

# Masculinities, Social Capital and Men's Experiences of Chronic Ill Health

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## **Abstract**

This thesis draws on theoretical and empirical research on men and masculinities, and on social capital to inform understanding of the experiences of chronically ill men. Levels of chronic illness are increasing in the Western Global North, and this phenomenon has been linked with health-related behaviour (Crossley, 2000a). A growing literature has explored the ways that people experience chronic illness and the implications of that for their health and wellbeing (e.g. Williams, 2000; Bray et al, 2014). There is a need however for further research that seeks a gendered understanding of men's experiences of chronic illness within a context of social relatedness. Connell's (e.g. 1995) theoretical description of hegemonic masculinities set within the 'gender order' has stimulated much research that moves beyond a simplistic understanding of gender that often characterises work in Health Psychology. Similarly social capital has become widely used to conceptualise aspects of social connectedness and its links with health and illness (e.g. Hu et al, 2014). A qualitative, narrative approach has been employed here to explore the experiences of chronically ill men. Semi-structured interviews were conducted with twenty five men to investigate the processes linking social capital, masculinities and experiences of chronic illness. A multi-level narrative analysis (e.g. Murray, 2000) was conducted on the resulting interview transcripts, and both case study and cross-case studies are presented in the thesis. The thesis demonstrates the value of a multi-level analysis (Murray, 2000) that incorporates the examination of personal, interpersonal, positional and ideological facets of men's illness narratives.

Key findings concerned the contestation of meanings of illness in men's social networks, the gendered context to family conflicts related to illness, and the complexities of reciprocal care and support amongst families over time. Issues around employment and the workplace such as stress, and the negotiation of accommodations in masculinist workplace contexts are also explored. These findings point to the complexity and importance of interdependence and masculine identities, and their links with chronic illness experience. The association of social capital with entirely positive or negative outcomes or experiences amongst chronically ill men oversimplifies the diverse and context specific processes involved. A gender-sensitive approach to family systems and broader social connectedness with community and work contexts however can aid in understanding how the experiences of chronically ill men are shaped. The importance of theories and interventions that do not rest on models of unconstrained individual choice is particularly highlighted. Such work may be useful to health practitioners and in contributing to public discourse around chronically ill men.

**Key Words: Chronic Illness, Masculinities, Social capital, Narrative, Gender**

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## **Table of Contents**

<b>Title Page.....</b>	<b>1</b>
<b>Abstract.....</b>	<b>2</b>
<b>Acknowledgements.....</b>	<b>3</b>
<b>Table of Contents.....</b>	<b>4</b>
<b>Chapter One: Introduction and Rationale for Study.....</b>	<b>7</b>
Rationale for Study.....	7
Drawing it all together: Chronic Illness, masculinities and Social Capital.....	10
The Research Questions.....	10
Thesis Structure.....	10
<b>Chapter Two: Health Psychology and Chronic Illness.....</b>	<b>13</b>
Chronic Illness.....	13
Health Psychology and Chronic Illness.....	14
Critical Health Psychology.....	21
Grounding Knowledge in the Experience of Chronically Ill People.....	24
<b>Chapter Three: Men and Masculinities.....</b>	<b>35</b>
Hegemonic Masculinity.....	35
Changing Masculinities.....	39
Intersectionality and Masculinities.....	44
<b>Chapter Four: Men’s Health and Chronic Illness.....</b>	<b>47</b>
Health Inequalities: Men’s Health.....	47
Gendered Patterns of Health-related Behaviour.....	48
Patterns of Chronic Illness.....	52
Chronic Illness and Masculine Identity.....	53
<b>Chapter Five: Social Capital, Health and Chronic Illness.....</b>	<b>58</b>

Social Capital.....	58
James Coleman and Social Capital.....	60
Pierre Bourdieu and Social Capital.....	67
Robert Putnam and Social Capital.....	71
Evaluating Social Capitalism.....	80
Social Capital, Health and Illness.....	84
Social Capital and Chronic Illness.....	88
Bringing Together Social Capital, Masculinities and Chronic Ill Health.....	90
<b>Chapter Six: Methodology.....</b>	<b>92</b>
Rationale for Use of Qualitative Methodology.....	93
Quality in Qualitative Research.....	94
Narrative Psychology.....	96
Research Design.....	104
Recruitment.....	104
Ethical Considerations.....	105
Interviewing Men.....	106
Participants.....	108
Conducting the Interviews.....	112
Narrative Analysis.....	115
Reflexivity.....	121
<b>Chapter Seven: Analysis and Discussion of Case Studies.....</b>	<b>123</b>
Case Study Number One – Sean.....	123
Case Study Number Two – William.....	147
<b>Chapter Eight: Cross-Case and Reflexive Analysis and Discussion....</b>	<b>164</b>
Bonding Ties and Illness Experience.....	164
Bridging Ties and Illness Experience.....	178
Linking Ties and Illness Experience.....	187
<b>Chapter Nine: Discussion and conclusions.....</b>	<b>202</b>

Summary of the Research.....	202
Rationale for Undertaking the Research.....	203
Overview of the Research Findings.....	203
Limitations of the Method.....	209
Implications of the Study for Policy, Practice and Research.....	210
Recommendations for Future Study.....	215
Concluding Comments.....	215
<b>References: .....</b>	<b>217</b>
<b>Appendices: .....</b>	<b>270</b>
Appendix One – Participant Consent Form.....	270
Appendix Two – Interview Schedule (First Interviews).....	272

## Chapter One - Introduction and Rationale for Study

This thesis explores how men construct masculinities amidst chronic ill health experiences in the UK, within a new decade and new policy regime. Men's experiences are also examined in relation to social capital, a concept which has proved attractive to policymakers and generated a vast academic literature. Individual narratives are explored with reference to the wider sociocultural backdrop. I track the rationale for the work below.

### Rationale for study

*Chronic ill health* - Levels of chronic illness are increasing in Western Global North societies – these are in part considered as lifestyle illnesses related to affluence, but the focus is often on individual choice and responsibility to change behaviour in mainstream psychology. Critical health psychology (e.g. Crossley, 2000a; Murray, 2014) has challenged this perspective. Drawing upon the approaches of more sociocentric disciplines such as sociology, and critical theory, work from this broad perspective highlights the impact of social context on individual, social, community and societal health. Implications for developing theoretical understandings of chronic illness experience, arising from the application of a critical psychological or critical health psychological perspective, will be explored in my thesis. In addition, there is a need to further develop UK policy and practice in response to the rising numbers of people with chronic illness, and here my thesis will suggest some of the ways in which the empirical and theoretical developments outlined may be useful in guiding service providers. In particular, my thesis will illustrate the need for services to 'mainstream gender'<sup>1</sup> in improving access and support for the rising numbers of chronically ill men.

*Masculinities* – Gender relations have undergone a degree of change in Western cultures such as the U.K. over the last 40 years. Feminist work has been concerned with how women are positioned and valued in societies, and the impact of this on everyday life. One consequence of feminist and feminist

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<sup>1</sup> Gender mainstreaming refers to attempts to improve policies by making visible the gendered nature of assumptions, outcomes and processes (Walby, 2005).

inspired research has been to open up masculinity as a topic for critique and debate in a way that it had not been previously. Studies of men and masculinity have been advanced greatly over the last 30 years through the work of Raewyn Connell (e.g. 1995). Work on masculinities and men's health has been concerned with the positioning of men in relation to access and engagement with health services. Notwithstanding such developments, the ongoing conceptual and theoretical debate about masculinities in the social sciences needs to be grounded in men's experiences. My thesis here will assist further theoretical developments. Given the complexity of enactments of masculinities in everyday life I will argue that there is a need to avoid a one size fits all approach to men in policy and practice. Work in the field of health inequalities has identified the socially stratified nature of mortality and morbidity patterns amongst men (Courtenay, 2002; Williams, 2003). Differences amongst chronically ill men framed in terms of intersectionality and their differing social and cultural locations will be explored here to inform suggestions for policy and practices.

Men's sense of masculinity is researched as if in a constant relationship to health, incorporating critical research that has previously linked men, masculinities and health (e.g. Gough & Robertson, 2009). The temporal aspect of masculinity construction within individuals' lives has been under-researched. My thesis will highlight the importance of contextualising men's experiences of chronic illness in relation to the lifecourse. This work will contribute to understandings of the lifecourse development of 'health identities' (e.g. Fox & Ward, 2006), exploring their importance and implications for framing policy and practise, particularly in relation to issues of 'choice' and the ways in which men deal with chronic illness in their everyday lives (health-related behaviour). Men's chronic illness trajectories (e.g. Corbin & Strauss, 1991) will also be examined from this perspective. The course of chronic illness is more complex than a simple downward trajectory in terms of functioning and wellbeing. My thesis will contribute to understandings of the reasons for ups and downs in men's illness trajectories. This empirically grounded work will have implications for policy and practice informed by an understanding of gender as advocated in recent work (e.g. see Williams et al, 2009).



*Social capital* –Social capital has become somewhat ubiquitous as a way of conceptualising social relatedness, encompassing disparate elements such as trust, norms, participation and reciprocity. In subsuming more longstanding social science concepts into a term that seems to imply measurability/quantification and an economics-based perspective (framing such in terms of resource to be accrued, ‘spent, invested in, etc.), Putnam’s (e.g. 1995; 2000) work on the topic has had appeal to policy makers of a neo-liberal bent (both New Labour and the Conservatives in the U.K.) as well as researchers. My thesis might be seen as an examination of the place of chronically ill men in the ‘Big Society’<sup>2</sup> envisaged by the current Prime Minister. The explanatory value of social capital has been questioned, however, and its usefulness as a heuristic is similarly open to debate. Further, Bourdieu (1986) provides an alternative perspective on the concept that draws attention to social structural inequalities in a way reflective of European social theory more generally. Social capital has been applied to the topic of health (largely from the Putnam-influenced perspective) largely proceeding by way of attempts to illustrate and discuss the relationship between ‘low’ levels of it and poorer health (and vice-versa). This research perspective stands somewhat in tension with the longstanding tradition of work on health inequalities based on social structural formations of class, ethnicity, gender, etc. Social capital researchers argue that social capital mediates the relationship between health and poverty for instance, a position vigorously debated with researchers taking a materialist perspective. Social capital has been both lauded as tool for empowerment and decried as a tool for victim-blaming in relation to deprived groups and communities (Lecerof et al, 2015). Further research is needed to evaluate the ways in which elements of social capital may help to provide a coherent understanding of social relatedness, and assess the usefulness of the concept. My thesis will critically engage with the concept, giving substance to conceptual debates via a focus on the person-in-context in relation to social capital and ill health. In particular the gendered nature of social capital in this respect will be illustrated, and implications for policy and practice examined.

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<sup>2</sup> ‘Big Society’ discourse coheres around core tenets of community empowerment, decentralisation and public service reform. As a feature of the UK 2010 Conservative general election manifesto (Conservative Party, 2010) it’s ideological positions are reflected in the subsequent coalition government’s Localism Act (2011) and initiatives such as the Big Society Bank and Free Schools.

## **Drawing it all together: Chronic illness, masculinities and social capital**

In my thesis I develop an understanding of men's experience of chronic illness that draws upon masculinities theories, and is firmly grounded in an understanding of their gender. Whilst an individual focus is maintained, an understanding of social structures and social relatedness within men's individual lives will be developed via critical engagement with the concept of social capital. This will be achieved by taking a dialectical approach to the individual and their social context, moving towards a synthesis of individual-in-relation to the social across the lifecourse. Here the work of Murray (2000) is drawn upon in order to interpret men's narratives at a number of levels. The work of my thesis stands in contrast to that of researchers who focus on one or other perspective exclusively. Indeed this overarching idea develops a perspective having important implications for future research practice beyond the current topic of men's chronic illness experiences.

### **The Research Questions**

1. What processes link social capital, masculinities and experiences of chronic ill health?
2. What are the experiences of men in their use of social capital in relation to chronic ill health?
3. How do participation in community life, relationships with friends and family, shared group norms, trust and reciprocity work to mediate men's experiences of chronic ill health?

### **Thesis Structure**

This thesis is divided into nine chapters. Following this introductory chapter, the remaining thesis is structured as follows:

Chapter Two – Health Psychology and Chronic Illness - This chapter discusses and reviews research on chronic illness. In the chapter I have discussed Health Psychology and the varied approaches taken within the field to the topic of chronic illness. I have aimed to illustrate how the development of Critical Health Psychology and integration of insights from disciplines such as medical sociology have highlighted both the importance of social context in understand experiences of chronic illness and the inadequacy of conceptions of gender in much ‘mainstream’ Health Psychology work.

Chapter Three – Men and Masculinities – This chapter reviews contemporary work on men’s gender and the intersection of gender with other social locations such as age, social class, etc. The aim of the chapter is to set out the more complex understanding of men and masculinities that may be incorporated into health-psychological research in order to better inform understanding of it’s links with men’s health and illness.

Chapter Four – Men’s Health and Chronic Illness – This chapter reviews gendered health inequalities and patterns of health-related behaviour that illustrate the relevance of theoretical understanding of the processes linking men’s gender with health and illness. I review research linking gender and health, and detail subsequently gendered patterns of chronic illness. The experiences of chronically ill men in relation to masculine identity construction are then discussed. The aim of the chapter is to discuss men’s health and chronic illness in relation to masculinity.

Chapter Five – Social Capital, Health and Chronic Illness – This chapter develops further issues of social context through the discussion of ‘social capital’. As a multi-level concept conceptualising social relatedness, social capital has been the subject of a vast literature. A body of research linking social capital with health and illness is reviewed in this chapter. The aim of the chapter is to illustrate the usefulness of critical engagement with social capital in further contextualising men’s experiences of chronic illness.

Chapter Six – Methodology - A Narrative Exploration of Chronically Illness experience, masculinities and Social Capital – This chapter aims to set out and

justify the methodology used in answering the research questions. The rationale for the chosen methodology, as well as relevant issues of epistemology and ontology are discussed. Methods of sampling, data collection and analysis, as well as ethical and reflexive considerations are discussed.

Chapter Seven – Analysis and Discussion of Case Studies – This chapter presents the analysis and discussion of in-depth case studies conducted in relation to two of the study participants. Here I have interpreted, discussed, and contextualised the experiences of two chronically ill men in holistic case studies.

Chapter Eight – Cross-Case Analysis and Discussion – This chapter presents the analysis and discussion of cross-case analysis focussing on a further five study participants. Similarities and differences amongst participants are thematised and interpreted, discussed and contextualised in relation to relevant literature.

Chapter Nine – Discussion and conclusions - this provides an overview of the findings in which they are discussed further in relation to recent relevant literature to synthesise the outcomes of the study in relation to the research questions. Limitations of the methodology employed are discussed. Implications of the research for policy, practice and research are reviewed. Subsequently I make recommendations for future research to follow from this thesis, and make some concluding comments.

## **Chapter 2 - Health Psychology and Chronic Illness**

This chapter explores and reviews the literature with regard to health psychology and chronic illness. I have commenced by briefly describing the nature of chronic illness, and then discuss the ways in which health psychology research has contributed to related understanding and interventions. The shift from biomedical to biopsychosocial model as a basis for incorporating psychological issues into research on chronic illness is discussed. Some of the limitations of a 'mainstream' health psychological approach are reviewed, leading to a review of critical health psychological perspectives and their relevance to considerations of chronic illness. Insights arising from experiential and socioculturally focused research are then explored. The aim of the chapter is to provide an account of the development of health psychological research on chronic illness, and the benefits of investigation that draws upon perspectives other than the positivist, social-cognitivist work that has largely dominated such work. In particular the importance of social context and an understanding of gender reflecting critical theoretical developments is needed.

### **Chronic Illness**

The World Health Organisation considers chronic illnesses to be 'health problems that require ongoing management over a period of years or decades' (WHO, 2005). A wide variety of illnesses are considered as chronic, and despite the common feature of indefinite duration they encompass diverse forms and onset patterns. Lubkin & Larsen (2013, p.5) note that:

'Chronic conditions can take many forms and there is no single onset pattern. A chronic disease can appear suddenly or through an insidious process, have episodic flare-ups or exacerbations, or remain in remission with an absence of symptoms for long periods.'

Some of the most prevalent chronic illnesses in the UK are Hypertension, Asthma, Diabetes, Coronary Heart Disease and Chronic Kidney Disease (Department of Health, 2012). Interest in chronic illnesses has burgeoned in the social sciences in the last twenty five years or so, as they have become more

prevalent in industrialised nations (Lubkin & Larsen, 2013). This phenomenon has both increased demands on health care systems (e.g. Strauss, 1990; Scarborough et al, 2011) and led to wider social problems related to quality of life and long term community care for sufferers.

In England for instance around 14.4 million people - a quarter of the population – have a long term condition, and it is estimated that 50% of all GP appointments, 70% of hospital bed occupancy days, and 70% of hospital and primary care budgets are used in care and treatment of chronically ill people (NHS England, 2015). As a result of the significant proportion of health care services used in relation to chronic illness, concern has grown to account for social and psychological factors that may influence the onset and course of a range of chronic illnesses.

### **Health Psychology and Chronic Illness**

Health psychology has developed, via its roots in clinical psychology, as the dominant social scientific discipline concerned with such influences (Stam, 2000). Some of the main aims of health psychology, and the ways in which researchers have attempted to achieve these will be briefly explored here. Health psychologists have aimed to understand, explain, develop and test theories that link social and psychological factors to health and illness (Ogden, 2012). Ogden (2004) describes several areas in which health psychologists have been active in furthering these aims.

Firstly health psychologists have been concerned to evaluate the role that behaviour plays in the causes of illness (Ogden, 2012). A wide range of behaviours are thought to influence the onset and course of a variety of chronic illness conditions (Scarborough et al, 2011). It is well established for example that there are causative links between smoking and circulatory diseases, respiratory diseases and cancers (Peto et al 1994).

Secondly researchers have also sought to examine individual and social variables associated with health-influencing behaviours. Gender is one social category that has been discussed as a variable. Differences between men and

women have been observed in a number of health related behaviours that are likely to influence the onset and course of chronic illnesses. For example, English men are more likely to smoke, less likely to consume recommended amounts of fruit and vegetables, more likely to be shift workers (Health Survey for England, 2013) and are more likely than women to drink more alcohol than recommended daily amounts (Health Survey for England, 2012).

Researchers have also attempted to model the relationships between various psychological variables and health-related behaviour. This has resulted in various 'models of health' that envisage the relationships between variables, and which have informed health promotion attempts targeting the relevant model variables. Two of the most widely cited models are the Health Belief Model (HBM)(Becker, 1974; Becker and Rosenstock, 1984), the Theory of Planned Behaviour (TPB)(Ajzen, 1985). Some key features of which are outlined in the following two paragraphs.

The Health Belief Model (HBM)(Becker, 1974; Becker and Rosenstock, 1984) proposes that some external or internal cue initially prompts a person to consider carrying out some health-related behaviour. This consideration involves a cost-benefit analysis based on their beliefs about the consequences of that behaviour. According to the HBM a person is likely to engage in a health promoting behaviour to the extent that believe they are susceptible to some illness, that the potential illness has potentially serious consequences, and that the behaviour will have few adverse consequences whilst leading to a positive health outcome. The model has been extensively evaluated and received support in empirical research (Roden, 2004).

The Theory of Planned Behaviour (TPB)(Ajzen, 1985) is a general social cognitive model of the relationship between attitudes, beliefs and behaviours. According to the TPB, a person's intention to perform a behaviour may be predicted from a combination of their attitude to the behaviour, their perceptions of and motivation to comply with subjective norms concerning a behaviour, and the degree of control they perceive themselves to have over their performance of a behaviour. Actual performance of the behaviour is proximally determined by

a person's intention to perform it and also independently by the degree of control they perceive themselves to have over their performance of a behaviour.

Thirdly health psychologists have explored pathways through which psychological processes may have physiological consequences (and vice versa). In this vein, research has suggested that there are physiological concomitants to stress that have consequences for both the onset and progression of illness, for instance (Ogden, 2012).

Fourthly health psychologists have also elaborated on the role of psychology in the ways people experience and cope with illness (Ogden, 2012). A large body of research has developed that focuses on peoples' beliefs and cognitions in regards to illness. One of the most well researched theories in this respect is the Self-Regulation Model (SRM), a cognitive theory developed by Leventhal et al (e.g. 1992, 2003). The SRM incorporates the categorisation of illness cognitions into five dimensions. These are identified as, in relation to the illness; (1) it's cause/s, (2) it's expected duration, (3) it's expected consequences, (4) it's curability or controllability and (5) it's identity (diagnosis or label). According to the SRM, illnesses and their symptoms are dealt with in a 'problem-solving' fashion, through stages of interpretation, coping and appraisal. Illness cognitions are the means, along with emotional responses, by which interpretations, coping processes and appraisal processes are given meaning. A number of empirical studies have supported the consistency and validity of these five dimensions (Rutter and Rutter, 2002).

Fifthly, the role of psychology in the treatment of illnesses has also been an area of research for health psychologists. When a person is diagnosed with a chronic illness there are often a variety of recommendations and prescriptions that are negotiated with healthcare practitioners. These often relate both to lifestyle choices (e.g. smoking, diet, exercise) and specific regimes of medication that may influence the course and severity of their illness. A further area of study generating much research has focussed on interactions between chronically ill patients and healthcare professionals (usually on the doctor-patient relationship) and the influence of these on compliance (e.g. Ley, 1982, 1989). Research that attempts to identify psychosocial factors affecting the



degree to which a person follows such advice is often marked by the use of the term 'compliance' or more recently 'adherence'. Compliance has been a major focus of research because it is viewed as playing an important role in enhancing quality of life, reducing symptoms and healthcare costs (Ogden, 2012). In addition to the social cognitive models, well researched psychological constructs such as 'self-esteem', 'locus of control' or 'self-efficacy' have been employed in studies concerned with how chronically ill individuals comply with medical advice and cope with their illness (Kihlstrom & Kihlstrom, 1999; Simoni et al, 2006; Johnson et al, 2007). Management behaviour self-efficacy, for example, has been found in a number of studies to predict diabetes (Jenkins, 1981; Padgett, 1991) and arthritis (O'Leary et al, 1988; Simoni et al, 1995) related health behaviour.

Further, health psychologists have aimed to develop practical applications based on theoretical and empirical research. In this way they have aimed to influence psychosocial and behavioural factors that impact on health and illness outcomes. Health psychologists have attempted to help people with chronic illnesses to adopt strategies and coping techniques that will assist them to maintain recommended treatment regimes. Illustrating this, Lorig et al (1999) developed the Chronic Disease Self-Management Course (CDC), which is grounded in the theoretical framework of self-efficacy. Participants engage in weekly planning sessions involving problem solving, decision-making, skill mastery, role modelling, persuasion and reinterpretation of symptoms. Participation in the CDC was associated with benefits in terms of psychological and physical well-being, which were still apparent at a two year follow-up (Lorig et al, 2001).

There has also been involvement of health psychologists in health promotion interventions that are aimed at preventing chronic illness. These have been designed to inform and influence people in relation to behaviours that are implicated in the onset of illness or that have implications for health and well-being. Cognitive/social cognitive theories have predominated research in this area, with the Health Belief Model (Becker, 1974; Becker and Rosenstock, 1984) and the Theory of Planned Behaviour (Ajzen, 1988) being those most widely used. Aoun et al (2002), for example, have used a worksite-based

intervention based on the HBM, identifying men aged between 40 and 65 who were at high risk for developing diabetes and referring them to their general practitioner. More recently the Transtheoretical Model of Change (TTM; Prochaska & DiClemente, 1983) has also been employed to inform behaviour change interventions amongst chronically ill people (e.g. Johnson et al, 2006; Teng et al, 2013).

A wide range of health related behaviours have been researched using the TPB, including smoking, sexual behaviour, exercise, food choice and alcohol consumption (Godin, 1993; Sparks, 1994; Blue, 1995; Manstead and Parker, 1995; Conner and Sparks, 1996; Godin and Kok, 1996; Conner and Armitage, 1998; Duncan et al, 2012; Karimy et al, 2012; Cooke et al, 2014; Rich et al, 2014; Watanabe, 2015). Many such studies have aimed to identify beliefs that may be then be usefully targeted by a persuasive message. By identifying the relative contribution of the model's components to intention formation amongst the target group, an intervention can be focused on changing the most salient beliefs. In sum, these models such as TPB and HBM as well as other cognitive/social cognitive models have been used in practical interventions designed to promote healthy behaviours and prevent chronic illness (Roden, 2004).

The above illustrates several ways in which health psychological work has contributed to understanding and intervention in issues related to chronic illness. A shift from a biomedical to biopsychosocial modelling of illness has been proposed as foundational to the development of health psychology as a discipline. Nonetheless, there have been criticisms directed at the assumptions underlying the dominant models and perspectives, and the ways that health psychologists have gone about achieving the aims of the discipline more generally. There has been little attention to the lived experience of gender in mainstream health psychological work, for instance, where it is generally assumed as a variable. Critics of a cognitivist or social cognitivist perspective applied to health psychology argue that the focus on the individual obscures important sociocultural dimensions of health and illness (Crossley, 2000). They have drawn upon other research traditions to develop alternative approaches

that may be loosely described as constituting a 'critical health psychology'. These developments are discussed below.

### *The Biomedical Model and Illness*

The place of health psychology in relation to the biomedical model, dominant within modern period medical contexts, is relevant in understanding its evolution. Essentially the biomedical model frames the object of investigation in relation to health and illness as being reduced to biological and physiological changes in the body (Ogden, 2012). Chronic disease therefore is seen as a long term response of the body to biological, cellular, chemical or genetic stimuli causing physical bodily alterations (Ogden, 2012). Individuals in the biomedical model are seen as targeted by these external forces that result in internal changes. A concomitant of this framework is that responsibility for effective treatment rests largely with the medical profession, and the model continues to form the basis in clinical medical practice for evaluations seeking objective evidence to support clinical interventions (Borrett, 2013). Psychology has a rather limited role from the biomedical perspective, in that it is dualistic (mind and body are seen as functioning independently of each other), and allows for psychological effects of illness, but downplays or excludes psychological or psychosocial causation for illness (Ogden, 2012).

### *The Biopsychosocial Model*

The institutionalised dominance of this model, with its focus on purely physical processes (e.g. pathology, biochemistry, physiology) has been challenged to an extent by the development of health psychology. Engel's (1977) biopsychosocial model is credited with legitimising psychological and social factors as objects of study in conjunction with biomedical concerns, and thus has had a foundational status within health psychology. Despite this, it has been criticised on a number of counts. The model essentially appends psychological and social factors to biomedical processes, and so assumes a dualistic conception of mind and body, although seeing them as interlinked systems. Connections between biological, psychological and social levels of analysis have remained inadequately theorised as a result (Crossley, 2000a). Hatala

(2012) calls for a more integrative and holistic approach that focuses on the interactions across bio-psycho-social domains empirically and theoretically, whilst acknowledging the role of culture as saturating all three of these domains.

### *Medicalisation and the Wider Causes of Illness*

As Chamberlain (2000) argues, that health psychology has from the outset been situated within a medical context has tended to encourage a separation of the individual as a subject of investigation from his or her social and cultural context. This separation has served to blind health psychologists somewhat to the ways in which individual health behaviours are inextricably related to social, cultural and political factors, and promote health management and education programmes that only attempt to change individual behaviour.

It has been argued that the biomedical approach depoliticises the impact on health of social structural inequalities (e.g. Zola, 1972). The 'medicalisation critique' illuminates the ways in which problems that may be more accurately viewed as resulting from inequitable societies are perceived through the lens of scientific medicine as biological or psychological problems of individuals. Mainstream health psychology, to the extent that it has ceded socio-political contextual influences to other social science disciplines, and the body to biomedicine can be seen as complicit with the medicalisation process. From this perspective the taken-for-granted benevolence inherent in the health professions has been questioned. Waitzkin (1991), for instance, analysed doctor-patient interactions from a Marxist perspective and illustrated how the medical encounter may be seen as a site of control and surveillance.

In contrast, critical psychologists have argued for more holistic conceptions of individuals as embodied selves, relational in nature to their social, cultural and political context. Writers such as Tolman (1999) for instance, have argued that individuals are societally constituted, whilst Crossley (2000a) draws attention to the ways in which individual health behaviours and outcomes are inextricably linked to social, cultural and political contexts.

## **Critical Health Psychology**

In recent years 'critical' perspectives on health psychology have developed, influenced by critical social (e.g. Gough & McFadden, 2001; Hepburn, 2003) and community (e.g. Orford, 1992; Kloos et al, 2011; Kagan, 2011) psychological literature as well as an awareness of other social science disciplines that have been concerned with health and illness matters. The development of a 'critical psychology' (e.g. Fox & Prillettensky, 1997; Ibanez & Iniguez, 1997; Parker & Spears, 1996; Parker, 2015) has reflected a desire on the part of many researchers and practitioners to reconstruct the discipline of psychology as a whole in ways that focus on:

'the central themes of pursuing social justice, promoting the welfare of communities in general and oppressed groups in particular, and altering the status quo of society and the status quo of psychology.'

(Prillettensky & Fox' 1997, p4)

Such an approach implies an orientation towards both understanding and change at social, cultural and political levels.

### *Critical Health Psychology*

Critical health psychologists (e.g. Crossley, 2000a; McVittie, 2006; Murray, 2014) have challenged many of the assumptions underpinning social cognitive approaches and the project of health psychology more generally. The tendency within health psychology to focus on individuals in isolation of their sociocultural contexts has been seen as central to the discipline's limitations by such writers. Chamberlain (2000) points to the historical development of health psychology within medical settings as one explanation for this.

Activities in other social science disciplines that do emphasise sociocultural influences on behaviour, such as anthropology and medical sociology, have had relatively little influence on the development of health psychology (Radley and Chamberlain, 2001).

In common with other 'critical' approaches to psychology, at best the critiques offered of 'mainstream' approaches open up new approaches, ideas and thinking (Tuffin, 2005; Gough et al, 2013). Improved research methods and understandings of the psychosocial aspects of health and illness are intended to result from such critiques.

### *Social Constructionism and Health*

Social constructionist perspectives (e.g. Burr, 2015) have informed much critical psychological writing. Broadly, from a social constructionist perspective, "the states and functions of the body become a cluster of cultural instead of natural, that is, biological constructions" (Baerveldt and Voestermans, 1996, p.695). Such claims do not necessarily deny the reality of physiological conditions or bodily experiences, but they do undermine the notion that issues of health and illness should be seen as having essentially biomedical foundations (Olafsdottir, 2013).

### *Sociocultural Influences on Illness*

There is much empirical evidence supporting the assertion that sociocultural conditions influence the onset and course of chronic illnesses. Epidemiological research has shown that income inequalities are associated with the distribution of such illnesses in the U.K. Graham (2000, p.6) notes that 'the distribution of ill health continues to follow the contours of disadvantage even as chronic illnesses have overtaken infectious diseases as causes of morbidity and mortality.' As Marks (1996) argues, a key challenge for 'critical' health psychologists is to articulate the ways in which social inequalities mediate health and illness at community and individual levels.

As noted above there is an acceptance within health psychological approaches that, in contrast to a strictly biomedical view, psychosocial influences can be important in determining the onset and course of illness. The expansion of focus beyond individualistic psychology to encompass sociocultural issues is illustrated below in relation to issues of compliance or adherence of chronically ill people to the recommendations of healthcare practitioners. This is an

example of a relevant topic to the current study that has developed a large literature, largely founded within an individualistic social-cognitive perspective with the work of Ley (e.g. 1982; 1987; 1997) but which has been lately critiqued for its assumptions that chronically ill people behave according with logical, rational decision making based on the provision of appropriate information (e.g. Price, 2008). As Crossley (2000a, p132) argues for instance, a 'failure to take account of the emotional, frequently non-rational and morally infused nature of doctor-patient interactions' is problematic.

