and to, to do what I want to do, but you know, pace myself to do what I want to do when I want to do it. My family are up, I don't have a career anymore, if I want to do something on the computer I do something on the computer, if I want to learn something I go to college.

(Kirkhead)

Thus, for these two respondents, health selection out of the labour market was initially experienced as an extremely negative life event, with harsh financial consequences that had an immediate impact upon the nature and quality of day-to-day life. However, exit from the labour market has also brought about positive changes to Mary and Lizzie's lives, which have served to enhance their psycho-

social well-being. These findings are an illustration of the opportunities provided by qualitative research for capturing the dynamic and complex influences upon health and well-being wrought by changes in labour market position, from the point of view of the individuals concerned.

5.10 Conclusions

In this chapter I have presented data which shed some light on the processes through which health inequalities might be generated and sustained via experiences of different social groups in relation to the labour market. The data suggest some stark contrasts between the employment experiences of the two sample groups. Respondents within the Kirkhead sample are more likely to have been located in lower occupationally-based classes than respondents in Braemore over the course of their lives. Larger scale statistical studies have already highlighted associations between low occupational class position and greater risks of mortality and morbidity (Arber, 1991; Marmot & Davey Smith, 1997); the data which I have presented in this chapter have suggested some ways in which respondents have experienced health risks related to their employment. The analysis presented in this chapter indicates that the respondents themselves understand there to be relationships between their position within the labour market and their experiences of health, illness and well-being over the course of their lives. This finding is not merely a construction achieved through the interviewing process, but was alluded to by respondents both directly and indirectly.

In this chapter I have demonstrated the social patterning of work-related health risks that respondents have been exposed to over the course of their lives, both in terms of the nature of their employment, and in terms of their employers' responses to illness episodes. On the whole, Kirkhead respondents have occupied positions in the labour market where they have been more exposed to health risks, and where their employment has been less secure at times of illness, compared to Braemore respondents. Furthermore, Braemore respondents are more likely to have held jobs that enhance their psycho-social well-being than respondents in Kirkhead.

I have attempted to demonstrate that reported interactions between the respondents' employment experiences and their experiences of health and illness need to be understood within the wider context of the web of other health-relevant resources within which their lives have been embedded. Sara Arber has asserted that:

For women, it is essential to consider the interactions between family roles, employment status and material circumstances. Groups of women who are disadvantaged on all these factors experience particularly poor health status.
(Arber, 1991: 429)

The themes which Arber identifies are precisely those which I have started to explore in this chapter. For example, I have argued that features of personal circumstances such as marital status and overall household income are relevant dimensions of the respondents' lives which have shaped the meaning of their employment experiences. In Chapter Six I discuss respondents' accounts of how their relationships with family members have shaped their experiences of health and well-being. In particular, I focus upon the interaction between the respondents' family roles and their paid employment, which Arber has identified as a central health-relevant dimension of women's lives.

Chapter 6: Resources for health and well-being (iii): Family Roles and Relationships

6.1 Introduction

The nature and quality of family relationships are central to lay accounts of everyday experience throughout the lifecourse. This chapter explores respondents' understandings of how these experiences have interacted with their health and well-being throughout their lives.

The literature suggests a number of reasons why focusing on family relationships may be a potentially fruitful site of enquiry in the study of health inequalities. The first relates to the health-relevance of women's roles within the family. Previous research on inequalities in women's health has highlighted the importance of interactions between various structural aspects of women's life circumstances (Arber, 1991, 1997; Denton and Walters, 1999; Macran et al, 1996). Findings from these studies show that women's health experiences are associated with their family roles, as well as (or in relation to) other structural factors such as employment status and household material circumstances. Sections 6.2 and 6.3 engage with these issues by considering respondents' multiple caring roles throughout the lifecourse.

A second reason for studying family relationships is related to the influence that the perceived quality of these relationships may have upon health. Supportive family relationships may be important for enhancing health and well-being, both directly, and through acting as a 'buffer', mitigating the potentially health-damaging effects of stressful experiences. On the other hand, family relationships that are experienced as stressful may serve to undermine health and well-being (Seeman, 1996; Stansfeld, 1999). Section 6.4 explores this with reference to respondents' accounts of marital relationships.

Thirdly, there are complex intersections between family relationships and geography, and these intersections may have a bearing upon health. Where family members live in relation to each other influences the nature and quality of family

relationships. Furthermore, life events associated with family relationships, such as marriage and divorce, have implications for housing trajectories. Thus, the study of intersections between family events and relationships may shed light upon some social processes which contribute to the geography of health inequalities. This theme is explored throughout the chapter.

6.2 Negotiating childcare and labour market participation: implications for health and well-being

Preceding chapters have demonstrated that socio-economic stratification is an important axis of inequality that has structured the respondents' lives and influenced their opportunities for good health and well-being. Generally, Braemore respondents have better health, live in more affluent household circumstances, and have worked in better paid, higher status jobs over the course of their lives than respondents in the Kirkhead sample. However, socio-economic factors are not the only structural forces which have shaped the respondents' life circumstances. Gender roles and expectations within the family can be understood as comprising another set of structural factors which have shaped the organisation of respondents' lives, with implications for their health and well-being (see Section 1.5.1).

For example, the accounts of almost all of the respondents regarding their employment trajectories reveal that, to a greater or lesser extent, their participation in the labour market over the course of their lives has been influenced by normative assumptions regarding gendered caring roles within the family (Arber and Gilbert, 1992). The data indicate that, even in cases where respondents reported that their earnings have made a substantial contribution to the household income, their jobs have generally been perceived (both by themselves and by their partners) to be of secondary importance to the household compared to those of their partners. Moreover, nearly all respondents reported that their family roles as wives, mothers and daughters have involved them having primary, if not sole, responsibility for unpaid caring work within the home, throughout the lifecourse. In this section I consider respondents' accounts of intersections between their childcare

responsibilities, labour market participation, and experiences of health, illness and well-being.

Of the twenty-four respondents in the study, twenty-one are mothers, and all of these respondents described themselves as having had primary responsibility for caring for their children whilst they were growing up. Thus, regardless of socio-economic position, there are some commonalities between the two sample groups in terms of respondents' reported experiences of gendered social roles which have involved unpaid caring work in the domestic sphere. However, the data suggest that these caring roles have been mediated by the material, social and cultural circumstances of individual respondents' households. The respondents' own occupational class, their overall household income, the presence or absence of a partner, and access to childcare have all served to shape the nature and meaning of respondents' experiences of particular social roles. In order to understand the nature of the relationship between respondents' negotiation of various social roles when bringing up children, and their experiences of health and well-being, it is necessary to take into account the wider context of their reported personal circumstances and resources.

6.2.1 Full-time childcare

Of the twenty-one respondents who have children, eight (four in each sample group) gave up paid work after the birth of their first child, with the intention of staying at home for several years in order to provide full-time care for their children. At the time, all of these eight women were married, and their accounts suggest that they were generally content to adhere to traditional gender roles within the family. Analysis of their accounts suggests that the respondents' socio-economic circumstances at the time of bringing up their children played a key role in shaping their experiences of full-time childcare. To illustrate this theme, I present accounts from two respondents in contrasting socio-economic circumstances. Diane is a relatively affluent respondent in the Braemore sample group; Linda is a relatively

deprived respondent in the Kirkhead sample group. Below, they both describe their perceived roles within the family:

Diane: On the whole I just assumed responsibility for that because I wasn't working, and that makes such a huge difference (yeah) because I saw that as my bit, and he was happy with me to take all that over (yeah) um, and I suppose that I've always felt that, that if I wasn't actually working myself, that you know he had a full day's work and my contribution was to cook and look after the house and the children as much as possible.

(Braemore)

Linda: I was content to get on with the children and never really thought about going back to work..

(Kirkhead)

However, Diane and Linda's decisions to stay at home and look after their children were made within starkly contrasting socio-economic circumstances. Diane's husband works in a professional occupation. In her account, Diane acknowledged that her husband's relatively high salary meant that she was not obliged to seek paid employment; she indicated that being able to stay at home and care for their children promoted a sense of well-being because she didn't have to "live with a lot of pressure":

Diane: I feel my, I've had the enormous privilege of having a fairly sort of measured lifestyle you know, because I haven't had to sort of rush out and work...and so I don't live with a lot of pressure really.

(Braemore)

Diane admitted that bringing up her three children was tiring but overall, she portrayed being a full-time mother in a very positive light – a social role which enhanced her sense of well-being:

Diane: It was the most significant, joyful experience of my life, to have had the children, definitely[...]of course it's very tiring, I mean I think I was very tired a lot of the time...um, what is there to say! I mean I just found their lives really interesting, and I suppose it was just such a huge difference from a lot of people that I wasn't hankering to be doing anything else to be honest.

(Braemore)

By contrast, Linda's husband worked as a low-ranking and relatively low-paid civil servant, and he was obliged to take a second job at weekends in order to make ends meet. Linda's account suggests that raising her children was a stressful period of her life, because of the family's financial difficulties:

LA: How did it affect you, having children, do you think?

Linda: Well I think it made me more...you know...you had to do things...you had to get on with it...maybe didn't always want to do things, you know...you felt you had to sort of, um...like take the kids, like on holidays and things like that [...] we didn't have transport, didn't have a car or that...so sometimes you felt...

LA: Did that make things harder?

Linda: Sometimes, I think, you know...um it was a bit harder.

(Kirkhead)

Elsewhere, Linda revealed that she and her husband were only able to survive financially because of the support that they received from her parents:

Linda: My parents were very good, my mother helped out, very much so, like with shoes even and buying clothes and things for the kids, I couldn't have done it.

(Kirkhead)

These data show how two apparently similar pathways out of the labour market after having children actually took place within markedly different household contexts. Thus, the data suggest that the material circumstances within which respondents undertook childcare may have had implications for their health and well-being. This observation is further supported by an account from another respondent in the Kirkhead sample, Celia. In the following excerpt, she describes the effects upon her health and well-being of undertaking domestic caring responsibilities in the context of financial hardship:

Celia: I didn't have a Hoover, I had a dustpan and brush to do the whole house, hands, and knees job, doesn't half get your tummy back. And uh...so it was very very hard, so I didn't think about my life too much, cos I wouldn't have managed it, I couldn't have stuck it, I just got on with the work. But it was a very hungry time because Pat [*husband*] didn't get paid enough...um so I, although we did have the three meals a day there wasn't enough to eat, uh my weight dropped down, when we had Lorraine, after I had Lorraine I was 5 ½ stone, uh it was just starvation, just enough on your plate [...] I was eating, but not enough you see, not enough to replace the calories I was burning, because it's very very physical work when you've got young children.

(Kirkhead)

Together, data from the subset of respondents who stayed at home to care for their children full-time suggest that the influence of this social role upon their health and well-being was mediated by the material circumstances in which they brought up their children.

6.2.2 Returning to paid employment

Thirteen of the twenty-one respondents who have children returned to paid employment whilst their children were of primary school age or younger. Their accounts suggest that marital status and household income were intertwining influences upon their experiences of returning to the labour market after having children.

Seven women within this subset (five in Kirkhead, two in Braemore) portrayed returning to work after having children as a matter of financial necessity. Four of these women, in the Kirkhead sample, indicated that their wages were needed to supplement their partners' relatively low wages. The following quotations are illustrative of this theme:

Kirsty: I took up being an Avon representative, you know the make up and door to door selling, doing that, cos you know financially, it was, we needed an income, cos Martin at that time was still working with the garage.

(Kirkhead)

LA: It seemed you had quite a lot of money worries and you were just scraping by a lot of the time//

Lizzie://Yeah, money worries was one of the things as well.

LA: And how did that affect your life?

Lizzie: Well I think that caused a lot of tension too, cos you've got kids and you're trying to scrape through and get them fed and keep a roof over their heads, and it does bother you, it's a main problem, and I think that makes you very very tense, when you know that you've got to keep kids fed and you've got to get things seen to, and you're husband's not pulling his weight by giving you the full wages, he's only giving you what he thinks you should have.

LA: Right, so was it up to you to manage the money?

Lizzie: It was up to me to manage the money, and it was up to me to go and get a job, even though I had kids, which I felt when you have children your husband should provide for you, and should be able to sit back and look after your children and when they're old enough, to go out and work. But I mean I worked from the time my kids were any height, you know.

(Kirkhead)

Lizzie's account suggests that she found it stressful trying to balance her caring responsibilities with her paid work – in the excerpt above she talks about feeling “very very tense”. She also implied that this tension was exacerbated by her unequal access to financial resources within the household.

The three other respondents in this subset (who explained their return to work as being primarily about financial necessity) were lone parents. Two of these women returned to work whilst they were still married; they could foresee that their marriages would end in divorce, and in their interviews they said that they had felt it was critical for them to build up as much financial security as they could before they left their husbands. For example, Jacqueline said:

Jacqueline: I knew I needed an income, cos we needed my income anyway, but also I felt that particularly during the pregnancy I would have to move on, so I would need to be working to be able to move on.

(Braemore)

The remaining six women (of the subset of thirteen respondents who returned to work after having their children) did not explain their return to paid work primarily in terms of the financial needs of the household. Five of these six

respondents are part of the Braemore sample. At the time of having children, all six were married to men in higher-earning professional occupations. These respondents' overall household income was thus relatively high at the time of having children. On the whole, these six respondents are relatively highly skilled, and they had been engaged in occupations with a career structure before having children.

This group of women portrayed returning to work after having children as something that they chose to do, rather than being compelled to do out of financial necessity. Their accounts clearly indicate that they perceive engaging in paid employment as something which enhances their sense of well-being. Four of the six women referred to the desire for financial independence as a factor in their decision to return to work. They perceived this independence as allowing them to have greater control over their lives; within the literature it is acknowledged that having a sense of control over life is health-relevant (Syme, 1996).

In explaining why they returned to paid employment, this group of women also identified non-material benefits to paid work. A common theme running through their accounts was the need for personal fulfilment outside of mothering. Linked to this, particularly amongst respondents who had worked in relatively high status jobs before having children, was the view that the women had not wanted to lose skills that they had acquired prior to starting a family. The following quotations illustrate the range of reasons why these respondents returned to paid employment; they point to the positive influence of paid work upon these women's sense of well-being:

LA: Was it important to you to be working?

Esther: Yes, just mentally, [...]it was really to have my own thing, I think because I knew I was a good teacher it was terribly important for me to keep that, and I, the money wasn't important in itself, but having some sort of financial independence was important.

(Braemore)

Hattie: So I went back part-time, that was partly so that I didn't lose my knowledge, I wanted to keep up my nursing, it was partly to get some money coming in, cos I'm a fairly independent person and I did not like being in the situation of needing to be given money, you know, plus, I actually thought it was quite important that Sam [*husband*] took some of the responsibility and basically when I wasn't there he had to deal with Peter [*son*]. So you know, it was probably in that order.

(Braemore)

Mary: I wanted to go back to work, I went back to work when Meg was 6 months, the reason for that was not because we needed the money, but I'm not a coffee morning person, and eh I didn't want to get into the role of meeting other young mothers and only being able to talk about babies and nappies and things like that, I. I began to realise my own worth I think, I began to realise that I had a brain (mmm) and I wanted to eh use my brain and I wanted to use my training as well.

(Kirkhead)

In this section I have illustrated some ways in which respondents' decisions about whether or not to return to the labour market were shaped by both their household circumstances and by their own occupations prior to having children. I have suggested that there are important differences between the two sample groups in terms of the motivation for returning to paid employment after having children. On the whole, those Kirkhead respondents who returned to paid employment whilst their children were of primary school age or younger did so out of financial necessity. By contrast, accounts from most of the Braemore respondents who returned to work when their children were young indicate that they did so out of choice. Generally, respondents themselves did not provide accounts of whether and how negotiating the demands of paid and unpaid employment may have influenced their health and well-being, although the data do offer some clues as to how this process might work. It seems reasonable to speculate that the experience of combining social roles may have enhanced or diminished the respondents' health and well-being, depending on the particular social contexts in which they were negotiated.

6.2.3 Combining paid employment and childcare

Despite differences between respondents with regard to the reasons why they returned to paid employment, a dominant theme within the data is that for all of the thirteen women who returned to paid work, part-time employment was perceived to be the only way in which they could both fulfil their domestic obligations and engage in paid employment. In all cases, engaging in paid employment was constructed by respondents as secondary to undertaking caring work in the domestic sphere (Brannen, 1992).

The data indicate that a major structural factor which influenced respondents' return to the labour market was the availability of childcare; only a few women were able to negotiate their working hours to keep them within school hours. Thus, arranging childcare was an issue faced by almost all of these women, regardless of their marital status, occupation, or access to financial resources. Only two respondents mentioned using statutory childcare at any point while their children were growing up; most of the women's accounts indicate that at the time of bringing up their children, there was very little formal childcare provision available.

Analysis of the data suggests that the lack of childcare provision shaped respondents' experiences of returning to paid employment in two ways. Firstly, a common theme is that, in order to undertake paid work, respondents were obliged to arrange informal childcare, not only with partners, but also with other family members, or with friends. Secondly, the complexities associated with arranging childcare meant that several respondents reported that they had few options but to undertake jobs during the evening and at weekends. Both of these sets of constraints upon respondents' opportunities for combining paid employment and unpaid caring work were frequently described as a source of stress during the life stage when respondents were bringing up their children. Thus, negotiating caring and employment roles had implications for their health and well-being.

Six of the thirteen respondents who returned to work did so during the evenings or at weekends, when their partners were at home to care for their children. One of the reasons commonly given for this was that respondents did not want

anyone but themselves or their partners to care for their children. Undertaking weekend or evening employment upon return to the labour market often entailed occupational downgrading. For example, Shona, a Kirkhead respondent who had worked as a telephone operator before the birth of her children, returned to the labour market to work as a weekend dishwasher in a hotel. She described the constraints upon her employment opportunities:

Shona: My husband was away from home every second week so I couldn't have taken a job... I wouldn't have put my children into care or anything like that, so I would have had to have worked in the evening and I couldn't do that because he wasn't here, but the weekends I could.

(Kirkhead)

Three of these six respondents are nurses, and they returned to work doing night shifts, as this fitted in with their partners. However, all reported that this had negative consequences for their health and well-being – working night shifts disrupted their sleeping patterns. Another woman in this subset, Tania – a Kirkhead respondent, did night shifts as a hospital domestic worker. In the quotation below, she recounts how financial pressures led to her taking two jobs at once – which eventually undermined her health and well-being:

Tania: I always had two jobs, had a wee evening job, in fact at one time I had the café and a night-shift job.

LA: Was that for financial reasons?

Tania: Um partly, and partly not, I mean I wouldn't say we were in desperate need, but with three children and Brian [partner] was in the building trade and he didn't work too often but when he could he did. [...] the night shift was a full-time job because I, I worked in the café from 10 til 3 and then I came home and made the kids their tea, and then I started on the night shift at 8, til 8 in the morning...I was a zombie at the time, like, but I did it.

LA: And working really long hours, and having three children//

Tania://it took its toll, I mean I could only last about, I think it was about six months I lasted the night shift job[...]I was so tired, I wasn't capable of anything at all, I was wasn't able to get up in the morning, and I came home to make the tea, I was going to bed for a couple of hours and then I was getting up to make the kids their tea, and then going out at night, and it was taking its toll.

(Kirkhead)

Three respondents, one partnered woman in Braemore, and two lone parents in Kirkhead, relied on their parents for childcare support. For the two Kirkhead respondents, the fact that their parents provided childcare was experienced as something of a mixed blessing. On the one hand, parental support was crucial in enabling these women to return to the labour market; they did not have partners to provide childcare, nor the financial resources to pay for care. However, this dependence upon their parents was also experienced as a stressor. Their parents' close involvement with their children led these two respondents to feel that they had been forced to sacrifice their autonomy in deciding how to bring up their children. In the quotation presented below, Josie explains the problems associated with relying upon her mother for childcare:

Josie: As a student when you got your placements on the wards you had to work shifts, so when I was working shifts on the wards my mum had Claire overnight if I was on a early shift, or a late to an early, and it was only on my days off or if I was going to be on a late shift that Claire would stay at home and I would take her to school and then she would go to my mum's after school. [...] There's been a lot of tension, a lot over the years when I was bringing Claire up we were always rowing about her basically sticking her nose in really too much, getting too much, too much involvement. But then I could see the other side, I mean she always felt that she was spending a lot of time with Claire while I was doing my training, um so she almost felt that she had a right to say and do the things she did. There's been a lot of stress, it's a funny kind of relationship, cos we're close in one way, but in another way there's quite a lot of resentment on my behalf for some of the things that have happened in my life that my mum's been involved in.

(Kirkhead, state enrolled nurse)

Other respondents also reported stress involved in arranging informal childcare, although not necessarily in the context of relying upon family members. For example, Stella, a locum pharmacist in the Braemore sample, recounted how having re-entered the labour market after the birth of her children, she gave up work again for several years after she was let down by someone who had agreed to look after her children:

Stella: I got three weeks of work, but then I had to organise my childcare and I advertised for someone, and I got a girl who looked after them for the first week no problem, but I also had a fortnight to do in September, but she let me down, so that was very traumatic, that's extremely traumatic, because one you've said you'll do a locum, you have to do it, you can't phone somebody up and say sorry you can't get your holiday [...] I mean I really found that very difficult to cope with [...]

LA: And did that put you off looking for jobs?

Stella: Yes, until the children were, you know, well until Joey was about 16, I maybe did an odd Saturday.