Kelly (2002) points out that however compliance is defined it has authoritarian and paternalistic connotations and is heavily value laden, with non-compliance implicitly or explicitly viewed as bad or immoral. Such criticisms have led to alternative terms such as 'adherence' and 'concordance' being increasingly used in the literature to reflect better a process of active choice and negotiation between patients and providers around an agreed treatment plan, and long term consistency in engaging with it (Price, 2008). As Marks et al (2005, pg.297) point out an important reason for the limited impact of research on adherence in actually reducing non-adherence is that:

...the majority of adherence research has been based on a static model of the phenomenon that ignores the broader social context of health care and the dynamic nature of health and illness behaviour. An alternative more social and psychological approach requires an understanding of the role of medicine in our society and of the actual lived experience of illness and managing illness.

There is evidence of a variety of reasons for non-compliance with regimens recommended by health professionals that call for a chronically ill person's perspective to be understood in light of social and societal conditions. Williard & Angelino (2008) discuss the influence of such factors as domestic violence, cultural and religious stigma, living conditions, socioeconomic constraints and networks of social support on adherence to long term HIV treatment. Axelsson et al (2014baker) in questionnaire survey research find evidence supporting their argument that a gender perspective should be taken into account in adherence research and care support planning.

### *Lay Rationalities and Illness*

In many cognitivist models, the patient is usually presumed to undertake a rational cost-benefit analysis of the issues involved in complying with the treatment regimen (Crossley, 2000a). It has been argued that models rooted in a biomedical or cognitivist approaches obscure 'lay rationalities' that may find unhealthy behaviours, such as those that are likely to exacerbate problems caused by chronic illness, rational strategies for negotiating lives in which health problems and decisions are occur in the context of all sorts of other problems and decisions (Crossley, 2000a). In the case of diabetes, for instance, Kelleher (1988) found that issues around control and sociality were central to understanding how (diabetic) study participants managed their condition.

Where people's social lives become circumscribed by it, the management of chronic conditions may also invite rebellion. The temptation to 'live life to the full' may be seen as crucial to a person's perception of the quality of life they are leading. This perception may be more important to them that the prospect of complications caused by transgressing medical instructions (Crossley, 2000a)

The construction of the chronically ill patient as a rational actor making cost-benefit analyses that determine her compliance/non-compliance illustrates how health psychology can be seen to produce totalising/normalising discourses that dictate how the self should be defined and experienced (Miller, 1997). Such discourses may be identified from a postmodernist perspective as constituting 'meta-narratives' or grand theories that have achieved the status of hegemonic ideologies.

### **Grounding Knowledge in the Experiences of Chronically Ill People**

In contrast to the objectifying and rationalising tendencies of mainstream health psychology there has been a will amongst researchers from a sociological background to attend to the subjective experiences and meanings attached to people's experiences of chronic illness (Field & Taylor, 1998). Chronic illnesses have proved to be particularly suited to this approach in light of their intractable



nature. The experience of chronic illness has been distinguished from that of acute illness, as Radley (1994, p136) notes:

‘Because they are, by definition, long-lasting illnesses, they raise a different set of questions about how people cope. When acutely ill, the patient moves from being a healthy person to being a patient at the doctor’s surgery. However, when chronically ill, she or he changes from being healthy to having to live with illness in the world of health.’

In light of this, critical health psychologists have tended to look to disciplines ignored by mainstream health psychology, such as medical sociology and anthropology, as well as insights that have emerged from the development of critical social psychology. A key avenue of interest for critical health psychologists then has been to explore the ways in which chronic illness is experienced and reflexively oriented to by people (Crossley, 2000a).

Researchers wishing to examine the meanings of chronic illness and the ways in which meanings are negotiated or constructed through social interaction have tended to use qualitative techniques that allow people to use their own words in describing their experiences (Field & Taylor, 1998). In contrast to the deductive approach centring round the testing of hypotheses, such work is ‘inductive and discovery-oriented’ allowing social action to be investigated as it occurs without the restraints of fixed-response questions (Pancer, 1997), and producing rich data that more fully reflects the complexities of people’s everyday lives.

Much qualitative work in the fields of medical sociology (and more recently health psychology) since the 1970s has attempted to explore the ways in which chronic illnesses are experienced in the context of everyday settings. Such work has served as a counter to earlier work that tended to focus exclusively on medical settings (Lawton, 2003). The ways in which experiences of illness share common aspects, or are diverse, according to the place illness assumes in people’s biographies has constituted an important area of both theory and empirical research.

Strauss & Glaser (1975) produced an early work using Grounded Theory to describe various themes common to experiences of chronically ill people as well as management strategies that they employed. The focus of their method is to produce 'theory based on data' that reflects the meaning of situations to participants. Strauss and colleagues subsequently produced a number of other works on chronic illness refining their application of this approach (e.g. Fagerhaugh & Strauss, 1977; Corbin & Strauss, 1988). The approach has proved popular with writers such as Charmaz (e.g. 1990; 1992) elaborating its use from a social constructionist perspective to highlight in particular issues of self and identity. Research based on Grounded Theory has identified themes common to experiences of a range of chronic illnesses, such as changes in self-concept and self-esteem, as well as illuminating contrasts and complexities associated with different chronic illnesses such as Alzheimer's disease (e.g. Gubrium, 1987; Orona, 1990) and testicular cancer (Charmaz, 1992).

For Hyden (1997) the experience of illness, in terms of events and symptoms, and the ordering of these temporally in relation to other life events are constituted via the 'narrative construction of an illness world.' The person is able, through this process, to gain some degree of control over the illness (Murray, 2000).

### *Illness as Disruptive*

Bury (1982) contributed to this area a seminal article, putting forward a view of chronic illness as a major disruptive event in people's biographies. Examination of narratives of chronically ill people has produced accounts that suggest 'biographical disruption' (e.g. Bury, 1982) as a consequence of chronic illness. The person's ongoing life is disrupted by the unexpected onset of chronic illness and their taken-for-granted identity problematized.

Williams (2000) finds that 'biographical disruption' has appeared as an enduring topic since Bury's (1982) work. The study out of which Bury developed the concept involved participants who had been diagnosed with rheumatoid arthritis at a relatively early age. Influenced by Giddens (1979) concept of the 'critical situation', Bury observed the potential for chronic illness to undermine people's

taken for granted assumptions and identities through the disruption of everyday life that it entails.

The concept of 'biographical disruption', for Bury, is multi-layered. Concerning the body, he illustrated how the onset of arthritic symptoms brought the body into a phenomenological awareness previously not part of participants' experience. A number of writers have argued that we normally experience ourselves as acting in the world through our bodies (Good, 1992; Crossley 2000), as an undivided total body-self (Leder, 1990). As Radley (1997, p.57) writes "the non-conscious deployment of the body is, each day, an affirmation of its 'normality'". The body in chronic illness may be said to have *dys-appeared* (to come to the perceptual foreground in a dysfunctional state) in the terms of Bendelow & Williams (1995). It has been argued that chronically people experience the body as separate from their 'selves' as a part of this phenomenon. Ellis-Hill et al (2000) illustrate how specific contexts, such as getting up out of a chair, or walking outside subject to the gaze of others, provoked this experience of a split between body and self amongst the stroke survivors they interviewed. This experienced psychophysical dualism (Vernick, 1989) highlights the 'contingent and tenuous nature of one's (embodied) experience' (Lawton, 2003, p25), both invading and threatening a person's subjectivity (Crossley, 2000).

Concerning assumptions about the future, chronically ill peoples' hopes and plans may be shattered, marking 'a biographical shift from a perceived normal trajectory through relatively predictable chronological steps, to one fundamentally abnormal and inwardly damaging.' (Bury, 1982, p71). Concerning identities, people's sense of themselves may be undermined due consequences of illness. Charmaz (1983) found that chronic illness is accompanied by the loss of self. This may occur through the limiting effect chronic illness has on people in their daily activities and consequent impact on individuality and independence. Illness may result in a person being discredited by themselves and others, particularly where they face stigmatisation as a result. A person may become socially isolated, where normal rules of reciprocity and mutual support become untenable (Bury, 1982; Charmaz, 1983), damaging social relations and leading to distress. Dependency on others and a loss of autonomy

threatens to limit the contribution chronically ill people may face leading to feelings of uselessness (Charmaz, 1983).

A large and still growing empirical literature has confirmed the existence of such processes amongst sufferers of a wide range of chronic conditions. Dickson et al (2008, p.459) for instance recently found that participants with Chronic Fatigue Syndrome (CFS) “reported an ongoing sense of personal loss characterised by diminishing personal control and agency. An inability to plan for the future and subsequent feelings of failure, worthlessness and insignificance ensued.”

### *Appraising Biographical Disruption*

Williams (2000) set out to critically appraise the concept of biographical disruption in relation to a number of wider theoretical and contextual developments since Bury’s development of the concept. A growing concern with embodiment (Turner, 1984, 1992) such as that exemplified in the work of Kelly and Field (1997) in relation to chronic illness, postmodernist critique, and challenges to ‘personal tragedy’ views of illness arising from the disability movement have all begun to move approaches to chronic illness in a more reflexive and self-critical direction (Williams, 2000).

Whilst acknowledging the usefulness of the concept Williams argues that there are a number of contextual issues that complexify the issues and militate against the theme of illness-as-disruptive being appropriate to apply in a homogenous way to describe chronic illness experience. Firstly much supportive research has been adult-centred, and whilst biographical disruption may appropriately describe the experience of chronic illness onset in mid to late life, it is not necessarily applicable for those who have early onset experiences. For people who have lived with chronic illness since childhood for instance, rather than being experienced as disruption, it is more likely to be “integral to their biographically embodied sense of self” (Williams, 2000, p.50). Hence, whilst having ongoing ramifications for everyday living and identity, biographical continuity and reinforcement rather than sudden disruptive change are likely to characterise their relationship with illness.

Secondly Williams (2000) draws attention to the ways that those in conditions of general hardship and material disadvantage may experience chronic illness onset as a 'normal crisis'. i.e. in such circumstances illness may be anticipated, and their disruptive aspects experienced relative to and alongside other ongoing life challenges. Biographical disruption then may be more relevant to relatively privileged people.

Williams cites the work of Cornish (1984) who documented the pragmatism and cheerful stoicism of working class people in the East End of London. Whilst for Bury (1983) the unexpected nature of chronic illness onset is partially responsible for precipitating a critical situation and consequent disruption, a number of researchers have illustrated various contexts of illness in which illness is less clearly unexpected.

Pound et al (1998) discussed 'biographical continuity' in relation to an older East End population following stroke where illness was absorbed or accepted as part of an expected ageing trajectory. Other studies have found similar themes in relation to people with osteoarthritis (Ong et al, 2011; Saunders et al, 2002).

The context of ageing is further examined by Faircloth et al (2004) in relation to the experiences of Stroke survivors, who also question some of the assumptions that are present in the 'illness-as-biographical disruption' literature. Even for those whose illness is marked by a dramatic onset, they argue, lives may not necessarily be disrupted in the manner that this concept suggests. Their paper accentuates the importance of factors such as age, point in the lifecourse, and expectations about or previous familiarity with the illness experience – their biographical position, in other words (Radley, 1994) - in determining whether it's onset is in fact experienced in terms as 'disruption.'

In differing contexts of social oppression Carricaburu and Pierret (1995) theorised 'biographical reinforcement' in examining homosexual or haemophiliac men's experiences of an HIV infection which unexpectedly reinforced existing identities through their collective involvement in LGBT movements or reassessment of priorities.

According to Conrad (1987) the knowledge that one is particularly at risk for developing a particular health problem can also to some extent be regarded as kind of chronic illness. The knowledge that one has an extremely high blood pressure or level of blood cholesterol, for instance (or that one is HIV positive) may lead to modifications in lifestyle, a reassessment of identity, 'mental preparation' for the onset of disease (e.g. having a heart attack or developing AIDS).

For older people then, illness may be seen as inevitable in later life, especially in circumstances of disadvantage, and such biographically anticipated events may be better characterised in terms of 'biographical flow' than biographical disruption (Faircloth et al, 2004).

Such work serves as a useful reminder of the dangers of reifying any singular notion of the way that illness is experienced by chronically ill people (Lyons & Chamberlain, 2006). There is continuing debate around these issues, with Larsson and Jeppsson-Grassman (2012) recently concluding on the basis of their empirical work that:

“biographical disruption may be used to understand a wider and more complex set of experiences in connection with repeated transitions due to bodily and functional losses over the life span in chronically ill and disabled people – losses that may have been both unexpected, feared and expected at the same time.”

Larsson and Jeppsson-Grassman (2012) and Bray et al (2014) both find that biographical disruption is a relevant concept amongst children and young people living with a long term condition and argue against Williams' assertion that those living with illness since birth will necessarily experience illness in terms of continuity.

Bray et al (2014) find that both biographical continuity and 'biographical enrichment' characterise experiences alongside disruption amongst children and young people with congenital conditions causing incontinence from birth. They theorise 'biographical enrichment' as a concept describing the positive

biographical changes following surgical treatment, offering new opportunities to develop a life course more in line with social expectations concerning employment and social independence to develop relationships.

Such work illustrates further the necessity of empirical work in differing contexts to tease out the meanings of illness for people socially located in a variety of ways.

Williams (2000) also argues that in terms of social location both gender and ethnic dimensions to illness experience are under-researched.

In this context, Williams (p.41) asks:

‘Just how useful a concept is biographical disruption to the diversity of experience which characterises chronic illness and disability in late 20<sup>th</sup> century Western society? Does a focus on disruption mask as much as it reveals? Can equal weight be accorded both to chronic illness in the creation of biographical disruption and biographical disruption’s role in the creation of chronic illness? Finally, are these processes confined to chronic illness, as traditionally understood, or are they more or less pervasive features of late modernity, conceived as a chronically reflexive order?’

### *Responses to illness*

As the relationship between self, body and the surrounding world alters, the reconstruction of one’s life story then becomes important (Williams, 1984). As Bury (1991, p264) writes:

‘Not only do language and narrative help sustain and create the fabric of everyday life, they feature prominently in the repairing and restoring of meanings when they are threatened. Under conditions of adversity, individuals often feel a pressing need to re-examine and refashion their personal narratives in an attempt to maintain a sense of identity.’

In *response* to the disruptions imposed by illness, people are likely to mobilise a variety of physical, temporal, social, medical, cultural resources to the extent that they are available. Explanatory frameworks, to the extent that those previously used have been disrupted may need to be revised or reconstructed (Williams, 1984; Williams, 2000).

In sum, people in such situations are in a position where it becomes necessary for them to ask questions of their biography (such as 'why has this happened to me?' 'what will my future look like now and how different will it be from my previous expectations?').

As the relationship between self, body and the surrounding world alters, the reconstruction of one's life story becomes important (Williams, 1984). According to Frank (1995) the reconstruction of identity is of paramount importance to *all* illness narratives. As Bury (1991, p264) writes:

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According to Frank (1995) the reconstruction of identity is of paramount importance to *all* illness narratives. People developing chronic illnesses are thus having to 'learn to live with illness in the world of health' (Radley, 1994).

### *Pluralistic Perspectives on Chronic Illness Experience*

Qualitative research on chronic illness experience has proceeded from a variety of approaches such as phenomenological or social constructionist, whilst more pluralistic perspectives have recently emerged. The current study will take a pluralistic approach that combines insights yielded from approaching analysis from a variety of perspectives (e.g. Murray, 2000).



Writers from a phenomenological perspective tend to 'read off' experience from illness narratives (Yardley, 1997), attempting to elucidate an 'insider' view of illnesses. Such work has been criticised for a tendency towards romanticisation and neglect of structural factors that shape people's storytelling (Crossley, 2000a). Bury (2001) argues that patient narratives should not be taken to represent a form of 'unalloyed subjective truth' but rather the diversity of narrative forms, their diverse purposes and functions at the level of social groups as well as individuals should be acknowledged. From a social constructionist perspective narratives are also socially structured in ways that reflect the societies and cultures in which they live (Crossley, 2000a).

Analysis at the interpersonal level attempts to understand the ways in which narratives are constituted within particular social contexts, and recognises the ways in which these shape the stories told (Murray, 2000). According to Hyden (1997) the range of social contexts in which illness narratives are related, and who they are being related to can be broadly categorised as institutional, everyday, or elicited contexts. The institutional context refers to a medical care environment of any kind, such as hospital or doctor's surgery. The everyday context refers to a person in their daily life telling another about their illness. Elicited contexts include those in which a researcher asks interview participants for their stories. Whilst it is arguably of great importance to attend to the differing contexts in which narratives of chronic illness occur studies situating illness narratives in a wider social context have been uncommon (Hyden, 1997). More recently Horton-Salway (2001) has used discourse analysis of the conversation analytic variety (e.g. Edwards & Potter, 1992) to illustrate rhetorical strategies undertaken by chronically ill interviewees as they relate illness narratives in the course of interviews. Whilst attending to the immediate social context of illness narratives, this approach alone still tends to ignore or even discount wider ideologies or discourses as shaping peoples' accounts (Edley, 2001).

Positional context refers to differences in social position between parties in conversation. As an extension to the interpersonal level it is intended to draw attention to the ways in which social position provokes or inhibits a particular

style of narrative (Murray, 2000). The doctor-patient encounter, for instance, is usually structured in such a way that the patient is hindered in recounting her or his illness narrative (Hyden, 1997).

### *Sociocultural Contexts to Chronic Illness*

At an ideological level of analysis it is recognised that cultural assumptions and relations of power shape narratives as they are constructed in social interaction (Crossley, 2000a). Illness narratives are therefore seen to reflect both political and social conditions, and may be used to illuminate the hegemonic power of health ideologies. Sakalys (2001) argues that medical objectification is an aspect of experience that is often present in illness narratives, and notes the struggle to preserve identity and subjectivity in the face of medical colonisation. Accordingly, researchers have wished to 'recapture the voices and experiences of people who have themselves suffered pain and disease.' (Crossley, 2000b, p78). In attempting to theorise the social and cultural structuring of illness narratives the Kleinman (1988, p3) in particular has noted how meanings of illness 'emerge from a dialectic connecting – and changing social structure and personal experience.'

This chapter has reviewed health psychological approaches, concluding that critical health psychological work has the potential to add significantly to understanding of chronic illness produced by 'mainstream' work. Critical and qualitative research has illustrated here the importance of both in-depth experiential accounts of chronic illness, and of contextualising chronic illness experience beyond atomised individuals to account for the way experience is shaped by a variety of sociocultural influences.

If we accept that social, cultural and political contexts are important to an ill person's experience and behaviour, then it becomes salient to discuss how these may be patterned to affect groups of people according to their social class, ethnicity or gender. This study focuses particularly on gender and its importance to men's experience of chronic ill health. Some discussion of theories of masculinity and their relevance to men's health is therefore necessary.

## **Chapter 3 - Men and masculinities**

In this chapter I review contemporary work on men's gender in order to better inform understanding of its links with men's health and illness. The lived experiences and understandings of chronic illness for men are intimately linked with conceptions of masculinity, underpinned by gender as a social construction. Sociocultural discourses of masculinity have been shown in a number of studies to greatly influence the ways in which chronically ill men negotiate the course of illness (Reissman, 2003; Robertson, 2006; O'Brian et al, 2007; Kvigne et al, 2014). It is useful therefore to consider here the theoretical background to such research taking an explicitly gendered approach to chronically ill men.

There has been a proliferation of texts on men and masculinities since the late 1980s (Willot and Griffin, 1997; Bridges & Pascoe, 2014), with many suggesting that the explanation for this lies in a contemporary "crisis" in defining masculinity (Kimmel, 1987; Roberts, 2014). However the historical evidence suggests that this is only the latest in a long line of such episodes of crisis (Edley & Wetherell, 1987). According to Connell (1995, 2005) the nature of masculinity as a concept or construct is such that there is an inherent tendency to crisis produced by its structuring of social relations.

### **Hegemonic Masculinity**

Connell (1995) incorporates the Gramscian (1971) concept of hegemony into his theorising of masculinity, referring to the cultural dynamic by which one group claims and upholds a dominant position in social life. The performance of hegemonic masculinity in contemporary Western culture involves constant validation that one is dominant and in control of oneself and others (Cheng, 1999). In Connell's work masculinity is framed within the context of gender relations as a whole, or what is termed the *gender order*, "a historically constructed pattern of power relations between men and women and definitions of masculinity and femininity" (Connell, 1987; p.98-9) that develop and are reconstructed within diffuse institutional contexts (Sabo & Gordon, 1995).

In this way Connell introduced a more critical approach to men and masculinities, acknowledging the inequalities characterising relations between men and women. Questions concerning patriarchal power and social change were not satisfactorily addressed in sex role theory, previously a dominant social science approach to gender relations (Demetriou, 2001).

Whilst not necessarily undermining existing power relations, there is a continual contestation of hegemonic definitions by those they subordinate, i.e. femininities and marginalised masculinities (Connell, 1995). Thus, conceptions of multiple, contested, masculinities have become used in place of the more monolithic term “masculinity” (Hearn & Collinson, 1994; Sabo & Gordon, 1995).

#### *Complicity and the patriarchal dividend*

Most men's gender performance varies to some extent from the hegemonic ideal of masculinity (Carrigan, Connell & Lee, 1985). Whilst such men do not embody hegemonic masculinity, Connell (1995) theorises their connection with the hegemonic project in relation to women as a relationship of complicity. This involves a degree of social consent sufficient for most culturally esteemed forms of masculinity, and their dominance over femininities, to continue. Connell sees the ‘patriarchal dividend’ as motivating such consent, i.e. the benefits accruing to men as a group from their group dominance.

#### *Marginalisation and Subordination: Masculinities in hierarchy*

Connell also theorised internal relations amongst ideals of masculinity as existing in hierarchy. The subordination of groups of men and their gender performances in relation to hegemonic masculinity is discussed by reference to what he describes as subordinated and marginalised masculinities.

Marginalisation relates to the interplay of gender with other structures of inequality such as social class and “race”. These issues other than gender socially locate men in ways that exclude them from dominance in the hierarchical system. Cheng (1999, p.301) for instance argues that social class is

“a hidden injury to male hegemonic masculinity”, reflecting the subversion of the claim to power and dominance inherent in hegemonic masculinity that low socioeconomic status entails. Although marginalised men may engage in hegemonic masculine practices, they are structurally excluded from the opportunities available to others.

Subordinated masculinities are most often related to sexual orientation (Connell, 1995). Sexuality, as a "nexus of the relationships between genders" (Rubin, 1984, p. 28) provides a key point of stratification between hegemonic and subordinated masculinities. Not only are sexual relations between men most often construed as the abandonment of masculinity, but homophobia is itself a key buttress of hegemonic masculinities (Connell, 1995; Lancaster, 1995). As Connell (1995, pg. 78) observes:

"Oppression positions homosexual masculinities at the bottom of a gender hierarchy among men. Gayness ... is the repository of whatever is symbolically expelled from hegemonic masculinity".

Schippers (2007, p.96) argues that what Connell (e.g. 1995) identifies as subordinated masculinity is more appropriately identified as 'hegemonic femininity embodied or enacted by men'. Since gender hegemony is inextricably bound up with the preservation of hierarchical relationships between masculinity and femininity, it is not masculine characteristics but an interpretation of certain characteristics as feminised that results in their devaluation. Men who are unable, not necessarily through reasons of sexual orientation, to successfully 'carry off' a normative standard of masculinity would similarly face subordination and policing of social practices undermining to the patriarchal system (Sheff, 2006).

One feature of Connell's theorisation is that the focus on masculinities as ideals or "configurations of gender practice that are constructed, unfold and change through time" (Connell & Messerschmidt, 2005, p. 852) seems to chime with poststructuralist notions of identity as fluid and performative. The influence of Gramsci on Connell's development of masculinities theory however is pertinent here. Whilst Gramsci's work may be seen by some as prefiguring

poststructuralist thought, for others his work lies in the materialist, structuralist tradition (Jubas, 2010). A criticism of Gramsci's work (Hekman, 1997) that may be similarly applied to Connell's masculinities theory also is that it effectively essentialises groups, and so presents more limited scope at the individual level for understanding ambiguity and contradiction within men's practices. Wetherall and Edley (1999, p.337) reflect this in their suggestion that that the theory is:

Mainly concerned with categorising groups of men into types dependent on their shared collective positioning in relation to gendered practices

Whitehead (2002) also argues that Connell's theory is structurally deterministic, whilst for Beasley (2012, pg.757) the focus on types or groupings of masculinity indicates a distinctly modernist view of identity which from a postmodern perspective would give way to "a qualitatively different attention to fluidity *across and within* subjects".

Hearn (2004, p.58) has also addressed the issue of clarity as to whether hegemonic masculinity refers to "cultural representations, everyday practices or institutional structures". Connell & Messerschmidt (2005) clarify that hegemonic masculinity should be seen as a multilevel concept that encompasses cultural, individual and structural factors simultaneously, although as Lusher and Robbins (2010, p.389) point out:

The problem lies in the fact that the interdependency between structures, individuals and culture has not been expressed theoretically.

From Connell's own works it should be clear that hegemonic masculinity should not be reduced to a quality residing within the individual, and so cannot be translated into a set of psychological traits or individual level variables (although see for example Gallagher and Parrott, 2011).

Schippers (2007), reviewing Connell's (1995) work, summarises his conceptualisation of masculinity as being firstly, a location in the social arena,

into which a person may enter via practice, irrespective of their gender. Secondly, it consists of those practices and features that are categorised socioculturally as masculine. Finally in being collectively embodied these practises. Masculinity can also be seen as an organising principle – both by which classifications and distinctions are made, and by which actions are taken at individual and other levels. The content of hegemonic masculinity in terms of patterns of practice is something to be empirically derived in accordance with it's historical and cultural variability. To apply the notion of multiple masculinities on a within-person basis involves a view of masculinity as identity performance, wherein men can “be expected to show different masculine ‘faces’ within different contexts.” (Spector-Mersel, 2006, p.68).

In their reformulation of the concept of hegemonic masculinity Connell and Messerschmidt (2005) accept that that the issue of embodiment needs to be integrated with greater sophistication. They also recognise the challenge and contestation of hegemonic masculinity as an underdeveloped topic in the field. As Johansson and Ottemo (2015, p.196) argue regarding hegemonic masculinity, “most of the critical voices accept the main premises and definitions of the concept, but are calling for elaboration of different aspects of it.”.

### **Changing Masculinities**

There has been debate regarding the significance and theoretical implications of change in contemporary performances of masculinity. Anderson (2009) agrees that homophobic discourse and practice are central to the construction of ‘orthodox’ or traditionally hegemonic masculinities. He argues however that as the culture of homophobia decreases in countries like the U.S. and U.K. the notion of hegemonic masculinity becomes less relevant in explaining the complexity of masculinity formations. Alongside conservative, or ‘orthodox’ masculinity sits ‘inclusive masculinity’, which involves social inclusion of masculinity formations that were previously held in opposition or subordinated. Neither are seen as hegemonic, but rather exist alongside each other as related sets of ideals and indicative practices. Anderson finds, in contradiction to Connell, that more than one form of institutionalised masculinity may be equally

esteemed in culture, so that the idea of a hegemonic process does not fit with a changed reality.

For Anderson the 'patriarchal dividend' seen by Connell (1995) as motivating men's complicity with hegemonic masculinity provides only partial explanation for its reproduction. Anderson argues that the role of social institutions in socialising men is equally important. He focusses particularly on the role of organised sporting participation (in particular gender-segregated competitive team sports) in Anglo-American societies as the central site for orthodox masculinity reproduction and socialisation. The argument may be broadened however to include the role of other social institutions. Anderson draws upon social-psychological theories of conformity and social influence (e.g. Asch, 1951; Zimbardo, 1974) and Latane's Social Impact Theory in articulating how such processes may occur. Several subsequent empirical studies have supported Anderson's proposition for 'inclusive masculinities' (e.g. McCormack, 2011; de Visser & McDonnell 2013; Morris & Anderson, 2015).

In contrast deBoise (2014) critiques Inclusive Masculinity Theory. She observes that Anderson frequently seems to refer to hegemonic masculinity as a type of person, or an archetype, and therefore misreads Connell's theory which opposes the idea of gender as a stable psychological entity that a person can possess. For Connell the Western cultural ideals that Anderson refers to as 'orthodox' have never represented the experiences of all men, and masculinity is seen as performative and thus unstable even in the experiences and practices of individual men. The legitimisation of hegemonic practices occurs only where they correspond to institutional power and privilege, which is also subject to change. For deBoise (2014), whilst legal and institutional change may reflect the diminishing of overt homophobia as a central element of hegemonic masculinity:

“...this may do very little to disrupt broader inequalities, hidden prejudice, and the continued institutional privilege of some groups of men.”

(2014, p.8)



In fact she suggests that the inclusive masculinity position is not at all dissimilar from Connell's description of complicit masculinities; whilst some men may actively reject homophobia they may still benefit from cultural homophobia. What is more the limited (university students) nature of sampling in Anderson's research may mean that his findings are limited to describing the behaviour of 'the "sexually liberal", complicit, and middle classes,' (deBoise, 2014, p.9). The distinction between 'inclusive' and 'orthodox' masculinity introduced by Anderson may actually obscure the complexity already envisioned in Connell's own account. Such typologies are reductionist and even detract from attempts to incorporate intersectionality in terms of class, gender and race into work on men and masculinities (deBoise, 2014). The notion of 'homohysteria' and its decline may also be questioned, since this is also not an essential quality that can be easily measured, but should be seen as context-specific; it may be that homophobia has changed in form so that its recognition through speech acts and behaviours such as same-sex kissing are not an adequate basis to conclude. The evidence cited by Anderson is also questionable on both methodological and empirical grounds (deBoise, 2014).

Cole (2008) takes a perspective that emphasises men's agency in negotiating masculinity to a greater degree than Connell (1995; 2005). He locates such practices in the theoretical context of Bourdieu's work, extending Bourdieu's (1993) notion of fields, which are socially defined arenas in which actors engage in competition or struggle over social positions, to the field of masculinity. Arguing that the concept may be readily adopted to describe the contestations and struggles over what may be considered as masculine/masculinity, Coles finds it complementary to the hegemonic masculinity concept. As hegemonic masculinity can be seen to characterise "that form of masculinity which is considered culturally to be most dominant at any given time *within the field of masculinity*" (Coles, 2009, p.235).

Somewhat similarly to Anderson (2009), Cole in empirical work finds that men simultaneously challenge hegemonic masculinity whilst experiencing their own masculinities as dominant. Elements of hegemonic masculinity may be drawn upon in negotiating 'mosaic masculinities':

“Mosaic masculinities refers to the process by which men negotiate masculinity, drawing upon fragments or pieces of hegemonic masculinity which they have the capacity to perform and piecing them together to reformulate what masculinity means to them in order to come up with their own dominant standard of masculinity.”  
(Cole, 2008, p.238)

Even for men subordinated by hegemonic masculinity, there may be elements of it's ideals that are accepted as they offer benefits (in Connell's terms this is a complicit position), or that can be reworked into individual circumstances:

“In essence some men build their own standards of masculinity in the field of masculinity, which allow them to define dominant masculinities within these boundaries (thus giving them status) and establish legitimacy by drawing upon elements of hegemonic masculinity (e.g. they may draw upon the hegemonic ideal of strength for their ability to be mentally strong, even though they may be physically weak).”  
(Cole, 2008, p.238)

Men may therefore have complex and ambivalent orientations towards hegemonic masculinity, supporting some elements whilst rejecting others, and resisting other subordinated masculinities in the process.

“Thus they form mosaic masculinities that operate as dominant masculinities relative to the masculinities of other men (despite being subordinated by hegemonic masculinity).”  
(Cole, 2008, p.240)

However, in contrast to Anderson, Coles does not assume that such practices illustrate a cultural decline in the relevance of hegemony or homophobia, nor can they be taken to show a growing culture of pro-feminism. Another strategy that Cole found amongst his participants was the conflation of maleness with masculinity, which facilitated claims to esteemed masculinity whilst not conforming to aspects of hegemonic masculinity. This however necessitated a

strong dichotomization between male and female, coincident with the separation of masculinity and femininity. This was perhaps reflected in the 'pervading sense of anti-feminism' that accompanied men's distancing themselves from women. Cole also discusses struggle for prestige within what may be described as subfields of masculinity, such as gay masculinity.

Bridges and Pascoe (2014, p.246) discuss such issues in relation to 'hybrid masculinity', or:

"Men's selective incorporation of performances and identity elements associated with marginalised and subordinated masculinities and femininities."

The implications of hybrid masculinity for systems of gender and sexual inequality in their view is a reconfiguration of masculinity performance that fails to change or challenge such systems. Unlike Connell and Messerschmidt (2005) they do see such developments as significant beyond local cultural variation in hegemonic masculinity.

Much recent research (e.g. Pascoe 2007; Schippers 2000; Ward 2008; Barber 2008; Wilkins 2009) has documented changes in style or performance of masculinity, primarily, amongst young, heterosexually-identified White men.

Firstly Bridges and Pascoe see hybrid masculine practices as working to create *discursive* distance between straight White men and hegemonic masculinity. This process however reiterates rather than fundamentally challenges gendered relations of inequality and power. Secondly they note that a defining feature of hybrid identities is cultural appropriation. Men occupying privileged social categories appropriate strategically from various "Others" in ways that work to obscure inequality, whilst they reframe privileged men as being symbolically part of socially subordinated groups.

Thirdly they observe that hybrid masculinity can be seen as a form of change that represents historically new ways of entrenching and concealing systems of inequality.

“By co-opting elements of style and performance from less powerful masculinities, young straight, White men’s hybridizations often obscure the symbolic and social boundaries between groups upon which such practices rely.”

(Bridges and Pascoe, 2014, p.254)

This often occurs along lines of class, gender, ‘race’ and sexuality. Hybrid masculinities therefore illustrate the flexibility of patriarchy and transformations in the “legitimizing stories” or rationalisations for prevailing structures of power and inequality (Bridges and Pascoe, 2014). Such conclusions are reflective of the nature of hegemonic forms of dominance, which are mutable in absorbing, assimilating and integrating counter-currents (Howson, 2008; Christensen and Jenson, 2014).

### **Intersectionality and masculinities**

Issues of class, gender, ‘race’ and sexuality have been viewed recently through the burgeoning literature concerned with intersectionality (Crenshaw, 1989). Scholars using the term have been concerned with the limitations of isolating single categories such as gender as the primary category of difference, disadvantage or identity (Coles, 2009). Such work may lead to implicit assumptions regarding other social statuses (Griffith, 2012; Coles, 2009). Coles (2009) argues that through a focus on either the multiple identities that define privilege, or on subordinate groups, such assumptions may be disrupted and the ways in which other identities shape the landscape of gender may be recognised.

Connell and Messerschmidt (2005) in reformulating the hegemonic masculinity theory recognised the necessity for incorporating observations that there is a mutual conditioning of gender with other social dynamics. Connell (2012) takes a nuanced view of intersectionality. Whilst praising efforts to make gender categories more locally relevant she criticises approaches to intersectionality that simply combine categorical approaches to differing dimensions of difference as contributing little to an understanding of social dynamics. Systems of categorisation ought instead to be seen as mutually constitutive through

processes that occur over time (Coles, 2009). Further, deconstruction of such systems and a focus on the complexity of relations across and within categories and identities (McCall, 2005) would lead to more sophisticated understandings. Christensen and Jenson (2014, p.69) similarly take the view that:

“an intersectional approach refers to a common analytical core i.e. that different social categories mutually constitute each other as overall forms of social differentiation or systems of oppression (Collins, 1998; de los Reyes & Mulinari, 2005; Mellström, 2003) as well as in creating complex identities, where different identifications are always mutually constitutive (Buitelaar, 2006; Staunæs 2003).”

Christensen and Jenson (2014) suggest ways in which an intersectional approach may be combined with the concept of hegemonic masculinity. Following Demetriou (2001) they distinguish between internal and external hegemony. Internal hegemony refers to the hierarchical differences and power relations between men. External hegemony refers to the relationship between a hierarchy of masculinities and the patriarchal gender order. The instability of gender here is specifically illustrated by it's successive variation in intersection with other categories. These may intersect with masculinity in configurations that support, challenge or subvert the hegemonic position and male privilege of some men:

“It can thus be argued that class, race/ethnicity, and sexuality can weaken or subvert the legitimacy of some men to the extent that they are either unable to gain any form of patriarchal dividend, or can only lay claim to a symbolic form of patriarchal dividend in the reduced form of being able to at least claim (hyper) masculinity – and heterosexual conquest – in a social situation where very little else can be claimed.”

(Christensen and Jenson, 2014, pgs. 69-70)

The patriarchal dividend therefore may vary in content, whilst as a dimension of social identity or symbolic form masculinity may be exaggerated through

interaction with, for instance, blackness and working classness. Coles (2009) in incorporating Bourdieu's notion of fields discusses such issues in relation to subfields that are located within the larger field of masculinity. So he envisages the field of aged, black, or gay masculinity within which there are distinct struggles over capital (e.g. social, cultural, etc. as described by Bourdieu). This is of value in that it becomes possible to see that whilst men may be subordinated within the field of masculinity, they may simultaneously enact a dominant identity in a subfield in which they possess esteemed capital. A range of dominant masculinities may exist separately from the hegemonic masculine ideal.

Finally as Connell (2012) points out, that certain ideals of masculinity will be hegemonic is likely to remain the case, her values-based argument is for change in existing patterns and a new form of hegemonic masculinity that does not support dominance and oppression of women or men.

I have reviewed contemporary developments in work on men and masculinities above. Having discussed research and theory regarding hegemonic and other ideals of masculinity and the gender order, I explored work detailing and theorising processes of change and contestation amongst masculinities. Finally I have discussed the intersection of gender with other social dynamics such as class, age and ethnicity. Whereas Health Psychology has largely treated gender as a variable, this body of research situates gender as a performance and an active social process, suggesting that the understanding of gender informing much Health Psychological work has been largely limited. As Kuhlman (2002) has argued, there is a great need for explicit engagement with gender theory in health sciences generally. A conclusion from research on men and masculinities is that there is a need to understand the relationship between gender and men's health in a different way in light of such work, which explores the generation of health consequences as part of the process of gender construction. I turn to this in the next chapter.

## **Chapter 4 – Men, Masculinities, Health and Illness**

In this chapter I review gendered health inequalities and patterns of health-related behaviour that illustrate the relevance of theoretical understanding of the processes linking men's gender with health and illness. I review research linking gender and health, and detail subsequently gendered patterns of chronic illness. The experiences of chronically ill men in relation to masculine identity construction are then discussed.

### **Health Inequalities: Men's Health**

Life expectancy in the U.K. has increased greatly over the past century, during the course of which, the major causes of death have changed. Whereas infectious and respiratory diseases predominated in the early 20<sup>th</sup> century, and infant mortality was high, it is now the case that chronic illnesses such as cardiovascular diseases and cancers are the biggest killers, generally affecting older age groups.

Life expectancy at birth for men in the U.K now stands at around 3.9 years lower than for women at 78.7 years (O.N.S., 2014).

This gendered disparity is reflected across the Western industrialised countries, and there is much evidence to suggest that lifestyle and behavioural differences between men and women are implicated. The current trend in the U.K. is actually for a narrowing of the gap in life expectancy by gender however; in fact the differences peaked historically in the period 1965-69 at 6.25 years (Longevity Science Advisory Panel, 2013).

Nationally inequalities in male life expectancy by socio-economic circumstances have increased during the period 1982-2006 despite the general improvement for all during this time (O.N.S., 2011).

The overall U.K. figures for life expectancy mask more localised variations that can be large in magnitude. Male life expectancy at birth in the North West

region was 77.7 years 2010-12, compared with female life expectancy of 81.7 years (ONS, 2014).

However at the level of local authorities, some of those in the North West have the lowest male life expectancy in England and Wales; 11 of the 25 local authorities with the lowest life expectancy were within the North West (ONS, 2004 op cit). For 2010-12 in terms of Life Expectancy at Birth for males, the difference between for instance Blackpool (74.0 years) and Cheshire East (80.4 years) is quite substantial at 6.4 years difference (O.N.S, 2014). Variations can be even larger when broken down into socio-economic categories.

### **Gendered patterns of health-related behaviour**

Some of the principle health problems in countries such as the U.K. (e.g. cardiovascular disease, cancers, diabetes) have shared behavioural risk factors that include smoking, poor diet and heavy drinking (European Health Report, 2005). Increasing morbidity with such conditions has also contributed to an increase in longstanding illness rates for men over the last decade (Health Survey for England, 2004). There is evidence that men's lifestyles may be characterised by the presence of a number of such behavioural risk factors to a greater extent than is the case for women.

Men in the U.K. are more likely than women to smoke (Health Survey for England, 2014), and although the gap between men and women in this respect has narrowed, men tend to also be heavier smokers than women (General Household Survey, 2004). Smoking has been identified as the single most common, preventable cause of death in the European region, and is also a significant cause of morbidity with the health problems noted above (European Health Report, 2005).

Men in the UK are slightly more likely to drink more than the recommended daily amounts, and are less likely to abstain than women (Statistics on Alcohol, 2014). Nevertheless men are more than twice as likely as women to drink at hazardous (33.2% of men compared with 15.7% of women) or harmful (5.8% of men compared with 1.9% of women) levels (Adult Psychiatric Morbidity Survey, 2007).



A greater proportion of male drinkers than female drinkers (29% male drinkers compared with 21% female drinkers) are classified as 'heavy drinkers' (O.N.S., 2012). Different styles of drinking are associated with overlapping patterns of harm. For instance, frequent heavy drinking has been linked to long-term conditions such as liver cirrhosis, whilst heavy episodic drinking increases the likelihood of being involved in accidents, assaults, or suicide (Alcohol Concern, 2005).

Men between the ages of 16 and 24 years are especially likely to engage in risky behaviour whilst under the influence of alcohol, such as injuring themselves or another (ONS, 2003).

In 2003, men were approximately twice as likely as women to die from alcohol-related causes, i.e. accounting for around 66% of alcohol-related deaths (ONS, 2005).

Moreover, lack of attention to healthy eating and exercise has seen the percentage of men who are overweight or obese climb alarmingly, with around two thirds of men being either overweight or obese (Health Survey for England, 2014). Obesity rates amongst men have trebled since 1986, and have increased more rapidly than those for women (Health and Social Care Information Centre, 2014). Men are especially prone to develop excess abdominal fat which is associated with 'metabolic syndrome', and thus linked with a greatly increased risk of heart and circulatory problems (Lakka et al, 2002). A number of long term conditions such as diabetes, cardiovascular disease and some cancers are associated with overweight and obesity (Prospective Studies Collaboration, 2009; Basen-Engquist & Chang, 2011).

### *Risk of injury*

The causes of men's increased risk of mortality over the lifecourse are not confined to the consequences of non-communicable diseases, however. Men also have much higher rates of both morbidity and mortality through road accidents for instance, being more than twice as likely to be killed or seriously injured in a road accident as women in 2001 (ONS, 2004). Evidence again

suggests that characteristic patterns of behaviour are implicated; men are much more likely than women to be convicted for a range of motoring offences, including drink-driving related offences, dangerous driving, and causing death by dangerous driving (Blears, 2005). In 2003 men were also the subject of 82% of speed limit convictions (Home Office Statistical Bulletin, 2005). Some of this difference is likely accounted for by the higher proportion of men who drive and higher mileages that they cover (ONS, 2004). However, rates of accidents are also demonstrably higher amongst men, and many researchers attribute this to higher driving speeds and less regard for traffic laws amongst men (e.g. Norris et al, 2000). Survey evidence suggests that men are less likely to wear seatbelts either as drivers or passengers than women, for instance (Transport Research Laboratory, 2005).

Issues around men's mental health may be linked to the fact that while more women attempt (para)suicide, more men succeed in committing suicide (Department of Health, 2002). A relationship between alcohol use and suicide has been noted above. The majority of suicides involve younger men (under the age of 40), and whilst rates have fallen recently, the most marked differences occur in the 25-34 age group, where four men kill themselves for every one women (NIMHE, 2005).

#### *Gendered patterns of help-seeking*

A further area of concern has developed around the possibility that men are reluctant to seek help when ill. Despite their higher mortality rates men in the U.K. have a lower frequency of G.P. consultations than women (Sattar et al, 2005). A number of reasons may account for this pattern. Women's more frequent attendance may relate to the medicalisation of pregnancy (O'Brien et al, 2005), use of preventative services targeting only women (such as cervical cancer screening), a greater tendency to visit on behalf of other family members, and consequent greater familiarity with the health care system (White, 2001). However, Galdas et al (2005) in a recent literature review found that there is evidence of a trend for men to delay help-seeking when ill, but also a need for further research to explore both the complexities of men's decision-

making around help-seeking, and possible variations amongst diverse groups of men

### *Theorising patterns in men's health-related behaviour*

Social science research into the area of gender and health has often treated gender as another demographic variable useful in identifying health patterns and risk factors. Differential rates of illness between males and females, or across male (or female) populations sub grouped by domain sociological variables such as ethnicity, socioeconomic status, or residential area, began to be uncovered in epidemiological studies. This growing body of research made it evident that sociocultural explanations of health and illness were not complete unless gender was taken into account (Sabo & Gordon, 1995).

Feminist writers have created a large body of research exploring the relationship between women's gender and women's health over the last twenty years (e.g. Muff, 1982; Coopersmith, 1978; Oakley, 1981; Graham, 1993; Doyal, 1995). As Sabo & Gordon (1995, pg. 4) point out, "one limitation of this pioneering scholarly work was that until recently researchers tended to equate the study of *gender and health* to studies of *women's health* and illness." Whilst males have frequently been used as study subjects in health science, the health risks associated particularly with men's gender had received little attention (Courtenay, 2000b). It is, however, important to recognize that men are gendered beings too, and to investigate the impact of this on men's health (Krieger & Fee, 1997) since there is otherwise the risk that the average lower life expectancy for men found in Western industrialised countries is assumed to be inevitable or natural (Courtenay, 2000b). Further, it has been persuasively argued that men's lack of awareness of themselves as gendered beings has itself reflected men's dominant position in the gender order (Connell, 1995). More recently there have been an increasing number of publications concerned specifically with men's health issues (Rieder & Meryn, 2001), with aspects of feminist theory and research in particular illuminating examinations of the gendered nature of men's health (Sabo & Gordon, 1995).

Courtenay (2000b) has developed perhaps the most thorough theoretical framework in which to understand the gendered aspects of men's health. A number of writers (e.g. Messerschmidt, 1993; Crawford, 1995; Connell, 1995; Messner & Sabo, 1994) have observed how activities can be seen as resources utilised actively by people in the service of gender construction. Courtenay, in applying this conceptualisation to health, concurs with Saltonstall (1993, pg. 12) that "the doing of health is a form of doing gender". Health actions are thus seen as social acts which "can be seen as a form of practice which constructs... 'the person' in the same way that other social and cultural activities do" (Saltonstall, 1993, pg.12). So, to take the example of 'binge drinking', this has been traditionally seen as a masculine pursuit, and engaging in it may demonstrate a form of masculinity, with knowledge and discussion of the negative health consequences (e.g. a hangover) it entails themselves contributing to the display of masculinity and being esteemed amongst a group of men (see Sixsmith & Griffiths, 2003).

Acknowledging that men and women's social experiences guide their beliefs and behaviour (Kimmel, 1995), Courtenay argues that in the context of both institutional structures and everyday social transactions related to health care people are presented with opportunities through which they may "do" gender by means of demonstrating health beliefs and behaviours. The use of health beliefs and behaviour to construct gender introduces differential risks and advantages corresponding to the social practices required for demonstrating masculinity and femininity.

### **Patterns of Chronic Illness**

Rates of chronic illness have been rising in the UK according to questionnaire survey evidence. Whereas 21% of adults reported a longstanding illness or disability in 1972, by 2011 the figure had increased to 32% (ONS, 2013). In fact the gendered differences observed in life expectancy are not reflected when looking at longstanding illness or disability, with rates reported by men (31%) and women (33%) being similar (ONS, 2013). Nonetheless the pattern of chronic illnesses does differ according to the most long term common conditions experienced by men and women (ONS, 2011); for women diseases

of the musculoskeletal system (159 per 1000 women) are most common, whilst for men diseases of the heart and circulatory system are most common (114 per 1000 men).

Rates of longstanding illness with age, such that 68% of adults aged 75 and over are affected (ONS, 2013). Indeed it is suggested that the increase in levels of longstanding illness reflect increases in life expectancy and smaller family sizes that have resulted in much higher proportions of the population in older age groups (ONS, 2013). An increase in longstanding illness amongst those aged 45 and over has been highlighted recently (ONS, 2013), with the rate amongst the 45 to 64 age group (42%) being almost double that of the 16 to 44 age group (22%). In the 65 to 74 age group the rate is 58%. There are therefore a growing number of people living with chronic illnesses through from middle to old age, such that it has been argued that we are living in a 'remission society' (Frank, 2005) characterised for many by periods of asymptomaticity or manageable symptoms where illness is in the background that shift in relation to periods of exacerbated symptoms where illness is in the foreground.

The General Household Survey provides evidence of variations in rates according to socio-economic status such that those living in households where the person surveyed (the 'Household Reference Person') worked in a manual or routine occupation group had the highest rates of long-standing illness (36% of males compared with 38% of females). Those in occupations classed as intermediate had the next highest prevalence (34% of males compared with 35% of females), whilst the managerial and professional groups had the lowest prevalence (28% of males and 29% of females) (ONS, 2013).

### **Chronic Illness and Masculine Identity**

Illness can undermine the taken for granted identities that support and sustain a man's position in the gender order, including his place in the dominance hierarchy among men (Messner & Sabo, 1990; Sabo & Panepinto, 1990). As Charmaz (1990) points out, illness can alter or end men's participation in sports, work, leisure and sexual activities that may be key to a man's sense of self.

A number of writers suggest that, through the reduction of a man's status in masculine hierarchies, the alteration of his power relations with women, and the stimulation of self-doubts about his masculinity, illness can relegate him to a position of marginalised masculinity (Connell, 1987; Messner & Sabo, 1990; Sabo & Gordon, 1992). As Charmaz (1995, pg. 267) points out, the identity dilemmas posed by illness for men tend to revolve around oppositions such as "active versus passive, independent versus dependent, autonomy versus loss of control, public persona versus private self, and domination versus subordination."

Despite this a number of researchers have demonstrated the rather complex interface between the social construction of masculinities and ill health, with both beneficial and adverse effects accruing to men as they attempt to construct normative masculine identities (Charmaz, 1995).

A consequence of chronic illness may be that men renegotiate and reorient themselves in relation to masculinity ideals in the context of limitations that their own and others' understandings of it's personal and social consequences (e.g. Green and King 2007, Hagen et al. 2007, O'Brien et al. 2007, Shuttleworth et al. 2012, Kvigne et al, 2014).

Gibbs (2005) has found support for the applicability of Gerschick and Miller's (1995) "Three 'R' Framework" (describing strategies adopted by disabled men in relation to masculine identity) to chronically ill men (with arthritis). Through *reformulation* men redefined the characteristics of hegemonic masculinity in their own terms. For other men a strategy of *reliance* involved overcompensating demonstrations of hegemonic masculinity and an internalisation of feelings of inadequacy. Finally *rejection* signified refutation of hegemonic masculinity ideals, which participants achieved either via denying their importance or relevance to their own lives, or the development of their own alternative principles and practices.

The central theme emerging from Gibbs' Grounded Theory methodology was the opposing influence that dominant social constructions of masculinity had vis a vis positive health behaviours (Courtenay, 2000). An unwillingness to show

weakness, to seek help for pain, to share experiences in support groups, and self-characterisation as being a failure in terms of masculinity due to the impact of chronic illness were evident. Other empirical studies with chronically ill men have produced similar evidence. Turner et al (2002) showed how ex-professional footballers managing osteoarthritis adopted a stoical attitude, attempting to minimise the impact that the condition had had on their lives. In particular they argue that it was important for their participants to avoid any imputation that they were unable to cope with their condition. Their demonstrations of strength of character were interpreted as a response to the notion of illness being a weakness (e.g. Blaxter & Paterson, 1982).

In Gibbs' study degree of impairment is highlighted as influencing responses to the dilemma of chronic illness and masculine identity. High severity of illness could override some of these barriers to help-seeking, with men adjusting their emotional and social outlooks and reformulating or rejecting hegemonic ideals as a consequence of the impact of illness.

Reformulation of hegemonic ideals was characterised for instance by intellectualising and reframing of self-management as a "technical problem to be solved" (Gibbs, 2005, p.296), so that behaviours could be recontextualised within a hegemonic context. Milder arthritic symptoms however did not seem to prompt such reorienting in relation to masculinity ideals.

There has been some debate regarding the implications of such responses for challenges to the gender order. Gershick and Miller argued that 'reformulation' (as opposed to 'rejection') did not present challenges to the gender order, since men's predicaments were still perceived as an individual project, unconnected to wider social issues or movements. They also cautioned that none of their participants fitted wholly into these response categories. Shuttleworth et al (2012) however argue that the distinction between 'rejection' and 'reformulation' is not actually so clear cut, and that in everyday practice resistance to hegemonic masculinity may embody both.

Both the pressures exerted by masculine ideals and the ways in which men formulate their responses appear highly context-specific when empirical

research is reviewed, so that the dynamics of such processes will vary considerably (Shuttleworth et al, 2012). Severity, type and visibility of symptoms are likely to influence the degree to which a person is subjected to gendered expectations (Gerschick, 2000) and the practices they employ in responding to these. Age of onset is further differentiating issue, and Shuttleworth et al suggest that further research is needed on the early onset conditions and the ways in which masculine identities are developed in such circumstances.

One possible consequence of the development of a chronic condition is that men may be perceived differently by others and become relegated to a position of marginalised masculinity. Men's reluctance to acknowledge chronic illness and to engage with health services (Refs) may perhaps be related to this (Gibbs and Reidpath, 2005).

Through exploring the coping behaviours of young men and women with asthma or diabetes, Williams (2000) also found that young men managed their conditions in ways that minimised the threat posed to their masculine identities. Positive consequences were that, due to their unwillingness to treat themselves with insulin in public, they stuck to a strict dietary regime, which generally resulted in good control of their diabetes. Men also expressed embodied masculinity through their participation in sports and exercise, and benefited also (in cases of both diabetes and asthma) from this. Many young women participated in little sport or exercise. The emphasis on sport amongst young men reflected its importance in serving to construct prestigious masculine identities (White et al, 1995). Willis et al (2001) found that masculinity construction had a positive impact on the course of cystic fibrosis amongst young men for similar reasons, and that their lived experience of the condition was enhanced by their enactment of hegemonic masculine ideals involving stoicism.

Negative effects of masculinity were also evident. The young men in Williams' study viewed asthma as a separate and minor part of their lives and consequently did not regularly take preventative inhalers. As an attempt to keep the condition outside their personal and social identities, this had resulted in a number of them being hospitalised due to severe asthma attacks. Further, for



the minority of boys who were unable to demonstrably control their conditions, this resulted in them having disparaged identities, which was not the case for girls with poor control over their conditions.

Chronic illness may similarly constrain men in practicing the configurations of behaviour which accrue patriarchal dividends (Gibbs, 2004).

There is a need for further exploration of the links between masculinities and health at the cultural level of analysis to the experience of actual men in their social contexts. In particular, through what social and community processes are masculinities reproduced and their effects on chronic ill health enacted? 'Social capital' is a concept that may provide some help with understanding these and has recently become widely discussed with the social sciences.

## **Chapter 5 - Social Capital, Health and Chronic Illness**

In this chapter I develop further issues of social context through the discussion of 'social capital'. As a multi-level concept conceptualising social relatedness, social capital has been the subject of a vast literature, and this body of research is reviewed here. Subsequently I discuss research linking social capital with health and illness. I argue here that it is useful to critically engage with research on social capital in order to further contextualise men's experiences of chronic ill health.

### **Social Capital**

The term 'social capital' has appeared in an increasing number of publications over the past decade. Across a number of social science disciplines (e.g. sociology, political science, economics, social psychology) and in texts produced by policymakers and corporate/institutional actors it has been applied to a plethora of interest areas (e.g. economic development, politics, education and health). (Svendson & Svendson, 2009). Indeed the 'staggering flood of discourse' (Mondak, 1998, p.433) has led one writer to suggest that the history of the social sciences is being rewritten in terms of social capital (Fine, 2000).

The popularity of social capital as a subject of debate and investigation has been largely associated with its employment by Robert Putnam, an American political scientist, in a number of works (Putnam, 1993, 1995, 2000). Indeed Putnam's work and perspective has so dominated much of the discourse around social capital that some (Farr, 2004) have called for a more broad and historically based approach to the concept. Upon further investigation it is clear that, as Putnam himself has stated, social capital represents 'to some extent merely new language for a very old debate' (Putnam, 2000, pg.24). Several writers have written extensive conceptual histories of the term, and my aim here will be to explore previous work in terms of focussed discussion and argument leading to a framework within which social capital may be envisaged in a way that is both 'critical' and 'contextualised'.

The term social capital itself is figurative, and directs us to look at the social in terms of a resource, analogous to 'capital'. As Parr (2003, p.4) notes, although there are varying definitions and perspectives on social capital, they can be said to share a 'family resemblance' in their focus upon issues of associational activity and social resources. Parr usefully distinguishes between those who have used the concept with and without the term. In seeking out literature using the broad concept without employing the term, it is possible to cite writers from the ancient world. The observation that community is important to the wellbeing of individuals can arguably be found in the writings of Aristotle (Halpern, 2005), or even more ancient texts (such as the I-ching; Sun and Jiang, 2000). Current interest in the role of associational life was presaged by Tocqueville's work 'Democracy in America' ([1840] 1998) in which he saw individualism as being counterbalanced by co-operation in American civil society.

Aspects of Durkheim's work also parallel contemporary concerns with social capital (Portes, 2014). Durkheim ([1893]1984) drew attention to the development of an 'organic solidarity' in industrial societies, which he saw as dependent on the establishment of certain obligations between individuals. These become enforced in two ways, firstly through sanctions (such as punishment administered by public authorities for law-breaking), and secondly through individuals disciplining themselves. This involves the internalisation of normative beliefs and expectations, based upon a consensus (Bourricaud, 1981).

Hanifan (1916) used the term in making an analogy between the development and expansion of business organisations with 'community building' in rural areas. In Hanifan's context, many others also drew on images and metaphors that derived from economics or business to describe aspects of social or community life. Halpern (2005) notes that Hanifan's use of the term was oriented strategically to his negotiations with businesspeople. Similar strategic useage characterises the attempts of social scientists to highlight the importance of social and community contexts to politicians making policy on the basis of economic concerns.

Thus many have 'invoked the broad concept, briefly or at length, but who also expanded or limited the concept's domain, stressed different norms or capacities, valorised certain associations or activities over others, or put the concept to critical rather than commendatory uses.' (Parr, 2003, p.4).

The concerns articulated in discussions of social capital are therefore far from new. The revitalisation of debate in this area rather reflects the prevailing socio-political climate of recent times. Recent mainstream academic interest in social capital has derived from the writings of Coleman, Bourdieu and Putnam. Their contributions are discussed below.

### **James Coleman and Social Capital**

Coleman's (1988) theorisation fed most directly into Putnam's initial consideration of social capital (1993). For Coleman, social capital consists of 'a variety of entities, with two elements in common: they all consist of some aspect of social structures and they facilitate certain actions of actors... within the structure.' (p.81). Coleman identifies a number of such aspects as 'obligations and expectations, which depend on trustworthiness of the social environment, information-flow capability of the social structure and norms accompanied by sanctions.' His broad definition leaves scope for further aspects to be identified, on a functional basis, in which 'the function identified... is the value of these aspects of social structure to actors as resources that they can use to achieve their interests' (p.83).

Notwithstanding this definition, Coleman's exposition of social capital rests within the larger theoretical framework represented comprehensively in his (1990) work 'Foundations of Social Theory', concerned with understanding social organisation, and the functioning of social systems (Marsden, 2005). In order to gain an understanding of Coleman's contribution to work on social capital it is useful to place it within the context of his larger body of work and the assumptions about social action and organisation that underlie it. Especially relevant are Coleman's longstanding contributions to and support for 'social exchange theory' (e.g. 1972, 1973) and relatedly an economic or rational choice approach. As Astone et al (1999, p.1) have noted, 'the social capital concept is

an extension of social exchange theory', insomuch as it reflects Coleman's work.

Social exchange theory (S.E.T.) originated with the work of Homans (1958, 1961) and Blau (1964), and appeared in both general sociological and social psychological textbooks (e.g. Emerson, 1981). This reflects the fact that it can be seen as micro-sociological or social psychological in terms of the level of analysis applied. Coleman's writings in this tradition extend over 30 years of his career (e.g. Coleman, 1966, 1990). As Emerson (1976, p.336) put it, 'the exchange approach... might be described, for simplicity, as the economic analysis of non-economic situations.' Aspects of social relationships are viewed as being analogous to forms of wealth in terms of their motivational influence on peoples' behaviours.

'A shipload of wheat obtained in return for dollars or human affection obtained in return for reciprocal affection are beneficial in exactly the same generic sense' (Emerson, 1981, p.32).

Despite the resonance with concepts of social capital, the term did not have a historical currency within the approach prior to Coleman's usage, although Homans, the founding theorist of S.E.T., did use the term in passing (1961, p.395), without theoretical elaboration. As Emerson's description implies, some of the ideas and assumptions of neoclassical microeconomic theory were brought to bear on social life in the S.E.T. In fact, Rational Choice Theory (R.C.T.) came to dominate within S.E.T. in its assumptions about the basis of individual action, so that S.E.T. has come to be seen as a sub-class of R.C.T. (Coleman, 1990, Cook, 2000, Zafirovski, 2005).

Ultimately R.C.T. is rooted in the utilitarian philosophy of John Stuart Mill and Adam Smith, in which behaviour was assumed to be predicated upon calculative rationality (Emerson, 1981). The provision of a fixed, universal, psychological motivation to actors (i.e. utility maximisation) was attractive to social psychologists seeking to move beyond behaviourism. It also proved attractive to some of those sociologists who criticised the 'oversocialised' concept of human action inherent in structural functionalism, which was the

dominant (American) disciplinary perspective in the 1950s and 1960s. Coleman became an advocate of this approach (Marsden, 2005). His aim in his later works (including those on social capital) was to employ the assumptions of R.C.T./S.E.T. to work up an account of social structures and collective behaviour based upon the interrelationships of purposive actors. It is in keeping with these assumptions that Coleman describes social capital as constituting 'a particular kind of resource available to an actor' (1988, p.81).

Further exploration of the approach is useful in elaborating the origins of components of social capital as described by Coleman and later reproduced by Putnam (e.g. reciprocity, trust, norms, etc.). The theoretical logic by which they came to be brought together can thus be illustrated.

*Reciprocity: benefits 'in exchange'.*

Coleman identified networks of reciprocal social exchange, characterised by expectations and obligations as a key aspect of social structures constituting social capital. This reflects a further key assumption underpinning S.E.T. that 'benefits obtained through the social process are contingent on benefits provided 'in exchange'' (Emerson, 1981, p.32). It follows logically from the view of individuals as 'utility maximisers', giving positive social acts towards another the character of an 'investment'. The focus is therefore on the reciprocal flow of benefits in social interaction. Initially, S.E.T. focussed upon dyadic relations, and correspondingly, instances of 'specific' reciprocity.

Moving beyond dyadic exchange relationships, S.E.T. theorists turned in the 1970s to study social networks and corporate groups as instances of more complex exchange systems (Cook, 1979). Coleman himself contributed to these developments (e.g. Coleman, 1972) and cites the limitation to microsocial relations as a deficiency of early S.E.T. in his (1988, 1990) papers on social capital.