(Kirkhead)

Other respondents were able to make reciprocal childcare arrangements with friends. On the whole, their accounts indicate that these arrangements were experienced positively – perhaps because of their reciprocal nature. The quotations presented below illustrate this point:

Jacqueline: I had a swap going with a friend who had a little boy 4 months older than Chloe and she went back to work 2 mornings, um and so we agreed that she would have Chloe 2 mornings and I had Ben two mornings a week, so that she worked 10-1 and I worked 10-1 and that was quite nice because it eased me back in and it got her back in as well, um and the children were close enough in age that it was quite an easy time to manage in fact.

(Braemore, secretarial work)

Lizzie: All I had was like wee cleaning jobs, cleaning a pub out and getting £2.50 for it, and taking the child with you [...] And then the friend that I was telling you about that I'd met at night school, we found out that we lived just doors away from each other, so it started that I took Barry up to her in the morning, and she looked after Barry. I went down and did the pub work, I came up fra my job there, and looked after her two and she went away and did her wee job.

(Kirkhead, cleaner)

The data presented in this section indicate that despite the differences in socio-economic and household circumstances within and between the two sample groups, those respondents who returned to work after having children were all required to tailor their paid employment around their domestic responsibilities; women in both sample groups reported that this could be stressful. These commonalities between the two sample groups highlight the need for a fine-grained

and qualitative approach to the study of the social patterning of women's health and well-being – an approach which investigates the health-relevance of gendered social roles as well as that of socio-economic inequality.

6.3 The accumulation of caring roles in mid-life

A strong theme within the data is the accumulation of multiple caring roles across the lifecourse. For many respondents within both sample groups, a significant source of stress in their lives in recent years has been related to their changing roles within their families. Analysis of accounts from respondents in both sample groups indicates that as respondents have entered their forties and fifties, they have frequently been required to provide care for elderly parents who have become increasingly in need of support and care. Additionally, four respondents have grandchildren, and they reported an expectation upon them that they will provide support and childcare for their adult children and grandchildren. Respondents' accounts indicate that adjusting to and negotiating these new roles can be extremely stressful, particularly if respondents feel bound by the gendered expectations of their families, and of society more generally.

6.3.1 Multiple caring roles

Two respondents in the Kirkhead sample, Linda and Fiona, offered vivid descriptions of the stress they experienced several years ago, when they found themselves caring for adult members of their families at the same time as bringing up their children. Linda described the toll upon her health wrought by simultaneously caring for her sick husband and their teenage children:

Linda: You never seemed to have, you know...a minute, you know, and sometimes you felt you know, I could run away from this situation. Uh, but you had nowhere to run, cos my parents weren't alive and you just had to get in with it, you know

LA: And were you still looking after your children at the same time?

Linda: Yeah, although they were getting on as well you know, getting older. But I think it seemed to be more difficult as they got older...

LA: So was it having a physical effect on you?

Linda: Yeah physically and mentally

LA: What kind of thing?

Linda: Well my legs, my knees you know, um...I had to have a hysterectomy [...] I think it was partly because I had to lift my husband quite a lot, like that chair was electrical but I still had to lift, help lift him into the wheelchair...it caused a lot of, you know...um stress on my knees as well. A combination as well, with having the diabetes as well, a bit of arthritis, but I think it, the pressure of having to lift my husband all the time. I did it for about 6 years you know.

(Kirkhead)

In her account, Linda linked the physical strain of continually lifting her husband to her subsequent health problems; she also alluded to the deleterious influence that this situation had upon her well-being – she wanted to “run away from [the] situation”. Fiona also found it extremely stressful trying to juggle paid employment with looking after her son, providing support to her parents, and living with her alcoholic husband. She explained that she started smoking as a way of coping with the stress she was experiencing; she also neglected her health in other ways:

Fiona: I started smoking and I was skipping meals, and I was trying to do too many things at once, I was trying to organise my personal life and get on with it, make sure my job, that I was doing that right, and in between, helping my mother out and my own family, so it was like...and then making sure my husband was keeping well, so it was like different things. My husband would come up feeling unwell, I would try to sort that side out, my son, he would help me, but I would feel sorry for him, because I wanted him to live his life. I'd go up to my mum, and she'd be worried about me, wondering "how can you keep a job down, how can you keep the house, I don't want to ask you to do anything", where I thought "no, I'm here for you", so there were a lot of obstacles in the way of it, affects a woman I think more than a man.

LA: Yeah, so it really seems like it, that you had //

Fiona: // Lots of things going on. There's a time in your life I think when you neglect yourself cos you're too concerned about other people.

(Kirkhead)

Fiona's account indicates that her experience of trying to balance multiple social roles was very stressful – her reported experiences are an empirical illustration of the theoretical concept of 'role overload' in the literature (Bartley et al, 1992).

6.3.2 Caring for elderly parents

Overall, sixteen respondents (eight in each sample group) referred to their role in providing care and support for elderly parents, whether at some point in the past before their parents died, in the present, or in anticipation of their parents needing support in the future. Their accounts of this aspect of their relationships with their parents indicate that their caregiving is (or was) rooted in the gendered assumption that caring is part of the daughtering role, rather than something that is gender-neutral. This is illustrated by the following comments from respondents whose brothers have not been subject to the same caring expectations:

Kirsty: I had to keep telling myself that she had two sons that she didn't bother with as well, who could have easily seen to her.

(Kirkhead)

LA: How do you feel about the possibility of taking on more of a caring role for her?

Jacqueline: [...] I've thought for a while now that if the time came, it would be me that did the moving and the caring, because my brother is a man and has children and a wife and all this sort of thing, so it would fall to me to do, so I suppose in a way I'm fairly realistic about that, but I don't look forward to it with any great prospect.

(Braemore)

The quotation from Jacqueline, as well as highlighting the gendered nature of assumptions about care-giving, also points to the significance of geography in care-giving relationships. Jacqueline can foresee a time when she will have to move house in order to provide support to her mother; two other respondents also mentioned the possibility of moving house in future to be closer to their parents. For one respondent, her housing trajectory into her current home in Braemore was strongly influenced by the availability of a retirement home for her parents, in close proximity to the flat that she now lives in.

Whether or not respondents currently live near to their parents is another way in which geography has implications for their caring roles. Of the eleven women who reported currently providing some support for elderly relatives, ten have parents who live in Edinburgh. These ten respondents have contact with their relatives at least once a week, and the support that they provide takes a variety of forms. The most common form of support offered is helping with practical activities such as shopping, collecting pensions, providing meals and transport, and helping with housework. Respondents are also involved in spending time with their parents in their own homes, and this tends to be described by them as providing emotional support for parents who are often lonely. Offering this kind of support for parents is not necessarily perceived by the respondents to be a source of stress, if the level of support required by parents is relatively minimal and does not require an onerous time commitment from the respondents. The following two respondents work part time, and so providing support to their parents does not clash with work commitments:

Stella: I take my father[...] since he had the fall, he's a bit diffident about going on the streets by himself, um, but I walk him along to the Post Office and he usually goes to the butcher and possibly the baker, it just depends, on a Thursday, and that's maybe about an hour or something, you know... not a terrible amount.

(Braemore)

LA: Thinking about um, about your mother and your aunt, how much time do you tend to spend with them?

Carol: Maybe a half-day each a week.

LA: And does that involve any aspects of care?

Carol: No, it doesn't involve care, it's more to do with more support, and any correspondence my mum's got or perhaps um doing a little bit of shopping for her, just listening to her.

LA: And how do you feel about spending that time with your aunt and with your mum?

Carol: I think that's good, I mean I, I would need to spend, if I was working full time I would need to spend it at the weekend, so it's quite good that I don't have to do it at the weekend, now that I'm not working full time.

(Braemore)

One or two respondents in both sample groups portrayed very positive relationships with their parents; they implied that offering support to them is something that they actively want to do – as illustrated by the comment below:

Fiona: My mum hasn't got my dad anymore, but she's happy just when I'm around, I'll do a shop and her washing and things like that and I'll be happy, she's happy.

(Kirkhead)

Providing support to parents was also constructed by a few respondents as being part of a reciprocal relationship (Finch and Mason, 1993). For example, Lizzie, a Kirkhead respondent, implied that she 'feels okay' about helping her mother with housework every week because of the financial support her mother offers at other times:

Lizzie: I usually stay overnight on a Thursday because I help mum on the Friday morning if she needs anything done, um, making up beds, changing dad's bed, getting the washing done, putting the washing down the stairs, bringing it back up.

LA: And how do you feel about doing that?

Lizzie: I'm okay with that, cos I'm doing something for her, and I go out with her, if we're going in town, if I need something, my mum will buy it for me, still. You know, if I've no got the money, she'll say "do you want it?" And I say "well I do, but I'll get it next month, or get it for me and I'll gie you the money". When I go to gie her the money, she'll not take it.

(Kirkhead)

The women's accounts suggest that providing support to parents becomes stressful when respondents feel that their parents are making excessive demands on their time, particularly when respondents have paid jobs and other responsibilities. In the quotation below, Josie, a Kirkhead respondent, talks about the stress generated by her relationship with her mother:

Josie: She usually says what are your days off next week, and I will say "oh Tuesday, Wednesday", and she'll say "oh right", I mean she never says "can we" or what, you know she says "well on Tuesday then we'll go to get my pension and then we'll go to Iceland, or we'll go to...". I mean don't get me wrong, I don't mind going, but it would be nice if she said "would it be alright if on Tuesday", but you know it's like "on Tuesday we'll do this and we'll do that". [...] I have to be firm with her, you know I only have 2 days off a week and I work full time and I work in a demanding job, and there's gonna come a time when I'm not going to have the time to do all the things she'll need me to do.

(Kirkhead)

Analysis of the data indicates that caring for parents can also be stressful if respondents are the sole source of support for their parents. This is shaped both by geography and by the dynamics of family relationships. Eight respondents (four in each sample group) reported that because they live closer to their parents than their siblings, responsibility for caring for their parents has fallen to them. A striking illustration of this is provided by Pam, a Braemore respondent, whose parents moved into her street twenty years ago. Pam has two sisters, but they live abroad, and so she has been expected by her parents to act as the primary source of support for

them. In the following excerpt, Pam describes the stress she has experienced in relation to this caring role:

Pam: My parents have always leaned on me ... they moved down the road here, just 200 yards down the road [...] I was just expected to step over and help if my mother was over-tired in the evening and I always used to feel “well how can I work um if I never know when we'd be called upon”, so//

LA: //And did that ever bother you at all?

Pam: Oh yes, oh yes, and once my mother became ill which meant that we, we needed to, well initially we managed just with domestic help, so she had help with cleaning and then uh help with giving my father supper and then clearing things away in the evening, um, but when she became ill and we needed day carers and sleepovers, oh...my father said “it's your duty to look after your mother” [...] I felt incredibly rebellious, I mean I couldn't say anything really because it didn't help. Once or twice if I did express um, any kind of hesitation um about the level of care I was giving, um...she was in a nursing home for a short time and didn't cope well there and seemed to be going downhill, and he said “oh we must bring her back” and I said “we haven't got the carers ready, uh I need to have care in place, otherwise it's all going to fall on me again”, “but it's your duty to look after your mother” [...] yes, so periodically I would feel rebellious, I would feel gosh I've got to put blinkers on, I can't even day dream about what um life might be like or what I might be doing, I just have to carry on. Um [...] when I really couldn't cope anymore and I felt my health was suffering, um, she was admitted to a special psycho-geriatric unit.

(Braemore)

Pam's account is perhaps an extreme example of the potential stresses associated with providing care to elderly relatives. Her account suggests that the fact that she lives so close to her parents has played a pivotal role in shaping the nature of the caring demands placed upon her. In her case, it not only disrupted her employment trajectory, but her quality of life and well-being were also undermined by the demands placed upon her by her parents. However, Pam's caring responsibilities were undertaken in the context of relatively affluent household circumstances. Her household did not experience material hardship as a result of her not being able to undertake paid employment because of her caring obligations. In another part of her interview, Pam also related how she was eventually able to reduce the number of hours that she spent caring for her parents, by buying in care.

The potential of material resources to act as ‘buffers’ against the stress of combining multiple social roles is also illustrated by Marion, a Braemore respondent who found herself needing to provide care to her elderly mother at about the same time that she started a new (and very challenging) job. In the quotation presented below, Marion describes the stress of being the sole support for her mother, but she also relates how her relatively high income enabled her to spend money on various stress-relieving therapies:

Marion: She went through a period of having physio and I was taking her, and then I had to take on her garden and then I had to take her places, so my time became very much more tied [...] I was having to sort of do a lot for her.

LA: Right, and how did you manage to fit that in?

Marion: Oh with great difficulty, yes, I became very very very stressed, very tired.

LA: And so how did you manage that situation?

Marion: Well I tried to do things like reflexology and have that and go to the floatarium and go for walks, try and do self-help sort of things, try and take time for myself, try and read, but it's very difficult, very difficult, it was a very very bad, it went on for about 3 years ...

LA: Right, and how did you feel about having that caring responsibility?

Marion: Oh um...I got quite angry about it at times, because of course Eleanor [*sister*] was in the south of England and it all fell on me, and I suppose it's a natural human response, at the same time I wouldn't have had it any other way you know, it's a sort of devil and the deep blue sea, you felt responsible and you wanted to do it, but at the same time it was just taking such a lot out of me.

(Braemore)

There are few specific examples in the data of how providing care for parents in the context of material hardship may exacerbate stress engendered by multiple social roles, although the health-relevance of intersections between social roles and material circumstances is well-documented in the literature (Arber, 1997; Macran, 1996). However, one relatively deprived respondent in the Kirkhead sample talked at length about the pressures she experiences in relation to providing childcare for her grandchildren. Celia has health problems and derives her income from benefits. She looks after her grandchildren every day, in order that her daughter can maintain her job as a nurse. In the course of telling a story about an argument she had recently

had with her daughter, she described the nature of the support she offers to her daughter:

Celia: I had done three years already with the grandchildren, feeding them and things like this, and that's not easy on the dole I can tell you. And she was giving me £20 a week. Now when you compare what she would have to pay a childminder...because I was doing really long hours for her, extra hours and things like this. And she somehow or other thought that £20 a week was good money.

(Kirkhead)

Celia feels obliged to assist her daughter by providing childcare, even though she finds this caring work stressful at times. This obligation to her two daughters is a source of stress for Celia, and it sometimes threatens to undermine her sense of well-being:

Celia: I am the complete and absolute support of the family. Without me...the whole edifice would crumble. They are so dependent on me for childcare. Marie [*daughter*] is dependent on me for emotional support and the odd financial help[...] And Lorraine [*daughter*] couldn't function at all, she wouldn't work at all if I didn't look after the children. So there'll be one less nurse for the NHS. Well I wish the government would pay me. And of course I don't think there is any doubt about it that Pat [*husband*] needs my absolute support as a person. So that's how I feel, and sometimes it can be a bit of a strain you know, a bit of a burden, and you don't always want to do it, because you're tired, uh and you do get physically tired. Or perhaps you'd just like not to do it sometime. It's a very very strict regime. You have to be there every day.

(Kirkhead)

In addition to the pressures associated with providing daily support to her daughters, a further potential stressor is the fact that Celia's mother, who lives in the south of England, may also need her support at some point:

Celia: There's also the worry of my mother. You don't know whether she's going to just drop dead or whether she's going to need long-term care. And my two sisters are both dead.[...] I can't tell you really how...old people can absolutely...uh how can I put it? Rearrange your life for you, because I'm already up to here with grandchildren and things and I have to think...of her.

LA: So you're caught in the middle?

Celia: Yes.

(Kirkhead)

Celia's account vividly illustrates how the accumulation of caring roles, particularly in the context of material deprivation, can be experienced as a major source of stress in women's lives (Walters, 1993).

6.4 Marriage, health and well-being

A clear theme to emerge from the data is that it is not simply women's social roles within the family which may shape their experiences of health and well-being: the perceived quality of family relationships is also understood by respondents to influence their health and well-being. Analysis of the data indicates that respondents perceive supportive family relationships to have a positive influence upon their well-being, whereas unsupportive relationships are portrayed by respondents as undermining their well-being, and even their physical health. The health-relevance of relationships is a theme that is present both in abstract accounts constructed in response to general questions about the determinants of people's health, and in personalised accounts of the respondents' lives.

In this section I focus primarily on respondents' accounts of their marital relationships, and their understandings of whether and how their health and well-being has been influenced by the nature and quality of their marriages. I have chosen to examine this relationship in particular for a variety of reasons. All of the respondents in the study are, or have been, married. The quality of the marital relationship has been identified within the health literature as a key determinant of well-being (Miles, 1991). This is borne out by the data in this study; in the interviews, almost all of the respondents talked about the influence that their marriages have had upon their well-being. The connections between the quality of

respondents' marriages and their health and well-being is particularly evident in the accounts of respondents who reported poor marital relationships. Four respondents in each of the two sample groups are divorced; a further three married respondents in the Kirkhead sample reported serious marital problems. Much of the discussion in this section considers the health-related consequences of marriage breakdown and divorce. First, however, I present a brief discussion relating to accounts of positive marital relationships.

6.4.1 Happy marriages: do they enhance well-being?

Of the eight married respondents in the Braemore sample, none reported marital difficulties, and several explicitly talked about their marriages in positive terms. By contrast, only four of the seven married respondents in the Kirkhead sample spoke positively about their marriages. Those respondents who did report happy marriages rarely made direct connections between their marriages and their health and well-being; their accounts tended to describe their relationships with their husbands as contributing more indirectly to their general quality of life, as illustrated by the quotations presented in Table 6.1

Table 6.1 The positive influence of marriage upon quality of life

Braemore respondents	Kirkhead respondents
<p>LA: If you feel that you have a problem you want to discuss, do you feel that you're able to share that with your//</p> <p>Christina: //With my husband, yeah...I wouldn't worry the children with any problems that I've got... my husband's there.</p> <p>Carol: I think I'm, I'm very fortunate, because I think I've got a husband that's very loving and interested in me and supportive and also very helpful.</p>	<p>Shona: I would really miss him if he went now you know, but, and you grow together and when you've had your children and you've been through all the traumas of that and now you've got your grandchildren and things like that, so he is my best friend now you know, cos he understands all my silly carries on.</p> <p>Ruth: George and I are like friends, like sometimes we'll say the same thing and there's really a closeness and like um...it's weird sometimes we'll both come out with the same things, cos we know each other so well and he's my best friend as well as my husband, you know what I mean.</p>

These respondents regard their husbands as providing friendship and emotional support; the data presented illustrate how close emotional ties may indirectly enhance health and well-being.

6.4.2 The influence of marital breakdown on health and well-being

The data reveal more obvious examples of how stressful, unhappy marriages are perceived by respondents to undermine their health and well-being. In total, eleven of the twenty-four respondents have experienced marital separation or divorce; seven in the Kirkhead sample and four in the Braemore sample. In all cases, respondents described their marriage breakdown as a stressful period in their lives, and one which had consequences for their health and/or well-being. In table 6.2 I present data from this subset of respondents, which illustrate this theme.

Table 6.2 The influence of marital breakdown upon health and well-being

Braemore respondents	Kirkhead respondents
<p>Jean: I started getting high blood pressure six months after we got married, which I think is quite telling.</p> <p>LA: Do you think the situation [marriage breakdown] affected your health at all?</p> <p>Jacqueline: Yes I think it did, it psychologically affected me, physically I was exhausted after [having]Chloe anyway, and I put on a lot of weight, huge amount of weight, um but it did come off quite quickly, but yes I got quite depressed.</p> <p>LA: Did this situation [marriage breakdown] influence your health at all?</p> <p>Rachel: I think I was probably quite depressed whilst it was happening, um [...] if I look back it was probably panic attacks I was having, being in the middle of the pub and feeling that I couldn't breathe, just having to get out and sort of rushing out into the car park, so yeah, those sorts of things going on.</p>	<p>Lizzie: I was not a very well person, I had sort of 2 or 3 things went wrong with me [...]bad migraines, really bad migraines</p> <p>LA: And what do you think caused them?</p> <p>Lizzie: Well I think it was living where we were living, and the fact that I didnae have a very happy marriage, cos I certainly got rid of my headaches when I got rid of him [laughter] but it's true...but I think migraines were the worst things.</p> <p>Kirsty: I did suffer a bit of post-natal depression[...] I did see a clinical psychologist, but I think he maintained it was more to do with my marriage, it was more marriage guidance I was needing</p> <p>LA: And did you agree with that?</p> <p>Kirsty: Yes, but Martin wouldn't [go to a counsellor].</p> <p>Tania: After I left Mick I started drinking [...]I committed, tried to commit suicide twice [...] it was all to do with leaving Mick [...] I think that's when I took my first panic attack.</p>

The quotations presented above demonstrate that these respondents understand the stress engendered the breakdown of their marriages to have triggered a range of mental and physical health problems.

6.4.3 Marriage breakdown and housing trajectories

Accounts of divorce also illustrate how marriage breakdown, as well as being inherently stressful, may also set in motion a train of events which have consequences for women's location within the social structure, and within geographical and social space. Analysis of the data reveals that, for many

respondents, marital breakdown precipitated social and economic disadvantage, particularly for those women who had been economically dependent upon their husbands. This had consequences for their subsequent employment and housing trajectories. Although all divorced respondents reported worsening financial circumstances following divorce, comparison between sample groups demonstrates that those in the Braemore sample have nevertheless been able to sustain more advantaged social positions than those in the Kirkhead sample. In total, five of the twelve Kirkhead respondents moved into the neighbourhood following marital breakdown; their reduced income meant that they were unable to access housing in other neighbourhoods with more expensive housing. Of these five women, two moved in with their parents who lived in Kirkhead, two bought flats, and one was housed in social rented accommodation by the local authority.