In attempting to expand the scope of the approach in this way, proponents of S.E.T. often looked to anthropological studies for empirical descriptions of reciprocal transactions (Emerson, 1981). Taken from the anthropological work

of Sahlins (1965), 'generalised reciprocity' came to be used as a concept within the approach. It described "putatively altruistic" behaviour (Sahlins, 1972, p.193), i.e. giving assistance to others without the expectation of immediate return. For Sahlins it characterised relationships amongst kin. In S.E.T., it's application was not limited to any specific category of group or relationships. As Emerson (1981, p.34) states:

'Now let the two-person reciprocating exchange relation... become a set of three or more relations among three or more persons, A, B, and C. Add to that set a special network-wide accounting system in which a benefit received by B from A can be reciprocated by a helping act either to A or to C, and the system is then an instance of what Sahlins calls generalised reciprocity.'

In the case of generalised reciprocity, obligations to provide benefits in exchange were diffused throughout the exchange system. The nature of obligations is often unspecified within reciprocal social exchange, and the time that may elapse between a person receiving and repaying a favour variable. Further, enforceable written contracts are not so often the norm in social life. Thus, notions of trust and reputation become important, in considering the risk inherent in one's social 'investments'.

### *Trust in Social Exchange Theory*

Trust and the trustworthiness of social structures consequently became a subject of much discussion within S.E.T. It was assumed that each person must ensure that he or she is seen to be trustworthy (e.g. Blau, 1964), trustworthiness being signalled through one's reputation. As successive investments were made and repaid, trust and reputation developed. Trust is therefore seen as emerging from social exchange relations over time.

It is on the basis of this logic that trust becomes integral to social capital according to Coleman. He sees 'trustworthiness of the social environment' (p.84) as underpinning social capital, noting that differing social structures may be characterised in terms of trustworthiness of their social environment.

Coleman's discussion of trust and obligations/expectations in reciprocal exchange are very similar to those of other writers on S.E.T. His approach is distinct however in that social context, in the form of norms, are 'brought in' when discussing the relationship between micro- and macro- social relations.

### *Rational Actors, Norms and Macro-level Social Structures*

Coleman, and others (e.g. Emerson, 1981), have seen in S.E.T. the basis for building from simple microfoundations towards accounts of macro-scale social phenomena such as institutions, collective behaviour, etc. (Marsden, 2005). This presumes the possibility of 'seeing the big through the small' through what has been variously termed 'sociological social psychology', 'microsociology' or 'sociological miniturism' (Stolte, Fine and Cook, 2001, Zafirovski, 2005).

There are however, a number of difficulties with using S.E.T. and R.C.T. to make the micro-macro transition. A classic problem in this respect is that of 'social order' or 'collective action' (Scott, 2000). Following from the assumption that individuals act purely for personal profit, comes the conclusion that 'in the absence of external constraint, the pursuit of private interests and desires leads inevitably to both social and individual disintegration' (Dawe, 1970). As Parsons wrote 'the relations of individuals would tend to be resolved into a struggle for power – for the means of each to realise his [sic] own ends. This would, in the absence of constraining factors, lead to a war of all against all – Hobbes's state of nature' (1937, 87). Observed empirical reality suggests that such constraining factors do indeed exist, i.e. social structures are often seen to function in an orderly and cohesive way, to an extent. Rational choice approaches have consequently been critiqued for their 'undersocialised' view of actors.

Parsons in his work 'The Structure of Social Action' (1937) had been concerned with just this point, and had theorised the role of social norms as constraining factors (influenced by Durkheim who had similarly been lead to move beyond strict utilitarianism). The concept of 'social norms' captures the idea that people feel an obligation to behave in certain ways that may override their self-interest. Coleman's solution to this problem is similarly to attempt to integrate



S.E.T./R.C.T. with this more social contextualist view of action, in which social norms constitute the necessary constraining factors. Coleman was concerned with norms from his earliest writings (e.g. 1964) involving R.C.T./S.E.T. and in his writing immediately preceding that on social capital (1986), he explicitly borrowed from Parsons work in respect of norms. Parson's own work in this respect can be traced back further through his readings of Durkheim, Pareto and Weber.

A further more contemporaneous influence on Coleman in respect of social context was the work of Granovetter (1985) on 'embeddedness'. Granovetter also criticised the undersocialised model of human action within much *economic* theory, and attempted to explain economic behaviour in terms of embedded social relations. The 'embeddedness' perspective similarly develops rational choice perspectives in that the agentic behaviour of individuals is seen as being influenced by normative beliefs and expectations characterising the social networks in which they are embedded. Granovetter also recognised the importance of sociality for the development and maintenance of trust, the establishment of expectations, and the creation and maintenance of norms of behaviour within economic systems. In light of his readings of Parsons and Grannovetter, it was Coleman's (1988) explicit concern to export the 'embeddedness' perspective beyond economics to explain the processes within social exchange systems more generally.

A necessary adjunct to norms are the social sanctions that are applied to those whose behaviour violates social norms (Coleman, 1988). Effective norms are dependent on a social organisation having a sanctioning system that is sufficiently effective to ensure conformity (Coleman, 1990). Durkheim also made this distinction of course, as noted above. Norms may come about as a result of actors in a social system having common interests. In incorporating norms as an explanation of how social structures function co-operatively, this variant of S.E.T. and Coleman's social capital are broadly functionalist (Blaxter and Hughes, 2000).

*Public goods and motivations to 'invest'*

Coleman also identifies a feature of social capital which his orientation to economic rational actor theories leads him to identify as problematic. This is because social capital is seen as 'public goods'. Those who invest time and energy in developing social capital only receive a proportion of the benefits, whilst others benefit although they have invested less.

The problem of collective action is not really resolved within the logic of social capital as Coleman describes it up to this point. There is no explanation of why, in the light of the public goods situation, actors should wish to produce social capital.

As Field (2003, p.25) notes, 'Coleman solved this problem by simply abolishing it; social capital arises not because actors make a calculating choice to invest in it. In this assertion Coleman fails to acknowledge that actors may well be aware that resources are obtainable via membership of social structures, and set out to gain such membership. Rather social capital is usually created and destroyed as a by-product of other processes. So whilst Coleman allows that others ('bystanders' in Putnam's terms) may benefit from the presence of social capital, it is individual actions within relationships and networks that he is primarily concerned with (Shortt, 2004).

#### *Coleman and methodological individualism*

R.C.T. is characterised by methodological individualism, where it is assumed that the aggregated product of individual actions explain complex social phenomena. In acknowledging emergent properties of social structures at a meso-level, Coleman moves somewhat beyond methodological individualism (Shortt, 2004). Coleman's (1986, p. 1312) assertion that 'the action, or behaviour, of the system composed of actors is an emergent consequence of the interdependent actions of the actors who make up the system' illustrates his convictions in this respect. He states that 'social capital inheres in the structure of relations between actors and among actors' (p.98). Social capital bridges between individuals and meso-level social structures, it is therefore both an asset that individuals can be said to have, and at the same time is composed of 'social structural resources' (Coleman, 1994, p.302).

Other writers have argued for social capital to be seen as an attribute of individuals (e.g. Astone et al, 1999), although the confusion between individual and collective is reproduced in the accounts of many subsequent writers. For Coleman, social capital is created or destroyed as there are “changes in relationships amongst persons that facilitate action” (1988, p.83), i.e. the development of trust, reciprocity and obligations amongst them.

Coleman also identifies two aspects of social structures that facilitate social capital. The first of these involves closure in social networks. The second is the appropriability of organisations. Where people participate in some organisation, which is directed towards a particular purpose (e.g. a resident’s association) this may be appropriated for other purposes, constituting a form of social capital (Coleman, cited in Lochner et al, 1999).

In illustrating the origin of these terms within social capital theory, it may be observed that underlying them are ontological assumptions that are often only implicit in later work (e.g. Putnam’s). Coleman himself (1990, p.304-305) noted that his use of the term ‘social capital’ was a device to group together the processes discussed elsewhere in his work, rather than to present any fundamentally new processes. Essentially these processes illustrate how it comes about that self-interested rational actors cooperate (Field, 2003), and links them with meso-level social structures. Marsden (2005) points out that it is thus ironic that his use of the term has received such attention, whilst the context of his wider body of work and it’s basis in R.C.T./S.E.T. is rarely brought into discussions of social capital. Fine (2001) similarly finds this bemusing. Coleman’s work has been overshadowed by Putnam, of course (see below), who although presenting a version of social capital that is perhaps undertheorised explicitly, uses language that reflects the ontological assumptions of Coleman.

### **Pierre Bourdieu and Social Capital**

As Coleman’s work on social capital arose out of his attempts to theorise micro-macro transitions, so Bourdieu’s theorising of social capital emerged from his

attempts to theorise everyday social practice whilst accounting for social stratification. Bourdieu directed towards economists the argument that the structure and functioning of the social world cannot be explained in terms of economic capital alone. Rather, the social world is characterised by an economy of practices in which it is salient to highlight the presence of several additional forms of capital (symbolic, cultural, social), and the socially structured nature of their distribution. It is necessary to give some account of Bourdieu's larger theoretical scheme, since his notion of social (and other forms of) capital is closely interweaved with related concepts, such as habitus, strategies and fields. Initially the notion of habitus will be discussed, as it is the central concept through which Bourdieu's model of the actor is realised.

### *Habitus*

The concept of habitus is key to his attempt to 'transcend subjectivism and objectivism', i.e. dualistic notions of individual/society, action/structure and freedom/necessity (Thompson, 1991). Habitus consists of '...a system of lasting, transposable dispositions which, integrating past experiences, functions at every moment as a matrix of perceptions, and actions and makes possible the achievement of infinitely diversified tasks.' (Bourdieu, 1977, p.82-83). Thus the concept points to 'history incarnated in bodies' (Bourdieu, 1990, p.190), which functions within the actors' present moment to mould social practice. Habitus is acquired within structured social contexts, and incorporates aspects of these, expressed in terms of inclinations and a 'modus operandi' (Crossley, 2001). Thus practices tend to be patterned according to social structural characteristics (Bourdieu focuses on class), whilst subjectivity and structure are linked in a way that is intended to avoid the reduction of either to the other.

In contrast to Coleman, then, Bourdieu does not envisage abstracted individuals acting based on interest through consciously made decisions. Indeed he has criticised R.C.T. as a sociologically theorised perpetuation of the illusions that agents themselves have in regard to their powers of rational, conscious decision-making. Rather, actors behave in accordance with their own habituated practical sense or logic, having 'a feel for the game' (Jenkins, 2002).

The sites of social action and related 'games' are designated as 'fields' within Bourdieu's scheme.

### *Fields*

Fields in Bourdieu's work are semi-autonomous, socially defined domains, seen as elements of the larger society (E.g. the fields of journalism, politics, or academia). Each field has a characteristic 'logic of action', and relatedly, within each field there are 'rules of the game'. Most importantly for Bourdieu, fields are seen as arenas in which actors are engaged in competition or struggle over social positions. Further, all fields are related to the larger field of class relations within a society (Jenkins, 2002). The centrality of fields however locates Bourdieu's scheme primarily at the meso-level (Anheir et al, 1995). Thus a field is structured as a 'network, or a configuration of objective relations' (Bourdieu and Wacquant, 1992, p.97). Those actors who are within a field are oriented to it on the basis of their habitus, and also their relative possession of capital (Jenkins, 2002).

### *Forms of capital*

As noted above Bourdieu discusses several forms of capital through his developing body of work. His most developed concepts are those of cultural and social capital, both of which are related to economic capital. Economic capital is to be taken in the sense of Marx, as money capital, or commodities. Whilst all the forms of capital are seen as interconvertible, economic capital is seen by Bourdieu as supremely so. Cultural capital includes one's command of (educated) language, manners, orientations or dispositions, as well as possession of valued cultural objects (e.g. artworks). It reflects an actor's location in respect of the hegemonic culture in a society, and related markers of social distinction.

Social capital appears in Bourdieu's work in the early 1970s, however his most systematic treatment of the concept appeared in English translation in 1988, in which he provides a definition of social capital:

‘social capital is the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalised relationships of mutual acquaintance and recognition – or in other words, to membership in a group...’ (p.51).

As Blaxter and Hughes (2000) note, the definition itself is little different to those given by others such as Coleman; the analytical framework within which it is set marks out Bourdieu’s concept as substantively different. For instance, whilst actors may or may not understand themselves to be making rational decisions to strategically invest in group membership, their actions are in fact seen as reflecting their habitus and position in a field. It is then ‘through the mutual recognition and the recognition of group membership which it implies’ that the group is reproduced continually. In this sense, it is necessary that relations are indefinitely ‘kept up’; ‘the reproduction of social capital presupposes an unceasing effort of sociability, a continuous series of exchanges in which recognition is endlessly affirmed and reaffirmed.’ (Bourdieu, 1988, p.52).

In keeping with his interest in the social reproduction of inequalities, Bourdieu details processes by which inter-generational transmission of social capital and boundary maintenance tends to exclude new entrants from differing social strata. For example, although aristocratic parents no longer arrange marriages for their offspring, the nature of social settings (expensive holiday locations, balls, etc.) in which their offspring are likely to meet future partners are highly influenced by parental social status, ensuring that those from other social strata are likely to be excluded from joining the kin group (Bourdieu, 1988).

Proceeding beyond one’s immediate kin, strategic investment is directed towards the transformation of contingent relationships in such sites as the workplace and neighbourhood into ‘durable obligations subjectively felt (feelings of gratitude, respect, friendship, etc.)’ (1988, p.52). Social capital (as the other forms) is seen as being accumulated through labour over time.

Bourdieu’s work has been met with qualified praise by many social theorists for the sophistication of his attempt to transcend subjectivist/objectivist

understandings of agency and structure. The forms of capital, *taken together*, constitute advantage and disadvantage (Skeggs, 2004); thus stratification and social reproduction cannot be understood by looking at one form of capital alone in Bourdieu's scheme. Indeed it might be added that Bourdieu's whole conceptual system taken as a piece is necessary to any description of social capital 'as Bourdieu sees it'.

Bourdieu's criticisms of RCT have been addressed with some scepticism by a number of reviewers (e.g. Jenkins, 2013; Calhoun et al, 1993). As Lash (1992, pg.155) notes 'his agents are very much self-interested, strategic actors. Only this strategy is not self-consciously calculated in any utilitarian sense. Instead we are strategic out of our *sens pratique*, the practical consciousness itself, without discursive articulation or calculation.' Bourdieu focuses on habit and practical consciousness whereas Coleman highlights self-conscious calculation, but both see social action as ultimately instrumental (Johnston and Percey-Smith, 2003). Work described by Fine (2010) as part of a BBBI (Bringing Bourdieu Back In) movement has attempted to reintegrate Bourdieu's ideas to social capital research. Fine (2010) argues however that this generally occurs in a piecemeal fashion that reinforces a RCT perspective and neglects the sensitivity to context of Bourdieu's concerns with actors navigating a social field via their use of social capital.

### **Robert Putnam and Social Capital**

It is through the work of James Coleman, rather than Bourdieu, that social capital was introduced by Putnam into his (1993) work on civic life and economy in Italy. Putnam transformed the concept however, applying it to engagement in civil society rather than as a predictor of human capital as Coleman had done.

Drawing on the work of Coleman he initially offered a definition of social capital as 'features of social organisation, such as trust, norms and networks, that can improve the efficiency of society by facilitating co-ordinated actions' (Putnam, 1993, p.167).

For Putnam et al (2000b, p.26) social capital refers to ‘the norms and networks of civil society that enable citizens and their institutions to perform more productively.’

More recently still, for Putnam & Goss (2002, introduction p.1), social capital is ‘social networks and the norms of reciprocity associated with them’.

For Putnam ‘the idea at the core of social capital theory is extremely simple. Social networks matter.’ (p.6, Putnam & Goss, 2002). The way in which they matter concerns the mutual obligations and norms of conduct that develop from them. In particular, where a social group, community or even a society develops a social norm of ‘generalised reciprocity’ there are gains in terms of both social and economic outcomes. Generalised reciprocity is seen as ‘self-interest rightly understood.’ (2000a, p.135). As for Coleman, norms of reciprocity are seen as being based on trust and trustworthiness. Working this out at the level of civil society, he argues that (2000b, p.26):

‘without adequate supplies of social capital-that is, without civic engagement, healthy community institutions, norms of mutual reciprocity and trust-democracies and market economies may begin to falter.’

Putnam’s theorising of the concept is intertwined with empirical study. Having initially applied the concept through his work on regional comparisons in Italy, Putnam turned to his own country (the U.S.). In *Bowling Alone* (1995, 2000) he amassed a large amount of quantitative evidence to suggest that social capital in the U.S. had in fact declined dramatically over a 30 year period. Although this conclusion has been disputed, and the finding does not necessarily apply to the U.K. context, the argument has resonated with concerns of both policy makers and publics.

Putnam has been greatly concerned with provoking wider public dialogue about the concerns raised in *Bowling Alone*, and to an extent eschewing theoretical ‘jargon’. Glancing back to Hanifan he states that ‘rather than the European intellectual, a gadfly... standing apart from current politics and viewing with a critical, philosophical eye the gap between what is and what ought to be, my



hero is the Midwestern progressive of a century ago, seeking to learn from the experience of non-academic reformers.' (2003, p.252). He sees his role as a political scientist as helping both to frame and remedy increasing civic disengagement.

Reflecting the above, Putnam's work on social capital does not involve a detailed or ambitious theorising about social action as in Bourdieu or Coleman. Rather he draws upon Coleman and a logic of a rational choice orientation to social participation; 'social interaction, in other words, helps to resolve dilemmas of collective action, encouraging people to act in a trustworthy way, when they might not otherwise do so.' (Putnam & Goss, 2002, p.7) and Grannovetter (1973; 1983).

Like Coleman, Putnam discusses the 'public goods' aspect of social capital, arguing that 'in many instances of social capital, some of the benefit goes to bystanders, while some of the benefits serve the immediate interest of the person making the investment.' (2000, p.7). Similarly 'if individual clout and companionship were all there were to social capital, we'd expect foresighted, self-interested individuals to invest the right amount of time and energy in creating or acquiring it... Some of the benefit from an investment goes to bystanders, while some of the benefit redounds to the immediate investment of the person making the investment.' (2000a, p.20). Putnam can therefore be said to implicitly adopt the framework used by Coleman (Fine, 2000) and it's internal logic.

Portes and colleagues have drawn attention to the 'downsides' of social capital, which Putnam has since accepted. He has seen the concepts of 'bonding' and 'bridging' as being analytically valuable in this respect.

### *Bonding and Bridging*

The distinction between 'bonding' and 'bridging' social capital was introduced by Gitell & Vidal (1998) and subsequently emphasised by Putnam (2000). Bonding social capital 'refers to the links between like-minded people, or the reinforcement of homogeneity.' (Schuller, Baron & Field, 2000, p.10), and is

'based on exclusive ties of solidarity between 'people like us'' (Edwards, 2004). Members of bonding networks are said to be similar in terms of social identity (Kawachi et al, 2004) or 'bounded within a given social category' (Putnam, 2004). Woolcock (1998) made a similar distinction between what he referred to as 'integration' (intra-community ties) and 'linkage'<sup>3</sup> (extra-community ties). Bonding social capital is usually associated with strong ties of kin and neighbourhood.

Putnam (2000, p.22) asserts that 'bonding social capital is good for undergirding specific reciprocity and mobilizing solidarity. Dense networks in ethnic enclaves, for example, provide crucial social and psychological support for less fortunate members of the community.' Although valuable in this sense, Putnam also discusses this dimension of social capital in terms of some of the 'downsides' or negative outcomes that had been suggested to be associated with social capital in certain contexts. For example network members may be constrained in their ability to act autonomously, due to the weight of normative obligations imposed upon them within bonding networks. Further, as bonding networks are exclusive in regards to non-members, there are possible tensions between participation in bonding networks and in the wider society. Therefore, 'we might expect negative external effects to be more common with this form of social capital' (Putnam, 2000, p.23).

Bridging social capital is said by Putnam (2000, p.22) to be 'outward looking and encompass people across diverse social cleavages.' It involves people from diverse backgrounds (for instance, in terms of ethnicity or class) coming together in cooperative networks.

Leonard and Onyx (2001) identify three uses of the concept of 'bridging social capital' that have appeared in the literature. These are firstly to refer to relationships bridging across divides of age, ethnicity, gender, etc. Secondly, to refer to developing connections across networks which may be relatively homogenous, but where there has previously been little connection (e.g. as a result of geographic distance). Thirdly to refer to the capacity to access

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<sup>3</sup> Not to be confused with Woolcock's (2001) concept of 'linking social capital'.

financial, informational, or other resources from sources external to a community or organisation.

Bridging social capital is seen by Putnam (2000) as being advantageous for 'getting ahead' in contrast to 'getting by'. He cites the work of Granovetter (1987) on the utility of 'weak ties' for gaining employment opportunities. Moreover, Putnam sees bridging capital as generating 'broader identities'. In relation to disadvantaged communities, it is suggested that bridging social capital is often lacking, whilst they may rate highly in terms of bonding social capital. Bridging capital therefore needs to be developed and activities, programmes and policies that can facilitate this are positively valued.

### *Norms of Trust and Reciprocity*

The components of social capital, aside from being disputed, are themselves complex concepts (Blaxter and Poland, 2001), some having a separate literature associated with them. Putnam (2000, p.136) distinguishes between 'thick' and 'thin' trust. 'Thick' trust is 'embedded in personal relations that are strong, frequent, and nested wider networks.' It 'refers to trust with a short radius, encompassing only others who are close to the truster, sociologically speaking.'(p.466). 'Thin' trust, in contrast, applies to 'the generalised other', i.e. those with whom one has had little personal experience. It 'refers to trust with a long radius, encompassing people at a greater social distance from the truster.'(p.466) This form of trust is based upon there being norms of reciprocity within a community that supports positive expectations that such people are likely to be trustworthy.

Generalised reciprocity is seen 'self-interest rightly understood.' Putnam (2000, p.136) argues that norms of generalised reciprocity are encouraged within 'dense networks of social exchange'. Putnam argues that particularistic reciprocity is supported by 'bonding' social capital whilst bridging supports a more generalised reciprocity. A particularistic reciprocity is specific to those that are known personally to each other - 'bounded solidarity' according to Putnam, whereas generalised reciprocity is seen as being 'the touchstone of social capital' (p.134). For Putnam (2000), norms of generalised reciprocity are central

to the concept of social capital. Putnam conceives of such norms within civic life, after Tocqueville as 'self interest rightly understood. In other words self-interested individuals uphold such norms because they may, for instance reduce 'transaction costs' and so communities characterised by high levels of generalised reciprocity are more efficient.

#### *Developing ideas about 'norms of trust'*

Tonkiss (2004) argues that much of the public debate with regards to trust and social capital has been centred around information from social attitude surveys, as used for instance in Putnam's (2000) work. Although such work may usefully illustrate how expressed levels of trust in public institutions are changing, they do not take us beyond common-sense notions of trust to an understanding of how people understand or act on trust. Relevant to this, Lomnitz and Sheinbaum (2004) conceive of trust as being culturally determined, and it's meaning as varying according to situational and cultural context.

In the accounts of Fukuyama (1995) and Putnam (2000), trust is envisaged at a macro level of analysis, as a potentially measurable feature of collective action, so that 'levels of trust' may be analysed and comparisons made between nations or regions.

Tonkiss (2004, p.18) juxtaposes this view of trust with a micro-level approach that attends to how 'individuals trust some people, in some situations, some of the time.' Trust from this perspective can be seen as 'a means of mediating the risks of social interaction' (p.18). Trust is situationally and contextually specific, whether in it's generalised or particularistic forms, and may be seen as fragile, insecure, and subject to reassessment over time. Tonkiss contrasts relations of trust with relations of confidence (Luhman, 1988; Seligman, 1997), i.e. those where forms of contract and regulation mediate social risks and uncertainties.

The distribution of both trust and it's benefits within societies are likely to be unequal (Gilson, 2003). For those who have benefited most from the existing social, economic and political system, and for those who have power, it is easier to trust. Marginalised groups, and those with lower socio-economic status are

likely to have a less positive outlook (Ulsaner, 1999, 2001) and to mistrust more. At a neighbourhood or community level, Ross et al (2001) focuses on the development of mistrust as a product of person and place in interaction. For instance they explain mistrust within disadvantaged neighbourhoods as a consequence of neighbourhood life that becomes a part of one's personal history. Perceptions of living within a 'disordered' neighbourhood foment mistrust both directly, and indirectly, through related perceptions of individual powerlessness. The perception of powerlessness is seen in terms of a process of 'structural amplification'. This occurs where a sense of powerlessness that is reinforced by a threatening neighbourhood environment amplifies the effect of that threat on trust. Mistrust therefore arises through a combination of personal and community disadvantage.

Many writers have acknowledged that a possible consequence of trust may be that cooperative behaviour is facilitated amongst groups, individuals and organisations (Jones and George, 1998).

Gilson (2003, p.6) notes that at the micro-level, 'trust benefits people by establishing stable relationships; indeed without trust successful relationships are almost impossible.' It is seen as reducing 'transaction costs' (Putnam, 2000) by reducing the necessity of close monitoring of performance. At the macro level, generalised trust has been seen as having additional gains including the promotion of re-distributive actions and a broader societal solidarity (Rothstein, 1998).

#### *Developing ideas about norms of reciprocity*

Blaxter and Hughes (2000) briefly discuss the notion that inter-group ties of reciprocity are positive. They note Putnam's (2000) suggestion that forms of asymmetric reciprocity, associated with vertical ties may reinforce inequalities between social groups (e.g. between the poor and wealthier groups). Whilst agreeing with this assertion, they argue that there is a neglect of asymmetric reciprocity observable within the literature on social capital, which is deeply problematic.

### *Developing ideas about bonding, bridging and linking*

A key question that has been raised regarding bonding capital concerns the notion of homogeneity amongst bonding network members. As Edwards (2004) has argued, the notion of homogeneity within, for example, families, is only sustainable if issues around gender and intergenerational differences are marginalised. Since the structuring of families is often on the basis of these, the use of the term may serve to mask the differing and possibly conflicting interests and subject positions of family members. Further, it is not unknown for there to be ethnic and/or social class differences between family members. Putnam (2000) himself does acknowledge that 'many groups simultaneously bond along some social dimensions and bridge across others' (p.23), however much academic research simply equates within-community or within-family social capital to bonding social capital without consideration of such complexities.

It has also been argued that negativity about bonding capital as relating to the wider society ignores the value of 'bounded solidarity' amongst marginalized groups (e.g. the gay liberation or disability movements) in effecting social change. Putnam has been accused of underplaying the role of conflict and disputation in public life, because of his emphasis on trust and cooperation across social difference. However, Putnam (2000, p.23) does acknowledge that 'under many circumstances both bridging and bonding capital can have powerful social effects'.

According to Szretzer & Woolcock (2004) bridging social capital should be taken to refer to connections between those who are dissimilar and yet 'more or less equal in terms of their status and power.'

However, the fact that 'bonding capital from one perspective is bridging capital from another' (Bruegal, 2005, p.12) illustrates the difficulties in attempting to characterise social capital as it exists 'out there' from the bonding, bridging or linking (see below) perspectives. Breugal argues that the distinction is unhelpful, and that a more useful distinction relates to the power that social

capital brings to different social groupings. From a critical feminist perspective, she suggests that the work of Bourdieu is instructive, and that the degree of hegemonic and/or transformative power that is embodied in any particular bounded social network is centrally important.

### *Linking Social Capital*

A further dimension of social capital has been suggested by Woolcock (2001), namely 'linking social capital'. Woolcock distinguishes linking from bridging capital on the basis that 'bridging is essentially a horizontal metaphor... implying connections between people who share broadly similar demographic characteristics.' (p.13). He argues that for those who are disadvantaged, it is desirable that their activities not only 'reach out' but are 'scaled up'. Therefore 'the capacity to leverage resources, ideas and information from formal institutions beyond the community is a key function of linking social capital.' (p.13). Woolcock particularly wishes to highlight the institutional context within which social networks are embedded, and especially the role of the state and the effect that it's institutions have on community life. Linking social capital does incorporate relations developed with other public institutions however (e.g. NGOs, banks).

Sretzer & Woolcock (2004, p.655) explicitly define linking capital as 'norms of respect and networks of trusting relationships between people who are interacting across explicit, formal, or institutionalised power or authority gradients in society.' Their intention is to delimit such relationships from being grouped within the category of 'bridging' social capital, acknowledging that this is how they would have previously been categorised. The authors argue that linking social capital has been shown empirically (citing Lipsky, 1980; Narayan, 2000; Krishna, 2002) to be central to the welfare and well-being of poor communities, i.e. 'it is the nature and extent (or lack thereof) of respectful and trusting ties to representatives of formal institutions – e.g. bankers, law enforcement officers, social workers, health care providers – that has a major bearing on their welfare' (p.655). It is the linking of such communities to representatives of institutions responsible for the delivery of key services that policy makers can most usefully facilitate, therefore. Sretzer & Woolcock argue

that the use of the 'linking social capital' concept may partially resolve the debate around materialist and psychosocial explanations of health inequalities by helping to explicitly address the role of the state in these.

Edwards (2004) notes that although the notion of linking capital is useful in highlighting a vertical dimension of relationships in relation to bridging social capital, it does not address the issue of asymmetrical gender and intergenerational relationships amongst families and other 'bonding networks'.

Putnam (2004) declares himself 'an agnostic' as regards 'linking social capital'. On the one hand he criticises the evidence that Sretzer & Woolcock (2004) themselves provide in relation to the role of the state in 19<sup>th</sup> Century U.K. public health measures as an example of 'linking social capital' as tautological argument. On the other hand he has no theoretical objections to the idea and suggests that some of his own recent, as yet unpublished work may provide some empirical support for their thesis.

Kawachi et al (2004) argue that in explicitly recognising power differentials through the concept of linking capital, Sretzer & Woolcock have produced a sophisticated, valuable and more complete framework for social capital research. Kawachi et al (2004) proceed to address some of the methodological implications of viewing social capital in terms of bonding, bridging and linking.

A further distinction has been made in the literature between cognitive and structural social capital; a cognitive component would include perceptions of trust, reciprocity, social support and sharing, whereas the structural component refers to actual associational activity and links (Bain & Hicks, 1998).

### **Evaluating Social Capitalism**

As Kritsotakis and Garmanikow (2004, p.44) note, the term social capital is 'pregnant with constituent elements of meaning which sometimes contradict each other.' (See also Whitehead and Diderichsen, 2001; Price, 2002; Durlauf, 2002). For instance, communities that are relatively isolated may be described as having high levels of social capital due to strong intra-community ties, whilst



at the same time manifesting distrust and intolerance towards other communities, which suggests a low level of social capital (Putnam, 1995; Cox, 1995). Another way of looking at this is that social capital can have both positive and negative impacts (Kawachi and Berkman, 2000; Caughy et al, 2003), or that communities may have different levels of 'bonding' (intra-community) and 'bridging' (inter-community) social capital (Putnam, 1995). Nonetheless it is a repeated critique that social capital lacks internal coherence as a concept. It is poorly differentiated from other existing concepts which offer adequate descriptions of phenomena and which, according to Bjørnskov & Sønderskovs' (2013) analysis of data used by Putnam (2000) can be shown to have differing functional impacts.

Cohen and Prusack (2001, pg.9) argue that there is a risk of the consideration of social phenomena and resources being skewed towards an economic rationality by the use of the term 'capital' to describe anything that is considered to be of value. This is evident in some of the work on social capital, in particular those who propagate 'rational-choice' theories of human behaviour. The notion of 'capital' evokes a web of discourses associated with capitalism. Fine (e.g. 2000, 2010) has vehemently criticised the term and its use partly on the basis that it marks the colonisation of the social sciences by hegemonic economics-based perspectives. Similarly, Blaxter and Hughes (2000, pg.34) argue that one of the reasons for the popularity of social capital is that it 'is in accord with profit, loss and accumulation as dominant ways of understanding human relations. Within such understandings the social world is primarily ordered around market-based individual exchange.' The continuing interest of organisations such as the World Bank in the concept, and the proliferation of research that speaks to the interests of such bodies may reflect the utility of social capital in rationalising neoliberal policies and promoting a globalising capitalist economy (Fine, 2010). Social capital in this way may serve to mask the power of economic and political structures of oppression, justifying policies that emphasise the promotion of social capital amongst deprived groups as a source of improved wellbeing (economic or otherwise) whilst subtly but firmly locating responsibility for solutions with such groups themselves (Fine, 2010).

Locating social capital in relation to psychology, Fine's critique regarding the importation of Rational Choice Theory is arguably less relevant, since mainstream psychology has long been characterised by individualistic theoretical positions carrying assumptions of economic rationality into social relations. The interdisciplinary dialogue that has opened up with widespread use of the concept has been praised (Bjørnskov & Sønderskov, 2013).

Both Popay (2000) and Blaxter and Poland (2001) argue for the importance of seeing social capital as processual. As Popay points out, social capital amongst a particular community will have a past, a present and a future. Or, as Blaxter and Poland (2001, p.6) argue:

‘social capital at the individual level can... be defined not simply as resources to balance against needs at one moment in time, but as a life-long pattern of relationships between the individual and society, something built up or dissipated over time.’

Much of the work on social capital ignores the conflicting interests and power differentials that may exist within and between communities and social groupings. Those who are at a disadvantage within hierarchies of power and wealth may have fewer opportunities for civic participation, or participate differently than those at an advantage (Shortt, 2004). As has been suggested, however, the work of Bourdieu, often marginalized, can be taken as an example of how social structural divisions can be made more central to studies on social capital. (e.g. Browne-Yung & Baum, 2013). Whilst not using Bourdieu's own framework of multiple forms of capital, asymmetries in power (based on gender, ethnicity as well as social class) are being brought in to work on social capital, as recent research such as that of Browne-Yung et al (2013), Julien (2014), Mithen et al (2015), and Lutter (2015) suggests.

The notion of 'linking capital' also brings in the vertical dimension. Putnam himself seems to have taken on board many of these critical points. For instance Putnam and Goss (2002, p.9) recognise that:

‘social capital might be most prevalent among groups of people who are already advantaged, thereby widening political and economic inequalities between those groups and others who are poor in social capital. Thus in talking about different manifestations of social capital and changes in social capital over time it is worth asking hard questions: Who benefits and who does not? What kind of society is this form of social capital encouraging? Is more necessarily better?’

As Fine (2010) argues, social capital ought to be seen in relation with other forms of capital and should not be overemphasised in relation to them. It should also properly be seen as a context-specific phenomenon, so that it requires rich description of particular contexts to enable us to understand the sense in which it appears in those contexts. Bourdieu’s focus on “class, power, conflict and the reproduction of hierarchy and oppression as opposed to positive-sum, collective self-help” (Fine, 2010, p.86) has attracted a minority of researchers to either use the concept as theorised by him (e.g. Browne-Yung & Baum, 2013) or to sensitise research interpretation to such phenomena when employing the concept (e.g. Eriksson & Ng, 2015 from a quantitative survey perspective). As Savage et al (2012) argue however, it may be that rather than looking to Bourdieu as a counterweight to the arguments of Coleman and Putnam, linking interests in social capital to broader current debates about inequality and stratification is more useful.

Whilst some have argued for a disinvestment from social capital (e.g. Foley & Edwards, 1999), some of the staunchest critics of the concept concede that it has utility as a heuristic for approaching social phenomena in new ways (Fine, 2001; Schuller et al., 2000; Woolcock, 1998). Empirical qualitative research has both contributed to critique and debate surrounding the concept, whilst producing insights into the complexities of community life (Kirkby-Geddes et al, 2013). It can be argued that social capital takes us beyond simple individualism to the degree that we use it to illustrate the social contextual features of human action.

Notwithstanding such criticisms, the social capital debate may be valuable in highlighting the ways in which social relatedness is an important source of

health and well-being. Given that there is no single form of healthy sociality, it seems clear that such debate does point to moral and political issues about what constitutes the 'good society' or 'good life.' (Edmonson, 2003). Social capital has been employed to good effect and with a degree of critical engagement by a number of health researchers using qualitative methodologies to produce useful accounts of community participation processes (e.g. Cattell, 2001; Boneham & Sixsmith, 2005; Patterson et al 2007; Kirkby-Geddes et al, 2013). The current study will similarly take a critically engaged and qualitative approach to use of the concept.

### **Social Capital, Health and Illness**

Much empirical research has pointed to links between social capital and a wide range of positive economic and political outcomes. Social capital may also be associated with positive health outcomes (Gillies, Tolley & Wolstenholme, 1996; Gillies & Spray, 1997; Gillies, 1998; Kreuter, Lezin & Koplan, 1997; Lomas, 1998). Following from Putnam's work, it has been argued that that social capital can have a positive impact on the well-being of entire communities, rather than just households or individuals with a lot of social capital (Narayan & Pritchett, 1997).

A number of empirical studies have found a positive association between social capital and population health (e.g. Lindstrom et al, 2001; Veenstra, 2000, 2002). Social capital has also been linked with better health in diverse contexts (Giordano, Björk, & Lindström, 2012; Han, 2013) although there have also been some contrary findings (Kennelly, O'Shea, & Garvey, 2003; Veenstra, 2000). Most survey research has used a cross-sectional design, though in line with calls for longitudinal research to support the interpretation of a positive causal effect of social capital, recent studies using British Household Panel Survey data have provided evidence to support a positive association in relation to both self-rated and physiological health (Giordano and Lindström, 2010, Giordano and Lindström, 2011 and Giordano et al., 2012) in the UK.

More recently researchers have looked at the links between social capital and health across different levels (e.g. individual, group/community, national). Elgar

et al (2013), using multilevel modelling techniques, distinguished links with self-rated health from individual perceptions of social capital and country-level social capital (as well as their interactions). Based on population surveys in 57 countries (including the U.K.) it is one of the more sophisticated cross-national survey studies on the topic, the researchers having grounded the survey items in the theoretical categories of bonding, bridging and linking social capital. In line with the majority of previous research in finding positive associations of individual-level social capital with health, the researchers found that such associations were also dependent on country-level social capital. This points to the importance in health research of the broader features of social capital that are theorised to characterise and be comparable between nations.

### *Problems with survey studies*

In quantitative survey questionnaire based research, the validity of attempts to assess links with population health have been hindered however by a “lack of standardised, reliable and internationally valid assessments of social capital” (Elgar et al, 2011, p.1044). The majority of such research, in particular large scale national studies, have used a limited number of measures of perceived trust and/or membership of groups as proxies for social capital. Whilst measures of trust have been found to correlate independently with health, both empirical (Carpiano & Fitterer, 2014) and theoretical (e.g. Portes, 1998, Lin, 2001; Glaeser et al., 2002; Field, 2003) work has pointed to the fact that trust is relevant to but conceptually distinct from social capital whilst being poorly indicative of social network connectivity. The predominance of survey studies measuring social capital via individual behaviour and cognition in the health field (Hu et al, 2014) has been seen as problematic (XXXX). The aggregation of individual-level data to make conclusions about social capital as a community or country-level phenomenon has also been criticised (e.g. Lochner et al, 1999). There is a tension also between the need for culturally specific measures based on observational or other methods that better capture social capital as an ecological phenomenon, and the need to standardise in order to facilitate cross-national comparisons (Harpham et al, 2002).

Harpham et al (2002) argue that quantitative measures are simplistic, and it remains the case that quantitative indicators need to be enriched by qualitative methods providing case studies and thick description (Bullen & Onyx, 1998).

#### *Processes by which social capital may be linked with health*

Whilst the largely survey-based research has focussed in large part upon illustrating links between social capital and health, the processes by which such links may occur also need to be mapped. Sundquist et al (2004) suggest that there may be a number of direct and indirect pathways through which social capital may affect health. Assuming that low levels of social capital are associated with poor health in a particular community or neighbourhood, this may be through the direct effects of resultant psychosocial stress, or crime such as assault and violence. Indirectly, low community social capital may result in a lack of health information being disseminated within a community, poor health-related behaviour norms, or poor access to health-relevant services.

Much discussion in this area has turned on the observation that the same communities tend to be identified as being characterised by low levels of social capital, high levels of deprivation and poorer health. There has consequently been vigorous debate about the relationship of social capital to health inequalities. It has long been observed that socio-economic status is strongly associated with health and mortality, with people of decreasing socio-economic status having higher mortality rates and poorer health (Pearce and Davey Smith, 2001).

Wilkinson (1992, 1996) presented cross-national evidence that income inequalities (rather than absolute levels of income) are positively associated with mortality rates in a range of relatively wealthy countries. He argued that lower levels of social capital/social cohesion mediate this relationship via psychosocial pathways. For instance, an awareness of one's low socio-economic position relative to others causes anxiety and stress, which has physiological effects and results in a decreased life expectancy. Gillies *et al* (1996) similarly argue that one of the ways in which deprivation, discrimination

and poverty may influence health is through the role they play in undermining health-enhancing stocks of social capital in deprived communities.

Opposed to this position have been those who argue that inequalities in wealth have a direct material impact on health inequalities (e.g. Lynch et al, 1998), and/or have problematised Wilkinson's findings. Lynch et al (2001) in a comprehensive cross-national analysis found that the associations between income inequality and health were limited to childhood health outcomes.

More recently, a number of cross-national (Muntaner et al, 2002; Carlson, 2004) and national (Joshi et al, 2000; Bolin et al, 2004) level studies have found that whilst indicators of socio-economic status have a stronger association with health than indicators of social capital, both are independently associated with health outcomes. In U.K. studies both Joshi et al (2000) and Cattell (2001) concluded that participation in the community and civic engagement are likely to have a protective effect on health amongst those living in poor areas, but that there are other pathways through which low socio-economic status mediates health independently of social capital. It should be noted that there have also been (survey) studies finding no significant association between social capital and health outcomes (Lynch et al, 2000; Rosenheck et al, 2001).

One of the ways in which the social capital debate may be valuable heuristically is by helping us to move beyond a false dichotomy between materialist and psychosocial explanations for public health issues (Edmonson, 2003). Whilst material conditions may be of prime importance in health inequalities, this is not to say that the kinds of social relatedness that characterise a community or society are unimportant, and indeed these may reflect and relate to socio-economic inequalities (Edmonson, 2003).

Lynch et al (2000) acknowledge that indicators such as relative income and status are only useful to processual explanations in the context of sophisticated descriptions of what they actually constitute in the societies concerned.

Future research should encompass the dynamic nature of social capital, as it exists in communal processes that occur amongst people in particular places

and historical/temporal contexts (Popay 2000). There is currently little research addressing the ways in which social capital and health co-vary over time (Bolin et al, 2003). A further need identified by Popay is for qualitative, exploratory research that elucidates how people subjectively experience social capital, its links with health, and the ways such experiences relate to their sociocultural position. According to Swann and Morgan (2002, p.6):

‘qualitative methods are uniquely useful in the study of social capital because they allow us to look beneath the surface at the hard-to-measure processes and actions of people’s relationships to others, at community structures, and the ‘life’ of communities and networks.’

### **Social Capital and Chronic Illness**

In the context of chronic illness a social capital perspective may serve to counter the prevalent policy emphasis on individual self-management, broadening consideration of a range of social relatedness issues that impact on support and efficacy of illness management. Similarly such issues may impact on quality of life and other aspects of experience that are important to people with long term conditions.

The association of social capital with chronic illness outcomes in extant published research was reviewed by Hu et al (2014). Differences in conceptualisations of social capital between studies made meta-analysis inappropriate, and a large number of studies were excluded from their review for leaving 17 published up to 2014. The researchers reviewed these on the basis of. Associations of social capital and health differed in the case of various chronic conditions.

Given the abovementioned dynamic nature of social capital and consequent limitations of cross-sectional designs, it follows that longitudinal studies may be well equipped to explore how changes in social networks affect the availability and use of social resources that support chronically ill people. Longitudinal survey-based research has shown that perceived social capital was positively associated with improved health (self-rated) over time amongst a Dutch sample



of chronically ill people representative of the general population (Wolfe et al, 2014).

In the UK context Reeves et al (2014) employed a mixed-method longitudinal design to examine how health-related outcomes and other changes occur over time for people with long term conditions in Greater Manchester. Social participation with a diversity of people and groups supported personal illness self-management and both physical and mental well-being. Support in personal networks expanded as participants health needs grew, which was helpful to participants coping both emotionally and practically with illness (although that did not directly impact on health per se).

The qualitative aspect of the research was rather limited however, in that only postal questionnaires were used at follow-up, whilst interviews were restricted in scope to the mapping of social network members, key attributes of network members, and their contribution to activities considered illness-related.

Notwithstanding that the limitations of survey-based research risk either the obscuring of elements of links between social capital and chronic illness, or overemphasis on components of social capital that surveys do access, such work tends to leave open many questions about the processes by which social capital does link to chronic illness.

Some of the issues around participation in community and voluntary organisations for people with vascular diseases across North West England have been investigated by Jeffries et al (2014) using qualitative methodology. The researchers found that barriers to participation included other ongoing time commitments, transport limitations, the existence of cliques or an unwelcoming atmosphere for newcomer and the nature of group activities not meeting their needs. The latter links to an issue highlighted by Ziersch and Baum (2003) (cited in this paper), wherein the health benefits of participation are likely to vary according to the nature of groups and their activities. Some groups for instance were engaged in physical exercise and their impact differed from other groups (Jeffries et al, 2014). Hobby and health support groups on the other hand were seen as more important in providing a place for illness management talk.

Chronically ill people may become involved in groups that specifically focus on illness-related concerns, or groups that serve other purposes. Again the context-specificity of the social capital and health link is important.

Bourdieu's framework has been employed in qualitative work to produce insights into the role of capital in self-management of Diabetes type 2. For Henderson et al (2014, p.340)

“Social capital can be understood as a measure of influence within a social network reflected in access to the social resources needed for effective chronic condition self-management.”

Limited access to social networks impeded their Australian participants' capacity to successfully negotiate informational resources, and in particular a lack of informal contacts with health professionals was noted. The researchers link such access with research showing that people with higher levels of socioeconomic resources are more likely to be associated with such access (Cornwell & Cornwell, 2008 cited in Henderson et al, 2014). As a form of cultural capital, knowledge and capacity to access informational resources are interrelated with both social and economic capital therefore. Those who are worse off may be unable to negotiate the field of chronic illness self-management as successfully. Whilst the mediating influence of social capital in health inequalities has been much debated (see above), in articulating the process through Bourdieu's multiple 'forms of capital' approach the element of class oppression is highlighted, countering the consensualist vision of Putnam.

### **Bringing Together Social Capital, Masculinities and Chronic Ill Health**

Putnam's conceptualisation of social capital has been criticised for its neglect of gender issues (e.g. Morrow, 2000; Wood, 1998). There is, however evidence suggesting that gender may play an important role in both the development and use of social capital (Morrow, 2000; Wood, 1998). There is much empirical research indicating that social relationships are patterned according to gender (Bolin et al, 2003). Campbell & Wood (1999, pg.157) in a UK study found that

“gender differences emerged as the most salient source of social capital differences” in the communities they studied.

Some studies have used male only samples in research relating to social capital and chronic ill health. For example, Kawachi (1997) in a U.S. study found a strong association between low levels of social capital and morbidity and mortality due to specific chronic illnesses amongst men. However, few have taken an explicitly gendered approach towards the processes linking social capital, health and illness.

Sixsmith *et al.* (2001) find that social capital as a health-enhancing resource is highly gendered, with men failing to mobilise social capital in times of need.

In the proposed study men’s use of social capital and experience of chronic ill health will be explored in relation to the social construction of masculinity. In managing chronic ill health, constructions of masculinity that necessitate the rejection of health promoting beliefs and behaviours are likely to be problematic for men. Constructions of masculinity that call for men to present themselves as invulnerable may have negative implications for their use of social networks and social support. The extent to which chronic illness undermines men’s social capital is yet undetermined and this research will explore the issue.

## **Chapter Six: Methodology**

The chapter is structured firstly to set out my rationale for employing a qualitative methodology. I then discuss issues of quality in qualitative research. I then discuss the specifically narrative approach to psychological research that informs my thesis, encompassing issues of epistemological pluralism, and implications for conceptions of self and identity. I describe the research design in this chapter, including recruitment of participants and ethical considerations. Following that I review work on qualitative interview methods and narrative analysis. I also discuss the issue of reflexivity in this chapter.

The aim of this research is to investigate the experiences of chronically ill men in relation to the social construction of masculinities, and to develop an understanding of social context and social relatedness pertinent to their lives via critical engagement with the concept of social capital. Whilst an individual focus is maintained, the study is grounded therefore in a critical approach that aims to bring to light interconnections of social, community, cultural and societal influences on their experiences.

In order to investigate how chronically ill men construct masculinities and to locate narratives within the abovementioned contexts, I have formulated the following research questions to address these issues:

1. What processes link social capital, masculinities and experiences of chronic ill health?
2. What are the experiences of men in their use of social capital in relation to chronic ill health?
3. How do participation in community life, relationships with friends and family, shared group norms, trust and reciprocity work to mediate men's experiences of chronic ill health?

In attempting to answer this research question, a qualitative methodology has been employed. In this chapter I will set out the approach to research, design and method of this narrative interview-based study.

### **Rationale for Use of Qualitative Methodology**

A qualitative research methodology has been employed throughout the study as the aims of my study are to investigate the lived experiences of chronically ill men. Through examining participants' accounts of social and community ties from a gender-sensitive perspective, the social construction of masculinities as a narrated process is highlighted. The aim is not to quantify or generalise their experiences beyond the participant group, but to develop rich descriptions of illness experience in the context of gender identity construction and social relatedness.

The research questions for the current study would not be well fitted to a positivist emphasis on quantification, probability testing, controlling the environment of participants, etc. (e.g. Camic et al, 2003) and are not intended to result in the rejection or acceptance of pre-set hypotheses. Indeed whilst epistemologically useful in (though not necessarily synonymous with) the natural sciences there has been much debate around the appropriateness of such measures in the case of studying human psychological and social life:

Dissatisfaction with the natural scientific approach in social science has given way to a shift that is expressed in another discourse: from a style in which lawlike propositions and explanations prevail toward one in which cases and interpretations are central. (Abma, 2002, p. 8).

The complexity and mutability characterising lived experience are inadequately captured by adherence to the tenets of positivist experimental or survey questionnaire psychology. Explanation and understanding of human psychosocial processes must arguably proceed in recognition of the limitations of attempts to derive psychological 'laws' in similar fashion to those sought in

the natural sciences. In contrast, in qualitative approaches exploration and meaning-making are central activities:

Qualitative research is multimethod in focus, involving an interpretive, naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them. (Denzin & Lincoln, 1994, p.2)

Whereas subjectivity from a positivist perspective is something to be 'planned out' of research studies, from an interpretivist perspective the subjectivities of both researched and researcher are valued and explored. The process of researcher interpretation is key to qualitative work, and that process itself may be unpacked via reflexive analysis. I have included reflexive analysis in Chapter Eight.

### **Quality in Qualitative Research**

In the light of the interpretivist nature of qualitative research the question of how to assess the relative value of studies is raised. In the absence of 'objective' criteria such as quantifiable reliability or validity measures, there have been a number of alternative criteria suggested. In quantitative psychometric testing research, there are a number of types of reliability which can be measured and indicate consistency of results. Validity on the other hand assesses whether a test measures what it aims to measure (Foster & Parker, 1995). Familiar terms such as reliability and/or validity may be reframed in the qualitative context. Gomez (2009) for instance argues that in relation to qualitative health research:

..validity responds, first of all, to a commitment to fidelity to the actual behaviour of the phenomenon under study, which requires maximum rigor in the study design as well as during data collection and validation.

Alternatively, it has been argued that alternative criteria are more useful in considering the value of qualitative work. Yardley (2000) suggests that a

number of criteria, such as rigour, sensitivity to context, coherence, commitment (i.e. evident prolonged engagement of the researcher with the topic), transparency, and impact and importance of the study should be considered. The plurality of trends and traditions encompassed by qualitative research however may render a common approach to quality assessment problematic or inappropriate (Gomez, 2009).

Qualitative research has been criticised on the grounds of a lack of generalizability, in the sense that results cannot be accurately assumed to apply to people or situations that were not studied. Rather than aiming for generalizability however, qualitative researchers may contribute valuable contextualised and in-depth descriptions of particular settings (Whittemore et al, 2001). As Polit & Beck (2010, p.1451) argue:

The goal of most qualitative studies is not to generalize but rather to provide a rich, contextualized understanding of some aspect of human experience through the intensive study of particular cases.

The process of qualitative research produces knowledge which is culturally and historically situated (which may not predict future practice) (Tracy, 2010). Notwithstanding the debate around the application of formal quantitative understandings of concepts such as generalizability to qualitative research, researchers have developed understandings of what may constitute transferability (Guba & Lincoln, 1985) or naturalistic generalisation (Stake & Trumbull, 1982). Transferability:

...is achieved when readers feel the story of the research overlaps with their own situation and they intuitively transfer the research to their own action. (Tracy, 2010, p.845)

Whereas naturalistic generalisation represents a recognition that improved practice derives from the sense of personal experience and knowing that good research may imbue readers with (Stake and Turnbull, 1982). Assessed according to such standards, research may achieve resonance to the degree that it will 'meaningfully reverberate and affect an audience' (Tracy, 2010,

p.844). Positivist quantitative research in psychology has been extensively critiqued for its tendency to objectify and decontextualize aspects of lived experience, whilst reifying social constructs. In the area of Health Psychology for instance the progressive separation of forms of knowledge from their original embeddedness in everyday life has been problematized by critical health psychologists such as Crossley (2000).

The issue of objectivity in research has been a further axis of difference between positivist and interpretivist approaches. Quantitative research lays claim to present objective findings about psychosocial realities, and employs a discourse that can serve to mask the processes of reification and social construction that are involved, particularly in the social sciences. In contrast, qualitative approaches are more likely to acknowledge the constructive and interpretive role of the researcher in creating knowledge. In acknowledging such, a reflexive and transparent approach to the construction of knowledge has been a feature in the development of qualitative research in psychology.

In the current study I have attempted to be mindful of my own subjective biases, values and inclinations, and to discuss these in a reflexive chapter. In attending to the personal meaning that men's experiences have for them I have presented a variety of participant voices as they relate to themes of relevance, illustrated with thick description and extensive extracts from the interviews conducted. I have employed a qualitative, narrative approach that can usefully facilitate such aims.

### **Narrative Psychology**

As the term suggests, a central feature of narrative psychology is a focus on stories or narratives. The key proposition made by narrative psychologists is that the telling of and listening to stories is important in making sense of events in our lives. It is in connecting disparate events together in a 'plot' (the process of emplotment described by Ricoeur, 1984) that they are imbued with meaning. The recent growth of interest in narrative psychology may be seen as an aspect of the 'turn to language' or 'turn to discourse' in the social sciences more



generally, which has perhaps developed more gradually within psychology than other related disciplines (Curt, 1994; Kroger & Wood, 1998; Tuffin, 2005).

The place of narrative in social reality is therefore central to the ontological position of researchers adopting this framework (Frost, 2011). The narratives that we compose reflect not just our unmediated experiences but also the normative discourses, values and moral judgements that characterise our sociocultural contexts (whether we are reproducing or resisting them) and through creating such narratives we construct our sense of self or identity (Crossley, 2003). Numerous researchers have noted the usefulness of stories for individuals in understanding change in identities and relationships (Bruner, 1987; Emerson & Frosh, 2004; Reissman 1993; 1998; Crossley, 2007). In this context the narrative approach has been used extensively to examine the experiences of people who become chronically ill.

### *Epistemological Pluralism*

Narrative psychology broadly reflects an epistemological position valuing the collection and analysis of stories, e.g. life stories. Locating oneself within this approach then has implications for all aspects of a research project including methodology.

Approaches to narrative psychology vary greatly and reflect various epistemological and pragmatic positions taken by researchers. One way of organising the range of approaches is to understand them as being variously located along an epistemological continuum from realism to relativism (e.g. social constructionism) (Stanley, 1992; Riessman, 1993; Plummer, 2001; Elliot, 2005). It is possible, and many have argued (e.g. Murray, 2000; Frost, 2009) useful to take a pluralistic or pragmatic approach to such positions.

### *Issues of Self and Identity in Narrative Psychology*

For the current study a Narrative Psychology approach is particularly appropriate in the light of its aims to explore processes linking social capital, masculinities and experiences of chronic ill health. As noted in the introductory chapter, contemporary work on masculinities has highlighted the plurality of

masculine identities, and their discursive, embodied production within sociocultural contexts. There has developed also a vast amount of literature on the topic of illness narratives. Popay (2000) has argued that ongoing work on social capital should also recognise it's temporality and the importance of it's experiential and subjective aspects. She calls for the consideration of narratives of social capital as important sources of understanding in research on social capital and health.

A narrative approach implies consideration of the storied nature of identity. The breadth of ideas about the relationship between narrative and identity again may be seen to reflect a continuum of realism and relativism. For McAdams & McLean (p.233, 2013):

*Narrative identity* is a person's internalized and evolving life story, integrating the reconstructed past and imagined future to provide life with some degree of unity and purpose.

As Wrigley (2001) argues though:

The relationship between self and narrative is a complex one, which entails exploring and analysing aspects of authenticity, authorship, time and emplotment to mention only a few

The use of narrative approaches has been promulgated in opposition to positivist research treating participants merely as objects of investigation, in order to create space for marginalised voices and with a view to their emancipatory potential (Blumenreich, 2004). Interest in illness narratives as noted above in Chapter Two emerged as a counterweight to biomedical and mainstream health psychology neglect of patients' embodied experience and reduction of such to psychosocial factors (e.g. Mishler, 1984). As Hyden (1997, p.49) argues:

'patients' narratives give voice to suffering in a way that lies outside the domain of the biomedical voice

Frank (1995, 53)) considers that illness inherently invites narrativity in the sense that:

Stories have to repair the damage that illness has done to the ill persons' sense of where she is in life, and where she may be going. Stories are a way of redrawing maps and finding new destinations.

It is also incumbent upon the ill person to provide illness narratives to employers, health professionals, and others to whom they are connected by 'bonding', 'bridging' and 'linking' ties. For Frank (p. 55) illness results in 'narrative wreckage':

The illness story is wrecked because its present is not what the past was supposed to lead up to, and the future is scarcely thinkable

Insights into the lifeworlds of people with a wide range of chronic illnesses have resulted from a 'realist' or phenomenologically influenced approach to research, giving rise to theoretical concepts such as 'biographical disruption' (Bury, 1983), conceptualising such disjunctures in life trajectory and implications for structures of meaning that may occur as a result of chronic illness. As a corollary the phenomenon of biographical disruption may be taken to illustrate that routinely human experience is characterised by a sense of order and coherence (Crossley, 2003)

The assumption that individuals possess a clear, stable and coherent identity has been troubled by postmodernist theorists such as Foucault and Derrida. Foucault wrote from a strongly historicist position to illustrate the role of discourses in determining the possibility of ideas and thought about psychosocial issues such as identity. Rather than clear, stable and coherent, identity may instead be understood as a 'fiction' emanating from humanist discourse:

In other words, individuals cannot be understood as having a fixed identity that is ontologically prior to their position in the social world. Identity is not to be found inside a person (like a kernel within a nutshell) but rather it is relational and inheres in the interactions a person has with others. In contrast to the humanist notion of the individual having an authentic core and an essential identity, the post-modern conception of the self therefore stresses the continual production of identity within specific historical and discursive contexts.

(Elliot 2005, p.124)

Foucault's strong historical determinism however is challenged by those such as Eakin (2011) who see the relationship between people and their social context as being dialogic process.

Derrida's work encourages the deconstruction of texts, highlighting the indeterminacy of meaning in concepts such as identity to provide dissenting or variant interpretations (Hughes & Sharrock, 1990).

Poststructuralist theories opened up spaces for researchers to identify processes of marginalisation and subordination in analysing activities and phenomena, and to work from a pluralising perspective that questions the possibility for coherent and objective accounts. Subjectivity then is seen as shaped and maintained relationally, whilst the notions of self and identity become both plural and contingent upon context. As such the self is seen as continually in a state of construction. A wealth of qualitative psychosocial research influenced by poststructuralist perspectives has focussed on the practices by which a sense of individual identity is constructed and reconstructed on an ongoing basis. The narrative construction of identity suggests:

...an identity that is grounded in experience and temporality and has coherence without being static and fixed.

(Elliot, 2005, p.124)

Seeing the self as 'worked up' through the construction of life narratives, a tension between human needs for a sense of coherence and stability over time, and change, development, even progress, exists. Identity comes into being through the process of managing such opposing forces (Smith, 1994).

Such processes link sense of self strongly to social and historical contexts, with narrative being a central way in which this is communicated and negotiated with others. Narrative locates a person's sense of self in place and time in both this broader sense and the more personal sense implied by the emplotment of life events within a life story.

Within narrative psychology issues of self and identity have been a particular focal point and such research has illustrated well the fluidity and active construction that occurs through the use of language – selves may be talked in to being, in relating stories about one's experiences for instance. Such self-constructions are open to contestation and revision in conversation and debate with others. The self is neither pre-existing nor finalised, but an ongoing project. Neither does identity construction occur in a vacuum, as narratives are both embodied and reflective of sociocultural discourses.

Thus we are constrained in the versions of self that we can successfully work up in narration. Smith and Sparks (2006) nonetheless identify differing nuances in narrative theory relating to self and identity, noting the danger that:

...taken to an extreme, conceptualising life essentially in terms of language, thereby drawing equivalence between narrative and identity, results in a kind of linguistic or social determinism or reductionism.  
(p.174)

As Eakin (1999, 2011) argues, whilst acknowledging it's important formative role, narrative identity should not be seen as encompassing the entirety of the experience of selfhood, given the diversity of selves and self-experiences. Nonetheless Eakin (2011) argues that we are embedded in a system of

narrative identity, whereby our social arrangements require from us self-narratives in the demonstration of culturally normal functioning.

Crossley (2003) sees the life story as being structured through narratives that reflect the norms and values of cultures in which they are embedded. As she argues, the narrative approach is useful in that it facilitates us to examine issues of self and identity in a way that acknowledges both psychological and sociological level phenomena, at a high level of complexity. For Crossley selves are experienced as 'real', and that individual subjectivity is generally experienced as having a greater degree of coherence and stability than is generally acknowledged by theorists who are influenced by postmodern perspectives. Her conception of self, is therefore not so context dependent that it is reconstructed anew with every moment to moment experience (c.f. Augustinous & Walker, 1995). She suggests that this description is more in keeping with the subjective experience that most of us have in everyday life. Crossley (2000b, p.54) illustrates how 'people orient towards the world with an implicit sense of temporal coherence, connection, order and experiential unity during the course of everyday practical life.'

### *Social Selves and Narrative*

Narratives of the self are embedded within a range of social relationships also (Gergen, 1992), and this should be seen as linked with issues of social relatedness or social capital. Indeed one of the productive potentials of social networks is the production of group or community narratives. Werner-Lin et al (2009) have demonstrated how family narratives of genetic disease are integrated into people's lives guiding expectations and providing resources for continuity and coherence in the face of illness. Chamlee-Wright and Storr (2011) explore the ways in which social capital as collective narratives shapes the strategies of individuals in a post-disaster recovery setting. Collectively negotiated narratives such as these may both constrain individuals in their individual self-narrations whilst also enhancing well-being in connecting them to others, and to larger narratives (Seaton, 2008).

### *Men's Narratives*

The narrative methodology employed in the current study is appropriate to enquiry regarding men's experiences of chronic illness. Men's interview narratives here are to some extent a counterweight to the medicalised public health narratives regarding illness, and can for instance contribute to evidence contextualising the notion of lifestyle choice as a series of rational strategies that men (should) choose in terms of coping, management and prevention issues in chronic illness. As noted above in Chapter Two there has been a vast amount of research on the topic of illness narratives, however men's gender is relatively less prominent even in research that includes men as participants. Sociocultural context has been shown however to be of great importance in the way that men construct identity in the face of illness. Sontag (1978) for instance in a seminal work notes that men are particularly likely to use war metaphors in describing illness experience.