Table 6.3 (overleaf) compares the post-divorce housing pathways of two respondents; Jacqueline, from Braemore, and Josie, from Kirkhead. Their accounts illustrate how a family-related life event such as divorce may intersect and interact with other dimensions of individuals' social circumstances, and with their health and well-being, in ways which shape trajectories into particular geographical and social spaces. Jacqueline's ex-husband bought her a flat outright as a divorce settlement. This enabled her to sustain home ownership whilst combining part-time employment with caring for her daughter. Jacqueline has been able to maintain a relatively advantaged socio-economic position since her divorce through a combination of steady employment and the accumulation of housing wealth through home ownership in a sought-after neighbourhood.

Josie's story differs from Jacqueline's in several key respects; her divorce settlement was less generous, and since her divorce her employment trajectory has been disrupted through illness. Since her divorce, Josie's story has been one of cumulative social disadvantage. Her divorce may be interpreted as a life event which formed part of a chain of events that together have led to a diminished stock of housing wealth, and which have shaped her housing trajectory out of Braemore and into Kirkhead, where she currently lives.

Table 6.3 How divorce may shape housing trajectories

Jacqueline's story (Braemore)	Josie's story (Kirkhead)
<p>Jacqueline's ex-husband bought her a flat outright as a divorce settlement, where she lived for 18 months</p>	<p>Josie bought a flat in Braemore using money from her divorce settlement as a deposit.</p>
<p>Jacqueline maintained steady employment, doing secretarial work.</p>	<p>In 1992 Josie gave up her job because she was experiencing constant panic attacks. She took two lower-paid part-time jobs. Josie's uncle helped out financially by lending money and buying items of furniture</p>
<p>Jacqueline later sold her flat, and bought a bigger property in a more affluent neighbourhood, where she lived for 5 years.</p>	<p>In 1993, Josie's uncle demanded repayment of the money that he was owed. Josie sold her flat in order to pay her uncle back.: Josie: I mean by this time I owed him about £3000.[...] And at the time the only way out that I could see was to sell my house, pay off my mortgage, pay back my uncle what I owed him and go into a rented flat.</p>
<p>In 1985 Jacqueline bought her current home in Braemore from a friend. She says: Jacqueline: I'd been looking because I had thought that it would be nice to have an upstairs and a downstairs, so that you could have a proper house with a garden and Chloe [<i>daughter</i>] could play in the garden, and [...] this call came through and I said thank you very much indeed, and we got a surveyor out and the surveyor valued it and had a look at it and said yes it would be alright, and Max [<i>friend</i>] and I spoke to each other and Max told me what he wanted and I told him what he'd get and we met in the middle and it was brilliant.</p>	<p>Josie moved into a privately rented flat, and because she was working part-time, she received housing benefit. In 1997 Josie decided that she wanted to work full time and move back into the owner occupied sector. She could not afford house prices in Braemore, so she bought a flat in Kirkhead: Josie: I mean Braemore, you're looking at £90,000, and I would have to be earning between £30- 40,000 to be able to afford that kind of mortgage and I clearly wasn't, so I was gonna have to move to Kirkhead [...] I mean the houses were cheap enough for me to be able to afford a 2 bedroom flat.</p>

The data presented in Table 6.3 demonstrate that the experience of divorce is linked into a range of other health-relevant events and circumstances. The contrasts between Jacqueline and Josie's experiences suggest that the potential relationships between divorce, employment and housing trajectories, and health experiences, are to a certain extent shaped by the prior accumulation of social advantage or disadvantage. These findings indicate that when studying the health-relevance of family events such as marital breakdown, it is necessary to consider the social contexts within which these life events occur.

One of the factors which shaped the impact of marital breakdown upon respondents' subsequent life circumstances was whether or not they were able to access various forms of support from their parents. For example, four respondents, one in the Braemore sample and three in the Kirkhead sample, moved in with their parents when their marriages broke down; this was perceived by these respondents as an important 'safety net'. For example when Marion split up with her husband, she moved in with her mother because she didn't have anywhere to live:

LA: What was it like moving back?

Marion: It was fine, it was wonderful, she's very laid back and there was not sort of...either recriminations, or you're disappointing, or you've failed...so it was fine.

LA: And how long were you there for?

Marion: Well I bought my house the following year, um well I had to wait until I got my job obviously, because you couldn't get a mortgage without a job [...] so probably about a year.

(Braemore)

Another respondent, Kirsty, described moving back in with her parents after her first marriage ended:

Kirsty: I went back to stay with my mum and dad, and they had enough room for me and Rose [*daughter*] [...] they were very very good. They didn't expect me to pay my way. I was spoiled in that respect, because I didn't have it hard, I'll be quite honest about that. I mean a lot of people nowadays, when I see how they struggle, it must be horrendous.

(Kirkhead)

This kind of support has not been available to all of the respondents who have experienced marital problems. Celia, a Kirkhead respondent, explained that her lack of financial resources, combined with unsupportive parents, meant that she felt forced to remain in a stressful marriage for want of viable alternatives:

LA: Why did you stay married?

Celia: For the children. And also I never had enough money to get away, and I once asked my mother if I could come home and she said no, she said I'd send you right back, so there was nowhere for me to go.

(Kirkhead)

Another Kirkhead respondent, Lizzie, also described feeling unsupported by her family, and by social services, when she experienced marital difficulties.

Lizzie: I walked out and left him when Barry was 3 years old, went and stayed with my mother for about 6 months. Then I had a fight with my step-father, so I ended up coming back, so I mean it's all...and at that time you didn't get the support that you get now. [...]I went along to all the nurseries and that, and asked for help, and I told them, but they turned round and said to me "you walked out on your husband, you walk back in. Why should you come to us for help when you've walked out on your husband. You've got a husband who's got a house, somewhere for you to live and you've walked out on him". They didnae take into consideration the kind of life I was having at that time.

(Kirkhead)

These data suggest that the level of support that respondents were able to access from their parents during and after marital breakdown may have mediated the socio-economic and health consequences of divorce (Finch and Mason, 1993). Exploring respondents' relationships with their parents in this context illuminates the complexity of interactions between respondents' family relationships (which are experienced in and through particular geographical settings), dimensions of their socio-economic position, and their health and well-being.

6.5 Conclusions

This chapter has explored respondents' understandings of interactions between their experiences of family roles and relationships, and their health and well-being over the lifecourse. I have considered how women's participation in paid employment has been shaped by both their gendered caring roles within the family, and by their overall household material circumstances – with implications for their health and well-being. Analysis presented in this chapter indicates that gender is a structural axis of social inequality which cuts across socio-economic inequality.

In particular, the chapter has shed light on how caring roles at mid-life may influence health and well-being. Women in both sample groups reported the accumulation of multiple social roles over the lifecourse; in many cases their accounts testify to the stress that may be engendered by 'role overload' (Bartley et al, 1992). There is evidence from both sample groups that having sole caring responsibility for elderly relatives, whilst also caring for children and/or participating in paid employment, can be extremely stressful and may deplete well-being. There are some indications in the data that more affluent respondents in Braemore have been able to draw on their financial resources in order to buffer the potentially health-damaging consequences of their stressful caring roles; for example, by purchasing social care for their parents, or by paying for stress-relieving therapies. By contrast, Kirkhead respondents have been more likely to undertake care in the context of material hardship; their accounts indicate that this has served to exacerbate the stress associated with their caring roles.

Discussion of respondents' caring roles at mid-life highlights the salience of geography for women's experiences of caring for their parents; those respondents who live in physical proximity to their parents reported that providing support to their parents is a significant part of their daily or weekly routines. Those respondents who do not live close to their parents indicated in their accounts that their parents' need for care in the future may determine their own future housing trajectories.

This chapter has also considered the influence of the reported quality of respondents' marital relationships upon their health and well-being. The data suggest that marital discord has more obvious effects upon health and well-being than marital harmony. Respondents in the Kirkhead sample were more likely to report unhappy marriages; however, divorced respondents in both sample groups reported that the breakdown of their marriages had negative consequences for their health and well-being. Accounts of divorce also illuminate some ways in which family events are connected to other health-relevant spheres of life. In particular, I have pointed to divorce as a key point in respondents' housing trajectories into their current neighbourhoods. The health-relevance of respondents' experiences within their respective neighbourhoods is the focus of Chapter Seven.

Chapter 7: Resources for health and well-being (iv): Neighbourhood

7.1 Introduction

In Chapter One, I outlined two approaches to understanding geographical inequalities in health; firstly, explanations which focus on compositional attributes of populations living in particular places, and secondly, explanations which concentrate on contextual features of places themselves (see Section 1.4). So far in this thesis, I have explored how respondents' lifecourse experiences of health, illness and well-being have been shaped by various dimensions of their individual or household socio-economic position. In seeking to shed light on some of the processes underpinning disparities in health between respondents in the two neighbourhoods, I have focused upon their access to material resources, their lifestyle behaviours, their employment trajectories, and their roles and relationships within their families. In other words, I have focused upon 'compositional' influences upon health as a means of understanding geographical inequalities in health. It is evident from the analysis presented so far that where respondents live now both expresses and shapes their material, social and psycho- social well-being. In this chapter I turn my attention more squarely to 'contextual' influences upon health – to ways in which the respondents' experiences of health and illness may be influenced by aspects of the physical and social environments within the two neighbourhoods.

The aim of the chapter is to tease out some ways in which composition and context may interact to shape health experiences. In Section 7.2 I describe the respondents' housing trajectories into their respective neighbourhoods. This offers an insight into the processes through which individuals are 'sifted and sorted' into particular housing tenures and particular neighbourhoods (Smith et al, in press). I present some illustrations within the data of how the experience of illness may itself shape housing pathways. Further on in the chapter I argue that the nature of respondents' housing trajectories into their respective neighbourhoods has had implications for the ways in which respondents experience day-to-day life in Braemore and Kirkhead (Gatrell et al, 2000).

Whilst Section 7.2 traces the respondents' housing trajectories into their respective neighbourhoods, the rest of the chapter does not focus upon housing per se, but rather upon a wider range of contextual features of the two neighbourhoods, considering whether and how these are perceived by respondents to influence their health and well-being. In Section 7.3 I begin my discussion of context by considering respondents' general views about whether where people live may influence their health. In Sections 7.4 and 7.5 I discuss respondents' accounts of their actual experiences of various dimensions of the physical and social environments in which they live. In particular, I explore some ways in which these experiences are understood to impinge on the respondents' sense of well-being.

7.2 Trajectories into Braemore and Kirkhead

Data constructed during the lifegrid interviews offer several indications of ways in which the respondents' housing trajectories have been intertwined with various aspects of their family circumstances and household socio-economic circumstances throughout their lives. The relationship between access to financial resources and the accumulation of housing wealth has already been elaborated in Section 4.3 of Chapter Four (page 103). To recap on this discussion, the respondents' housing pathways reflect the obvious point that more affluent people tend to live in neighbourhoods with relatively expensive housing, whereas less affluent people tend to live in neighbourhoods with cheaper housing. Generally, women in the Braemore sample group have had higher household incomes throughout the lifecourse, which has enabled them to afford housing in Braemore. By contrast, women in the Kirkhead sample have had lower household incomes throughout their lives, and they have ended up living in Kirkhead largely due to the affordability of the housing stock and the presence of local authority housing, which is allocated according to need.

Family pathways are also relevant in the respondents' accounts of their housing pathways. The data indicate that marriage, divorce, the presence of children, and caring responsibilities for elderly relatives may all shape housing trajectories.

Some intersections between family pathways and housing trajectories have been discussed in Section 6.4.3 in Chapter Six.

Tables 7.1 and 7.2 show simplified pathways by which respondents have ended up living in their current homes in Braemore or Kirkhead. The sample groups have been divided according to tenure category. This is important because it gives some indication of the social processes which shape respondents' pathways into particular neighbourhoods (which may then be experienced as health-enhancing or health-depleting). Owner occupation is accessed by ability to pay, whereas local authority housing is allocated according to need. Since health needs have always been prominent among these needs, the presence of local authority housing might account for at least some of the spatial patterning of health problems between the two sample groups.

Table 7.1 Pathways into Braemore

Owner occupation (n=10)	Private renting (n=1)	Housing association (n=1)
<p>6 married R who have spent majority of their married life in one house. (>20 years in current home)</p> <p>2 married R who were brought up in Edinburgh, but spent several years of married life living in other Scottish cities, due to husband's job. Moved back to Edinburgh in recent years, again due to husband's job. (2 years & 15 years in current home)</p> <p>2 divorced R who have moved into the neighbourhood since divorce. (1 year & 15 years in current home)</p>	<p>1 divorced R who moved into the neighbourhood from north of Scotland in order to send daughter to private school. (5 years in current home)</p>	<p>1 divorced R with chronic health problems who stayed with a friend in Braemore after leaving husband. Subsequently moved into newly built housing association house. (10 years in current home)</p>

Note: R= respondent/s

Table 7.2 Pathways into Kirkhead

Owner occupation (n=6)	Owner occupation through Right to Buy (n=4)	Local authority renting (n=1)	Housing association (n=1)
<p>1 married R moved into area to live with parents after divorce. Bought house with 2nd husband. (7 years in current home)</p> <p>1 married R moved into area when children were young, to buy a bigger house. (30 years in current home)</p> <p>1 married R moved into area when husband offered a job. (5 years in current home)</p> <p>1 widowed R moved into area when husband's health problems required home without stairs. (13 years in current home)</p> <p>2 divorced R who moved into area since divorce. (5 years & 2 years in current home)</p>	<p>1 married R who moved into husband's flat upon marriage. (25 years in current home)</p> <p>1 married R whose family were housed in the area by the local authority (medical priority). (15 years in current home)</p> <p>1 married R who was housed in the area by the LA. (35 years in current home)</p> <p>1 divorced R who returned to area to live with mother after divorce. (20 years in current home)</p>	<p>1 divorced R who was housed in the area by the local authority after being forced to leave prior accommodation due to health and safety rules. Remained in flat after divorce. (25 years in current home)</p>	<p>1 separated R who was housed by the local authority after leaving husband. Has recently moved to a house let by a housing association. (6 months in current home)</p>

Note: R= respondent/s

In Chapters Four and Six, I presented data which show how access to financial resources, or family events such as divorce, may shape housing trajectories into particular neighbourhoods. However, one influence upon housing trajectories which has not yet been explored is the presence of chronic health problems. Table 7.3 presents a comparison of the accounts of two respondents whose housing trajectories are similar in that they have been shaped by health problems. However, one respondent now lives in Braemore, and the other lives in Kirkhead.

Table 7.3 How illness may shape housing trajectories

Jean's story (Braemore)	Morag's story (Kirkhead)
<p>Jean and her husband bought a house when they got married.</p> <p>Jean gave up work when her son was born. Pre-existing chronic health problems worsened after her son was born, and prevented Jean from re-entering the job market. She has claimed state benefits for several years.</p> <p>In 1992 she left her husband and went to live with a friend for 9 months.</p> <p>During that time, she heard that a housing association was building homes in Braemore, where she grew up.</p> <p>She managed to secure a house with them, by writing to them explaining her situation. She said:</p> <p>Jean: I wrote a great big long letter to ___ [<i>the housing association</i>], with 10 points of why I wanted to be in this specific development, you know, that I had a sensory impairment, that I had been brought up in Braemore, that I knew the doctors, I knew the churches you know, blah blah blah, I knew the buses, I knew the schools...just please give me somewhere to live in this development. And eventually they finished building and we [<i>Jean and her son</i>] were fortunate enough to get a house.</p>	<p>Morag and her husband bought a house when they got married.</p> <p>Their son was born with a chronic health problem. Morag did not return to work after the birth of her son.</p> <p>When their son was 2 years old, the family were advised by their GP to move house for the sake of his health: Morag: The doctor had said to us we had better get a proper house, because Sandy [son] wasnae well every week, he always had colds and sore ears and everything.</p> <p>Morag's husband changed to a job with tied accommodation, which was considered to be a healthier living space for their son.</p> <p>A year later, Morag's husband was forced to give up his job due to health problems, and the family had to move from their tied accommodation. The family were eligible for local authority housing (medical priority). They moved into a local authority housing estate in 1983.</p> <p>Morag and her family had problems with their neighbours. They requested a transfer, and in 1985 they were allocated a flat in Kirkhead. They are buying the flat under Right to Buy.</p>

These case study examples are illustrative of how housing trajectories interact with individual health status, as well as with employment trajectories and life events such as divorce. Accounts from both women show how health problems may lead to health selection out of the labour market. This precipitates a reduction in income, and makes owner occupation difficult to sustain. In turn this may lead to health

selection out of the owner occupied sector (which allocates housing according to ability to pay), and into the social sector (which allocates housing according to need). What is interesting about these examples is that although both respondents are now in the social rented sector, Jean has managed to access housing in a healthier neighbourhood than Morag. In her account, Jean explained how she applied for housing with a housing association, and was able to secure accommodation in Braemore by emphasising her biographical association with the neighbourhood. By contrast, Morag and her family, in local authority accommodation, have been able to exercise much less choice in where they live.

7.3 General views about relationships between place and health

In the context of discussions about women's experiences of their neighbourhoods, I asked all of the respondents a general question – “Do you think that where you live can influence your health?”. A key finding is that in both neighbourhoods, nine out of twelve of the respondents indicated that they think that where people live *can* influence their health. An important theme in the respondents' accounts relates to how they interpreted 'health' in this context. Amongst those respondents who indicated that they *do* think that where people live may influence their health, almost all of their accounts suggest that they perceive the relationship between area of residence and health to be predominantly related to notions of quality of life and well-being, rather than to physical health. Five respondents in Braemore made passing reference to features of neighbourhoods which may pose a threat to physical health, such as pollution or damp housing, but they then went on to talk in more detail about ways in which well-being may be influenced by aspects of particular neighbourhoods. None of the Kirkhead respondents referred to physical health in their general accounts of how neighbourhood and health might be linked – their accounts focused solely on well-being.

A second important theme, and one which is related to the focus on well-being, is that, on the whole, women responded to this direct and generalised question by focusing on those features of neighbourhoods which may deplete well-being via

the experience of stress, rather than on positive features of neighbourhoods which may enhance well-being. However, in this context, few of the women directly talked about their own neighbourhoods in this way. Rather, respondents tended to place themselves in hypothetical situations in deprived neighbourhoods in their process of thinking through and talking about ways in which their well-being might be undermined by living in a particular type of neighbourhood.

The data extracts which I present below are rather long, but it is necessary to preserve their length in order to illustrate the points which I have made in the preceding paragraphs. I have chosen data extracts either because they are typical of the accounts offered by other women in the same sample group, or because they encapsulate a variety of themes present within the data. The first account is from Hattie, a respondent in the Braemore sample, who places herself in an imaginary situation in order to communicate her views about how place might influence health:

LA: Do you think that where you live can affect your health, or can have any influence upon health?

Hattie: Yeah, well I would say, well yes, if you've got damp housing and things...but can where you live affect your health? I think that probably it's the other way round...let me think about this...if I...if I had split up with Sam [*husband*] and I had no money and I ended up in a flat in the middle of Kirkhead I would be stressed because I wouldn't be living besides like people, um, and I would be fearful for my child for instance, I would be worried about getting mugged, I would be worried about getting burgled, so socially from that sort of side of things, I think that probably it would be very stressful, so you, and that would then affect your health, so with regard to what actually happened within my own house I don't think that it would make much difference, because I would probably make a nice home wherever I was, if you know what I mean, I don't need a lot of money to make things sort of reasonable and nice, but then if you've got a roof that leaks and things then it would be different, you know windows that are letting the cold in, and you can't afford to have the heat on, then...you know, everything's relative, um...But I think people live generally in circumstances that reflect their social standing shall we say.

(Braemore)

Hattie's account makes reference to aspects of the physical environment which are directly health-related, such as damp and cold housing. However, her

account primarily focuses upon her perceptions of what it would be like if she were forced to live in a relatively deprived neighbourhood. She suggests she would find this stressful because she would not be living amongst people that she felt comfortable with – she would not be “besides like people”. Thus, the main focus of her account is upon aspects of the socio-cultural environment that may potentially be experienced as stressful, and undermine well-being.

The second quotation is from Fiona, a Kirkhead respondent. Her account is similar to Hattie’s, in that she also imagines herself in a neighbourhood that is more deprived than Kirkhead, and identifies aspects of the socio-cultural environment that she perceives would undermine well-being:

LA: Do you think where you live can have any effect on your health?

Fiona: Well I suppose so yeah. I think if you were to put me in [*a more deprived area*] and every day you were to see people that didn’t work, and maybe young teenagers that are on drugs and um there’s no motivation in the area[...] I think it would be quite depressing to stay in an area like that.

(Kirkhead)

Another Kirkhead respondent, Kirsty, also indicated that she understands there to be connections between place and health, which again is mediated by the experience of stressors associated with the social environment:

LA: Do you feel that where you live can have an influence upon your health?

Kirsty: Well I think you can, because I think if you have a stressful time with people, with neighbours, or with, just upsetting, you know depending on people's level of coping, and standards etc. if there's difficulties I think then that can reflect, that can make people more insular, cos they can't handle it, therefore they don't go out and they want to keep in their homes, so I think that can have a big influence. [...] if you feel threatened, if there are gangs of youths hanging around on street corners and things like that, that can threaten people and therefore have a bearing on how, you know, whether you feel comfortable walking around the area, or whether one wants to, if you can afford to have a car, and are lucky enough, or whether you have to stand at bus stops, and therefore whether or not you feel comfortable to go out at night, or feel frightened of coming back late at night, going through dark streets, so I think that the environment does have a big bearing on health .

(Kirkhead)

The final quotation is from Diane, a Braemore respondent. In common with the other respondents whose accounts have been presented in this section, Diane perceives the relationship between place and health to be primarily associated with well-being (although she does initially refer to pollution and physical health). Diane's account contrasts with the others because she draws on her own experience of her neighbourhood to illustrate ways in which place might enhance health:

LA: And just thinking generally about places and neighbourhoods, do you think that where you live can have any effect on somebody's health...do you think that places can affect your health in any way?

Diane: Well, pollution would affect your health if you lived in a city centre, I would have thought it could, and that's something you know that I'm aware of, I have a feeling of the air being reasonably clean - I'm sure it's not very clean at all, but the fact that it's sort of open and accessible to the country and so on makes me feel that it might be reasonably healthy...um, I mean noise levels affect people's mental health and this is very quiet...um, neighbourhoods...and obviously neighbourhood relationships affect your sense of well-being in the sense that if you have problems with your neighbours it can really get you down...geographically I don't know...having a garden means a lot to me, but it doesn't mean a lot to certain people, but if it does mean a lot to you then it would affect your general well-being, um, I mean there are some people who don't ever want a garden and I mean that's fine, but um, it's incredibly important to me to have somewhere that you can go out into you know, a sort of safe space where you can have a sense of things growing.

(Braemore)

Together, these data illustrate not only that respondents *do* perceive there to be a relationship between place and health, but they also indicate *how* they understand this relationship to operate. There is some reference to physical features of the environment which may influence health, such as pollution and housing quality. However, the data which I have presented here are illustrative of a dominant theme within the data, which is that respondents in both sample groups indicated that they perceive there to be a relationship between place and well-being (rather than physical health). The emphasis which respondents placed upon notions of well-being (in a context where I used the term 'health' in my questions) reinforces an argument that I made in Chapter Three, which is that the majority of the respondents consider well-being to be a key dimension of 'health', and one which may be both conceptualised and experienced independently from aspects of physical health such as the presence/absence of disease and illness (see Section 3.2). Furthermore, these data clearly suggest that there are psycho-social dimensions to the experience of place.

In the next section, I move beyond generalised views about the relationship between place and health/well-being, to explore respondents' accounts of their own everyday experiences in Braemore and Kirkhead. I discuss respondents' understandings of contextual influences upon their own health and well-being, and interpret these findings with reference to theoretical ideas about the interactions between place and health.

7.4 Contextual influences upon health and well-being – respondents' own experiences

Data on the topic of everyday experiences within Braemore and Kirkhead were constructed in a variety of ways. As well as asking open ended questions, such as “How would you describe the neighbourhood?”, I also asked women specific questions about particular aspects of their neighbourhood, if they hadn't already been mentioned spontaneously in the respondents' accounts. These specific questions covered a range of topic areas, including housing, relationships with neighbours, whether they know their neighbours, and whether they feel that their neighbourhood is well served with facilities and services. I also asked respondents about their perceptions of features of the neighbourhood that are good for health, and those that are bad for health. Data relating to neighbourhood experience were also constructed indirectly, in the course of respondents talking about their everyday routines.

The data collected on respondents' experiences in their respective neighbourhoods are complex and richly detailed. My analysis of respondents' understandings of how their health and well-being is shaped by contextual features of their neighbourhood has drawn on the conceptual framework proposed by Macintyre et al (1993). Macintyre and colleagues suggest that contextual influences upon health fall into five main categories – these are presented in Box 7.1.

Box 7.1 Contextual influences on health

(adapted from Macintyre et al, 1993: 220-221)

- 1. Physical features of the environment shared by all residents in a locality**
Air and water quality, climate etc.
- 2. The availability of healthy/unhealthy environments at home, at work and at play**
This relates to issues such as housing quality, affordable and nutritious food, and safe recreation. Opportunities for healthy environments may be spatially uneven.
- 3. Services provided, privately or publicly, to support people in their daily lives**
For example, transport, health and welfare services, street cleaning and lighting, and community organisations
- 4. Socio-cultural features of a neighbourhood**
Including the socio-economic history of the area; norms and values, the degree of community integration, levels of crime and other perceived threats to safety, and networks of community support.
- 5. The reputation of a neighbourhood**
How areas are perceived, by their residents, and by outsiders, may influence the self-esteem and morale of the residents, and also who moves in and out of the area.

Analysis of the data within this conceptual framework revealed mixed findings with regard to respondents' perceptions of contextual features of their neighbourhoods. There is some overlap between the two sample groups – for example, in terms of their experiences and views of the physical environment, and the provision of services and facilities. There are also some commonalities between the two groups in terms of their accounts of their relationships with neighbours – an aspect of the socio-cultural environment. However, what emerged most strongly from the data were the stark contrasts between the two sample groups in relation to their accounts of the healthiness of their home environments, various aspects of their socio-cultural environments, and the reputation of their respective neighbourhoods. Data from the Kirkhead sample group are particularly illuminating in suggesting how contextual features of particular places might be experienced in ways that influence well-being. In Subsections 7.4.1 – 7.4.4, I consider commonalities in the experiences and perceptions of the two sample groups.

7.4.1 Common themes: the physical environment

Three respondents in Braemore and two in Kirkhead talked about their neighbourhoods as being healthy because they are located on the outskirts of the city. Proximity to countryside (particularly to the “hills”) was offered as a reason for the perceived healthiness of the two neighbourhoods, as is the observation is that “the air here is good”. The two quotations below illustrate this theme:

Morag: That’s why they had the [*local hospital*] here, because [*it*] used to take people with [...] chest complaints and that, and that’s why they used to put them out here, because the air here obviously isnae as polluted as it is in the town, and being near the hills.
(Kirkhead)

Esther: The proximity to somewhere like [*local park*], to be able to go and have fresh air and exercise, and the switch-off thing is very good for you.
(Braemore)

The fact that the perceived healthiness of the physical environment was only mentioned by a minority of respondents perhaps reflects a point made in Section 7.3, that respondents primarily indicated that they perceive place to influence well-being, rather than physical health.

7.4.2 Common themes: the provision of services and facilities

Respondents in both neighbourhoods tended to describe their local areas as being well-served by services and facilities such as public transport, supermarkets, doctors’ surgeries, libraries and post offices. It is important to note that these accounts were not offered in response to questions about what might promote ‘health’ per se; rather, women talked about services and facilities in the context of what they like generally about their neighbourhood. However, this theme corresponds with the second and third categories of contextual influences upon health identified by Macintyre et al (1993). Whilst not directly related to health in the respondents’ accounts, the data indicate that respondents regard the availability of these services as a positive feature of their neighbourhoods, promoting the quality of day-to-day life in the area.

Provision of public transport emerged as a particularly strong theme in the Kirkhead data. This is not surprising, given that ten out of twelve of the Kirkhead respondents either do not have a car, or do not have access to a car during the day time. Many of these women are dependent upon public transport in order to undertake routine activities such as going to work, doing food shopping, visiting relatives and engaging in social activities. Table 7.3 shows data from women in both neighbourhoods, indicating similarities in their perceptions of the provision of services and facilities in their local areas.

Table 7.4 Health promoting aspects of the local area: provision of services and facilities

Braemore respondents	Kirkhead respondents
<p>Stella: I mean you hop on a bus and you're down Lothian Rd down to Princes St so I mean it's very convenient for the town and so on, not that I'm down the shops all that lot, but I think it's just the fact that you know, it's easy, you know to do it.</p> <p>Christina: The local school's very good, convenient for public transport, plenty of open parks...church is there, tennis is there, you can walk to the library, walk to the shops, very convenient.</p> <p>Sarah: [...] just to be able to have the post office, the doctor's, the dentist, the chiropodist, the basic shops in the same place.</p> <p>LA: In terms of thinking about things like services and transport and shops and things, how well placed would you say that you are?</p> <p>Rachel: Very, very well placed indeed, compared to some of the places that I've lived in, in the lap of luxury [<i>laughter</i>] definitely, yes, extremely well off in all those departments.</p>	<p>Lizzie: You've got the buses running up and down. That's the thing I like about it is I can go down to the bottom of my stair and I get a bus and it takes me into town, I get off the bus just opposite and I'm home. You know, I'm easy, even going up to my mum's, I go across the road there, I get any bus that takes me up to my mother's. And across the road at her's and there are 3 buses than can bring me back down.</p> <p>Mary: We're lucky in Kirkhead, we've got a good library up the road, um if you're religious there are plenty of churches of different denominations, um the two supermarkets, well in fact three supermarkets, cos there's the Co-op along the road as well, there are shops up at the [<i>main street</i>] and shops just across there, shops at [<i>local shopping centre</i>], ah doctor's surgery just up the road, community centre and there's a new one across there [...] I've got a park nearby.</p>

It is important to note the similarity of responses between the two sample groups, as it would be easy to assume that Kirkhead, as a relatively deprived neighbourhood, is inadequately resourced in terms of services. The need to engage with lay accounts in order to 'look beyond' taken for granted assumptions about the nature of particular places has already been identified in the literature (Macintyre et al 1993; Gatrell et al, 2000). This is reinforced by the comments of two women within the Braemore sample, who live some distance from the main road through the area, which is where most of the shops in the neighbourhood are located. These two women do not have access to any shops in the immediate locality, and their accounts suggest that they perceive this to be a disadvantage associated with where they live. Although these women have cars and thus are able to access shops some distance away, their comments indicate that proximity to shops is as important as accessibility:

Hattie: There's sort of nowhere just to go and get a pint of milk...the closest shops are actually at the bottom of those high rise flats, which is about 10 minutes walking round [...] that's Kirkhead, so I mean that's the housing estate, so it's not the ideal place to be pram pushing.
(Braemore)

Carol: [...] Not very well placed in terms of shops...um yep, not particularly well placed [...] the nearest shop's Kirkhead, or down at [*local school*], or the, the service station on the main road.
(Braemore)

7.4.3 Common themes: relationships with neighbours

The degree of community integration and networks of community support are two health-relevant aspects of the social environment which have been identified by Macintyre et al (1993) as part of their proposed conceptual framework for exploring area influences upon health. In the wider social capital literature too, the nature and density of social ties (within particular neighbourhoods for example) is held to be an important component of social capital – a construct routinely linked with psycho-social well-being (Bullen and Onyx, 1998; Wilkinson, 1996). Within this literature it is argued that the level of social capital within a locality may be assessed by examining social networks, associational activity and social trust (Kawachi and

Berkman, 2000; Kawachi et al, 1997; Lochner et al, 1999; Putnam, 1993). Within the field of public health, proponents of the social capital thesis contend that social capital mediates between income inequality and poor health, arguing that the poorer health profiles of relatively deprived areas may be explained by low levels of social capital (Cattell, 2001; Wilkinson, 2000).

My research was not designed to explore how theoretical concepts such as 'social capital' might find expression in individuals' accounts of their life experiences. However, there are some connections between various themes within the social capital literature and data constructed during the research - particularly with regard to respondents' views and experiences of aspects of social relations in their neighbourhoods. Here, I consider respondents' accounts of their relationships with their immediate neighbours.

According to the social capital literature, it might be expected that respondents in the Braemore sample would report relationships with their neighbours which are qualitatively different from (and more health-enhancing than) those reported by the Kirkhead respondents. In fact, there are strong similarities between the two sample groups in terms of respondents' accounts about their relationships with their immediate neighbours. Within both sample groups there are women who reported very positive relationships with their neighbours; there are also respondents in both sample groups who reported minimal contact with their neighbours. A very small minority of respondents reported negative or hostile relations with their neighbours.

Four respondents within the Kirkhead sample and six within the Braemore sample reported good relationships with their neighbours. The accounts of this subset of respondents indicate that these women actively engage with their neighbours in a variety of ways. A range of comments from this subset of respondents is shown in Table 7.5.

Table 7.5 Positive relationships with neighbours

Braemore respondents	Kirkhead respondents
Friendly neighbours	
<p>Diane: In terms of the people, I think it's, I find it very friendly, I have quite a sense of community here I suppose.</p>	<p>Fiona: I've got really nice neighbours. I've got a girl up the stair, wi' her husband and they're really friendly, and I've got a man across, he's a paramedic, so he knows certain people I work with [...] it's good.</p>
Social activities with neighbours	
<p>LA: How would you describe the people round here? Marion: Quite outgoing, aha, but very friendly, yes, it's a nice, this street in particular, is very friendly, very pleasant, we do a lot of things together, there's a wives' dining club, we sort of go out every 3 months for dinner as a group, which is good fun, and I've been included, well I knew them all anyway, so that's good.</p>	<p>Shona: I've always had quite a good neighbour, I suppose it's quite sociable. We had a fabulous New Year party round in my garden, cos I've got that great um... great bit there and uh we had a wee committee that was set up and there were fireworks in the garden, and tables and balloons, and all the kids came, it was a fabulous night, a really good night.</p>
Exchanging favours with neighbours	
<p>Hattie: If I need an egg for a cake I will not hesitate to go and ask Diane if she can lend me an egg for instance, and she does the same with me, um... so I mean it's, and if I needed help, if I had an emergency I wouldn't hesitate to go and ask them for help and again they would hopefully do the same.</p>	<p>Ruth: If there's anybody ill they're all there to help you, if there's an emergency they're there to help, if there's anything wrong with your car, anything like that they're all good to each other.</p>
Looking after neighbour's houses when they are away	
<p>Hattie: I've got keys for Diane and Bill's, and I've got keys for Caroline, and water their plants when they're away, you know, keep an eye on the place, and move the curtains and they do the same for me, so I mean you know it's supportive from that point of view.</p>	<p>Ellen: When Betty goes away on holiday I look after, shut her curtains and water her plants and vice versa, if I'm going away she'll shut my curtains and water my plants.</p>

These data suggest that these respondents' positive relationships with their neighbours contribute to their quality of life, and to their overall satisfaction with living their neighbourhood. First of all these women conveyed a general sense of friendliness between themselves and their neighbours: in other examples in the data,

this is expressed with reference to stopping to talk with neighbours in the street or over the garden fence. Engaging in social activities with neighbours is another indicator of positive relationships, even if this only takes places relatively infrequently. The data also indicate the existence of reciprocity and trust between these respondents and their neighbours; this is variously expressed with reference to exchanging small favours with neighbours, being able to call on them in emergencies, and looking after neighbours' homes whilst they are away.

The similarity of accounts presented in Table 7.5 is very interesting in light of the literature on social capital, which suggests that social ties, trust and reciprocity (indexes of social capital) are weaker in relatively deprived areas compared to those found in more affluent neighbourhoods (Kawachi and Berkman, 2000). There is no evidence from the data presented in Table 7.5 that the relationships that this subset of Kirkhead respondents have with their neighbours are qualitatively different from those experienced by these Braemore respondents.

A common theme within the accounts of this group of respondents (who reported good relationships with their neighbours) is that what makes relationships with neighbours work is a sense of friendliness combined with a respect for other people's privacy. The following quotations are illustrative of this theme:

Diane: There's no sort of intrusion, we all live separate lives really.
(Braemore)

Shona: Yeah, we're neighbourly but it doesn't extend, I mean we all know one another, and I'm sure if anything happened, I mean well Roger died and we were there for Maggie and organised the funeral and everything, but if anything happened, but we don't....go in and out each other's houses, I think that's probably why it's such a success....nobody makes demands on the other.
(Kirkhead)

Ruth: Everybody's there for everybody, but we don't go in and out of each other's houses. I'm not saying that I don't ever go in, but what I'm saying is we don't make a habit of going into each other's houses.
(Kirkhead)

My interpretation of these data is that whilst these respondents do seem to experience reciprocity and trust (supposedly key dimensions of social capital) in their relationships with their neighbours, at the same time, this is balanced with the need to maintain an appropriate distance.

The theme of living separate lives, and “not going into one another’s houses” is central to the second category of accounts, from those respondents who report more neutral relationships with their neighbours. The accounts of five respondents in Braemore, and four in Kirkhead may be considered to fall into this category. In common with the first group of accounts, this subset of respondents indicated that they feel able to call upon their neighbours in an emergency, or exchange small favours with their neighbours. However, there is also a sense within these accounts that the respondents do not feel that they have much in common with their neighbours. There is also little indication in these accounts that this subset of respondents have a desire to develop their relationships with their neighbours. Table 7.6 presents a range of data from respondents in both neighbourhoods, which illustrate this subset of respondents’ more distanced relationships with their neighbours.

Table 7.6 Distanced relationships with neighbours

Braemore respondents	Kirkhead respondents
<p>LA: Do you know your neighbours? Esther: I have always got to know the neighbours in the adjoining houses reasonably well. LA: Right, right Esther: I mean sufficiently so we can help out in emergencies, and yes, but I often feel quite guilty that new people that come in opposite or down the road, I, I don't have time to get to know...I feel guilty about that.</p> <p>LA: Do you know your neighbours? Jacqueline: Yes I do, but only because I've lived here for a long time, um and they, the houses have all changed hands since we've been here, so we've always said hi to the incomers, and when I first moved up here, there was a family living across the road who had children either side of Chloe [<i>daughter</i>] in age, and they um introduced us to the neighbours and things, and that was nice, that was lovely, it's not something I've done, but on the other hand I've always said hello to them, we're all on nodding terms, all of us [<i>laughter</i>] and that's nice but we don't um impose on each other's lives, which is nice.</p>	<p>LA: Do you feel part of the neighbourhood here? Mary: Um, I've never mixed very much...with the...with the neighbours, you know, I've never lived in their houses, that's to say gone in and out for coffee and things, but that's just me, cos when I was working you know I didn't have the opportunity, and er I like to have my little bit of privacy.</p> <p>Kirsty: Well I don't really bother with neighbours, I have to be honest. I think um...I mean I can say hello to a neighbour and be aware, but I've not ever created since I've been here any social contact with neighbours, I just come and go, say hello and get in my car, or say hello when I'm in the garden. I don't want to particularly cultivate, at my stage in life I feel I have enough social life you know established that I don't need any more people in my life. But I mean I would help somebody if they needed it, if I was aware of an elderly neighbour who needed shopping, you know I'm not unaware of the people who live in the houses.</p>

Respondents in this subset tended to explain their more distanced relationships with their neighbours in terms of their own personal preferences. This suggests that these respondents perceive their relative lack of close relationships with their neighbours to be an internal issue relating to choices that they themselves have made, rather than as a reflection of more general characteristics of their neighbourhoods. Furthermore, there is little suggestion in the data that these respondents perceive the nature of their relationships with their neighbours to be related to their sense of well-being.

As with the previous subset of respondents, what is interesting about these data is that there is little difference between the two sample groups in terms of their views and experiences; respondents' accounts of relationships with their neighbours do not seem to be differentiated by social class. So, in the quotations presented in Table 7.6, Jacqueline says that introducing herself to her neighbours is not something that she herself has done, and Esther comments that she hasn't had time to get to know new neighbours. Similarly, in the Kirkhead sample, Mary and Kirsty indicate that they have actively chosen not to engage with their neighbours, although Mary also links this to not having the opportunity to get to know her neighbours during the years when she was working.

These data raise questions about the social meanings attached to relationships with neighbours, and about the health-relevance of these relationships. Analysis of the data offers no indication that the nature of these respondents' relationships with their neighbours has a bearing upon their perceptions of more general social relations or quality of life in the neighbourhood. Moreover, it would appear that this subset of respondents do not view the quality of their relationships with their neighbours as having relevance for their own health and well-being. Indeed, the data suggest that these respondents do not expect their relationships with their neighbours to fulfil particular emotional or practical functions that might be related to health and well-being. If respondents made any reference at all to the health-related aspects of personal relationships, it was much more likely to be in the context of talking about their friends and family. (It is interesting that out of the twenty-four respondents, almost all reported that their close friends do not live in the neighbourhood). The relative unimportance of the quality of relationships with neighbours, compared with those of friends, is illustrated by the following comments from Sarah:

Sarah: Every so often I think you know all these people round and about, I really have very little to say to them. But of course, when you choose where to live you don't choose to go, you don't know the neighbours, you don't choose where to live where you're going to have something that fundamentally in common, or spend your whole life with neighbours, so therefore that in some ways that is what neighbours are, as opposed to friends that you choose.

(Braemore)

These data suggest that for this subset of women, having minimal or no contact with their neighbours is not perceived to have a detrimental influence upon their sense of well-being.

To summarise the discussion about relationships with neighbours so far: analysis of the data indicate that whether or not respondents reported close ties with their neighbours does not vary noticeably between the sample groups; a finding which supports the results of a recent quantitative study by Mitchell et al (2000). Neither do relationships with neighbours appear to be significant in explaining differences in well-being between the two sample groups. There is little evidence of poor quality relationships with neighbours, and so it is not possible to say (on the basis of these data) whether aspects of relationships with immediate neighbours might have a negative effect on health and well-being. (However, in Section 7.5.2, I consider how the quality of social relations in the wider neighbourhood might undermine well-being.)