Narrative analysis is used in this thesis to illustrate also the tensions between men's power as an aggregate, and the power of hegemonic masculinity as an ideal, with the diverse experiences of men for whom chronic illness is both impacted by and impacts positioning in relation to such issues. Whilst the work of Connell and Courtenay are acknowledged as key theoretical resources in the current study, there are some issues which the narrative approach may help to address. Connell's (1995) work may insufficiently illustrate the heterogeneity of men's emotions, lived experiences and motivations. Indeed Connell herself (2014) has called for a rethinking of masculinities in a more diverse global context, whilst researchers such as McCormack (2012) ground in ethnographic detail shifts in masculinities within the U.K. Courtenay's (e.g. 2000) work builds on Connell's to advance thinking about the implications of masculinity construction for health, but there is a need for further in-depth studies to better exemplify the arguments and data he puts forward, and to illustrate within a non-U.S. context how masculinities and health issues interrelate.

The representation of men's chronic illness is bound up with discourse around both individual responsibility, choice and 'welfarism'. Given the 'breadwinner' discourse associated with hegemonic ideals of masculinity and growing public

stigmatisation via corporate media and politicians of those unable to work or claiming benefits in the U.K. due to illness, the narratives of men who were largely of working age is increasingly prescient. Narratives illustrating the life experiences of such men provide an alternative perspective.

For all of the above, the sense of temporality inherent in narrative can provide additional insight into men's experience, and this is something that discourse analytic or grounded theory perspectives less frequently highlight.

## **Research Design**

Narrative methods were used in order to co-create semi-structured interview narratives with participants as discussed above. I conducted longitudinal interviews with the men participating in the study. Initially I engaged in efforts to recruit participants.

## **Recruitment**

In order to recruit men for the study I employed a number of strategies. Initially I acquired two chronically ill participants who were connected to me by social networks and piloted the initial interview schedule with these. Secondly, several local newspapers in the North West region were contacted with a press release requesting chronically men to respond. A number of newspapers did publish this. Thirdly I contacted a number of illness-related charities such as the M.E. Society, British Heart Foundation, Raynaud's and Scleroderma Society with similar press releases. Again this resulted in publication of calls for participants. Finally I contacted a number of local GPs in Manchester U.K. and requested they place notices in their surgeries calling for participants. Participants were recruited through all of these methods, although the most successful method was via illness-related charities.

A participant information pack containing information about the study and its aims, with a consent form was conveyed to participants prior to the interviews and I answered questions and arranged convenient dates and times for interview via telephone or (in one case) via email. Participants were interviewed



at times and places convenient to them; the vast majority in their own homes at their request. This was important, given that a number of participants were experiencing considerable mobility difficulties as a result of illness. I agreed with participants to telephone them the day before our appointment, and all participants had my telephone and email contact details. A flexible approach was considered appropriate here, respectful of participants time and the incursion into their homes, whilst several participants suffered from fluctuating conditions and on two occasions participants rescheduled interviews at short notice due to illness symptoms.

### **Ethical Considerations**

Prior to commencing the study an ethics proposal was submitted to the Manchester Metropolitan University Ethics Committee detailing the study design. This was approved by the Committee prior to the data collection phase. All interviews were conducted in adherence with the British Psychological Society Guidelines (BPS, 2009).

Participants were informed about the nature of the study, research aims, and the broad topics that were to be covered in the interviews. This was achieved by means of the initial participant pack and verbal discussion by telephone prior to meeting for the interviews. All participants signed a consent form indicating their informed consent to their participation in the research process.

The consent form and discussions also covered issues of anonymity and confidentiality. Participants were assured that their names would be changed to pseudonyms in the written up report and transcripts, whilst other potentially identifying details such as those of other people in the accounts and place names would also be changed where they arose in interviews. Participants were informed that confidentiality in contrast cannot be offered as the content of interviews is transcribed and the anonymised content would be in the final report and may also appear in other forms such as journal articles, conference presentations, etc. The interview narrative itself is thus preserved and published as well as analysed in detail. Anonymity in a qualitative project may be preserved at the level of readily identifiable features, however given the many

unique details to the content of a life story it remains possible that a person may be identifiable to a reader who is familiar with the person's life already (Smythe et al, 2000). It was important therefore to discuss with participants the actions which would be taken regarding anonymity and confidentiality so as to gain their fully informed consent.

### **Interviewing Men**

Many previous writers have suggested difficulties with getting men to talk at length or in an open way about their lives and emotions (e.g. Finch, 1984; Cunningham-Burley, 1984). However, Brown (2001) draws attention to the importance of topic in influencing men's engagement with the interview process over and above the importance of such variables as gender of the interviewer. In regard to interviewing men about health-related matters, she suggests that for many men, unlike for women, health is not a part of their everyday discourse. Indeed men who do not themselves have health problems may see the issue of health as being irrelevant to them. Where a serious health problem has occurred however, she notes that the topic will become likely more salient. Further, she identifies relocation from the public to private sphere as a result of illness as causing shifts in gender identity performance that may lead to health talk becoming more acceptable to men.

Schwalbe and Wolkomir (2001) view interviews with men in terms of their being a setting in which masculinity is signified or performed. Such a view highlights the need for researchers to be attentive to gender enactments that occur before, during and after the interview, in which men may attempt to ensure that they are seen and treated as men. The reproduction of gender in interview settings is a joint accomplishment. Interviewers therefore need to be aware of the threats to masculinity construction that can inhere in the interview as experienced by participants. Vaguely perceived threats may stem from the expected surrender of control to the interviewer's agenda, stripping away of a public persona by the interviewer's questions, and solicitation of men's vulnerabilities and emotions for instance. Schwalbe and Wolkomir suggest several possible strategies aimed at allowing men to construct credible masculine selves, minimising the felt threat of the situation.

Peni & Pease (2013) similarly raise questions about the way that hegemonic masculinity may be reinscribed through 'male bonding' during interviews in which men interview men and highlights a need for reflexivity. They also cite Flood (2007) in calling for consideration of the ways in which notions of empathy, may be inappropriate for the researcher in such circumstances. I have negotiated these debates by offering reflexive understandings of the research process that are discussed in Chapter Eight. In terms of interview practice, I strove to be respectful of the time that participants were giving me, and develop rapport through empathetic listening and talking.

### *Qualitative Interviews*

The collection of material of texts for analysis may proceed in diverse ways when using narrative methodology. In light of the broadly constructionist epistemological approach used to frame the research, the qualitative interview, with its corresponding themes of experience, meaning, conversation, dialogue, narrative and language (Kvale, 1995) was chosen rather than methods such as questionnaire or survey research more suitable to the production of numerical data. Whilst quantitative methods are not necessarily incompatible philosophical assumptions of constructionism, in seeking to understand narratives of the life world of participants, the detailed responses given in qualitative interviews were more suitable in lending themselves to the textual analysis usually involved in the narrative approach.

Qualitative interviewing may involve varying degrees of structuring by the researcher. The fully structured interview in which interviewers adhere rigidly to a pre-set series of questions enhances comparability between participant responses and potentially assists with a focus on the research topics in question. Nonetheless this approach relies upon the researcher defining topics of interest and relevance extensively in advance, and may restrict the exploration of unexpected themes or responses. Unstructured interviews in contrast may be very restricted in terms of planned input from the researcher, with perhaps a single opening question followed by freely flowing conversation. Whilst enabling participants to have a greater role in guiding the course of interviews and encouraging spontaneity and rapport, insufficient material of

relevance to the research questions may result, and relevant issues identified from reviewing previous research on the topic may remain unexplored.

For the current study a semi-structured interview approach was selected, in order that a degree of structuring in relation to the research questions pertained, whilst openness and flexibility to avenues of interest and relevance to participants could also be incorporated. By semi-structured, I refer to the sequence of themes and suggested questions of the interview schedule that were used to guide the interview, and the openness to changes of sequence and forms of questions where necessary to follow up the answers given and the stories told by the participants (Kvale, 1995).

I therefore created interview schedules containing guidance on interview formats designed to elicit narrative accounts of life stories with a particular focus on health and illness. The life story may be seen as a particular form of narrative in which diverse stories are brought together, connected, and 'owned' by the person (Crossley, 2003). As such it is perhaps the key linguistic representation of self-identity, emphasising the moral value and values of the person, and the interweaving of time, place, and circumstance to summarise who a person is. Connell (1995) sees life histories as enabling a focus on subjective experience in historical context and potentially providing a window into "social structures, social movements and institutions" (p.89).

I conducted interviews over two time points with participants, allowing for follow up on issues of relevance in a more in depth manner as well as gaining an update on experiences during the intervening time between interviews. A second interview schedule was created containing both generic topics specifically relevant to the research questions as well as follow up issues based on a review of the initial interview and field notes for each participant.

### ***Participants***

Twenty five participants in total were interviewed initially for the research. I interviewed each participant twice where possible. The first interview conducted was designed in order to gather life story narratives. The second interview was intended to follow up in depth some of the issues apparent from observations on the initial interviews and to explore developments in men's lives in the intervening period.

Twelve participants agreed to be interviewed for a second time. The mean time between interviews was 14 months, allowing for a longitudinal element to the study. Ten participants were unable to be contacted using the contact details for second interview, whilst three participants declined a second interview. In cases of those who declined further interview worsened health was given as a reason. I recorded all of the interviews on a tape recorder or mini disc recorder.

Field notes were created following each interview noting key biographical features, issues and reflections on the interviews. I listened to and reviewed all of the thirty seven interview recordings produced for the study, which, in combination with a review of all field notes resulted in the compilation of extensive notes on the central issues of relevance to the research aims.

This initial interpretive process fed through to inform the subsequent transcription and further analysis of a smaller subset of fully transcribed interviews. The benefits of sequential interviews being apparent, in the case of eleven of the participants who had been interviewed twice, both interviews were fully transcribed. For the remaining double interview participant, the second interview had suffered from audio quality problems and so was not transcribed. All transcripts were fully coded and analysed in detail.

In the interests of focussing in-depth using narrative case and cross-case study approaches, the transcripts of seven of those participants were subsequently employed in the presentation of interview excerpts and corresponding pluralistic narrative analysis. These were selected on the basis that the interviews were particularly rich in material on key issues identified amongst the whole data set, whilst presenting a diversity of experiences, social locations and identity performances. Two participants were selected for a case study approach to analysis (described below), whilst a further five participants were selected for cross-case analysis.

Brief biographical details of participants are listed below. Pseudonyms have been used for participants in all cases:

1. Sean was a 61 year old white man at time of first interview. He was unemployed. He was suffering from M.E., hypertension, and arthritis. He was single and living alone. He was interviewed twice in his home.
2. William was a 53 year old man. He suffered from colitis, Coronary Heart Disease and dystonia. He was unemployed. He lived with his spouse. He reported little change in his health between the two interviews. He was interviewed twice in his home.
3. Tony was an 83 year white man who was living alone and retired. He was interviewed twice in his home. He was suffering from asthma, glaucoma, and was recovering also a stroke.
4. Alex was a 26 year-old-white man, living with his wife and daughter. He was suffering from asthma and Raynaud's syndrome. He was employed full time and was interviewed twice in his home.
5. Steven was a 58 year old white man living with his wife and daughter. He was employed full time and suffering from M.E. He was interviewed twice in his home.
6. Barry was a 52-year-old white man living with his wife and son, and suffering from M.E. He was unemployed and was interviewed twice in his home.
7. Raymond was a 58-year-old white man, living with his wife. He was suffering from arthritis, Raynaud's syndrome and sclerosis. He had taken early retirement due to illness. He was interviewed twice in his home.
8. Cary was a 32-year-old white man living with his girlfriend. He was employed full time and suffering from Urticaria. He was interviewed in his home and was unavailable for a second interview.

9. James was a 23-year-old white man, in full time Higher Education. He was suffering from a chronic heart condition. He was living with his parents and was interviewed twice in his home.
10. Mark was a 46-year-old white man, who was living with his two children and unemployed. He was suffering from ulcerative colitis. He was interviewed in his home and was unavailable for a second interview.
11. George was an 82-year-old white man living with his wife. He was retired, and suffered from asthma and rheumatism. He was interviewed twice in his home.
12. Richard was a 65-year-old white man living with his wife. He was retired and suffering from asthma. He was interviewed twice in his home.
13. Andrew was a 63-year-old white man who was single although living with a lodger in his house. He had taken early retirement due to illness. He was interviewed twice in his home.
14. Edward was an 82-year-old white man who was living alone. He was retired and suffering from arthritis. He was interviewed in his home and was unavailable for a second interview.
15. Frank was a 57-year-old white man living with his wife and two children. He had taken early retirement due to illness. He was suffering from Coronary Heart Disease and diabetes. He was interviewed in his home and was unavailable for a second interview.
16. Robert was a 58-year-old white man, living with his wife. He had taken early retirement due to illness and was suffering with M.E. He was interviewed in his home and was unavailable for a second interview.
17. Shane was a 32-year-old white man who was living alone. He was unemployed and suffering from M.E. He was interviewed in his home and was unavailable for a second interview.

18. Adrian was a 33-year-old white man, living with his male partner. He was employed full time and suffering from M.E. He was interviewed in a room at Manchester Metropolitan University and was unavailable for a second interview.
19. David was a 60-year-old man who was living with his wife. He had taken early retirement due to illness and was suffering from Coronary Heart Disease. He was interviewed in his home and was unavailable for a second interview.
20. Paul was a 56-year-old white man living alone. He was unemployed and suffered from diverticulitis. He was interviewed in his home and was unavailable for a second interview.
21. Edmund was a 79-year-old white man who was living alone. He was retired and suffering from arthritis and asthma. He was interviewed in his home and was unavailable for a second interview.
22. Gary was a 52 year old white man, living with his wife and two children. He was working part time and suffered from epilepsy and hypertension. He was interviewed in his home and was unavailable for a second interview.
23. Jonathon was a 45-year-old man who was living alone. He was employed full time and suffering from diabetes and asthma. He was interviewed in a room at Manchester Metropolitan University and was unavailable for a second interview.
24. Donald was a 44-year-old man living alone. He was unemployed and suffering from M.E. He was interviewed in his own home and was unavailable for second interview.
25. Nicholas was a 75-year-old man who was living with his wife. He was retired and had suffered from Coronary Heart Disease. He was interviewed twice in his own home.



## **Conducting the Interviews**

### *Pilot Interviews*

I conducted two initial pilot interviews in order to ensure that the study design in its conceptual, ethical and practical elements was appropriate to meet the research aims whilst adhering to published guidelines (e.g. BPS, 2009). After briefing participants and gaining written consent I used conducted interviews based on the interview schedule I had adapted from McAdams. The most important practical change as a result of these interviews concerned the interview schedule itself. Aspects of the schedule, in particular the 'life chapters' approach was confusing to participants and did not work to enhance flow and rapport within the interviews. Participants found it difficult to summarise their experiences into 'life chapter headings' and considering the interview framework more I found this artifice to be unnecessary. Conceptually, the notion of thinking of life as a book could also tend to obscure the co-constructed nature of the interviews, since the interviews were not wholly self-authored by participants and this aspect is not acknowledged in McAdams exposition of the interview method. Consequently from further review of methodological literature I decided that a focus on 'key turning points' would be more useful in keeping the interview schedule in line with participants everyday ways of thinking and talking about their lives. I also wished to access issues related to aspects of social capital such as reciprocity, trust and norms in a more focussed way, and so adapted the interview schedule to encourage participants to discuss these in a temporal context. I retained the interest that McAdams displays in the 'nadir point', reframed within a participant's illness trajectory, as well as the interest in spiritual and political outlook.

I also created field notes immediately following the interviews. These were initially in the form of tape recorded observations, and were subsequently written up. The process consisted of outlining both practical and reflexive notes on the dynamics and success of the interviews, as well as commentary on key issues in the interview. These were useful in highlighting the issues noted above regarding the interview schedule and capturing the reflexive dynamics of

the interviews and also the meeting with participants prior to and immediately after recording of the interview began and ended at a point very close in time to the event. Further, it was sometimes quickly apparent to me that there were issues that called for follow-up questioning that had not been highlighted during the initial interview.

### *The Interview Schedule*

For the initial pilot interview with each participant I created an interview schedule adapted from McAdams' (1993) life history interview schedule (see appendix), further adapted following the piloting process. McAdams' interview protocol is designed to focus interview participants on the significant stories in their life development. It directs the interviewer to access both 'narrative-episodic' and 'semantic' knowledge (Flick, 2002) about participants' experiences and this interest was retained in the interview schedule following pilot interviews. The suggested questions ask for narratives (e.g. 'describe some of the key events in your life and the people involved') and also contain some concrete, pointed questions (e.g. 'do you have a particular political point of view?'). It is argued that the combination of these two types of data make accessible 'situative forms of experiential knowledge' (Flick, 2002, p.105). The interview schedule was adapted specifically to structure the interview in a way that accesses narrative life history accounts focussing on chronic illness in the context of social and community involvements.

As noted above whereas McAdams asks interviewees to think of their life as a book structured with named chapters, in practice this artifice was found somewhat confusing or difficult by the initial participants. From reviewing the literature I decided that a focus on 'key turning points' would be more useful in keeping the interview schedule in line with participants everyday ways of thinking and talking about their lives. I also wished to access issues related to aspects of social capital such as reciprocity, trust and norms in a more focussed way, and so adapted the interview schedule to encourage participants to discuss these in a temporal context. I retained the interest that McAdams displays in the 'nadir point', reframed within a participant's illness trajectory, as well as the interest in spiritual and political outlook.

Second interviews with participants were based upon both issues identified in the initial interview that were considered worthy of further follow up and developments in participants lives over the intervening period. These were therefore individualised rather than standardised in content to an extent for each participant.

### *Semi-Structured Interviews*

Semi-structured interviews are driven by the research aims of a study. The researcher guides this process firstly through an element of structuring the interviews by means of the predesigned interview schedule. The topics to be covered and an indication of the order in which they are addressed were indicated in the interview schedule for the current study. A further element of structuring or guiding is provided by the interview's spontaneously generated questions, probes and comments. As a guided conversation, a key feature of the semi-structured interview is the flexibility of approach nonetheless (Kvale, 1995) within the framework of interest in addressing the research aims

### **Narrative Analysis**

Narrative analysis methods also vary greatly, varying in the level of interpretation and structuring of materials engaged in by the researcher as well as the epistemological assumptions informing interpretation. In this study the nature of the research questions regarding social relatedness, illness experience and masculinities suggested pluralistic modes of interpretation would be appropriate to both represent men's lived experience and the meanings attached to such issues, as well as examination of underlying ideological formations or discourses that were identifiable in interview narratives. In addition the context of the interview as mode of narrative generation was examined to inform the analysis from the perspective of the co-construction of the interview narratives. I have broadly adhered to Murray's (2000) (see below) scheme for weaving together an analysis that encompasses personal, interpersonal, positional and societal levels of analysis. As a heuristic for thinking about multiperspectival analysis this was useful in the iterative

process of interpretation. I have also been informed by both work on narrative analyses from researchers working at each of these levels and other pluralistic approaches towards analysis (e.g.) which overlap somewhat with Murray's.

One element of structuring in analysis that required consideration was the role of thematising the interview materials. Both case study approaches that (often) present themes of experience in the narrative a successive individual participants, and thematic analysis approaches that compare and construct thematic categories across participants have been employed in interpreting narratives. The case study approach is useful for presenting a holistic interpretation of individual life stories, illustrating connections between strands of meaning through illness trajectories in a way that particularly values individual subjectivities. Flyvbjerg (2006) argues that case studies are an invaluable means of producing exemplars, which have been generally undervalued in the social sciences. Nonetheless both empirical research and theory has been advanced by cross-case analyses of chronically ill people. Whilst the cross-case approach may fragment the narratives of individuals, it has the advantage of highlighting commonalities and divergences (Ayres et al, 2003). Both approaches have been employed in the current study.

Discourse analysis, Grounded Theory, Thematic Analysis, and Interpretive Phenomenological Analysis amongst other qualitative approaches could all be considered in relation to the topics of study here, and there is a degree of overlap between some of these and Narrative Analysis. The person-centred nature of Narrative Analysis however allows well for a holistic case-study approach to understanding and description that forms a chapter of the analysis:

“..personal narrative encompasses long sections of talk – extended accounts of lives in context that develop over the course of single or multiple interviews.” Reissman (2009, p.1)

A cross-case analysis complements this to develop common themes emerging from interviews with a range of men of differing ages and backgrounds.

Narrative analysis is focussed more particularly on the process of analysing texts. The literature overviewing narrative analysis (e.g. Reissman, 2005) often points to early work by Labov (e.g. Labov, 1972, 1973; Labov and Waletzky, 1967) as originating narrative analysis. Labov's work was structuralist in orientation; an empirically-derived model of narrative structure formed a template that could be used to analyse narratives. The researcher identifies the elements of abstract, orientation, complicating action, evaluation, resolution and coda within texts. Such work highlighted the utility of narrative analysis for understanding the place of language in society (de Fina & Georgakopoulou, 2008).

Perceptions of the research interview and its uses, the identification and exploration of narrative genres, and interest in the linguistic features of narrative developed as researchers began to take a 'narrative turn' (Frost et al, 2010). Such work has offered a way to understand narratives and condense material within a given framework.

There is debate about the extent to which Labov sufficiently focussed on how the material within these categories should be understood as relating to lived experience.

Moreover in the subsequent development of Narrative Psychology the connections between narratives and the broader sociocultural context in which they are created have been explored in the light of postmodern/poststructuralist perspectives?).

Labov's work assumed relatively direct relationships between experience, cognition and representation; narratives are seen as descriptive of events in the past in a way that does not attend to the socially constructed nature of lived realities (Squire, 2005). Reissman (2008) critiques the decontextualizing nature of the results of a strict adherence to this approach. The Labovian approach may lead to a limited conception of interview-based narratives, through both filtering out dialogical aspects and more disorganised pieces of talk also.

The influence of a variety of realist or phenomenologically-influenced approaches has been marked in the field of narrative analysis Crossley (2000, 2007). In contrast to positivist research, the focus of such work is on understanding and 'thick description' (Geertz, 1972) of a person's lived experience. Subjectivity is privileged and the researcher attempts to faithfully describe and interpret the ways in which people experience and make create meaning through the life situations they encounter. Within psychology such a position has been connected to a social justice agenda:

Shifting the power base as phenomenology does to the participant and their narrative of lived experience allows individuals or groups to position themselves and to have their own story told, rather than having to be positioned as pathological or deviant by the stories told of them by professionals or researchers through various structural or theoretical frameworks.

(Bannister et al 2012, p.16)

A shift in focus, towards the constructive or co-constructive act of storytelling as identity performance, situated in sociocultural contexts has characterised the further development of narrative analysis (Frost et al, 2010). The structuring of peoples' subjective experience by language and other aspects of sociocultural context (e.g. politics) has not traditionally been addressed within phenomenologically oriented perspectives. The goal of retaining a focus on narratives of lived experience, whilst also making explicit the structuring role of discourse and practices has been highlighted by the work of numerous writers more recently (e.g. Crossley, 2000, 2003; Murray, 2000; Langdrige, 2007; Stephens, 2011).

Josselson (2004) similarly draws upon Ricoeur (1970, 1981) ideas to distinguish between two basic interpretive stances in narrative analysis.

In the 'hermeneutics of faith' or 'hermeneutics of restoration' there is a focus on subjective experiences of participants and their meaning-making. Researchers aim to 'give voice' to participants via such interpretation, linking to phenomenologically influenced work. Such analysis may involve re-ordering

meanings inherent in the interview materials, whilst staying close to evaluations offered by participants.

In the 'hermeneutics of suspicion' or 'hermeneutics of demystification' there is a focus on underlying psychosocial processes that are the foundation for interview narratives. The researcher recognises that certain discourses may be available and others unavailable to the narrator. In doing so there is a recontextualising or demystification of meanings by the researcher that may unmask the unsaid or unsayable. This may include analysis in terms of concepts such as social class, power dynamics or gendered experience that are not consciously recognised by the participant. Psychoanalytic perspectives on narrative similarly argue for underlying psychic realities which stories not only cannot fully express but which they may serve to mask or protect against (e.g. Holloway & Jefferson, 2000).

Josselson suggests that it may be beneficial to combine and integrate these stances to produce multi-perspectival analysis. Thomas (2008) illustrates well how material from her interviews with cancer patients could be useful from a realist perspective as providing insight into the ways that oncologists' actions are invested with meaning, and/or from a social constructionist perspective as exemplifying a range of discourses that demonstrate the exercise of regulatory power and other manifestations of bio-power (Foucault, 1973).

In keeping with a pluralist approach, Murray (2000) uses the levels of explanations suggested by Doise (1986) to characterise levels of narrative analysis according to their descriptions of personal, interpersonal, positional and ideological aspects of narrations.

Explanations at the personal level have dominated much work in narrative psychology, and reflect the abovementioned influence of the phenomenological approach. Analysis at the interpersonal level attempts to understand the ways in which narratives are constituted within particular social contexts, and recognises the ways in which these shape the stories told (Murray, 2000). Whilst attending to the immediate social contexts of participants, this approach alone still tends to ignore or even discount wider ideologies or discourses as

shaping peoples' accounts (Edley, 2001). Positional context refers to differences in social position between parties in conversation. As an extension to the interpersonal level it is intended to draw attention to the ways in which social position provokes or inhibits a particular style of narrative (Murray, 2000).

At an ideological level of analysis it is recognised that cultural assumptions and relations of power shape narratives as they are constructed in social interaction (Crossley, 2000). Participant narratives are therefore seen to reflect both political and social conditions. Bruner (1987) has illustrated how people draw upon narratives and life histories that are already present in their culture in shaping their own accounts.

Ideally, Murray argues, an analysis of narratives should attempt to integrate all of the levels of analysis. Indeed it has become common for narrative researchers to combine analytical methods in order to enrich a multi-layered analysis (Frost, 2011).

The multi-layered analysis of meaning envisaged here is appropriate to the research questions posed in the current study. On the one hand men's experiences of chronic illness, seen through gender-sensitive lens, require attention to lived experience encompassing the meanings men ascribe to chronic illness and social relations. Illness experience is grounded in the men's own voices, recognising the potentially marginalising impact of chronic illness, and countering the traditional dominance of medical, psychological, and political discourse. However it is also useful to understand how sociocultural discourses or 'public narratives' (Somers, 1994) around chronic illness and masculinities feature in men's accounts.

Narrative analysis method was used in analysing dyadic interview materials. The recorded interviews were first transcribed. At the initial phase of analysis short biographies of participants were drawn up, which included a chronological display of events identified as meaningful in the life history. In the second phase narratives presented within the interview transcripts were isolated and sequenced according to their relation with the chronological life history. A number readings of the material were then conducted, in keeping with the



'levels of narrative analysis' (Murray, 2000) or 'reflexive methodological' approach' (Alvesson and Skoldberg (2002). These writers acknowledge that analyses proceeding from single perspectives give only partial insights into phenomena under investigation, according with their ontological or epistemological underpinnings

Having developed an account for each participant that integrates these levels of analysis, the results were subjected to a contrastive analysis highlighting common themes or processes within participants' biographies. Divergent themes or processes were also presented as such. Such themes and processes are likely to touch on many of the aspects of lives that 'life course' perspectives (e.g. Giele and Elder, 2000) or biographical have identified as important.

#### *Case Study Analysis*

The participants for case study analysis were selected due to a combination of factors. Participants had been available for two interviews. Both interviews were particularly rich and characterful, whilst there was also a considerable degree of diversity between the two participants in terms of experiences and outlook relevant to the research questions. In addition, the case studies with Sean, a 61 year old man with M.E. and arthritis, and William, a 53 year old married man with colitis, dystonia and heart disease illustrate contrasting contexts in relation to health-related social capital (single/married, deprived/not deprived areas) and also in styles of masculinity.

#### *Cross-case Analysis*

The participants selected from cross-case analysis were similarly interviewed twice, and diverse in age, illnesses suffered and employment status. They were also representative of many of the key themes identified across the wider sample of participants.

#### **Reflexivity**

A reflexive approach to research recognises that the researcher is inherently a part of the process of data production and interpretation (Green & Thorogood, 2013). In contrast to the assumptions of positivist approaches within most qualitative interpretivist approaches there has been an emphasis on accounting for research subjectivity and making the researcher visible. As a number of writers have pointed out (e.g. Finlay, 2002; Green & Thorogood, 2013) there are a variety of approaches and concerns that have informed reflexive qualitative research.

In the current study I have recognised that I have navigated the research process experiencing and interpreting it from a particular perspective (Shaw, 2010) and have considered my role in generating and analysing the data by means of a reflexive analysis (see Chapter Eight). I have explored the ways in which who I am as a researcher, for instance encompassing my age, gender and health status, have shaped the interview process. Acknowledging and analysing the processes of co-construction in the research interviews also speaks to the interpersonal and positional levels of analysis in Murray's (2000) discussion of 'levels of narrative analysis'. I have also reflected on the political and social context to the research, both in considering how discourses may shape the interview narratives (for example, discourses around masculinity) but also on the origins and place of the research within a broader context.

## **Chapter Seven: Analysis and Discussion of Case Studies**

This chapter presents the analysis and discussion of in-depth case studies conducted in relation to two of the study participants. Here I have interpreted, discussed, and contextualised the experiences of two chronically ill men in holistic case studies. A cross-case approach to analysis and discussing is presented in the subsequent Chapter Eight.

The first case study concerns 'Sean', a 61 year old white man. He was not employed and in receipt of disability-related benefits. He was suffering from M.E., hypertension, and arthritis. He was single and living alone in a two bedroomed terraced house. His health had deteriorated quite considerably in the period between first and second interviews. He had little contact with family members but did retain friendships and some community involvement.

The second case study concerns 'William' a 53 year old white man. He suffered from colitis, Coronary Heart Disease and dystonia. He was identified himself as a 'househusband', being married and not having formal employment. He lived with his spouse (who was employed). He reported little change in his health between the two interviews. He was living in a two bedroom detached house. He maintained both family and friendships and also had some community involvement.

### **Case Study Number One - Sean**

Sean had lived in a terraced house in a built up area at the centre of Millvale, a small North Western town, for nine years at the time of interview. He had moved to the house, in an area rated high for multiple indices of deprivation, from a more affluent area when his business failed.

#### *From the world of health to the world of illness*

Sean, a 61 year old divorced man with no children, presents himself as a stoical, independent, and well educated man. He emphasises his earlier

success and career achievements in business (17-21; 35-40), marking the contrast between 'then' and 'now' as he does so:

Sean: I was studying accountancy which I found extremely boring so I went into sales and it was just like up and up, You know, I did well I was good at what I did... so I was always successful... every company I worked for I was top salesman...

Sean: I set a couple of real deals up... let's just say I made some money... champagne and jets...

After leaving the employment of international corporations and setting up his own business however, he then experienced it's failure during the financial crisis of the early 1990s. The events of 'Black Wednesday' in 1992 marked the beginning of financial difficulties (44-53).

Sean: I set up a brokerage in Ninety-two... two things happened that week, I broke my tib and fib... and that clown what's-his-name? that little fat bastard... chancellor of the exchequer...

Int: Lamont?

Sean: Yes he gambled with 25 billion pounds worth of our money... trying to beat the Germans and the French... so that virtually wiped out my insurance business and my mortgage brokerage..

This week became a major turning point in his life professionally and in terms of health, as he also had an accident whilst drunk from which recovery was unexpectedly prolonged, which was followed in succession by prostrate problems, and then the onset of M.E (54-66).

Sean: this accident which should have been six to eight weeks of a job actually took two years.. an infection set in.. it was a strep infection they couldn't do anything about it.. they tried antibiotics nothing worked so eventually after a year they took the metal out of me... just getting back in and I developed prostate problems... and it was pre-cancer cells actually.. never got to full blown cancer but I knew.. soon as I couldn't

pee and I wanted to pee I knew what the problem was .. so I went down and saw my doctor.. and eventually he got it.. and had the thing removed.. which was fine but.. just after coming out the hospital I developed M.E. so you know..