There is one potentially important exception to these findings relating to respondents' relationships with their neighbours. For five women in the study, a lack of contact with their neighbours does seem to contribute to a sense of social isolation, which in turn I interpret as having deleterious consequences for well-being. Four of these women live in Kirkhead, and four are in the low income category. All five of these women have at least one chronic health problem. Accounts from this subset of respondents suggest that there are overlaps between poverty, poor health and social isolation; in combination these seem to contribute to diminished well-being. All five women exhibit signs of poor mental health, and three have received treatment for depression, either currently or in the past. Below, I present accounts from two of these five women in order to illustrate how a lack of contact with neighbours may act in conjunction with other dimensions of social deprivation to influence well-being.

Vignette 7.1 Linda's story

- **Linda, a widow, lives with her daughter, in Kirkhead. She does not know her neighbours:**

LA: Do you know your neighbours?

Linda: Um, not really....the lady above me is not living there at the moment, she's in her 80s, she's just along the road with her daughter I think, but she's not been here for about 9 months you know, so I've nobody above me at the moment, um....next door that way, no, don't even know their name you know. That way, yes, and sort of vaguely, just you know say hello and that sort of thing, but nothingno, not in each other's houses or anything like that.

- **She believes that her health problems have prevented her from getting to know people in the neighbourhood:**

LA: Do you enjoy living in this local area?

Linda: Yes, aha....it's okay....maybe if I did get out, was able to get out more you know, and meet more, maybe be more mobile, you'd probably meet more people, but that's not their fault, you know, it's because you're not able really.

- **She has one friend, who she sees every three weeks. However, Linda has mobility problems, and she finds travelling on public transport increasingly difficult:**

Linda: I'm finding that more and more difficult, getting the bus, I find that quite hard, you know.

LA: Yeah, do you think that prevents you from going out more often?

Linda: I think it does, yeah.

- **Linda's accounts indicate that her well-being is relatively poor. I interpret this as being connected to her social isolation She acknowledges that sometimes it is hard to get on with life:**

LA: So what do you do when you feel like you've got problems or things? How do you deal with that?

Linda: Um...now just inclined to...just keep them to yourself you know...um...and just sometimes have a wee you know, a weep. Um...and then you sort of, you've got to get yourself out of it you know, as soon as you're into it, and you've got to get on you know, can't let things um...sometimes it's harder than others.

Vignette 7.2 Celia's story

- **Celia, a married respondent who lives in Kirkhead, does not know her neighbours:**

LA: Have you got to know any neighbours here?

Celia: No, in fact that lot next door won't speak to us, I say hello and straight past, and I thought *what have I done?* They don't know us, they don't know me. Uh, and I thought funny people, so I thought I won't bother, it's their problem, not mine, you know. Uh...so um and the lady downstairs, she's a pensioner now and she has her own life. She's a wee bitty odd, but then I'm not surprised, she's had a tough time of it. She had her elderly mother until a couple of years ago, and I think it was sending her round the twist. We always say hello, but she's not um, not somebody I'd like to really, I couldn't actually get really close to her.

- **Celia and her husband are both on state benefits. Poverty restricts their opportunities for social participation:**

Celia: When you are unemployed you cannot afford a car. And yet you're expected to raise the cash for your bus fares to get to sign on. Um, you are literally pinned to the house. You can go for a walk locally around the pavements, but that's it.

- **The stigma of unemployment has also led to reduced social contacts:**

Celia: You know, this must happen to lots of people. Of course, you never hear about them, cos everybody's hiding, you know we're ashamed...so nobody really contacts each other, you know. [...] I don't have any friends at all.

- **Celia suffers from depression:**

LA: how would you say you feel on a sort of day to day//

Celia: //With the Prozac, not too bad, but without it, impossible, I just couldn't cope.

These accounts from Linda and Celia suggest that whether or not individuals know their neighbours may be more relevant for health and well-being in the absence of other material and social resources (Cattell, 2001; Whelan, 1993). Linda and Celia suggest in their accounts that the fact that they don't know their neighbours is less a matter of choice as it is a case of constrained circumstances. Linda is not

physically able to spend much time outside of her home. For Celia, perceived rejection by her neighbours, and the financial hardship and shame of unemployment are all portrayed as barriers to social participation. For the five women who are socially isolated, the lack of relationships with their neighbours seems to be a dimension of social disadvantage that overlaps with and reinforces their economic deprivation; cumulatively, these aspects of their social circumstances serve to deplete their sense of well-being.

In this section, I have explored accounts of respondents' relationships with their neighbours. The data indicate that there are considerable similarities in the reported experiences of the two groups of women; in both sample groups there are some women who reported positive and close relationships with their neighbours, and others who indicated that their relationships with their neighbours are more remote. If social networks and levels of trust between neighbours are taken as indicative of social capital, then there is little evidence from these data to indicate that respondents in Kirkhead have access to lower stocks of social capital than those in Braemore. From these data at least, the social meaning and health-relevance of relationships with neighbours is ambiguous. Although those respondents who reported good relationships with neighbours suggested in their accounts that this is a feature of their neighbourhood experience which enhances quality of life (and, by implication, their well-being), it is not obvious that those women who do not have close relationships with their neighbours perceive this to undermine their experience of the neighbourhood or their sense of well-being. There is some indication in the data that for a minority of respondents who experience multiple forms of social deprivation, a lack of contact with neighbours serves to reinforce a sense of social isolation; this may be connected to the poor well-being reported by this subset of respondents.

7.4.4 Summary of common themes between the two sample groups

So far, I have presented data which indicate that there are some commonalities between the two groups of respondents in terms of their perceptions and experiences of various health-related contextual features of their neighbourhoods. However, in the rest of this chapter I wish to highlight the contrasts

in accounts offered by respondents in the two neighbourhoods. I draw on the data to argue that aspects of the physical and social environment in Braemore tend to be experienced as resources which enhance well-being, whereas there are several aspects of the physical and social environment in Kirkhead that tend to be experienced as stressors, which deplete well-being. In the following sections, I first discuss accounts from the Braemore respondents, and then move on to discuss accounts from the Kirkhead sample group.

7.5 Braemore: an environment which may enhance health and well-being

The accounts offered by respondents in the Braemore sample suggest that, on the whole, these women's sense of good health and well-being is enhanced by various aspects of the neighbourhoods in which they live. Almost all of the Braemore respondents talked about having positive perceptions of a range of features of their physical and social environment. Furthermore, several respondents also highlighted the absence of potentially stressful neighbourhood features, and again concluded that Braemore is a healthy place to live. Braemore respondents tended to talk about the neighbourhood as being both a healthy place for 'people generally', and also as a place in which they themselves feel happy and secure. Very few of the respondents made negative comments about particular aspects of the neighbourhood, and those points that were raised were generally acknowledged by the respondents to be relatively minor. Several respondents, when I asked them whether there are aspects of the neighbourhood that they don't like, were unable to think of anything at all.

I have already highlighted geographical location as a positive aspect of the neighbourhood that was identified by some of the Braemore respondents (see Section 7.4.1). Two respondents also made more specific comments about the pleasantness of their neighbourhood's physical environment. For example, in describing the neighbourhood, Christina said:

Christina: This is a nice area, the houses are well-kept, the gardens are well-kept, there's not litter in the streets.... People care about their environment, apart from the dogs....no, it's a nice place to stay.

(Braemore)

And again, in response to a question about whether she considers Braemore to be a healthy place to live, she commented:

Christina: Yes...well there's not litter lying around in the gutter, there's no burst plastic bags lying around, like there is on some of the housing estates.

(Braemore)

Most of the women's accounts revolve around positive aspects of the socio-cultural environment. For example, the quietness of residential streets was mentioned by five respondents, as illustrated by the following quotations:

Jean: It's good along here because there's not much noise at all. I mean you get the occasional students and things walking along here back to their flat, drunk, screaming and shouting, but it's not that often.

(Braemore)

Pam: It's a very nice neighbourhood, um it's amazingly quiet, I mean people who use this room, maybe visitors who come and use the bed-settee are amazed how quiet the front is, and certainly the back is.

(Braemore)

Although in itself, living in a quiet neighbourhood may not appear to be a significant predictor of health, these lay accounts indicate that it is an important contributor to quality of life. Later on in the chapter, in Section 7.5.1, I offer contrasting data from the Kirkhead sample which suggest that for some respondents, noise is a significant stressor associated with living in Kirkhead.

Another positive feature of the socio-cultural environment identified by women in the Braemore sample is that generally, respondents feel very safe in the neighbourhood. Fear of crime has been identified within the literature as a potential mechanism underlying area differences in health (Chandola, 2001; Jones & Duncan, 1995; Macintyre et al, 1993). Thus, a neighbourhood in which individuals feel safe

might be considered to be relatively health-promoting. The following quotations indicate how a sense of safety contributes to the respondents' quality of life in the neighbourhood:

Rachel: It feels safe here, I mean I think that's another reason why I'm quite happy to go and leave the flat with Joanna (*daughter*), because I feel as if I'm leaving her in a safe environment.
(Braemore)

Diane: It feels like a safe area, and quite a quiet area in terms of traffic.
(Braemore)

For the purposes of discussing how particular features of neighbourhoods might promote or undermine well-being, I have so far in this chapter considered individual features separately. However, a strong theme within the data is the extent to which respondents talked about various positive aspects of the neighbourhood together. This suggests that individuals may perceive their neighbourhoods to be more or less health promoting on the basis of the interaction, or the cumulative impact of individual features of the physical and socio-cultural environments. For example, Carol said:

Carol: It's a pleasant environment with nice neighbours and no threats to your personal safety, you've got a good bus service and um...all these things all add up to, you've got a park nearby, you've got [*local park*] just over there, all these things add up to being more healthy.
(Braemore)

This sense that there are multiple dimensions of the neighbourhood that together are experienced as being beneficial for health and well-being is perhaps best summed up in the following lengthy excerpt from an interview with Jacqueline. This excerpt is extremely rich in detail, and draws together many of the themes in this section. Jacqueline's account was prompted by a general question about whether she thinks that where one lives may influence health, but it is in fact a very personalised account, based upon her own experiences. It offers a very useful insight into lay understandings of how health and well-being may be influenced by the neighbourhood context:

Jacqueline: It's a very easy place to be very healthy, um because the air is good and it's not near any pollution, um particularly, um we're high up so the air is fresh and we don't get the sort of dips that there are in valleys and things, um and I think that's probably made a big contribution to keeping me well, and physically, and mentally and psychologically as well, because it's, it's you know, I'm content, I love it here, um and that must have a big effect on my being well, on my well-being, um cos I feel happy when I'm here and I like pottering about, so yes, I think it does, um, when I said earlier that if the worst came to the worst and I had to move, and be re-housed in one way or another I don't know how I'd cope in a high-rise flat, I would because I had to, but I think the combined effect of the necessity and the location and the kind of amenities that would be available, it wouldn't have been easy to deal with at all, and it's because I've been very lucky, I've got this and I don't need to think about it too hard, but I think they all contribute a great deal to how you feel, but worry's not there, and stress isn't there, and noisy neighbours you know [...] I think I've been extremely fortunate because we have escaped some of the horrendous stories you hear about other people, and...I've lived this long up here without a burglary, um and I'm actually a bit relaxed about security now, I didn't used to be but I am now, the window stays open from time to time, but it's a good area to be in, it's a good safe area, parking's free, what more could you want? [laughter] So I think we've got a very very good quality of life.

(Braemore)

In summary, my interpretation of the data is that it is of personal significance to women in the Braemore sample that in the course of everyday life, they generally do not have to contend with stressors arising from the physical and social environment. Furthermore, the potential health benefits of living in Braemore extend beyond the absence of contextually based stressors; positive features of the neighbourhood are recognised as being important contributors to the nature and quality of everyday life. Some women made explicit connections between these features and their own sense of health and well-being. I suggest that, in combination, various aspects of the physical and social environment may serve as health protective psycho-social resources for residents within Braemore, regardless of individual socio-economic status.

7.6 Kirkhead: an environment which may deplete health and well-being

A dominant theme within the accounts of the Kirkhead respondents is that there are several aspects of the physical and social environments which are perceived by these women to undermine the quality of their daily lives. These contextual features of the neighbourhood may be collectively termed 'neighbourhood incivilities' (Herbert, 1993; Smith, 1989). Empirical studies have demonstrated that neighbourhood incivilities may undermine the quality of life in neighbourhood settings:

...certain visible neighbourhood conditions such as dilapidated buildings, litter and vandalism, and such things as noisy neighbours, unruly youths hanging about, and drunks on the street (collectively termed incivilities) can come to signal to outsiders and residents alike that the neighbourhood is in decline.
(Hope and Shaw, 1988, in Herbert, 1993: 46)

In this section I present respondents' accounts of their experiences of neighbourhood incivilities and I argue that compared to Braemore, Kirkhead may be considered to be a relatively health-damaging neighbourhood. However, my discussion also considers how respondents in the Kirkhead sample may draw on personal resources in order to try and mediate the potentially health-damaging consequences of neighbourhood incivilities.

7.6.1 Neighbourhood incivilities associated with the physical environment

In over half of the accounts offered by respondents in the Kirkhead sample, the condition of the physical fabric of the neighbourhood emerged as a feature of their environment which undermines their quality of life and depletes their sense of well-being. Several aspects of the housing in the neighbourhood are felt to be of poor quality. For example, some accounts refer to poorly fitting windows and inadequate heating, leading to cold housing, which has been demonstrated to pose a direct threat to physical health (Blane et al, 2000; Macintyre et al, 2000). One respondent said:

Tania: They are old houses, and they weren't central heated, they're freezing cold in the winter and this whole block is not central heated, unless like ourselves we've done it ourselves. Oh, in the winter it is so cold. They put windows in, not these ones, these I done myself, but they never double glazed them and it was very draughty.

(Kirkhead)

The possibility that there may also be psycho-social mechanisms linking the physical fabric of housing with the well-being of its residents is illustrated by the accounts of six women who identified poor sound-proofing in their homes as a factor which undermines the quality of their day-to-day lives. All six women live in council-built housing, and each one had vivid stories to relate that illustrate how noise from their neighbours routinely pervades their living space in a way that they feel powerless to control:

Lizzie: At the moment you can hear Jack and Sue just talking and their voices are coming up and they can probably hear us mumbling, not what we're saying, but talking to one another. You cannae help it, it's the housing, it's bad sound-proofing.

(Kirkhead)

Morag: That's only plasterboard walls, and your ceiling's only plasterboard and there's only about that much space between our ceiling and his floor and he clonks about. Last year we put up with nine months of him doing his house up. The folk in the bottom, two old ladies in the bottom, they thought it was us. I says "it's no us, we're no doing repairs to our house, it's him above" Well they could hear it in their place.

(Kirkhead)

For one respondent, living with inadequate sound-proofing threatens her sense of well-being not only because she can hear other people, but also because she feels that she is restricted from doing what she wants in her own home out of consideration for her neighbours:

Mary: The sound-proofing, now that's, that's more of an emotional thing, a mental thing, cos you can't totally relax in that you can't have your music loud late at night, some people can but I wouldn't, I wouldn't like to annoy the neighbours, eh so I would say that, from a health point of view, can aggravate you.

(Kirkhead)

Thus, these women's accounts suggest that for them, inadequate sound-proofing means that they lack control over some aspects of their living conditions. This may be stressful at times, posing a threat to their sense of well-being.

Even if respondents reported that their own homes are in a good state of repair, the data indicate that badly maintained homes and gardens in the neighbourhood tend to give rise to negative perceptions of the local area. It seems that houses and gardens that are not well kept are sometimes regarded not only as being undesirable in themselves, but also as visible indicators of undesirable residents. This opinion was expressed by women who have lived in the area for many years, as well as by respondents who have moved into the area more recently:

Shona: There's always that sort of rough element and they always let the place look so run-down looking if you kind of travel down there.

(Kirkhead, long term resident)

Kirsty: That was one of the criteria on the list when I was buying, I thought well I'll be aware of you know what the gardens round about are like and if people care for them. I mean I know people have huge big houses and let them go run-down and that doesn't mean anything, you know, but um...

(Kirkhead, recent resident)

Although these two comments refer perhaps only obliquely to how poorly maintained homes and gardens might negatively influence these women's quality of life, the next quotation, from Mary (who lives in a council-built property), is a clearer illustration of how the state of the housing in the neighbourhood may impinge upon well-being:

Mary: I think also the type of house, the type of flat that we're in, that's to say the outward appearance, these are the oldest flats in the area and they've had the least done to them and uh they've been badly maintained on the outside, I think that's where sometimes embarrassment comes in, when uh you know you're saying to people you know come and visit me, whereas it never bothered me when I lived up at [*more affluent neighbourhood*].

(Kirkhead)

Mary's comments reveal a two-fold source of stress associated with her housing situation. Not only has her block of flats been poorly maintained, affecting the quality of the housing, but associated with this is a feeling of shame. This is highlighted by her comment that she feels embarrassed when friends come to visit - something she did not feel in her previous home in a more affluent neighbourhood. Mary's comments indicate that aspects of the neighbourhood's physical environment may threaten to undermine health and well-being via psycho-social pathways, even in cases where the quality of the individual's own housing does not pose a direct threat to physical health.

This section has presented examples of women's experiences of neighbourhood incivilities associated with the physical environment. I have argued that these incivilities can be experienced by respondents as a source of stress and shame, which in turn serves to undermine their sense of well-being. The next section will discuss women's experiences of incivilities arising from the social environment in Kirkhead.

7.6.2 Neighbourhood incivilities associated with the social environment

Within the women's accounts, the quality of social relations in Kirkhead seems to be an important element of their experience of the neighbourhood which influences the quality of their day-to-day lives (East, 1998; Gatrell et al, 2000). The behaviour of other residents in Kirkhead was frequently mentioned as something which mars their experience of the neighbourhood, in some cases directly threatening their sense of well-being. For example, a common theme within the women's accounts relates to the activities of children and teenagers, which they feel has a detrimental effect upon the quality of life in the area:

Ruth: They do have problems with the kids [...] they can be destructive at times, like they've done things to the bowling club along there, like trying to break in and spraying graffiti and things like that.

(Kirkhead)

Mary: We still have a bit of bother with the young boy who lives up on the other side [...] when I was a child here there was never graffiti in the stair, but when he started growing up, we got some graffiti.

(Kirkhead)

One respondent in particular indicated that the persistent noise and unsociable behaviour displayed by children and teenagers in the area is something that undermines her sense of well-being:

Morag: They're all shouting and screaming and when you're getting older you cannae take the shouting and the screaming the same as you can when you're younger and it doesnae bother you. But if they would only take a telling off people and werenae so cheeky to folk. They throw stones at folk's windows and everything.

(Kirkhead)

This quotation vividly conveys the stress that Morag experiences as a result of young people's behaviour – she “cannae take it”. Her account suggests that the stressfulness of this situation is compounded by her observation that these young people are resistant to attempts by other residents to control their behaviour.

Children are not the only group of people in the area who tended to be portrayed negatively by the respondents. A dominant theme in the women's accounts of poor social relations in the area is a sense of change in the composition of the local population over time (Cattell, 2001; Gatrell et al, 2000). Four women in the sample expressed the opinion that individuals and families housed in the area by the local authority are a source of social problems in the neighbourhood, such as crime, drugs and vandalism. These residents were described as either “problem” tenants who have been re-housed from elsewhere, or homeless people in emergency accommodation, or ex-psychiatric patients housed in the area as a result of Care in the Community legislation. This minority of respondents frequently drew on their biographies to compare their current experiences of the neighbourhood with “how things used to be in the past”. By referring to their biographies, respondents were able to illustrate and support their opinions that an influx of undesirable residents has resulted in a deterioration in the quality of social relations in recent years - with

deleterious consequences for well-being. In the following quotations, Ruth talks about no longer feeling safe in the neighbourhood, whilst Morag refers to incoming residents whose behaviour left her feeling that she was “a bundle of nerves” :

Ruth: I would think that when we first came here it was really really good, and it was um...very friendly orientated and you knew everybody. But as the years have gone on, and because of these high flats down there, they put a lot of homeless and emergency housing into them and there's all kinds of um walks of life in there. A lot of junkies and different things. And I used to always feel safe but I wouldn't feel safe walking the streets at night now here, cos there's too many hooligans sort of element. There's a lot of care in the community people put into housing.

(Kirkhead)

Morag: This is nae as nice a scheme as it used to be. If they would watch the folk that they were putting in, there's nothing wrong with the houses, it's the folk that they're putting in[...]We had Asians in here before they two old ladies, and they made folks lives hell[...] I was a bundle of nerves then and I could hardly sleep at night.

(Kirkhead)

In these two extracts, the respondents explicitly relate their negative perceptions of the social composition of the neighbourhood to their personal sense of well-being. Ruth's comment that she doesn't feel safe walking on the streets at night, and Morag's description of herself as being “a bundle of nerves” are suggestive of psycho-social pathways which mediate between the experience of incivilities within the social environment, and poor well-being. Within the social capital literature, feelings of trust and safety have been identified as key components of social capital (Bullen and Onyx, 1998; Cooper et al, 1999; Gatrell et al, 2000). The data presented here shed some light on how the absence of trust and safety may actually be experienced within a neighbourhood context, and the consequences that this may have for well-being.

The theme of ‘undesirable’ residents is linked in many of the respondents' accounts not only to social problems within the neighbourhood, but also to the issue of Kirkhead's reputation. Roughly half of the respondents directly expressed an awareness that Kirkhead has something of a negative, stigmatised reputation within Edinburgh. A neighbourhood's reputation is the fifth category of socio-

environmental influence upon health identified by Macintyre et al (1993); they argue that a neighbourhood's reputation may affect the self-esteem and morale of residents, and may thus exert a psycho-social influence upon health. From their accounts, it seems that the way in which respondents personally experience the neighbourhood's reputation is to some extent shaped by elements of their biographies. For example, some women who have lived in the neighbourhood for most or all of their lives reported that their own personal identities have at times been stigmatised by other people living outside the area. This has been experienced as a threat to their self-esteem:

Mary: You say 'Kirkhead', some of the reactions are actually incredible, and uh they therefore tar you with being somebody who comes from a council estate and uh therefore has nae brains and you know no etiquette, common if you want to use that word, they just can't believe that you could be well brought up and educated

LA: Yeah, and how does that make you feel?

Mary: Um, it makes me feel a bit angry.

(Kirkhead)

However, these long-term residents also contested the stigmatised reputation of the neighbourhood. They drew on decades of experience of living in the local area in order to justify their opinion that Kirkhead is a good place to live in, despite its reputation. Often, they argued that it is only a small minority of people that give the place a bad name (the "incoming trouble-makers" previously referred to), and that therefore it is unfair that their own personal identities should have become stigmatised merely because they lived in the same neighbourhood:

Mary: I just get angry with people who, you know, they tar everybody with the same brush basically [...] the majority of the people are nice people, it only takes one or two you know to give the place a reputation.

(Kirkhead)

For longer-term residents then, Kirkhead's poor reputation has resulted in their own personal identities becoming unfairly stigmatised. Although the data indicate that these women attempt to resist being "tarred with the same brush" as other (stigmatised) residents, the neighbourhood's reputation is nevertheless experienced as a source of stress.

The accounts of longer-term residents contrast with those of two respondents who have previously lived in more affluent neighbourhoods but who moved to Kirkhead when their income dropped substantially following life events including divorce. Accounts from these two women reveal that they had felt reluctant to move to the neighbourhood because of its poor reputation. Their comments convey a sense of shame associated with moving to the area:

Kirsty: If I'm being completely honest, um...for me personally, it's not where I would have wanted to be staying, I'll be quite honest with you, I would have preferred...it's an area of town that is, is sort of okay, I mean I'm not ashamed of being here, but I'm not particularly proud of staying here. I think it's um, there's a mixture of um social standards in this area, and um I'm probably being a total snob in saying that, um...and it possibly, it worried me a wee bit moving here, because of my financial situation I was limited obviously.

(Kirkhead)

Josie: Kirkhead itself has a reputation for being quite a rough housing scheme, so when I was looking to buy a house, and looking at what areas of town I could afford, Kirkhead was certainly an area I could afford, but initially I was a bit reluctant cos I thought Kirkhead, that's really rough up there, not that I had ever been up here, but it just has that reputation for being a bit on the rough side [...] at first I didn't want to say to people I live in Kirkhead, cos it's, I suppose...well I'm not a snob by any stretch of the imagination, but people's attitudes you know, can get you down sometimes.

(Kirkhead)

My interpretation of these accounts from Josie and Kirsty is that Kirkhead's reputation serves to reinforce their awareness that, in comparison to previous stages in their lives, they are now living in relatively deprived circumstances; the current social environment is a reminder of their downward social mobility. I suggest that their reported reluctance to move into the neighbourhood reveals their understanding of Kirkhead as a place which does not reflect the perceptions that they hold of their 'rightful' place within the social structure. The respondents imply that their 'proper place in the world' was more accurately represented by their residence in more affluent neighbourhoods prior to the various life events which left them financially

worse off. Thus, for these two women, Kirkhead's reputation is a source of psycho-social stress because it engenders within them feelings of shame (Wilkinson, 1996).

These findings support Macintyre et al's assertion that neighbourhood reputation may be understood to be a psycho-social influence upon well-being (Macintyre et al, 1993). Taken together, the accounts from both longer and shorter-term residents suggest that Kirkhead's poor reputation is indeed experienced as a psycho-social stressor which negatively impacts upon their well-being. It is important to note that the way in which respondents described Kirkhead's negative reputation as impinging upon their own sense of identity seems to be related to the extent to which they personally identify with the neighbourhood; this in turn is bound up with the length of time that they have lived there. These findings highlight the need for research which seeks to understand inequalities "within the complexity of the social world" (Forbes and Wainwright, 2001: 813).

So far, I have presented accounts from Kirkhead respondents relating to the influence of neighbourhood incivilities upon their well-being. In the next section, I will explore in greater detail these women's responses to the contextual psycho-social stressors that they identified.

7.6.3 Managing the 'context': negotiating neighbourhood incivilities

The data presented so far indicate that a theme running through the respondents' narratives in a variety of ways is their experiences of neighbourhood incivilities and the deleterious consequences that they consider incivilities to have for their quality of life. Despite talking at some length during the interviews about how their experience of various neighbourhood incivilities undermines their sense of well-being, many of the respondents also seemed keen to compare their experiences favourably against those of people living in more deprived neighbourhoods. This tension is illustrated in the following quotations from Lizzie. She referred to "roughies" in Kirkhead, whose activities make her unwilling to leave her house at night:

Lizzie: I'm not keen on going out at night

LA: Why's that?

Lizzie: Up at the King's Arms you get quite a lot of, you get one or two roughies up there coming out the pub and that.

(Kirkhead)

However, Lizzie also maintained that, on the whole, Kirkhead is a good place to live in – certainly better than some of the other neighbourhoods in the city:

LA: Do you think that where you live can have an effect on your health?

Lizzie: I would think so...if you've got a place that's riotous and you're fighting to go away for any length of time...I can go away here, I can go down to my daughter's for a month, give Ros a key just to check my mail and check my plants and check my house, and know that it's quite safe. Where other places, like going down to [*more deprived area*], you couldn't leave your house for any length of time, you'd have it broken into. No, I think it's quite a good area.

(Kirkhead)

Ellen's account offers another example of comparing Kirkhead favourably with other neighbourhoods in the city:

Ellen: It's quite nice living here, compared to some places. I think I'm quite lucky really, when you hear of some houses being broken into, and//

LA: //Yeah, what kind of areas?

Ellen: Well my friend lives up at, where is it, [*more deprived area*], and it's quite bad up there with people getting their houses broken into.

LA: Right...has that ever happened round here?

Ellen: Not that I know of, never heard any, touch wood...most people likes of Betty my neighbour, everybody looks out for your house.

(Kirkhead)

I suggest that these accounts may be interpreted as attempts by respondents to establish some form of spatial hierarchy of health risk, in which their own neighbourhood does not occupy the bottom rank. The fact that several respondents within this sample engaged in the process of comparing Kirkhead favourably with other neighbourhoods indicates the potential psycho-social importance of social comparisons (Gatrell, 1997; Graham et al, 200). Social comparison theory suggests

that being able to compare oneself favourably in relation to others may enhance well-being (Sherrard, 1994). The data presented here indicate that this theoretical approach may usefully be applied to the study of spatial, as well as social dynamics of inequality.

Analysis of the respondents' active engagement in social comparisons highlights an important tension between two dominant themes in the data. On the one hand, there is an articulation of the negative influence of incivilities upon well-being. On the other hand, respondents also conveyed a reluctance to portray themselves as victims of their circumstances (Blaxter, 1993, 1997; Bush et al, 2001; Gatrell et al, 2000). The data indicate that, during the interviews, some of the respondents made efforts to dissociate themselves from neighbourhood incivilities. One way in which they did this was to emphasise the physical distance between their own homes and the locus of whichever problem it was they were discussing. In this context, it seems that women were actively constructing understandings of the geographical area that constitutes 'their neighbourhood' at a very small spatial scale. Thus, the imagined spatial boundaries of what women reported to be their neighbourhood were erected close to home – their street, their block of flats, or even their front door. The following quotations are from women who live across the road from the high flats perceived to be the locus of a variety of social problems; they illustrate how a sense of neighbourhood might be constructed at a very small spatial scale:

Ruth: I think it would be a nightmare if you stayed further down the road, and the noise from the flats and the goings- on.

(Kirkhead)

Ellen: I feel it's separate from round here. And I'm not a snob or anything [...] but no, I wouldn't like to live round there.

(Kirkhead)

It would appear that the purpose of constructing imagined limits to 'their' neighbourhood at such a micro-scale is to enable the women to exclude from their sense of neighbourhood those features of the wider social environment that they perceive to be negative, stressful and thus potentially health-damaging. So, for

example, two respondents spontaneously mentioned that they believe that their 'parts' of Kirkhead were secure, and that therefore their own homes are not at risk of burglary:

Shona: Nothing really happens up here, everything that you hear happens down there, I mean I haven't heard of one single person being broken into or anything in this street in all the years I've lived here. Never had anything like that, so we're quite secure up here.

(Kirkhead)

Tania: I lived here when I first got married, in 1966...I've never had any bother up here, never. I think we're in quite a good part of Kirkhead, there is a lovelier part up there, but for the housing side of it, this is quite a good part to be in. I've never had any troubles, any break-ins, anything.

(Kirkhead)

Both Shona and Tania referred to their immediate neighbourhood as "up here". This suggests that they understand their homes to be situated in a location that is geographically distinct from "down there", despite the fact that the geographical area represented by the term 'down there' is actually only a few streets away from their homes. However, this distancing strategy serves the purpose of enabling these two respondents to dissociate themselves from an area of housing that is stigmatised due to a reputation for high rates of burglaries. The women's attempts to dissociate themselves from crime in the wider neighbourhood and emphasise their personal sense of security were reinforced by their references to the length of time that they have lived in their homes without ever having been the victims of crime. Thus, these women drew upon their personal biographical experiences during the interview, in order to support their strategy of distancing themselves from the stigma of crime in the area.

David Sibley has commented upon the importance of spatial boundaries in maintaining separation between different groups:

... spatial boundaries are in part moral boundaries. Spatial separations symbolize a moral order. (Sibley, 1995: 39).

Sibley's point about the overlapping of spatial and moral boundaries can be observed in the women's accounts. In the interviews, respondents actively attempted to dissociate themselves from social problems that they identified in the area, by emphasising the 'otherness' of the people deemed to give the area a bad name. Thus, they distanced themselves socially as well as spatially from problems that they feel undermine both the quality of life and the reputation of the area (Bennett et al. 1999; Popay, 2000). This process can be identified in several women's accounts of the drug taking and drug dealing that reputedly occurs in the area. Most of the women who talked about drugs made a point of saying that, although drugs are a problem for Kirkhead as a whole, they are not an issue in the immediate vicinity in which they live. Drugs generally tended to be portrayed not only as a highly localised problem, centred mainly around the council tower blocks in the area, but also as a problem that is perpetrated by socially distant "others". For example, Ruth made the following comment:

Ruth: Years ago it used to be all older people and that that were in them, but as they've died off they've used them as emergency housing to put people in, so um yeah I realise that they've got to have somewhere to live, and yes I realise it's giving them somewhere to live if they are homeless and everything, but um the drugs-related um has obviously got an impact on it, and that's all what goes on in there.

(Kirkhead)

In Ruth's account, the phrase "all kinds of walks of life in there" is a clear expression of her effort to maintain a social identity that is physically and socially separate from social groups whom she perceives to be the (morally inferior) perpetrators of neighbourhood incivilities.

Sibley's notion about boundary construction is useful for understanding the relationship between the social contexts of the respondents' lives and their individual agency. My interpretation of the data is that, by emphasising the moral boundaries that separate themselves from 'trouble makers' in the neighbourhood, the

respondents were actively engaged in a process of attempting to protect their personal identities from the stigma associated with the social environment in Kirkhead. Given that the data set is complex and relatively small, it is difficult to ascertain from the data the strength of potential links between distancing strategies and well-being; this is a topic that would benefit from further research. Nevertheless, I suggest that distancing strategies may be understood as one way of attempting to render neighbourhood incivilities 'not personally stressful' – a finding which echoes those of other empirical studies (Smith, 1986; Bush et al, 2001). In the context of everyday life, engaging in distancing strategies may represent a potentially important way in which the respondents exert their agency in order to resist psycho-social stressors associated with the social environment. This finding supports calls within the literature for a closer interrogation of the relationships between structure and agency, which would allow for the development of more sophisticated understandings of the processes through which health inequalities are perpetuated (Bartley, Blane and Davey Smith, 1998; Curtis and Rees Jones, 1998; Forbes and Wainwright, 2001; Popay et al, 1998; Williams and Popay, 1998).

7.7 Conclusion

Discussion in this chapter began with an overview of respondents' housing pathways, which revealed diverse trajectories through which they came to live in their respective neighbourhoods. Analysis of the women's accounts has indicated that housing pathways are shaped by a variety of life events and personal circumstances. However, the data also demonstrate that ability to pay for housing is a major factor which influences people's trajectories into different neighbourhoods. Data presented in this chapter offer some insight into the processes through which individuals, whose health chances are structured by dimensions of their socio-economic position, 'cluster' within specific neighbourhoods.

This chapter has sought to bring together compositional and contextual explanations for health geographical inequalities. I have done this by suggesting some ways in which, once people are living in particular neighbourhoods, their health and well-being may be further shaped by contextual characteristics of those neighbourhoods, via the impact that contextual characteristics have on the nature and quality of everyday life. Thus, whilst respondents' past experiences of social advantage or disadvantage, of health or illness, may have influenced their trajectories into Braemore or Kirkhead, their experiences within the two neighbourhoods have implications for their future life chances.

I have argued that respondents in Braemore, who generally already experience health advantage by virtue of their relatively privileged position within the socio-economic structure, live in a physical and social environment which promotes their quality of life, and enhances their psycho-social well-being. For these respondents, their neighbourhood might be considered to be a setting which offers them resources for good health and well-being. By contrast, respondents in the Kirkhead sample, many of whom report chronic health problems, are forced to contend with a variety of contextually based stressors, which undermine the quality of their day-to-day lives. This has potentially harmful implications for their well-being in the short and the long-term. It also has potentially harmful implications for their physical health in the long term, as the experience of chronic stress may be

involved in the process of chronic disease aetiology (Wilkinson, 1996; Stafford et al. 2001). Thus, for those respondents who on the whole already have limited access to resources for good health, Kirkhead is a place which offers few contextual resources for good health; furthermore, it is also experienced as a social context which may deplete well-being.

The focus upon quality of life and well-being in the respondents' accounts suggests that psycho-social dimensions of health merit much more attention in geographical health inequalities research than they have been accorded until now. Chronic diseases have long and complex latency periods, and lay actors are unlikely to draw connections between their experiences within particular places, and the onset (or not) of such health problems. However, inequality experienced through everyday life in neighbourhoods with particular contextual characteristics clearly does have implications for quality of life and well-being. As Davey Smith has commented:

[...]inequality may make people miserable long before it kills them.
(Davey Smith, 1996: 988).

Chapter 8: Conclusions: pulling the threads together

In this final chapter, I draw together the substantive findings which have been presented throughout the thesis, and I highlight some interconnections between the different thematic topics which have been explored in Chapters Three to Seven. I evaluate the contribution that this research makes towards understanding social and spatial inequalities in health, and suggest how further qualitative work could complement and extend existing bodies of knowledge regarding the causal processes which underpin the geography of health inequalities.

This thesis, based upon a qualitative investigation of the health and illness experiences of women in two socially contrasting Edinburgh neighbourhoods, has illuminated some of the social processes through which geographical health inequalities are generated and sustained. The study illustrates the important contribution that qualitative research can make to the field of health inequalities research. Adopting a qualitative approach offered an opportunity to explore lay accounts of life experiences in particular socio-spatial contexts; this has enabled consideration of various dimensions of the relationship between place and health which frequently remain hidden in quantitative analyses.

This study makes an innovative methodological contribution to the field of health inequalities research (and, in particular, to research into the geography of health inequalities), by fusing together a focus upon the lifecourse on the one hand, with a focus upon current everyday experiences in specific places, on the other. The research has illuminated a range of complex interactions between individuals' social position, where they live, and their experiences of health, illness and well-being. The analysis has shed light upon ways in which social position is actually experienced through the lifecourse. Lay accounts thus offer an insight into ways in which the *meanings* attached to relative position within the social structure may have psycho-social implications for health.

Chapter Three outlined details of respondents' self-reported health, highlighting stark contrasts between the two sample groups in terms of respondents'

experiences of chronic health problems. Respondents in the Braemore sample reported much better health than those in Kirkhead. To re-cap, only one respondent in the Braemore sample reported chronic health problems, compared to nine women in Kirkhead. Respondents' current health experiences, described in Chapter Three, are the outcome of lifecourse trajectories through particular social and geographical contexts, within which their health has been moulded. Chapter Three thus sets the scene for subsequent chapters, which seek to explain the health divide between the two sample groups by exploring various processes through which the respondents' health has been built-up or worn-down over the lifecourse.

Chapter Three also highlighted the centrality of well-being within respondents' concepts of health. Analysis presented in this, and subsequent chapters, clearly illustrates that respondents in this study understand well-being to be a dimension of health which may be conceptualised and experienced separately from physical dimensions of health – a finding also reported by Blaxter (1990). The emphasis placed upon well-being within respondents' definitions of health suggests that the social patterning of well-being (both positive and negative) is a topic that merits further research. Data presented throughout the thesis demonstrate that well-being is closely related to subjective experiences of social circumstances – and in particular, to experiences of social inequality. A key argument throughout the thesis is that the study of well-being provides an opportunity to explore the role of psycho-social processes in the generation of health inequalities.

In addition to presenting respondents' concepts of health, Chapter Three also considered data relating to the respondents' conceptualisation and experience of stress. A central theme which runs through the thesis is an analysis of the women's experiences of stressful life circumstances, and their understandings of whether and how stress is related to health and well-being. Respondents in both sample groups reported experiences of stress that they perceive to have undermined their sense of well-being, and even their physical health. However, evidence presented in the empirical chapters points to the stratification of stressful life events and circumstances along a socio-economic gradient; relatively deprived respondents in the Kirkhead sample consistently reported more stressful life events, and more

enduring stressors throughout their lives than did relatively affluent respondents in the Braemore sample. The analysis also indicates that access to a range of stress-buffering resources is socially patterned – again, in ways that have favoured more affluent respondents. This is consistent with findings from the stress literature (Aneshensel et al, 1991; Turner et al, 1995).

Chapter Four considered access to financial resources as a key aspect of respondents' life contexts, which has shaped their opportunities for good health and well-being over the course of their lives. Data were presented which illustrate material, behavioural and psycho-social pathways between money, health and well-being. Taken together, these findings suggest that both absolute and relative levels of income and wealth are important for health and well-being. More affluent respondents (most of whom are in the Braemore sample) have been able to secure material living standards which they recognise as having a positive influence upon both their physical health and their well-being. By contrast, less affluent respondents in the study, most of whom are in the Kirkhead sample, indicated that they have been much more constrained in their ability to secure healthy material living conditions.

The analysis presented in Chapter Four points to psycho-social mediators between access to financial resources and well-being. This theme was illustrated through discussion of the respondents' accounts of whether or not they perceive themselves to be financially secure. My interpretation of the data is that perceiving oneself to be financially secure may enhance well-being, whereas perceiving oneself to be financially insecure can be experienced as stressful, serving to deplete well-being. An important finding is that the respondents' perceptions of being financially secure or insecure are not necessarily related to their absolute income levels, but rather are bound up with their personal expectations of their living standards, which have been moulded over the lifecourse. This is illustrated by examples of respondents in reasonably paid work, whose current incomes mean that they are not poor in an absolute sense, but who nonetheless perceive themselves to be relatively deprived and financially insecure, because their current living standards are low in relation to their experiences during previous stages in the lifecourse. This finding hints at the complexity of psycho-social links between the experience of relative

income and well-being – complexity that cannot easily be uncovered through quantitative studies.

Chapter Five explored respondents' participation in the labour market over the lifecourse, engaging closely with their biographical accounts. The first part of the discussion considered socio-cultural influences upon the women's educational attainment and their entrance to the labour market, demonstrating that on the whole, respondents in the Braemore sample gained higher qualifications, and entered higher occupational classes than respondents in the Kirkhead sample. Subsequent analysis indicates that these occupational class differences between the two sample groups have been sustained throughout the lifecourse.

A central strand of discussion within Chapter Five relates to interactions between health and employment. The analysis indicates that Kirkhead respondents have been exposed to more health risks at work, and have encountered more stressful working environments than respondents in the Braemore sample. Furthermore, the experience of illness has had more serious consequences for the employment trajectories of respondents in the Kirkhead sample, compared to those in the Braemore sample. Braemore respondents, in more secure employment with employers who have offered sickness benefits, have generally been able to sustain paid employment during episodes of acute illness. By contrast, Kirkhead respondents, who have generally been employed in relatively insecure occupations, are more likely to have been forced to give up work due to health problems, resulting in health selection out of the labour market. Thus, the relatively disadvantaged position of some Kirkhead respondents within the labour market has been compounded over the lifecourse by illness-related disruptions to their employment trajectories.

In Chapter Six, the analysis turned to a discussion of how respondents' experiences of gendered social roles within the family have shaped their experiences of health and well-being. In this discussion, gender was considered as a form of social stratification which intersects with socio-economic position, in ways which may have differential health consequences for individuals in particular class

positions. A key focus of the chapter relates to respondents' current caring responsibilities for elderly relatives, and the influence that this has upon their sense of well-being. The analysis did not identify clear differences between the two sample groups in terms of the reported stressfulness of respondents' current caring roles. Thus, the discussion indicated that not all forms of stress arising out of the respondents' social contexts are necessarily structured by their socio-economic position. Nevertheless, the discussions presented in both Chapter Five and Chapter Six have highlighted the fact that analysis of the health-relevance of women's multiple social roles – their caring roles within the family and their paid employment outside the home, must take into account the wider material and social contexts within which women undertake these roles.