Sean's readiness and promptness in seeking help from his G.P. here is linked to his level of health knowledge and the potential seriousness of the condition. Diversity amongst men as a group in relation to help-seeking has recently been discussed (Farrimond, 2012; Galdas, 2010) in research seeking to dispel the overgeneralisation that men are reluctant to visit the doctor. As these authors note, men in differing social locations may be more or less likely to seek healthcare assistance. Farrimond (2012) found that for men of high Socioeconomic Status experiences of help-seeking were constructed in terms of being in control, problem-solving and taking responsibility. She notes a resonance between men's action-oriented reframing of help-seeking with the 'self-management' approaches increasingly valorised in Western healthcare systems. Galdas (2010) found that dominant South Asian ideals of masculinity framed help-seeking for CHD as an entirely appropriate behaviour for men, and this linked with patterns of talk about help-seeking that differed amongst his sample of South Asian and white participants.

Similarly older men may be more likely to see help-seeking more appropriate to their life stage than younger men, and those with serious conditions more likely to do so than those with symptoms which are perceived as minor.

Financial difficulties resulting from these events necessitated a move from a more affluent area to Millvale, an area rated high for multiple indices of deprivation. The move came after recovery from his accident, but prior to his treatment for prostate problems.

#### *Contradiction and ambiguity in evaluation of life story*

Despite the identifiable drama involved in this period, Sean's own evaluation locates a particularly important turning point in his life much earlier, to his move in employment away from the major corporation he joined in 1968 (26-27).

Sean: Anyway after that... and it started to go downhill...

Whilst there is description of continuing career achievements and financial success up until the 1990s, the descriptive metaphor 'downhill' is employed again later (353-367) later on in the interview. It is a theme that might be used to characterise this interview narrative as a whole, where a long (around thirty years), uneven, but ultimately negative trajectory from the early 1970's to the time of interview is related.

Int: I was interested in whether you could identify particular peaks and troughs during your life?

Sean: I've had a... couple of excellent times... but there's never been a peak you know... it's all downhill... cos you know... the troughs... I was fortunate... I had a beautiful young woman... I married her when she was 16... she was about 16 going on 30... very bright girl... erm and we had an excellent 23 years together... and then it went downhill but that's probably my fault... erm... nah there's been so many... sat on that yacht in Majorca... there... that photo [pointing to photo of self on yacht with attractive young woman]... that's Sue... erm... every day has been Christmas... apart from the bad things [laughs]...

It seemed to Sean that had he stayed in the relatively secure employment of this international corporation, events much later such as the business failure would not have happened. Domestically the breakup of his marriage is an area of regret for which he holds himself responsible (although he did not go in to detail about these events). Relevant to his evaluation is the fact that he does not imagine that in the future he will experience positive changes (411).

Sean: there isn't a future... I shall continue and die...

Notwithstanding that assessment, contradiction and ambiguity are evident as Sean (492-497) reviews life in the 1960s as a young man and maintains that he continues to have a positive outlook on his life.

Sean: suddenly the sixties... it was a whole new scene... there was money around... people could buy nice clothes... could buy cars... go out to restaurants and I was in my twenties then so I had er... an excellent time... and I've never ever stopped having an excellent time..

The incongruity here relates to what is almost a parallel narrative where the focus is on internal, psychological life as opposed to life circumstances; through engaging with the trajectory of his life circumstances by means of acceptance and stoicism he claims to have 'never stopped having an excellent time' (496). Sean's assertion here may be interpreted firstly as a form of coping; the narrative has a personal function (e.g. Murray, 2000) in that one tells oneself and others that one's experience is positive, in order to make it become so, reframing difficult circumstances in accordance with available cultural scripts (narrative salvage), bringing order to and taking control over the situation. In doing so he divorces his emotional life from his material circumstances. Simultaneously it may be seen as a self-presentation to the interviewer that is in accordance with cultural scripts prescribing positivity (see Held, 2002) in the face of difficult circumstances. There is a vulnerability inherent in relating long term unhappiness at life circumstances in a culture permeated with exhortations to 'be positive', to the extent that non-conformity may well result in negative, internal attributions regarding the unhappy person. Hollway & Jefferson's (2000) ideas about anxious defended subjectivity inform this interpretation. Such an understanding does not necessarily imply that Sean does not believe what he is saying at this point, but acknowledges the multivocality in his account and its attendant contradictions.

One can see Sean then as actively in the process of identity construction, whilst striving to avoid getting caught up in negative feelings and thoughts, both self-evaluations and anticipated evaluations of others. A major theme of the interview narrative as a whole then concerns the successful negotiation of adverse life circumstances. As there is little prospect of positive change in his circumstances, success for Sean in this respect means the successful regulation of his inner world of feelings and thoughts. Sean's claim to having an excellent time may be seen not as a state of affairs that is settled or given, but that as worked up in talk.

### *Co-constructing masculinities in the interview*

Sean's account (594-607) of the accident that marked the beginning of his period of ill health exemplifies well the process of co-construction of masculinity during the interview process.

Sean: I've had all the bits that a man could really want... erm... the bits that went wrong... even during the accidents... the illness. You know... I've still no regrets... I could have done... I should have done things different... when I broke me tib and fucking fib I was chasing two Polish birds... over to the bleeding car park inviting them back to my place to abuse their bodies [laughs].... So you know I can't blame anyone for that... I didn't even see the [inaudible] whose car park I was on... my fault... eleven o'clock at night... I'd been on the piss with some mates... I'd seen these two Polish girls... I'm not gonna whinge about it... I think one has to be responsible for his actions... you know and that's just my philosophy...

Briefly mentioned during his initial outline of key events in his life story, Sean returns to pick up on his earlier report of the accident near the end of the interview, in the context of summing up his life, and in particular (without interviewer prompting) his own focus on issues of responsibility. The colloquial, pejorative language is regarded as appropriate and acceptable in the context of the interview, and together with the narrative enactment of aggressively heterosexual manhood Sean clearly identifies himself with hegemonic ideals. There is a jovial state of masculinist rapport being reproduced here, common to many men's talk around drinking and women (Coates, 2005). Indeed one may regard this small story as canonical in relating to dominant ideals around British heterosexual masculinity, and its employment in summing up his life as a whole as an enactment of that.

The laughter at this point in the interview reflects Sean's call to shared assumptions about and experiences of this sort of episode. He seems to assume that the interviewer, being also a man, will accept and identify with the



content and objectifying language regarding women. The co-construction of masculinity here therefore implicates the interviewer, who appears to be in good health, is married and employed. It raised an ethical question about how to respond, and whether his narrative should be challenged.

As noted above (see methodology) the setting and purpose of the interview were considered to militate against such action. It is interesting in terms of self-presentation that Sean's account does not seem to conform to the idea that interviewees aim to present themselves in a positive light. However this may reflect differences between the interviewee and interviewer in socio-political outlook, i.e. in Sean's limited social network such utterances may not be seen as unacceptable in talk between men.

Responsibility for the accident was clearly accepted by Sean, but this did not seem to impinge on his status as a moral being or as a man. In fact, whereas illness has associations with weakness and vulnerability, an account of this type of incident may be an enactment of claims to hegemonic masculinity entailing esteem and prestige (Courtenay, 2000). Given the constraints placed upon his social and sexual life by illness, in relating this incident the past is brought into the present so as to authenticate his identity performance. The narrative can also be related to moral discourse around health and social welfare. Neoliberal healthist ideologies frame the individual as morally responsible for reducing risky or detrimental health-related behaviour, and for the health consequences where this course is not followed. Whilst Sean may accept this his talk here can be seen in relation to the way that "...risky behaviours constitute a symbolic rebellion against dominant social and cultural values." (Crossley, 2000, p. 48). There is a tension between healthist ideology and dominant ideals of masculinity that may be resolved by reframing or adopting a rebellious position towards healthism that itself reinforces masculinity ideals.

The juxtaposition of simultaneous business failure and the start of health problems can be seen to have instigated biographical disruption (e.g. Bury, 1982). Recovery from his accident was unexpectedly drawn out after infection set in, and following this Sean developed prostate problems necessitating

treatment, and then M.E. Sean's financial and material circumstances deteriorated, so that his demonstration of emotional resilience.

*'Exiled round here': rejection of perceived norms and values characterising the local community*

Shortly after treatment was successfully completed, Sean downsized, moving from Roseacre to Millvale. The forced nature of the move as a consequence of changed financial circumstances is apparent in the choice of metaphors used to describe it; he describes himself as being 'exiled round here' (321) or 'shipped into here' (338). Both the move and the place hold negative meanings for him. The move is described in terms of the loss of his old, more commodious home, and the negative characteristics of the less prestigious area of Millvale and its people (329-351).

Int: This local area... erm... since you moved here... have you... d'you feel rooted here?

Sean: Nah... I hate the people... they're peasants... that's alright though... I mean don't get me wrong there's some lovely people.. like Tom and Leslie next door... there again they're old people.... But they're really nice people... I've known Tom for thirty years... cos he's a member of the local Conservative club... which I was... so we met down there... and suddenly I'm shipped into here... I didn't know they were next door.. but no they're super... but most of the... the herd... all that crap coming down from the [North West city] council estates... as they did with [another City]... they see these small towns... they degenerate because of the crap they fire into them.. so at one time you know we had the highest murder rates per capita in the country... but that generation is sort of dying off but there's some just come around... I mean I'd much rather live down on the West coast... where I could just sort of take me fishing rod out and catch tea... I mean the way I feel... the state I'm in though... it doesn't really matter...

The language used to describe people in his local community is pejorative, and Sean implies that he is of a higher social status than most in the area. In the

language of social capital, the 'generalised other' (e.g. Putnam, 2000) consists largely of incomers who are responsible for the degeneration of local community. Sean's description of high levels of violent crime imply little trust in the 'generalised other, whilst community norms at this level are not conducive to him feeling that he belongs, aside from belonging to the local Conservative club. As Forrest and Kearns (2001, p.2140) write 'belonging to the place and it's people' is a key indicator of neighbourhood social capital, but Sean actively rejects belonging.

Sean's move to Millvale was partially a result of macroeconomic circumstances, however there is no sense of solidarity in the face of broader societal conditions that are responsible for the nature of local community. His account here (re)produces difference and the 'othering' of deprived community members and to this extent it may be said that neoliberal, individualistic discourse permeates and shapes his understanding/account at this point.

The ideas fit with the 'victim-blaming' account of social capital as being low in deprived communities due to the shortcomings of the communities themselves. In Sean's account here he is able to construct a positive identity for himself, via differentiating himself from 'the herd' of other community members. This might be related to a process of avoiding negative self- and indeed interviewer-evaluations in light of his presence in a community vulnerable to stigmatisation. As Forrest & Kearns (2001, p.2130) argue: 'Who and what we are surrounded by in a specific locality may also contribute in important ways to both choice and constraint and, less tangibly and more indirectly, to notions of well-being and social worth.'

The point emphasises how in talking about issues pertinent to community social capital in a deprived area, a community member can be seen to be not only giving a factual account, but an account that is inevitably bound up with the dialogic construction of self. Attention to interpersonal and performative levels of analysis here usefully facilitates an interpretation that often goes unacknowledged in qualitative work on the topic taking an unambiguously realist, phenomenologically oriented approach.

*'It's a women's illness': gender identity and M.E.*

After subsequent prostate problems were treated, he very quickly began to suffer the symptoms of M.E. The symptoms impacted immediately with great severity (132-146).

Int: Was it a gradual decrease in your social life?

Sean: Well look you see... I'm just trying to think back to '96 when it started... erm.. no it's very severe onset... because the onset of M.E. was very severe... you know it wasn't something that crept up on me... I came out of hospital after a prostate operation and within a couple of days I was lying up in bed shagged out... erm... so people didn't see me... so people were quite... you know... where's Sean? What's he up to? oh he's not well, he's in bed so it went on and on and as people began to know and people realized what the illness was.. and you know it's a women's illness... they all think it's a depressive illness.... I'm feeling down... and it's not it's a debilitating... tiring illness...

Becoming ill with M.E. meant significant change in patterns of social relatedness for Sean. These were apparent from the very beginning of his time with M.E, when his associates became aware that he was largely confined in bed. The brief narrative above then illustrates at the personal level Sean's perceptions of circumstances in his social milieu at the time of his withdrawal. It exemplifies the reassuring concern of friends and embeddedness in social networks. Simultaneously this brief narrative works at other levels; with a storied answer, Sean provides evidence, including the witness of others, that the impact of M.E. was sudden and severe. It is an account constructed in the context of others too, speaking of the misperceptions of friends in a way that attempts to define the nature of the illness as not being related to depression. Sean (re)produces the cultural commonplace of the excessively emotional woman (Emmons, 2008, p.111) in order to firmly reject it's application to himself, an instance of gendered identity work

The following elaboration on the topic of 'a women's illness' sees Sean referring back to his stoical handling of previous negative life events. Again this may be

interpreted in terms of masculinity construction, and also warranting (Edwards & Potter, 1992) of his capacity for the kind of response he describes. The stoical masculine self that is constructed here in the present of the interview has coherence over time and place, calling upon an essentialist discursive framework to instantiate personality or character. Sixsmith & Griffiths (2003) have previously examined very similar instances of men's health talk where this sort of logic is employed to privilege the rational and de-emphasise the power of emotion to hijack a person's experience during a time of crisis. There are a specific set of meanings to being a man that are available to be employed in illness narratives, in order to counter identity threats.

Sean describes having spent (for around seven years up to the point of first interview) most of his time at home in bed, fatigued, maintaining little face-to-face social contact. Being divorced (no children) and largely lacking family contact, his isolation is relieved somewhat by communication with neighbours and friends. There is great disparity between Sean's social life prior to and subsequent to the onset of M.E. (103-114).

Int: Perhaps you could tell me a little bit more about how your social life and social networks have changed?

Sean: Well they've gone now I think... I used to be a socialiser... always a party animal... champagne, yachts, jaguars...erm... I've probably got... one. Two.. two of the old gang I still speak to... and that's only by phone... and it's normally my fault that I put them off... they wanna come across and see me... one lives in Harbury [town in North-West] the other lives in [city in North West]... it's... I'm normally too knackered to want people in...

In contrast to the negative meaning of the generalised other of Millvale, Sean's description of concrete relationships with certain other local community members such as his neighbours Tom and Leslie is much more positive (548-555).

Int: and have you had people trying to erm emotionally support you?

Sean: Oh yes... it's been offered... erm... it's been offered... and... grateful for it...

Int: Can you tell me about a specific time?

Sean: Well not really no... because I can't think of one... erm... next door... they do my shopping for me... it's stuff that's fairly expensive round here... like coffee... erm... dried milk.... eggs... erm... some of the tinned stuff... Tom and Leslie always go down to Aldi... erm... once a fortnight... and they do a shop for me and it saves me a whole lot of dosh... I get that sort of support... which is physical... but I don't need emotional support... I don't need a shoulder to cry on...

Sean values their help, but draws a distinction however between practical and emotional support. Whereas the former is appreciated the latter has connotations of emotional dependency and need that are unacceptable to him. Whilst his relationship with Tom and Leslie is fairly superficial, their willingness to offer this practical assistance is disproportionately important to the strength of the tie (e.g. Grannovetter, 1985), in terms of Sean being able to maintain his independence.

Sean goes further in denying altogether his capacity for emotion (Interview 1; 515-534).

Int: Perhaps then... going back to your health... can you tell me about what support you've had from other people?

Sean: In what way? Emotionally... don't need it I don't have emotions.

Int: hhhhmm

Sean: I'm serious about that... I'm what you would probably call a sociopath... I don't have any depth of feeling...

Int: Right...

Sean: I don't wanna kill anyone you know... I'm not a psychopath but I probably am a sociopath... I don't have any depth of feeling so I don't need any emotional support... I've always looked after me.. apart from those that you need like doctors dentists greengrocers erm... people that provide our infrastructure... but no... I've had no support cos I haven't wanted any.

Sean picks up on the interviewer's sceptical response here as representing a rejection of his identity construction work, or initial 'identity bid'. His more extreme formulation using the pathologising concept of the 'sociopath' reinforces his claim to non-emotionality, and this is not challenged further during the interview. Notwithstanding the possibility that Sean is somehow lacking in emotion, notions of vulnerability and masculinity can be employed to contextualise his assertion. Denial of emotion may serve to inoculate against admittance of vulnerability on the topic of relationships, pertinent here for a (heterosexual) man who has few intimates and does not foresee any possibility of more close and caring relationships than those he has at present (Interview 1; 426-431).

Sean: you can get to an age where you've done all the bits and enjoyed all the bits... but you realize that... it ain't gonna change... you know come in with a bird... get her ratted on champagne... and find your dick doesn't work cos you're getting' old... my marriage like any relationship it run it's course...

The status of the interviewer – known by Sean to be married – brings a further layer of relationship-related context to this segment of the interview. A normative masculinity script involves intimate heterosexual relations, and a man's emplacement in a partnership is a powerful identity anchor and symbolic of social esteem. Sean does not share in this canonical storyline, but in shaping a narrative via such a strong identification with hegemonic discourses of masculinity that privilege the rational over the emotional, he is accounting for himself in a credible and socially recognisable way. As Beech (2008, p.65) observes, in the dialogic construction of identity, the consequences of a speaker's intended identity construction:

'...are mediated by the strength and pliability of contextual discourses and by the reinterpreted work of those who receive the utterances.'

The non-emotionality that is an ideal aspect of hegemonic masculinity in this case serves as a strong contextual discourse in the co-construction of Sean's identity during the interview. The analysis here supports Coles' (2008) argument regarding 'mosaic masculinities'; one of the ways in which men who are unable to fully live up to hegemonic ideals of masculinity negotiate masculinities in everyday lived experience is to draw upon particular elements of hegemonic masculinity that they are able to bring off. By drawing attention to particular identity constructions that conform with hegemonic masculinity whilst rejecting or ignoring others, men reformulate dominant masculinities, albeit in a way that is always open to contestation. It's interesting also to consider the positive utility of this discourse for Sean's wellbeing. Hegemonic masculinity discourses are generally negatively associated with men's wellbeing in the literature (Gough, 2007), but the co-construction of this version of Sean here seems to allow for both intra- and inter-personal resilience in the face of circumstances that seem immutable.

Sean has maintained few other relationships with local people in the Millvale area. He does have a friendship with an older man, Jack, which developed through the shared, traditionally masculine pursuits of regular attendance at licensed premises, conversing at the bar about football and horse racing (Interview 1, 320-328).

Sean: When I was first exiled round here we became drinking buddies... so I'd go to the bar and he's be at the bar and we just got talking about football... racing and... as you do you know when you're drinking... and then it was a case of you know... pop round for a drink... sit outside in the summer.. just developed like that that you know... naturally... he's ok yeah... he's not a bad lad...

The scope of their conversations after ten years still reflects these sorts of interests that they have in common (Interview 2, 200-203).

Sean: Well we normally talk about football... erm racing... the odd whinge about the odd politician... erm and that's about it... you know we don't live in each others' pocket...



The friendship offers Sean easy going and emotionally undemanding conversation where the habitual topics are fairly clearly marked as being within the domain of 'blokey talk' and usually take place over a drink. There is an ongoing mutual construction of masculine identities based around these sorts of topics and activity. As Jack is older than Sean, retired, and also has health problems, status differences based on current employment don't figure in the relationship. There is an element of mutual functional limitations that both recognise in their talk, however this is only obliquely referred to with more extensive talk about poor health seeming to have negative connotations (Int 2: 168-175).

Int: Oh right... so that's quite along friendship then... do you talk to him about erm the ME?

Sean: No... Christ no we don't bother each other... he comes in and he can't walk cos his knees are hurting... and I just say 'I'm fucked'... and we have a glass of whiskey...

Int: Yeah

Sean: No we're not whingers...

The implication of 'bothering' each other and 'whinging' reflects an aspect of hegemonic masculinity that can be performed by both men, and by Sean in the interview. In the construction of stoical masculine selves, dominant masculinity is reformulated to mean that reference to health problems is closed off from talk about feelings about them, and calls to sympathy or emotional support are problematised. It is the prescriptive nature of the enactment of this ideal that subordinates other masculinities and femininities, which come to be defined pejoratively. Sean refers to images of older people who have become isolated and in poor health when discussing talking about illness with an older person such as Jack (Interview 2, 187-189).

You know you see the old girls sitting in front of the fire burning their legs surrounded by their medicines... watching daytime television you know...

It draws upon discourses around aged femininity, preoccupation with poor health, and powerlessness in the face of the body's deterioration. The same imagery had also been employed in the first interview when he was asked about the prospect of getting welfare support to employ a carer (Interview 1, 581-589).

Int: Maybe in the future you could get attendance allowance?

Sean: Well if it gets to that stage I'm off... I'm not gonna hang round watching daytime television surrounded by my medicine... with the gas fire burning me legs.. like these old folks... ain't gonna happen... it'll be crushed tablets... bottle of scotch... some very loud Beethoven... you know.... off...

The imagery is used in constructing what would be to him an unacceptable diminution in his quality of life, at which point he would exert himself in a final act of will the power to end his life. (

At the time of the second interview ongoing meetings had been disrupted due to Jack's illness (Interview 2, 159-165).

Int: Last time you were talking about the chap who got you involved in [local community group]... can you tell me a bit more about him?

Sean: Yeah he's in Hallfields isolation ward with TB at the moment... he's being tested for TB.. ah but he's getting' past it now... what is he 78... whether we'll see each other again I don't know...

The developing friendship led to Sean becoming treasurer for a local community group, for which Jack is the chairman, although Sean's participation is limited to bookkeeping and he does not attend meetings. He took on the role in order to help his friend out, and he sees it in terms of participating in this friendship rather than the wider community (Interview 1, 313-319).

Int: Is that something you've had a long history of involvement with?

Sean: No... talking to Jack... yeah he's 76... he's secretary of [the local community group] and as he gets older he gets tired... so I've just taken some of the responsibility away from him... if it wasn't for him I wouldn't

be involved... in fact when he decides to get out it'll probably fold round here...

Indeed Sean is at pains to stress that his involvement should not be taken to mean that he is interested in involvement with the wider community (Interview 1, 281-289).

Sean: I do the books... I'm treasurer of [local community group] I'm not a meeting attendee... I don't like attending meetings... I've always been a... well let's put it this way I'm not a team player... I'm a loner... 'cos team players are sheep... so no erm... I'm not really interested in what goes on around here... if they wanna fuck their lives up that's up to them... because that's the way the world is... as long as they leave me alone I'll leave them alone...

Nonetheless he plays a role in keeping the group going and contributes to the community in this sense. Sean is trusted to do the book-keeping and through it demonstrates his technical competence in this area, reflecting his accountancy training and linking to professional dominance or technocratic forms of masculinity (Cheng, 1996). His friendship with Jack contributes to positive self-identity construction, enabling him to see himself as being useful and valued. Sean has assisted the older man with plumbing and electrical problems in the past, and was intending at the time of the first interview to make a visit to his house to help set up some new televisual equipment. Jack reciprocates with gifts of bottles of Scotch as well as regular visits and ongoing contact. He also extends yearly invitations for Sean to go over to his and his wife's house for Christmas dinner, although these are not taken up (Interview 2, 221-225).

Sean: Right... invites me over for Christmas dinner which I refuse every year... I can't do with all that sitting around you know and silly hat business... .. ffff... having fun... [interviewer laughs]

This possibly relates to the different norms of conversation and activity in the context of Jack's wife also being there (234-236).

Int: So d'you go for the odd meal with him and his wife...

Sean: No... I used to yeah... but as I say I'm not a sat round the table type... making polite conversation...

Int: So you... what sit and have a drink?

Sean: Yeah we'll have a Scotch... have a natter you know...

In light of the difference in relationship status between them, Sean is perhaps more comfortable in the masculinised context of one-to-one conversation with Jack. This illustrates how one doesn't just have an exclusive relationship with one person often, it's in the context of their and your other relationships. Norms in the relationship are clearly masculine and perhaps reflect older styles of masculinity common to men of an earlier age.

Sean is in contact with two old friends out of town. Contact is maintained via telephone calls and, less frequently, visits to his home (I1, 106-119).

Sean: ... I've probably got... one... two.. two of the old gang I still speak to... and that's only by phone... and it's normally my fault that I put them off... they wanna come across and see me... one lives in Harbury [town in North-West] the other lives in [city in North West]... it's... I'm normally too knackered to want people in... because we're making a lot of meaningless conversation and I'm just too shagged out... too tired to want to get involved

Int: physical limitations...

Sean: It's physical and mental... they know... they understand I mean I've told them you know the lie of the land they understand the illness... so they're not offended when I say "look no don't bother today"...

It's particularly important to him that these friends understand and do not seem to take offence when he rejects or cancels arrangements to visit him at home. Being able to maintain the friendships whilst regulating visits in this way is important to him as he cannot cope with the demands a visit places on him when he is highly fatigued. One can see him as drawing upon social capital built

up over the history of these relationships prior to him becoming ill here, in that the visits are one-sided and offers to visit are repeatedly made in spite of being rebuffed when fatigue is overwhelming.

He has known his friend Steve for around 35 years, since they both worked together for a large international corporation. They both lived in Rosacre at overlapping times, although Steve moved on to a very well-to-do village prior to divorcing and moving to Finbury, an upmarket suburb of a large North West city where he currently lives having remarried. Sean hasn't visited him in Finbury for around five years, but enjoys Steve's visits for the intellectual rapport they share, displayed (as with Jack) over 'a couple of scotches' (I2, 282-293).

Sean: No... we both have... a similar intellect... and we understand neutrinos and we understand the cosmos... we understand all the things that people talk about when they've had a couple of scotches! [laughter]

Int: You have wide ranging er... conversations... over a couple of scotches

Sean: We both enjoy similar books... cos I can't get to the library now... he does a lot of traveling... and he gets airport books... but they're always serious ones... so when he's finished with them he'll bring 'em home for me...

In this friendship Sean has the opportunity to go beyond the prosaic conversational topics covered with Jack. The cultural capital developed via his higher education background and love of reading can be called upon here in the construction of identity, and so their divergent courses in terms of relationship and health status may constrain but do not end their ongoing friendship. There is a mutual trust and reciprocity also between them, as evidenced by Sean using his credit cards to lend Steve thousands of pounds (I2, 257-267).

Sean: Steve used to be very wealthy... private plane... Jaguar... all the bits... well he's fallen on hard times... erm... cos of the tax man actually... spirited a lot of money away... and as usual they get you... so I've lent him... what... three and a half grand on my cards... not to pay his tax cos his tax is... like fifty grand... but just for the... he couldn't really show income while

he was being investigated... otherwise they'd want some of that... so I just got some money on my cards... let him have it.. and he's paying me back bit by bit...

Steve in turn brings Sean books that he might not otherwise be able to access himself. This is an important contribution to Sean's quality of life given that he spends most of his time in bed with books, TV and music dominating his everyday activities. As with Jack, illness is not a major conversation topic (294-307), although the symptoms have been discussed somewhat.

Int: Right... and he understands about the M.E. and everything... how you are?

Sean: Yeah...

It: Is that... you've just told him over the years how you are...

Sean: No... he says 'how are you' and I say 'fucked'... he'll say 'why?' and I'll tell him... I'll say how are you and he'll say

Int: So you go into some detail then about it?

Sean: No.. only how it affects me... that it makes me very tired... and all I want to do is sleep a lot of the time... and the aches and pains it gives me... but you know it's not a... a major topic of conversation...

There is a sense that both men share in facing adversity, Sean because of his health problems and Steve because of his tax debt. Sean has less contact with Ray, his other friend, again from his days with the large international corporation. Ray has a successful business and has become very wealthy.

Int: Ray comes here?

Sean: Yeah... only two or three times a year... he's up and down the country most of the week and he's too knackered at weekends to wanna travel over here... I've told him that... I've said 'look... don't bother'... you know... 'when you're up to it fine... but don't er...'... mind you he's a [football team] supporter as well with a season ticket so you don't.... tied up every other Saturday...

Int: Right... and is it similar to when Steve from Finsbury comes round you know sit and...

Sean: No... we only talk football Ray and I...

Int: Er... similar in terms of he understands... he knows about your M.E.?...

Sean: Yeah...

Int: Ok....

Sean: As I say we don't make a big deal of it you know...

Int: No... no...

Sean: We've always looked at it this way... shit happens... er it's happened to Ray.... Financially... it's happened to Steve financially... in ninety-two when... you know... the market collapsed... erm... it happened to me... that's when I lost everything... but we've all made comebacks in our own little way... Ray made it in a bigger way... erm... I've got... the things my health will allow me to need at the moment...

Their conversation is more limited in scope than with Steve, but again there is a sense of shared encounters with adversity, as Ray has also had financial difficulty in the past, which seems to contribute to a meaningful or worthwhile friendship here. Mutual experience of adversity and also the sense that all in their own way have 'made comebacks' is interesting as a common thread in Sean's talk about these friendships. For Sean the comeback is in terms of his coping through acceptance and stoicism and ability to maintain an acceptable quality of life and independence. As men who have undergone adversity themselves perhaps this informs his friends' understanding and maintenance of the friendship.

Although he socialised a lot before his illness he has always seen himself as independent, even something of a loner – an identity position based upon non-conformism, but rather emphasising independence of thought and action was being constructed here.

Sean also described having only very limited contact with family members, being estranged from all but one of his siblings. He counts his ex-wife also, who lives abroad, as a good friend.

Although Sean has since developed a number of co-morbid conditions (such as hypertension and osteo-arthritis) M.E. is overriding in it's importance, and colours his whole experience of living (67-78).

Sean: I've developed other.. you know... diseases of the month... [phone rings – Sean has short conversation – break in tape] we're up to now.. erm M.E. you're a student... or have been... Friday night out with the lads... Saturday morning you wake up and you feel shite.. hangover... that's as good as I ever feel.. now... long weekend house party... starting Friday Saturday Sunday... wake up Monday morning... and you're fit for nothing apart from death... that's as bad as it gets... so most of the time I survive in between those two extremes.. but never feel good... erm... well not as good as I used to you know...

The experience stands in contrast to conditions where the symptoms become noticeable less frequently. The onset of further conditions then may be seen in relation to the concept of 'biographical flow'. Succeeding illnesses follow in what seems to Sean an irredeemably changed context in his health and social locations. The focus previously in work on biographical flow or disruption has been on how the concepts may apply differentially across cases depending on a person's life context. Close attention as here to a life story indicates the way in which both concepts may be applicable at different points in the same case, or life story (journal article here?). Given a very debilitating illness, onset of subsequent less debilitating illnesses may be more likely to be received with a degree of equanimity reflecting the relativity of their impact upon the lifeworld of the person. Sean's account of the onset of comorbid conditions is marked by black humour.

### *Presenting ME in the present*

Health and moral identity are increasingly intertwined as lifestyle illnesses become leading causes of morbidity, and neo-liberal governments make welfare support for the chronically ill increasingly conditional and subject to surveillance. In the case of M.E. the status of the illness has also historically been disputed amongst medical professionals, whilst mass media corporations have given the



condition sceptical coverage, simplifying and picking up on the negativity of some medical professionals. Lay discourse on the condition not uncommonly reflects this, creating a context in which a person with M.E. may be on the defensive. Sean's account of earlier success in employment is a resource that may be deployed to inoculate against negative associations about an M.E. sufferer, in a context where it's status as a 'real' illness condition has been debated across the medical and public/media realms.

(17-21; 35-40)

so I went into sales... and it was just like up and up, You know, I did well I was good at what I did... So I was always successful... Every company I worked for I was top salesman

I set a couple of real deals up, let's just say I made some money Champagne and jets Then I had to go back into the mainstream And I went to work for the government I was running a community programme I was the general manager It worked very well It worked well I set up my own insurance brokerage

The debated status, in addition to the stigma often attached to persons claiming benefits and not working, has made M.E. sufferers particularly vulnerable to accusations of 'malingering'. In asserting his background as an entrepreneur and high-achiever, Sean was perhaps defending against identity threats, and challenging any assumptions the interviewer may hold regarding persons with the illness. For instance it was clear that then both interviewer and participant should proceed in the knowledge that Sean is not unemployed and isolated in bed because of idleness or lack of ability. Given his own right wing opinions and deprecation of other disadvantaged community members during the interview some consciousness of his own position in relation to the broader context of societal discourse around the position of people with long term illness/unemployment cannot have escaped him.