Chapter Six also highlighted some interactions between respondents' family circumstances and their trajectories into Braemore and Kirkhead. As demonstrated in Chapter Four, married women in Braemore are the respondents likely to have accrued the most housing wealth over the course of their lives, enabling them to live in owner occupied, prestigious homes in a 'healthy' neighbourhood. Chapter Six indicated how divorce may have resulted in a loss of financial resources, with implications for respondents' housing trajectories. Analysis presented in Chapter Six also suggested that marital status is not the only family-related influence upon housing trajectories; having caring responsibilities for elderly relatives is another factor identified in the data as having a bearing upon some of the respondents' current (and also perhaps their future) residential location.

Chapters Four, Five and Six sought to convey the richness and complexity of respondents' views and experiences concerning interrelationships between different dimensions of their social contexts, their trajectories into their respective neighbourhoods, and their health and well-being. There is considerable heterogeneity within and between the two sample groups, both in terms of their reported past and present life circumstances, and in terms of their accounts of health, illness and well-being. However, despite this diversity, it is nevertheless possible to pull together the various threads of these chapters in order to identify general

contrasts between the lifecourse experiences of respondents in Braemore compared with those respondents in Kirkhead.

Accounts offered by the majority of Braemore respondents reflect pathways of accumulated social advantage over the lifecourse. Most were born into relatively affluent middle class families, and were encouraged or expected to gain educational qualifications. They have secured high household incomes throughout their lives, either through their own employment, or through that of their spouses. Braemore respondents are more likely than Kirkhead respondents to have inherited money from their families, adding to their material resources. These financial resources have enabled them to access home ownership in a relatively affluent neighbourhood, thus securing housing wealth. The relatively advantaged position of the Braemore respondents within the socio-economic structure has enabled them to access a wide range of resources over the course of their lives that have enhanced their health and well-being; analysis suggests that these resources are material, social, cultural and psycho-social in nature. These findings are not simply artefactual products of the interview process. Braemore respondents themselves made links between their good health and well-being and the fact that they live in good quality housing, enjoy a sense of financial security, can afford to engage in 'healthy' lifestyle habits, and perceive themselves to have choice and control over their lives.

By contrast, most of the Kirkhead respondents reported trajectories of accumulated social disadvantage throughout their lives, associated with relatively restricted access to health-enhancing resources, and greater exposure to potential health risks compared to Braemore respondents. Most, although not all, of the respondents in the Kirkhead sample were born into working class families in relatively constrained financial circumstances. Few of these respondents gained many educational qualifications, or stayed on at school beyond the minimum leaving age. Compared to the Braemore respondents, they were more likely to report employment in insecure, hazardous and poorly paid occupations. Relatively low household incomes have restricted the extent to which these women have been able to invest in housing wealth, hence their housing trajectories into Kirkhead – a neighbourhood in which a substantial proportion of the housing stock is allocated by

the local authority according to need, rather than by ability to pay. Whereas accounts from Braemore respondents are more likely to illustrate how their past and present social circumstances have served to promote their health and well-being, accounts from Kirkhead respondents are more likely to demonstrate how health and well-being may be worn down over the lifecourse by material risks associated with low socio-economic status, and by psycho-social stressors engendered by their relatively deprived social contexts.

The analysis presented in Chapters Four, Five and Six focused upon separate yet interrelated dimensions of respondents' social circumstances, which were identified by respondents themselves as influencing (and being influenced by) their experiences of health, illness and well-being over the lifecourse (Kuh et al, 1997). The analysis presented in these chapters contributes to understandings of the causes of health inequalities because it provides an insight into how various individual-level 'risk factors' might actually be subjectively experienced, and made sense of in relation to experiences of health and illness, by people in particular socio-economic positions. This thesis has demonstrated how individuals' experiences of health, illness and well-being are constituted within a multi-dimensional and dynamic web of health-relevant resources that varies through space and over time.

As well as presenting an analysis of how access to financial resources, employment experiences, and family roles and relationships have been experienced by respondents as resources which have either enhanced or depleted their health and well-being, Chapters Four, Five and Six have also exposed ways in which these dimensions of the respondents' social circumstances have had a bearing upon their trajectories into either Braemore or Kirkhead. To frame these chapters using the terminology of the geographical health inequalities literature, they have engaged with health-relevant *compositional* characteristics of the two sample groups. Exploring the respondents' trajectories into their respective neighbourhoods suggests that 'compositional factors' may account for much of the health divide between the two areas. However, this is not the whole story.

The analysis presented in Chapter Seven reveals lay perceptions of a relationship between place and health. The findings indicate that respondents understand contextual features of their respective neighbourhoods to contribute to the enhancement or depletion of their health and well-being. Whilst respondents in both sample groups identified positive contextual features of their neighbourhoods, Kirkhead respondents were far more likely than Braemore respondents to identify aspects of the socio-cultural environment that they experience as being stressful, and which may threaten to undermine their sense of well-being. However, the analysis also considers an important theme within the data, which relates to respondents' active attempts to resist the psycho-social stressors arising from the social environment, through engagement in what I have termed 'distancing strategies'.

This thesis contributes to an understanding of the geography of health inequalities through an exploration of subjective life experiences in particular places. I have shown how respondents' perceptions of Braemore and Kirkhead have been strongly influenced by the nature of the intersections between their personal biographies and their trajectories into their respective neighbourhoods. I have argued that the ways in which respondents' biographies have been bound up with particular neighbourhoods have implications for whether and how they draw connections between where they live and their experiences of health and well-being. The approach taken in the study, of studying individual lifecourses in and through specific geographical and social spaces, has allowed for an appreciation of how individual social attributes and health experience may shape trajectories into particular neighbourhoods, whilst also demonstrating that the contexts of those neighbourhoods may themselves sustain or undermine current and future health and well-being - as well as structuring the likelihood of further social advantage or disadvantage.

In themselves, the individual influences upon health and well-being which have been discussed throughout this thesis may appear to be insufficient to explain the contrasting health experiences of the two sample groups. However, one of the aims of this thesis has been to illuminate interactions between the different spheres of respondents' lives. The findings point to multiple, cumulative influences upon health

and well-being, which operate over time and through space, but which are distributed unevenly throughout the population. This conclusion is supported by Shaw et al (1999a), who make the following comments:

Each directly material factor (eg occupational hazards, poor housing, unemployment, childhood deprivation and so forth) may on its own make a modest contribution to the total socio-economic gradient in health. The modest size of these individual contributions can appear inconsistent with the powerful effect of the influence of such factors, as indicated by area deprivation correlations and the stepwise relationship between income and mortality. However... the form of social organisation we live under leads to the clustering of advantage or disadvantage over time and place ...social class gradients in health can be explained in materialist terms by the accumulation of multiple factors over the course of life.

(Shaw et al, 1999a: 101)

Whilst Shaw et al argue that health inequalities may be understood purely through the clustering of material advantage and disadvantage, empirical evidence discussed in this study suggests that psycho-social processes may also contribute to the social gradient in health. The findings indicate that the subjective experience of stress is associated in lay accounts with depleted well-being and physical health (although rarely with chronic disease). The data collected in this research support claims that psycho-social stress is patterned along a socio-economic gradient (Pearlin, 1989; Turner et al, 1995; Wilkinson, 1996). There are also clues within the data relating to the social determinants of positive well-being; analysis suggests that respondents whose socio-economic status is high make connections between their relatively privileged life circumstances and their positive reported well-being. Thus, a key contribution of this study is to illustrate some ways in which experiences of good health and positive well-being might be influenced by social position. This contrasts with much existing health inequalities literature which focuses primarily upon morbidity and mortality.

There is still much research to be undertaken before the causes of geographical inequalities in health are fully understood. Findings from quantitative studies can only infer for example, psycho-social links between social position, place

and health; they cannot capture the complexity of social experience, or uncover ways in which individual agency may shape experiences of social inequality (Gatrell et al, 2000). The findings of this thesis suggest that, in order to gain a more detailed understanding of potential mediators between individuals' social and spatial locations, and their health and well-being, more in-depth qualitative work is required which explores people's subjective interpretations of and responses to the life circumstances in which they find themselves. Further research could fruitfully expand on the findings presented here by comparing the experiences of social groups with different compositional attributes to the respondents studied in this project – for example, by studying the experiences of men as well as women, by focusing on different stages in the lifecourse, and so on. Understandings of the processes contributing to geographical health inequalities could also be extended by focusing on a wide variety of different neighbourhoods.

In conclusion, I suggest that the analysis presented in this thesis highlights the need for researchers to move beyond polarised debates about whether geographical health inequalities are explained by contextual or compositional factors, to explore instead the potential interactions between these two explanatory approaches. Lay perspectives have a crucial role to play in illuminating how health experience over the lifecourse is constituted in and through experiences of place. It seems appropriate to conclude with a quotation from Jennie Popay, which encapsulates the purpose of this thesis:

These narratives 'challenge' the research endeavour that concerns itself with the arguably 'artificial' pursuit of separation between the composition and context of an area. Rather than seeking to disentangle the characteristics of the people who live in places from the characteristics of places – including at least some material characteristics – these narratives tell a story of close and compelling linkages between people and the places they live in. (Popay, 2000: 401)

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Appendix One: Letter of invitation from GP and information sheet for patients

Dear

Research on Women's Health in Edinburgh

This letter is to introduce Laura Airey, a researcher at the University of Edinburgh. She is doing a study of women's views about their experiences of health and illness. The study is focusing on women living in different parts of Edinburgh, aged between 45-59, as this age group has tended to be overlooked in previous research. Laura is looking for women who are willing to chat to her informally about the things that have affected their health in the past *and* things that affect their health now – both good and bad. She is interested in women's opinions and experiences whatever their state of health – excellent, poor or somewhere in between!

The purpose of this letter is to invite you to participate in the study. The research involves two informal interviews. The first interview will focus on your health over the course of your life. The second interview will involve talking about your health now, and your general everyday life. Each interview will last approximately an hour and a half, and the interviews will be arranged at a time and a place that suit you.

I can assure you that anything discussed during the interviews will be kept strictly confidential and anonymous. No information about individuals will be provided to the practice from this research, although a report of the study will be sent to the GPs.

I would be most grateful if you would consider taking part. If you would like to participate in the study please complete and return the slip attached to this letter in the postage-paid envelope provided by 7th August 2000. Laura Airey will then contact you to arrange an interview time. If you would like more information about the project, please call Laura directly on (0131) 650 9535. You may also like to read the enclosed information sheet.

Regards,

Dr _____

Information sheet for patients

Research Project: WOMEN'S HEALTH IN EDINBURGH

Laura Airey is a researcher based at the University of Edinburgh. She is carrying out a study of women's experiences of health and illness.

Why have you been asked to take part?

The research involves talking to women aged between 45-59 from different neighbourhoods in Edinburgh.

Your GP agreed to help Laura to find women who might be willing to help with the research. In order to do this, your GP made a list of **all** the women born between 1941-1955 who are registered at the practice, and then picked a number of these at random to ask to take part. There is no special reason why you have been asked to take part.

What will be involved?

The research involves **two** informal interviews. During the interviews, the researcher will have some questions and topics to discuss, but the idea is to find out about your views, opinions and experiences of health and illness. Each interview will last approximately an hour and a half, but it could be longer or shorter depending on how much time you have and how much you want to say. If there are a lot of topics that you wish to talk about, Laura may ask to meet with you a third time if necessary.

The interviews will be recorded on audio-tapes, so that Laura has an accurate record of the interviews. The tapes will be destroyed at the end of the study. Anything you say will be completely confidential. Although your GP is helping with the study, he or she will not be asked about you and no information that you give will be passed onto them.

If you would like to take part in the study, please let Laura know by returning the form attached to the letter in the postage-paid envelope provided. Laura will then give you a phone call to answer any questions you may have about taking part in the study. If you are still interested in taking part, Laura will then arrange an interview with you, at a time and a place that suit you. If the interviews take place outside of your own home, Laura will pay for your travelling expenses.

You do not have to take part in the study. If you do agree to take part you can change your mind at any stage.

If at any time you wish to ask anything about the study, you can contact Laura Airey on (0131) 650 9535. If you would like to discuss the study with an independent contact at Edinburgh University you can telephone Dr. John Davis (Research Unit in Health and Behavioural Change) on (0131) 650 6197.

July 2000, version 2

Appendix Two: Summary of respondents

Braemore

Name	Household Income category	Marital status	Occupational status	Housing tenure	Self-reported health status
Carol	High	Married	Charity worker (PT)	Owner Occupied	Good ; no chronic health problems
Christina	Middle	Married	Childminder (PT)	Owner Occupied	Excellent ; no chronic health problems
Diane	High	Married	Counsellor/ Proof reader (PT)	Owner Occupied	Good ; no chronic health problems
Esther	High	Married	Secondary School Teacher (PT)	Owner Occupied	Excellent ; no chronic health problems
Hattie	High	Married	Staff nurse (PT)	Owner Occupied	Good ; no chronic health problems
Jacqueline	Middle	Divorced	Personal Assistant (FT)	Owner Occupied	Excellent ; no chronic health problems
Jean	Low	Divorced	Permanently sick	Social Rented	Poor ; chronic health problems
Marion	High	Divorced	Nursing sister (FT)	Owner Occupied	Excellent ; no chronic health problems
Pam	High	Married	Voluntary work (PT)	Owner Occupied	Good ; no chronic health problems
Rachel	Low	Divorced	Cleaner (PT)	Private Rented	Good ; no chronic health problems
Sarah	High	Married	Personal Assistant (FT)	Owner Occupied	Good ; no chronic health problems
Stella	High	Married	Pharmacist (PT)	Owner Occupied	Good ; no chronic health problems

Notes:

Household income categories: categorised according to net monthly income as follows: Low - below £800, Middle - £800 to £1,600, High - over £1,600.

Occupational Status: PT (Part Time), FT (Full Time)

Housing Tenure: RTB: Owner occupation accessed through Right to Buy sales of local authority housing.

Health Status: Respondents were asked to rank their health on a scale of 1 to 4 where 1 = Excellent, 2 = Good, 3 = Fair and 4 = Poor.

Kirkhead

Name	Household income category	Marital status	Occupational status	Housing tenure	Self-reported health status
Celia	Low	Married	Unpaid domestic/ Carer	Owner Occupied	Fair; Chronic health problems
Ellen	Middle	Married	Laboratory Technician (FT)	Owner Occupied	Fair; Chronic health problems
Fiona	Low	Married	Auxiliary Nurse (FT)	Social Rented (Housing Association)	Good; No chronic health problems
Josie	Middle	Divorced	State Enrolled Nurse (FT)	Owner Occupied	Good; Chronic health problems
Kirsty	Middle	Divorced	Library Officer (FT)	Owner Occupied	Excellent; No chronic health problems
Linda	Low	Widow	Unpaid domestic	Owner Occupied	Fair; Chronic health problems
Lizzie	Low	Divorced	Voluntary worker/ Permanently Sick	Social Rented (Local Authority)	Good; Chronic health problems
Mary	Low	Divorced	Permanently sick	Owner Occupied	Fair; Chronic problems
Morag	Low	Married	Unpaid domestic	Owner Occupied (RTB)	Fair; Chronic health problems
Ruth	Middle	Married	Auxiliary Nurse (FT)	Owner Occupied (RTB)	Fair; Chronic health problems
Shona	Middle	Married	Receptionist (PT)	Owner Occupied	Good; No chronic health problems
Tania	Middle	Married	Pub Landlady (PT)	Owner Occupied (RTB)	Fair; Chronic health problems

Notes:

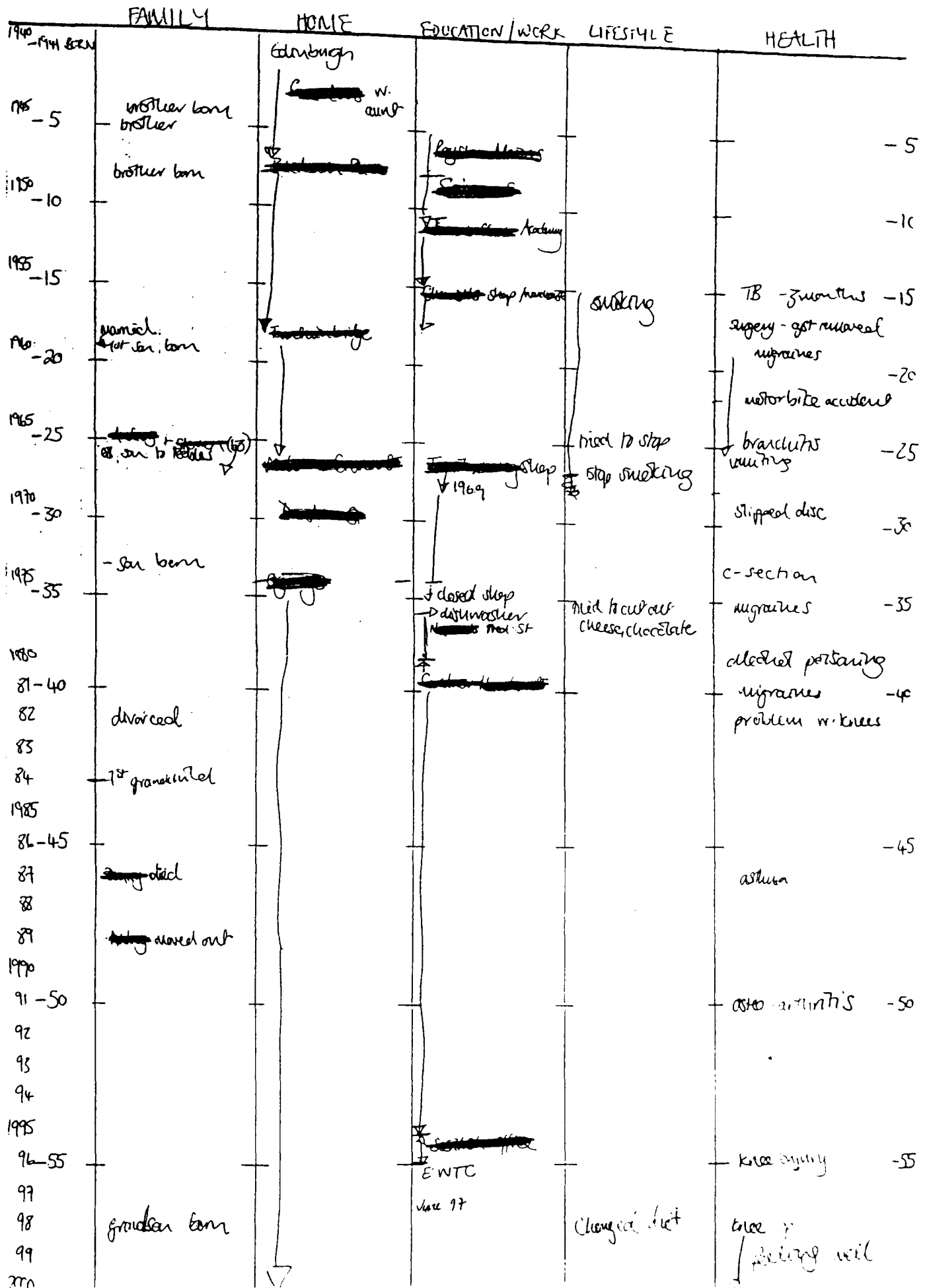
Household income categories: categorised according to net monthly income as follows: Low - below £800, Middle - £800 to £1,600, High - over £1,600.

Occupational Status: PT (Part Time), FT (Full Time)

Housing Tenure: RTB: Owner occupation accessed through Right to Buy sales of local authority housing.

Health Status: Respondents were asked to rank their health on a scale of 1 to 4 where 1 = Excellent, 2 = Good, 3 = Fair and 4 = Poor.

Appendix Three: Lifegrid



Appendix Four: Lifegrid interview topic guide

CHILDHOOD

Family and home

Where were you born?

Do you have any brothers or sisters? When were they born?

Where did you live as a child?

Can you describe your home to me?

Did your parents own or rent your home?

What was the neighbourhood like?

Did you ever move house as a child? Why did you move? What was moving house like for you?

Did you go to school in the local neighbourhood?

How well-off would you say your family were when you were a child?

Can you remember how that made you feel?

Were you aware of people being better-off or worse-off than your family?

Lifestyle

What sort of meals were you brought up on as a child?

How would you describe your diet as a child?

Was exercise or sport ever a part of day to day life when you were a child?

Can you remember your parents or teachers ever talking about doing things to stay healthy?

Health

Can you remember what your health was like as a child?

How healthy do you think you were as a child?

Did you have any major illnesses or accidents?

Significant events

Thinking over your childhood, can you remember any significant events that you think have influenced the way your life has gone?

Can you remember any events that you think may have had an impact on your health later in life?

TEENAGE YEARS

Education: secondary school

Do you remember moving from primary to secondary school?

What did it feel like moving up to secondary school?

On the whole, did you enjoy school?

How old were you when you left school?

Did you have any qualifications when you left school?

Did your parents or teachers encourage you to follow a particular career path after you left school?

How did you feel about the options open to you after school?

Health

Can you remember what your health was like as a teenager?

Apart from your physical health, can you remember how you tended to feel sort of “in yourself” when you were growing up?

Can you think of anything that influenced your health when you were growing up?

Were you ever interested in looking after your health as a teenager?

Lifestyle

Can you remember making conscious decisions about aspects of your lifestyle as a teenager?

Can you remember what prompted these decisions?

Did you ever go on diets as a teenager? Why?

Did you ever smoke as a teenager? How did you start smoking?

Did you drink alcohol as a teenager?

Can you remember the kind of situations when you would tend to have a drink?

EARLY ADULTHOOD

Leaving school

If went to university /college:

Where did you go to university? Why did you go there?

What did you study at university?

What was it like changing from school to university?

Did your lifestyle change at all?

What did you do after you left university?

If looked for a job:

What was your first job after you left school?

How easy was it to find a job?

What did your job involve doing?

Did you enjoy your job?

Did you ever find the job stressful? How did that affect you?

How long were you in that job for?

Why did you leave that job?

How easy was it for you to find another job?

If experienced unemployment:

How long were you out of a job?

How did you feel during that time?

What effect did it have on your finances?

Leaving home

How old were you when you first left home? Why did you leave home?

How did you feel about moving away from home?

Where did you move to?

What was your first home like?

How easy was it for you to find somewhere to live?

Did you need financial help to pay for your house/flat?

MOVING THROUGH THE HOUSING MARKET

When did you move house?

Why did you move?

Where did you move to?

How did you end up living in that particular neighbourhood?

Did you enjoy living there?

How did you feel about that neighbourhood?

If a home owner:

What was your experience of getting a mortgage as a first time buyer?

Was it important to you that you owned your own home?

How did it make you feel, knowing that you owned your own home?

Do you think there are advantages of owning? Disadvantages?

If Renting:

How did you/do you feel about renting your home?

Have you ever wanted to buy your own home?

Why have you never bought your own house?

Do you think that renting has advantages compared to owning? Disadvantages?

FAMILY RELATIONSHIPS

MARRIAGE/COHABITING

Have you ever had a long term relationship with a partner?

When did you get married/start living together?

Where did you live when you first got married/started living together?

What was it like adjusting to being newly married?

Have you ever had stressful times in your relationship?
How did you cope when things got stressful?

PARENTING

What was it like becoming a parent?

How did having children affect your life?

How did you tend to feel generally when you were bringing up the children?

Do you think bringing up your children affected your health in any way?

Do you think that having children affected your relationship with your partner?

How much of the responsibility for bringing up the children was shared between you and your partner?

How did you feel about that?

Work and parenting:

Did you ever have a paid job whilst the children were growing up?

How did you feel about working at that time?

How easy was it for you to get a job when you returned to work?

Did having children affect your finances?

Parenting and lifestyle:

Did your lifestyle change when you were bringing up your children?

eating habits, exercise, drinking, smoking

Do you think that your role within the family has changed as your children have grown up?

Have you been involved in caring for elderly relatives?

How have you felt about that?

If not a parent: is this something that you are willing to talk about?

Did you ever want to have children?

How do you feel now about not having had children?

DIVORCE/RELATIONSHIP BREAK-UP

Is this something that you are willing to talk about?

Why do you think the relationship ended?

How did the break-up affect you? How did you feel at the time?

How did you cope at the time?

Did you have any support from friends or family?

How did your circumstances change?

Where did you live?

Did things change for you money-wise?

Do you think that your health was affected at all by the break-up?

How long did it take for you to feel settled again after you broke up?

DEATH OF FAMILY MEMBERS/FRIENDS

Do you feel able to talk about this?

How did losing _____ affect you?

How did you cope?

Did you have people to support you?

Do you think your health was affected by the bereavement?

WORK & FINANCES

How important has your job been to you throughout your life?

Have you found your work fulfilling?

Has your income been enough to live comfortably?

How do you feel about that?

If has never worked:

Have you ever wanted to have a paid job?

Are there particular reasons why you have not had a paid job?

How do you feel about not having had a paid job?

Job insecurity

Has your job ever been insecure? Can you tell me about it.

How did that affect your life?

How did it make you feel?

How did you cope with the situation?

Do you think that the situation had any effect on your health?

Did you have to find another job?

Money

Looking back over your life, how much would you say your life has been affected by how much money you have had?

Have you ever had financial difficulties? How have you coped?

How do you feel about the way that your financial situation has influenced your life?

LIFESTYLE HABITS

Do you think that a person's lifestyle can have an effect on their health?

Thinking back over your life, have you ever changed aspects of your lifestyle?

Has a concern for health ever been a factor in these changes?

Did changes in your lifestyle habits ever happen at the same time as other changes in your life?

Smoking:

Have you ever been a smoker?

What kind of situations would you smoke in?
Did you know about the health risks? How did you feel about that?
Did you ever try giving up smoking? Why?

Eating habits:

Do you think that your eating habits have changed at all over the course of your life?
In what sort of ways?
What kind of things have influenced your eating habits?
Has a concern for health ever influenced your diet?

Dieting & body:

Have you ever dieted? Why
Has the way that you feel about your body changed over the years?

Exercise:

Has taking exercise or doing sport ever been a part of your routine?
What have been your reasons for doing exercise at particular times in your life?

Drinking:

Have your drinking patterns ever changed over the years?
Do you think that drinking can have an effect on your health?
What has influenced your drinking patterns over the years?

STRESS

Have there been any periods in your life that you think were particularly stressful?
How did that stress affect you?
Do you think that stress have ever affected your health?
This may seem like a silly question, but what does it feel like when you are stressed?

HEALTH

How would describe being healthy?
Generally speaking, would you describe yourself as a healthy person?

On the whole, how would you describe your health over the course of your life?
Looking back over your life, can you think of times when you felt particularly well or healthy?

*Do you think there are particular reasons why you felt well then?
How do you feel in yourself when you feel well?*

Looking back, what kind of things do you think have influenced your health over the course of your life?
When you haven't been well, do you think that might have been connected to other things that were happening in your life at the time?

Menopause

What have been your experiences of the menopause?

How do you view the menopause?

Did it/does it have any effect on your day to day life?

Have you had any advice/information about the M? Who from?

CHECKLIST OF QUESTIONS

- Have we missed anything out about your health over your life, that you think is important?
- How healthy would you say you've been over the course of your life?
- What do you think have been the main things which have influenced your health throughout your life?
- *Check health-related behaviours – diet, smoking, alcohol, exercise*
- Have we talked about all of the major events in your family?
- Have we talked about all of the jobs you've had?
- How would you describe your financial circumstances throughout your life?
- How similar would you say your current circumstances are compared to your family's when you were a child?
- Have we talked about how you ended up living in this neighbourhood?
- Is there anything else that we haven't covered, that you think is important to mention – either about your health in particular, or about another aspect of your life that you think is relevant?

Appendix Five: Daily routines interview topic guide

HEALTH: CONCEPTS AND CAUSES

Do you think of yourself as a healthy person? Why/why not?

Compared to other people that you know, how healthy would you say you are?

Is being healthy something that's important to you?

For you personally, what kind of things are important in staying healthy?

Can people do anything themselves to keep themselves healthy?

Some people tend to be healthier than others. Do you think that there are any particular reasons why that might be so?

What kind of things do you think can put people's health at risk?

Do you think that a person's lifestyle can affect his or her health?

How would you describe a "healthy" lifestyle? An "unhealthy" lifestyle?

Do you think that you personally have a healthy lifestyle?

OWN HEALTH

How would you describe your general state of health?

Do you think of yourself as a healthy person? Why/why not?

On a day to day basis, do you think about your health at all?

Do you ever worry about your health?

Are there any particular health issues that you are concerned about?

What do you tend to do if you are worried about your health?

Do you ever seek advice about your health? Who from?

How do you tend to respond when you fall ill?

When would you go and see your Doctor?

Can you remember how many times you have seen your Doctor in the past year?

On the whole, how satisfied are you with your doctor?

GENERAL QUESTIONS - relating to household routines throughout the day/week

What time do you normally get up in the morning?

Do you have a morning routine?

What do you normally do when you get home from work ?

What sort of time do you normally eat in the evening?

What kind of things do you do in the evening?

When do you normally go to bed?

When do you normally do your household chores?

Are the chores shared with anyone else in the household?

[if married] How do you feel about the way that household tasks are shared between you and your husband?

Do your routines change at weekends?

What do you do in your spare time?

FOOD/MEALS

Do you normally have breakfast?

(If yes: What do you normally have?)

Why do you eat what you do, rather than anything else?

Is it important for you to eat breakfast?

Do you have the same thing for breakfast at the weekend?

Same questions for lunch and dinner

On the whole, what would you say influences your choice of foods that you eat on a regular basis?

SHOPPING

Where do you go to do your main food shopping?

Why do you go there?

How do you get there?

How often would you say you go food shopping in a week?

Main weekly shop or every day?

ALCOHOL CONSUMPTION

Do you drink alcohol?

If yes: How often do you drink? What sorts of situations do you drink in?

Do you think that drinking can have any effect upon people's health?

SMOKING

Do you smoke?

If yes: Can you tell me about your smoking?

How many cigarettes/day/week?

When do you tend to smoke – are there particular times or situations when you will have a cigarette?

Do you think that smoking has had any effect upon your own health?

Do you think it might in the future?

Have you ever wanted to give up smoking?

Have you ever tried to stop smoking?

Why did you (or do you) want to stop?

Have you ever had any advice from a Doctor or another medical professional about giving up smoking?

Do you have any particular views about smoking?

EXERCISE

Do you ever take any kind of exercise/do any sports/other physical activities?

How often do you do this?

How do you fit doing exercise into your daily routine?

Is it something that you do by yourself or with other people?

Do you enjoy it?

What would you say is your motivation for doing _____?

Do you think that taking exercise (or not taking any exercise) has had any effect upon your own health?

EMPLOYMENT *(if engaged in paid work)*

Can you tell me about your job - what does it involve doing?

How many hours a week do you work?

Where do you work?

How do you travel to work?

Do you have any choice in how you arrange your working day?

Do you enjoy your job?

How well do you get on with your colleagues/ your employer?

Do you ever find your job stressful? How do you cope with stress at work?

You don't have to answer this question, but do you mind telling me how much you earn?

How important is your wage to the family income?

Would you choose to have a paid job even if you didn't really need the money?

How secure do you think your job is? Do you ever worry about being made redundant?

Do you have plans to retire?

How do you feel about retirement?

MONEY/FINANCIAL SECURITY

Does a concern for money affect decisions that you make on an everyday basis?

Do you feel that you have enough money to get by okay?

Money can often be a source of stress for people. Do you ever worry about money?

Is it a worry that is shared by other members of your family/household?

Is it ever difficult for your household to meet the cost of bills that come in?

Food/necessities? Treats & luxuries?

Do you ever have to do without something that you need or want because of a lack of money? How does that kind of situation make you feel?

If you were ever short of money, what kind of items would you economise on?

If you had more money, what kind of things would you spend that extra money on?

Who has responsibility for the finances in your household?

How do you think your financial situation compares with other people that you know personally?

Do you think that somebody's level of income or wealth can influence how healthy they are?

Do you think that your own health has ever been affected by how much money you've had?

FEELINGS ABOUT HOME

How much time do you tend to spend at home over the course of a week?

On the whole, how do you feel about your home?

Do you enjoy spending time here?

Do you feel comfortable here?

Do you feel safe here?

Is there enough space for everyone?

Is there somewhere that you can go if you want to spend a bit of time by yourself?

Have you ever had any problems with your home?

Damp/condensation?

Keeping your home warm enough?

Poor state of repair?

Is there anything about your home that you think is positively good for your health?

Anything about your home that you think is bad for your health?

LOCAL NEIGHBOURHOOD

What do you call your local neighbourhood?

How would you describe the neighbourhood?

In general, how would you describe the people who live in the area?

Are most people similar to you/your family, or are there different groups of people?

Do you have friends living locally?

What are your neighbours like?

Do you get on with them? Do you talk to them?

Have you ever had any problems with your neighbours?

Generally, how much of your day is spent in your local neighbourhood?

How well placed do you think your home is for things like supermarkets and other shops, public transport, health services and leisure facilities?

How do you feel about living here?

*Do you enjoy living in this part of the city?
What do you like most/least about living in this neighbourhood?
Is there anywhere else in Edinburgh that you would rather live?
Are you involved in local activities?*

Do you think that your neighbourhood has changed at all since you have been living here?

In what kind of ways? For better or /worse?

Do you think that this neighbourhood has any sort of reputation?

Do you think that where you live can have an influence upon your health/quality of life?

Do you think that there are any features or aspects of this neighbourhood that are positively good for your own health? Any that are bad for your own health?

TRANSPORT/CAR ACCESS

Do you drive?

Do you own a car or have access to a car?

If Y, how often do you tend to use the car?

What do you use the car for?

If N, would you like to have a car?

Do you think that there are any benefits of having a car? Drawbacks?

Do you ever use public transport?

When do you use public transport?

Do you think that there are any advantages to using public transport?

Disadvantages to using public transport?

On the whole, how easily do you feel that you are able to get around when you need to or want to?

How well does the transport that you normally use fit in with your day to day routines?

FAMILY RELATIONSHIPS & FRIENDSHIPS

How would you describe your role within your family?

Are you involved in looking after any elderly relatives?

What does that involve?

How do you feel about that?

Lots of people find it really helpful to have someone that they can talk to about things that are going on in their life. Do you have anyone outside of your family that you can confide in, for example when you are having a hard time?

On a day to day basis, how often do you have contact with your friends?
Do they live locally?
Do you tend to see your friends, or talk to them on the phone?
Can you exchange favours with your friends?

STRESS

Do you ever find aspects of your daily routine stressful?
What kind of situations make you feel stressed?

This may seem like a silly question, but can you tell me what it actually feel like when you are stressed?

Can you describe to me what actually goes on inside your body or inside your head when you are stressed?

How stressful do you think your day to day life is?

How do you tend cope with or respond to stress?

Do you have somebody that you can talk to when you are feeling stressed?

Do you think that your health has ever been affected by stress?

Can you think of anything that would make your life less stressful?

REFLECTIONS ON DAY TO DAY LIFE (end of interview)

Do you have the opportunity to relax or have time to yourself on a typical day?
Just thinking over the past few weeks, how have you felt generally on an average day?

Can you think of any aspects of your day- to- day life that you feel might have a positive influence on your health?

Can you think of any aspects of your day-to-day life that you feel might have a negative influence on your health?

On the whole, how content are you with your life ?

How much control would you say you have over your life?

How do you feel about the future? How do you feel about growing older?

Is there anything that you would change about your life now if you had the choice?

Is there anything else that we haven't yet talked about that you think is important when it comes to thinking about either your life in general, or about your health in particular?

CHECKLIST OF QUESTIONS

- What kind of things would you say are important for you personally to stay well or healthy?
- How healthy would you say you are?
- How important is your job to you?
- How important is your salary to the family income?
- Does a concern for money affect your day to day spending decisions?
- Do you think that the amount of money that someone has can influence how healthy they are?
- Do you think that where you live can have any influence on your health or quality of life?
- How stressful would you say your day-to-day life is?
- What does it feel like when you are stressed?
- How do you cope with stress?
- How much control do you feel you have over your own life?
- How content are you with life generally?

Appendix Six: Household information questionnaire

FINALLY
PLEASE LEAVE ME WITH SOME SUMMARY
INFORMATION ABOUT YOURSELF. THIS WILL BE KEPT
STRICTLY CONFIDENTIAL.

1. Please tell me about all the people, including yourself, living in your household.
(I am interested in all those who usually share your home even if they are not related to you).

Please tell me what relationship they are to you (for example, your husband, son or friend), whether they are male or female, their age, how you would rate their health (excellent, good, fair or poor) and whether or not they are working at the moment.

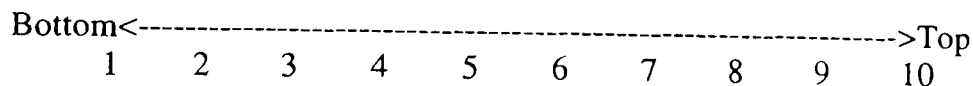
	Relationship to you e.g. husband, partner, son, mother, step-father, friend, flatmate	What sex are you/they? Male ↓ Female	How old are you/they?	How would you rate your/their health? Please circle the appropriate number: Excellent ↓ Good ↓ Fair ↓ Poor	What are you/they doing? Please circle the appropriate number: Working ↓ Unemployed ↓ Permanently sick ↓ Carer ↓ Looking after house or children/ Retired ↓ Student
Example	Husband	M F	47	1 2 3 4	1 2 3 4 5 6
Person 1	Yourself	M F		1 2 3 4	1 2 3 4 5 6
Person 2		M F		1 2 3 4	1 2 3 4 5 6
Person 3		M F		1 2 3 4	1 2 3 4 5 6
Person 4		M F		1 2 3 4	1 2 3 4 5 6
Person 5		M F		1 2 3 4	1 2 3 4 5 6
Person 6		M F		1 2 3 4	1 2 3 4 5 6

2. Does anyone in your household receive any of the following benefits?
 Please tick ALL the benefits that anyone receives.

Attendance Allowance
 Disability Living Allowance
 Disability Working Allowance
 Incapacity Benefit
 Industrial Injuries Disablement
 Invalid Care Allowance
 Severe Disablement Allowance

Family Credit
 Income Support
 Jobseeker's Allowance
 State Retirement Pension
 Other
 please specify.....

3. In our society, there are groups which tend to be towards the top of the social scale and groups which tend to be towards the bottom. Where would you put yourself on this scale? (circle a number)



4. If incomes became more equal in Britain, some people would get higher incomes and some people would get lower incomes.

If incomes became more equal, would your income:

definitely go up
 probably go up
 stay the same
 probably go down
 definitely go down
 can't choose

5. Could you tell me approximately what your total household income is? Please include benefits and pensions, and tell me whether the amount is what you receive before or after tax.

My/our income is approximately £ per week / month / year (circle as appropriate).

This amount is before / after tax (circle as appropriate).

THANK YOU VERY MUCH FOR TAKING TIME TO HELP ME WITH MY RESEARCH

Appendix 7 Coding framework

HEALTH CODES

BeingHlthy	Concepts of health
GenHlthInf	General views on influences upon health
HlthyMinHP	Considers self healthy/only health problems are minor
MjrHP	Has major health problems/does not consider self to be healthy
HlthFam	Description of other family members' health experiences
M	Views/Experiences of the menopause
HcarePos	Positive experiences of National Health Service
HcareNeg	Negative experiences of National Health Service

CHILDHOOD CODES

Cpriv	Relatively privileged childhood circumstances
Cdep	Relatively deprived childhood circumstances
Cfamsec	Secure family life as a child
Cfaminsec	Insecure family life as a child
CHgood	Good overall health as a child
CHbad	Poor overall health as a child

EDUCATION/WORK CODES

SchTrans	Transition from primary to secondary school
SchAdv	Left school with qualifications; went on to further training/education
SchDisadv	Left school without qualifications; straight into labour market
WrkPpos	Positive experience of a job in the past
WrkPneg	Negative experience of a job in the past
JCpos	Positive job change (e.g. promotion)
JCneg	Negative job change (e.g. redundancy)
JChprobs	Unable to maintain job due to health problems
WrkHprobs	Able to maintain job despite health problems
JobNow	Description of current job

WrkPos	Positive experience of current job
WrkNeg	Negative experience of current job
WrkMean	How important paid work is to respondent
PjobSit	Details of partner's employment (past and present)

HOUSING CODES

HomeSmth	Smooth transition between leaving home and establishing own home
Homebumpy	Problematic transition between leaving home and establishing own home

MvePos	Positive experience of moving home
MveNeg	Negative experience of moving home
MveHP	Moving home due to health problems

Owning	Comments about home ownership
Renting	Comments about renting (including social renting)

HNpos	positive experiences of current home/neighbourhood
HNneg	negative experiences of current home/neighbourhood
plHlth	general comments re links between place and health

Trnsprt	Mode of transport used by respondent
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FAMILY CODES

MgePlus	Positive experiences of marriage
StrsMge	Stressful/negative experiences of marriage

Splitpos	Divorce had positive effect on quality of life/ well-being
Splitneg	Divorce had negative effect on quality of life/well-being

KidsWBpos	Positive experiences of parenthood
KidsWBneg	Negative experiences of parenthood

FamRelPos	Positive relationships with family members
FamRelNeg	Negative relationships with family members

JpthMge	Job change upon marriage & throughout marriage because of spouse's job
JpthFCare	Employment situation whilst caring for children/other family members
JpthDiv/Wid	Consequences of divorce/widowhood for employment situation

GenDivLab	Gender division of labour within the household
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MONEY CODES

- MnyPrtWB** Financial circumstances have promoted quality of life, health and well-being
MnyHrmWB Financial circumstances have undermined quality of life, health and well-being
HlthMny General opinions on links between money and health

STRESS CODES

- StrsDesc** Concepts and experiences of stress
StrsCpe Coping with/responses to stress
StrsHlth Views and experiences re influence of stress upon health

SOCIAL SUPPORT

- SS** Able to access social support from family/friends/neighbours
NoSS Unable to access social support from family/friends/neighbours
SSprof Support from professional services e.g. counselling

LIFESTYLE CODES

- Drinking** Description of own alcohol consumption
Eating Description of own diet
Exercise References to doing sport/exercise
Smoking References to own smoking behaviour
- LSc** Feeling of choice and control over life
LscNo Feeling of little choice and control over life
- LIFEgood** Feels content about life on the whole. Life relatively stress-free
LIFEbad Feels unhappy about life on the whole. Life relatively stressful