One can also relate this to ideas about narrative reconstruction, where the past serves as a building block for the development of the reconstructed life. Thus one can identify in this narrative the intertwining of moral and gender identity

claims, and their relation to a wider social context of ideologies around health, illness, economic activity, and gender.

The second case study reports on William, an exemplar of a differing style of masculinity presentation.

## Case Study Number Two - William

William was a 53 year old married man with no children. He has no memory of life events prior to the age of around 10-11, but does recount memories based on what family members tell him.

### *Lost memories of childhood*

A notable feature of William's account is that he reports being unable to remember anything about his childhood until around the age of 11, and can only recall his sister's accounts of his life up to that point. He was unable to explain the reasons for this but cites his sisters' recollections are that he had a happy childhood up to that point, and it is these that he largely draws upon in discussing his childhood. Later on in the interview he discusses the very negative feelings he has about his childhood however, encompassing feelings of resentment and anger towards his parents for having him (204-243).

William: Erm, I think I, I can't, I think it's erm, around ten, eleven that I start to, I've got memories erm of actual events and things, I can remember being very very very lonely and isolated actually because round the time that I, I was at grammar school and I was really miserable and I remember that er when I was 15 my sister, the middle sister who's older than me got married and left home and my other sister Sue went to university so all this happened more or less around the same sort of year or so and it was like I was abandoned because my Mum was ill then, she actually, she was put into hospital and, they obviously did know, but I didn't, I knew she was ill and it was a bloody awful time, it was, from that sort of age so I can remember all that stuff and looking at, we've got photographs, old photographs as a family in places like Southport and Blackpool and we seem to be OK and I've got , like, school photographs and I've got a smile on me face I looked just like, you know, any sort of normal lad but I don't remember, I can't feel it, I can't feel any sort of warmth, happiness all I can feel is, I feel all

sorts of things like resentment and anger towards me parents as well actually, that really, I wish they hadn't had me a lot of the time, I do, cos I don't think they could afford me, cos when June and Sue were growing up, me Dad was an engineer and I think, you know he was doing quite well he worked nights and he was earning, he had lots of overtime and stuff like that I think, relatively well off, but later on er I think engineering started to go into decline, he job meant he wasn't bringing as much money home, we were in a lot of debt, they used to HP debt, loads of debts, erm, and I feel, I used to always feel hungry all the time, I don't know whether lads do feel that, but I wonder if I was actually ill then because one of the symptoms I get when I've got colitis is that I feel that I've got to eat all the time you know, cos I'm not like absorbing the nutrients properly.

This relates to the context of debt and poverty in which the family lived, and the feeling that they consequently should not have had a child that they could not afford. The loss of memory for this early period is not complete, and he does have some vague memories of being taken to hospital as a child. In addition to positioning William as a sufferer of adversity, the narrative locates temporally where early symptoms of colitis might have begun to colour his experience. William is retrospectively ascribing ill-related meaning to this period of his life perhaps in a quest to better understand and explain it's place in his lifecourse.

*"That's when I think things started to go wrong"*

He locates an important turning point in his life to the time of his transfer to a grammar school where he had both bad experiences with the teachers and the subjects he studied after being placed in stream for high academic ability were not enjoyable to him (17-33).

William: I think me and me two sisters were looked on as being like really nice kids, we grew up on a council estate and there was a lot of poverty really, er and I think we were brung up quite well like and the teachers liked us and it was nice but then that school closed down because I think they ran out of money and we, well me two

sister's went to grammar school and I went to another junior school for one year until I did the eleven plus and then that's when I think things started to go wrong because erm I think, I was quite bright and I went into an express stream which was purely an academic sort of, all the subjects were academic so we dropped things like woodwork and art and things like that and I hated it, I absolutely hated it, I was frightened of the teachers, they were bullies and anyway I was there until I was sixteen and I couldn't wait to get out

He reports remembering being 'very very very lonely and isolated' during his secondary school years (206-207), feelings which were exacerbated when his older sisters left the family home, and his mother spent time in hospital.

Subsequent to this episode being recounted he narrates his life story largely using his working life and different occupational positions to structure the account. He describes having moved between different fields and being dissatisfied or unhappy at work. After leaving school at 16 he went to Art College and then into a graphic design job at a gas appliance company. Leaving after a row with a more senior colleague he then worked in a university library whilst gaining qualifications to 'A' level. Subsequently he started but didn't complete a teacher training course. After a period of unemployment he spent some time working for the Civil Service before being employed by a housing association for 15 year period. The context of social and organisational change accompanying the Thatcherite changes of the 1980s, and it's impact upon his work are cited as reasons for him becoming extremely 'stressed' and he links this with the onset of colitis. Following the onset of colitis he resigned from this job and after a period of convalescence set up a small retail business but gave this up after developing angina.

William describes a period of profound unhappiness beginning prior to his commencing the uncompleted teacher-training course, that related to the breakdown of a romantic relationship (59-79):

William: ...in fact I went on to do teacher training at Dotherbury, but I didn't stick at that because the, before the course started I had a

summer job at Butlin's and I fell in love with this Finnish girl and I was really really in love and I did a year and then I went over to Finland and I didn't really want to come back and it just went wrong and we split up and I came back and I just, I got very depressed actually, er then I'd be about 19 something like that, and I remember intending to start the second year, and I went with friends we were moving into a house together and I started stuttering when I was talking to me friend and I'd never stuttered before and I knew there was something wrong there so I just sort of curled up and didn't do anything for a long time actually, I was very very depressed and er after probably a couple of years being pressurized by the Job Centre I got a job in the Civil Service in the County Court which was barmy really because I'm just not cut out, I'm not a form filler or anything erm

In contrast to Sean, he does not present as stoical, but rather as deeply emotionally affected by difficult life circumstances. In terms of masculinity construction then William's presentation here fits with Connell's description of 'subordinated masculinities'. The course of his life does not lend itself to drawing upon societal discourses that equate esteem and prestige for men unequivocally with career advancement and success. The discursive resources then are those from the political left that enable him to articulate an understanding of the social context to his distress. A number of writers have argued that 'depression' (or "profound and enduring unhappiness") is ontologically of the same status as other forms of distress (Cromby, 2004, p.189), and highlighted the flow of causation from sociocultural structures, organisations and practices to the individual (e.g. Pilgrim & Bentall, 1999; Fan & Eaton, 2001; Ritsher, Warner, Johnson, & Dohrenwend, 2001; Williams, 1999). Access to such conscientizing discourses can be seen as empowering William to speak of his distress whilst inoculating against and signalling resistance to individualising, victim-blaming, negative judgements, at least with those who accept the political worldview. William also talked about the death of his mother around this time (79-99).

William: ...but my Mum Died during that year, first year, and er that was, really I should've referred to that because the previous 5 years she'd been really ill, I mean she had cancer, but I didn't know that and my 2 sisters apparently knew and my Dad knew it, but they decided not to tell me because they thought I'd be too upset about it, I've actually been having some counseling and I keep really going back to that issue, why didn't, what was wrong with me that they couldn't share that information, and its only recently that I've talked to one of my sister's about it, it was quite a big issue erm so anyway, 5 years of me taking time off college as well I had to come to look after my Mum on occasions, but finally she died in an hospice, and long after that I gave up that job, and what did I do then after that? Oh I think, I went into housing management, worked for a housing association, working with young people in housing need and stuff, and for 5 years that was a brilliant job

Beyond the fact of her death it has been difficult for William to come to terms with being excluded from the knowledge of her terminal illness by his father and sisters. Their decision is presented as relating to their belief that he would have not coped with knowing about the situation, and so in his best interests. It has been problematic for his relationships with his family nonetheless to be excluded from the truth and he has sought counselling over the issue. He describes their actions in terms of them implying that there was something 'wrong' with him, perhaps beyond the profound unhappiness he has described. Despite his emotional vulnerability at the time, he resents being excluded from this knowledge, and the events placed him in a marginalised position with regards to his status in the family. He speaks of it seemingly without defensiveness, and perhaps this relates to him having talked about it in counselling and impressions of the interviewer as being 'a psychologist'.

*Nadir experience: The isolation ward*

William found himself admitted to an isolation ward in hospital with an unknown illness for six weeks (108-121) when he was 29:

William: I got really, I thought very pressurized so when I was er 29, I got ill and I had a dreadful time in an isolation ward because they didn't know what I had, they thought I might have had some kind of tropical disease, I'd only been to Spain on holiday, I came back er and I just had diahorrea constantly, after 2 weeks the doctor came and gave me antibiotics which was apparently was the last thing to do, and eventually I got, rushed into Henshall Hospital and I was there for 6 of the worst weeks of my life actually it was awful, in this little room with there was nothing, no stimulation at all, just in this little isolation ward, an absolute nightmare

The lack of stimulation and company were extremely distressing and he describes this as being a nadir experience. His state of mind became very disturbed, to the point that he perceived that he was receiving messages from the TV set in his room telling him to leave the hospital. He describes having 'escaped' at that point by climbing out of the window and getting a taxi home (653-679).

William: Well that really has got to be when I was in memorial Hospital, Yeah it was it was awful, it was absolutely awful, one stage, probably the worst time was when I erm, escaped, there was no TV up or anything for the first two weeks, eventually I got this little black and white TV in there and I was watching a play and it sent these messages to me, I was psychotic or whatever, I don't know, and it said to me 'you're OK, you shouldn't be in a hospital, you can go home', so that night, I mean you've gotta remember, I could hardly move I was absolutely, you know, I was like a last erm, I made the bed up to look like there was somebody in it and I climbed out through the window and went across the grass to the perimeter wall ad jumped down, and It was a high jump er, and I waved a taxi down and I went home, er, got into the house and Susan who I was living with was absolutely gob smacked and drove me back to hospital straight away and all hell let loose apparently [laughs] me sister phoned the hospital and shouted at them and then they moved me, they didn't tell me they were moving me but they moved me to a room that didn't have a



window, they said they'd moved me because they needed, but now I look back, er, and that was, you it was awful, because I was just feeling so absolutely awful, I can't describe it, terrible.

He was returned to the hospital, to a room with no window. Here again, his self-presentation does not fit with ideas about hegemonic masculinity but rather a marginalised position, wherein his emotional and mental resilience is freely represented as being low or problematic. He talks about feeling embarrassment and guilt as being associated with the 'weakness' that his position might be thought to indicate (362-383).

William: When I was 29 I was so embarrassed by the decease I didn't tell anybody at work nobody really knew how ill I was, cos it's just a horrible thing the whole experience, it was completely shitty, literally, and the second time I was in, actually the first time two of the people I worked with, the secretary and one of the assistants came and visited me at home, which was quite nice, but I was embarrassed I felt weak, I felt Like it was my fault somehow that I got ill and I was sitting there you know in my pyjamas and I just felt dreadful, like a fraud almost, even though I couldn't, I suppose I hadn't really accepted that I was seriously ill, and I think I still have that problem to an extent that it's to do with your sort of acceptance that you know you're knackered really, you know your body's just not working the way it should, and it is, and it is I feel, I feel like I've done something wrong and I feel guilty, I feel a tremendous sense of guilt that, and embarrassment, you know I try and cover up the symptoms

William recounts the experience from a position presenting himself as being in a difficult process of re-evaluating these feelings. Whilst still feeling the same way he is able to describe himself as trying to accept the physiological nature of his condition and it's consequences. This is an alternative view of him to that of 'weakness' and in presenting this position whilst demonstrating his difficulty with adhering to it he is positioning himself in relation to hegemonic ideals

defensively. It's also perhaps relevant that it is in the context of visits from work colleagues that these feelings were particularly acute. In terms of social support/capital the account highlights the gendered complexities that are involved in it's value, since although the visit may be taken to indicate that William is esteemed and cared for by work colleagues, at the same time it placed upon him the task of appropriate self-presentation in the professional context.

### *Persuaded to resign*

A further acute episode of illness five years later and resultant sickness absence from work was instrumental in William resigning from his employment with a Housing Association. For him, as with the earlier episode, the flare up of his bowel problems is linked with 'pressure of work'. In fact he describes being 'persuaded to resign' at this point (141-164), which coincided with other difficulties he was having at work.

William: When I was 29 and er, I got better eventually but not, not, I was down to 7 stone, I was bleeding and allsorts, I was anaemic, I was really bad, erm then I went back to work part time, I eventually came back full time but 5 years after that incident I got ill again erm, and I'm sure it was to do with pressure of work and the sort of frustrations and everything, same thing same hospital but this time for about 4 weeks and then erm, I went back part time but, I was an assistant area manager, and the area manager job came up for grabs and I applied to it, I wasn't really, my heart wasn't innit, I didn't get it, the person who got it I think, we didn't get on that well and she wanted to transfer me to another office and I was absolutely, well I was still struggling with the colitis and I just went off sick, and er, I was, I was really ill but I don't think they thought I was, It just happened that they thought that I was being sort of bolshie, you know, cos I didn't want to move, and there was an element of that there, it's true but I was poorly, I had to go back into hospital again at that point and I was in for several more weeks erm and then I was talking to the director of a company in Dane, who was very canny and persuaded me to resign, so I resigned,

There is some sense of having been misdirected in Williams's account of this episode, as evidenced by his retrospective evaluation of the manager's actions in persuading him to resign as 'canny'. This may relate to the workplace benefits such as a redundancy package that one would forgo by resigning. It can be said then that he places himself in the story as being treated unfairly or manipulated by his employer to his detriment, at a time when he was stressed and unwell. The powerlessness and vulnerability of his position rather than his agency in resigning is highlighted in the narrative. Additionally there is the suggestion that his trust in the manager's advice was misplaced, and the adverse effects of social linkage or embeddedness within institutions wherein one becomes subject to hierarchical relations with others having agendas based upon conflicting interests. The account here may also be interpreted in relation to issues of legitimisation and the morally charged discursive context regarding William's status at the time of interview as unemployed and in receipt of state benefits. Whilst for a short period he ran a shop following the resignation, further ill health combined with a lack of success and the shop's closure brought him seemingly to the end of his working career. The narrative works to give an explanation of this trajectory.

### *Biographical disruption and multiple crises*

The following period of his life was marked by the development of further chronic health problems. Following a short period of recuperation William opened a shop selling recycled goods in partnership with a friend, however this did not turn out to be a viable business. Furthermore following further investigation of pains thought initially to be indigestion, it was discovered that he had suffered a heart attack and also developed angina. From this point onward he has been unable to work:

William: I was sort of convalescing for a few months and I decided with a friend that we were going to set up a business saving the world selling recycled goods and things, so we did, and I set up a shop erm and it was Ok but I, when I look back at, I must have been pretty ropey all the time, and not realizing it, and in the background there's all this

stuff going on I met Jean who's now my wife just before that period and we were moving house and all this was going on, there was a lot of stuff going on the shop didn't take off there it was in the wrong position, and I got, and I started to have erm, I started to get these pains which I thought was really bad indigestion and I went to the doctor several times and they were treating me for indigestion and then eventually one of the doctors thought well we'd better send him to the hospital and erm, discovered that I'd had a heart attack and I started to get angina, I just basically couldn't work because I was, you know I had the pains in my chest and I was having colitis, and then a few months after that I started to develop what turned out to be dystonia, and that was when we were in a house, when we had the neighbours from hell on both sides, and there was a lot of stuff going on there, we were having fertility treatment cos we wanted to have children, I was going to the same hospital being treated for colitis (165-191)

Just prior to this episode he had met his wife-to-be, and they subsequently had problems with neighbours and were also undergoing fertility treatment. The account presents this time as being overwhelming, and indeed the events are linked by William right through to the time of interview as he returns at that point to the present. The advent of these further conditions marked the point at which his daily experience of life changed as his mobility became greatly reduced whilst chronic fatigue also began to overwhelm him. The impact of these events are consistent with Bury's (1982) description of biographical description.

#### *Fallout problems and support*

The impact of illness on William's inability to act out a valued masculinity, and in particular the 'male breadwinner' ideal had also impacted on his family relationships. He had argued and was no longer speaking to his father-in-law, as he felt his father-in-law lacked respect for him and had failed to reciprocate support during difficult times:

William: In terms of your health problems then can you tell me something about the way that other people have supported or not supported you?

More recently, this has actually cause us a lot of problems because Jean's father and I have really fallen out in a big way because of this, because he has never expressed any form of support at all for Jean and myself through all these things that have been going on, yet when Jean's Mum died about 3 years ago and we were really very supportive, we were there for them you know, we did loads of stuff for them but her Dad just doesn't have it in him to understand, he doesn't seem to have any empathy for his family, it's not just us, he seems, he's very, I know he must have gone through a period of mourning and so on but to be honest he was always like that and er we've been married now for about 15 years, cos we married quite late and throughout that period something's been building up between the two of us and I don't think he respects me because I've never worked during that period and I think he's, he, I mean we have had times when we, you know, we've shared things because he, one thing he does like, he likes company and er I think he's enjoyed my company when its suited him but it was always on his terms but I think I guess that it comes from the fact that you know I'm not his ideal son in law, so we had a big fall out about nearly 3 years ago now, I haven't spoken to him since then, and it's been much better between me and Jean actually our relationship's improved because of that, cos there was always some contentious issues when her Dad was in the picture. (283-315)

It has previously been noted that an aspect of the biographical disruption associated with chronic illness may be that the person becomes discredited and stigmatised, whilst reciprocity and mutual support becomes difficult to maintain (Bury, 1082; Charmaz, 1983). Nonetheless here William emphasises his resistance to stigmatisation and positions himself as ultimately in control and actively shaping his social environment by standing up to his father-in-law and ultimately discontinuing direct contact with him. The narrative here situates his father-in-law as an unsympathetic character, and emphasises Williams'

unwillingness to be victimised. The identity threat associated with illness is articulated clearly:

Interviewer: Are there any ways in which particularly being a man and being ill makes it more difficult or more easy?

William: Oh yeah, yeah it's, like I say, its, I don't know why it should be but I say I think I would use the word illness as a weakness, I feel like it's my fault that I've, like I've done something bad by being ill, and maybe not being able to do things that I should do, you know working, erm, bringing in the cash and what have you but Jean is very good actually cos she works full time and she's doing a job she doesn't particularly like but she understands you know, and we have a very good relationship, erm, but I don't think I'm like most blokes, most blokes er, with illness it, I think a lot of blokes don't particularly talk about it they used try and sort of stiff upper lip stuff, but I've done a lot of thinking about it, I've had a lot of time to think about it and yet I still feel like this [laughs] er so I might not be the fact that I'm male, it's just me personally, you know, cos I've had counseling and stuff about it (394-412)

To an extent William seems to have internalised the idea of 'illness as a weakness' that resonates well with the work of Charmaz and Courtenay. He distances himself however from 'most blokes' in that he is open to talking about his feelings and indeed has sought counselling to support him in coping with his circumstances. He is ambivalent about relating this to masculinity, which may be interpreted as a way of (and perhaps also to the difficulty of perceiving how one is resisting or reproducing discourses in one's own practices and talk.) As a positive sense of identity William is demonstrating his propensity to actively shape his experience through the use of social resources available to him.

Further family relationship problems had developed between William and his sister. These related to his recollection that she did not visit him in hospital when he had to undergo an operation for his colitis.

I've had 2 operations for this dystonia, and I had to go to Birmingham to have them because it's a specialist unit, and er nobody came and visited me except Jean, nobody came down, my sister didn't come down, my other sister, I don't talk to her now either, you know er, and I was really angry with June because we were very close actually, we were really quite close and I thought she couldn't be bothered to come down to the hospital said something to me, er, and I subsequently discovered that the same time I was in hospital, my other sister, one of her daughters had gone into hospital because she had what they'd thought what I'd got, I think something like that, but it wasn't it was just inflammatory bowel, sorry irritable bowel syndrome re, so but I think she went to see her in hospital, and that's down in Chesterfield around the same time and I'm thinking well, she could go there but she didn't come and see me, so I was, and I told them when I came back and then I had a second operation 2 years later, and apparently her and her partner did come to see me after the operation, but I couldn't remember it, and I think it was because of all the anaesthetic I think I'd lost some of my memory but apparently they came and we sat eating grapes and chatting and went in the day room and everything, I can't remember anything about it, and I was holding this sort of resentment because there again, they'd not been and I said to Jean you know, 'they've still not been' she said 'but they have been' and I said 'I can't remember that' so I had to apologise because, you know I'd been really off with them, so I've got that to put, but I don't feel that people generally are, our friends have been much better than the family. Family somehow, I don't know, they don't either they don't want to understand or they don't understand the impact that this has had on Jean as well as me. (315-352)

Whilst he later realised that his resentment about the issue with one sister was unjustified, the ongoing rift with his other sister fed into William's perception that his family have been less supportive than he might reasonably have expected through his illness.

As with Sean above, the interview with William illustrates the complex and ambiguous nature of 'bonding' ties. As support needs increase at such times of health crisis then expectations and the degree to which they are met become more apparent.

### *Supportive friends*

In his local neighbourhood William finds it easier to make friends with older people, finding that friends around the age of himself and partner have become preoccupied with their children. Also, in being childless he notes that the networks people tend to develop through having children are less available.

I am isolated you know there is no doubt about it because err, but it's like we have shared we have friends but I mean the friends that I used to have went when I split up from a long term relationship an ex-girlfriend and all that kind of stuff. And then I met Chris our friends were her friends you know I sort of got... but what has happened now is that they have got young families and it is an issue with us. And we do find it difficult because you know they have friends who also have got children and you know like that. And childless couples are not sort of catered for. They have not got a lot going for them because you know people meet friends through schools and stuff through the whole system she has got loads of friends but it's through taking her kids to school actually

(Interview 2: 358-370)

Although limited in terms of friendships a further source of neighbourhood sociality for William derives from dog-walking, which leads him to meet and speak with local acquaintances. Dogs provide a focus for initial introductory conversation, and of course a reason to walk around the area regularly.

P: Yeah, yeah I mean Holly has been our sort of ... if you like because when we go out up here there are lots of people who walk dogs and we do know people. But it's not the sort of thing were you would say do you want to come back for a coffee except for a couple who looked



after holly when I was in hospital they are ageing in their seventies and eighties. And again it's, we are actually quite good friends with them because they ... for us but that was because of Holly

I: Because you are just sort of regularly walking

P: No they haven't got a dog they used to have but it died but Holly is blind and it runs out I didn't know at the time because he was out cleaning... because they live in a cottage of the estate and I just started chatting to him I had spoken to him two or three times and I didn't realize he is virtually blind and I met his wife and err, she said we will look after Holly if you ever need and they did so we see each other

I: So I suppose Holly has been a talking point

P: Well if we didn't have Holly we wouldn't have met them that's a fact

I: Yeah

P: And I think a lot of people do actually but I think a lot of it is just passing the time of day it's not you know... we have discussed this... it is very hard when you reach a certain time of life to actually create new friendships because it takes a long time. Unless you particularly hit it off with someone but we I suppose don't, we don't go anywhere where that is likely to happen. Well largely because of me because I rarely go out I just don't want to do anything yeah

(Interview 2: 373-400)

In contrast to the unmet expectations that characterise some of his relations with family members, he characterises relationships with friends as being understanding and a positive source of support.

We have found some friends who been very understanding, I think a lot of its cos we haven't got children, we wanted to have children and they you know a lot of, certainly we've got 3 friends who are in couples who've had children relatively late in life and sort of try and get us involved with that, that's quite good

(355-362)

Part of what is meant by that support is the way that friends 'see through' his attempts to conceal pain, that he does not necessarily appear ill, and his reticence to actually ask for support.

You know I try and cover up the symptoms, especially with this dystonia now people see me and think er 'oh what's wrong with him' but, there's a lot of effort that goes into controlling the movements, stuff like that, the pain so in some way I mean the lack of support is down to me because I've not asked for it and I've tried to hide things, but erm, would think that people that really, knew me, and knew me and Jean would be able to see through that and there are ones that do see through it and have been supportive.

(388-392)

It's important for William that friends see beyond superficialities and his attempts impression management. In trying to hide his symptoms he perhaps means to avoid the stigma and shame associated with his experience of 'illness as a weakness', although he recognises that he a consequence of this may itself be reduced support. He tends to discuss matters concerning his illness with older friends, such as the neighbour with whom both he and his wife have become friends:

William: My next door neighbour who's 80, who, his wife died about 3 years ago and we've become quite good friends so we play chess and he's er, he's a good lad really, not bad for an 80 year old, he beats me and he's got a better brain than I have.

Interviewer: Oh tell me some more about that.

William: Yeah well I think they moved in here and It was almost like they became our substitute parents somehow, relatively quickly, but within a year erm, Gail had had a couple of falls and she went into hospital and they discovered that she had quite advanced cancer and she died after about a year, er but, I used to, I did things like I went and got some of their prescriptions and we were, I felt I got, Richard's got a son, he's got two sons, one's in Australia but one lives locally, so I mean they've got the family support, but he's quite a lively minded

chap, you know, he's got a good sense of humour and er we just sort of hit it off together and he's out in the garden or whatever and er, and we just seem to, yeah he's like, a dad really, like the Dad I would have had if he hadn't died so young, erm, but he still does, he used to do er stand-up routines for the American songs ad things him and his brother, plays musical instruments, er he tells jokes he does, you know, he still does it now for local charity groups although he's definitely slowing down now, but he still beats me erm [laughter] yeah, but it's nice because he gets something out of it and so do I really.  
(713-752)

His neighbour is accessible, personable and there is reciprocal support. The age difference is talked about in terms of a parental relationship, with it's associations of caring and wisdom.

In the above case studies I have presented in-depth multi-level analyses for two of the participants, illustrating links and processes by which social capital, masculinities and chronic illness experience are linked. In the next chapter I employ a more thematically oriented cross-case approach to narrative analysis.

## **Chapter Eight: Cross-Case and Reflexive Analysis and Discussion**

This chapter presents the analysis and discussion of cross-case analysis focussing on a further five study participants. Tony, an 83-year old retired man was living alone with asthma, glaucoma, and was also recovering from a stroke. Alex, a 26-year old employed man living with his wife and daughter, suffered from asthma and Raynaud's syndrome. Steven, a 58-year old employed man was living with his wife and daughter and suffered from M.E. Barry, a 52-year old unemployed man was living with his wife and son and also suffered from M.E. Finally, Raymond, a 58-year old man who had taken early retirement was living with his wife, and suffered from arthritis, Raynaud's syndrome and sclerosis. Similarities and differences amongst participants are thematised and interpreted, discussed and contextualised in relation to relevant literature.

### **Bonding Ties and Illness Experience**

For several participants, the onset and course of illness was reconstructed as intimately bound up with close family relationships and associated emotional and behavioural issues. For some men family difficulties were seen as linked with the course of illness from childhood onwards in a negative way.

Tony: As a small child, and that's still continued in bouts, well the thing is I can't remember, I can only remember I was at someone's side, sitting up in a bed, and choking with these fumes, and that was my first recollection of it, what happened before that I don't know. But it came and went, and as I say my mother was a very fussy, protective mother, and I could have done with a less protective one or some brothers and sisters, I was an only child you see, and erm, I mean such things as when we got married, erm, I said to my mother one day I said, "we're expecting a baby", "well I hope you wanted it", you know? What a funny attitude for a grandmother, "and I hope it doesn't call me grandmother" and that was it, I just flipped then, I said "you'll be bloody lucky if he even speaks to you." quite

seriously, and this was my reaction, but I was looking after my wife, not this old bat, which I view her very much as even these days, so I mean why couldn't she be nice about it all? I mean other grandmothers are.

(Interview 1, 244 - 263)

"And the day when the baby was being, in the hospital being born, I was having a bad attack in the flat, and she was sitting there and all she could say to me was "it's that baby that's causing all this", you know, so I just got up, got in the car and drove off, you know, she was so self-centred over me, erm, that it just made life unbearable really. So, from then on it was just all sort of downhill all the way as far as she was concerned."

(Interview 1, 457-465)

Chronic illness can serve as a discursive resource that others in a social network may draw upon to achieve particular ends. This may be via attributing the cause of the illness to social relationships, lifestyle, or even questioning its legitimacy.

In Tony's case a problematic relationship with his 'very fussy, protective mother' was presented as being implicated in his experiencing asthma at later points in life. Although it was unclear the extent to which he ascribed the original cause of illness to this relationship, he described a pattern whereby illness was exacerbated due to it at various points in his life. His reconstruction of chronic illness in early family life experience illustrates family 'bonding ties' in a suffocating, oppressive and health-depleting aspect. A number of writers have previously observed that strong bonding networks can negatively impact health (Ferlander, 2007; Due et al, 1999), with social relations having the potential to become oppressive particularly where people have little choice about those upon whom they are dependent (Kunitz, 2004). Clearly relations with close family members such as parents are characterised by decreased choice, in particular for younger people and children. Most writing on social capital and

chronic illness implicitly or explicitly assumes that such relations are positive for the ill person, focussing on the harmful consequences of isolation.

Steven's situation was complicated by the lack, until relatively recently in his life, of a diagnosis for symptoms of M.E. so that for much of his life he suffered from undiagnosed chronic illness. He represented his mother as negative, controlling, cold and encouraging him to isolate indoors when experiencing (what were later seen to be) symptoms of M.E., to the detriment of his school attendance.

Interviewer: Could you tell me about some of the key people, your experience with the tiredness, how have people made an impact and been involved?

Steven: Well it has got to be parents, but as I say my mother was always peculiarly cold, except when I was ill, she was always quite pleased when I was ill, so that response was always fairly positive, she was always discouraging of me being adventurous or me doing things on my own and going out.

(Interview 1: 589-594)

Steven saw this as a stifling of his development due to his mother's own emotional investment in him being incapacitated by illness. He related that to the fact that his mother had suffered from both long term mental and physical health problems herself. Caring for a chronically ill child is of course demanding emotionally, financially and physically on the family system (Anderson and Davis, 2011), which may or may not be able to incorporate such demands sufficiently well that the ill person perceives care to have been unequivocally positive. It is recognised in the Health Psychological literature that "mothers worry about their ill/disabled child, feel guilty they cannot do more to manage the condition and develop a degree of hypervigilance within their care so as to minimise their child's distress" (Gilmartin, 2009, p.158). There has been some related discussion of the overprotective dominating mother and relation to emotional problems amongst chronically ill children (e.g. Power et al, 2003). The conclusion is challenged by Gilmartin who interprets their empirical findings differently.

Narratives of this variety speak to the interdependency of family members and the complex psychosocial processes that shape experiences of being cared for as an ill person. Assessing such experiences in terms of 'levels of social capital' would seem hopelessly simplistic in the face of such complexity.

Discourses of masculinity and gender relations may be identified in these narratives of illness onset and experience. For those men who ascribed psychosocial influences and interactions to illness, talking about family experiences variously involved taking a marginalised or vulnerable position. Tony and Steven were positioned as relatively powerless, constrained in their abilities to resist oppressive social relations within families, whilst at the same time speaking in interview from the position of adult men able to reinterpret and re-story their childhood experiences. Such men negotiated the disjuncture between their discordant childhood experiences and dominant cultural discourses of masculinity (Kia-Keating et al, 2005) to construct 'resilient survivor' narratives. Tony for instance had ensured that his mother did not have contact with his own child, and so prevented him from what was presented as a toxic relationship waiting to happen. In doing so he may be seen as establishing a position of control and independence. The positioning of mothers as problematic, overprotective, oppressive, is recognisable in cultural discourse as the 'fearsome, dominating mother' that Kaplan (2013, p.13) argues became a dominant post-WWII paradigm in cultural representations of motherhood. This illustrates how at the same time as the narratives hold a personal/social reality they also sit within a dominant system of gender relations.

Family or 'bonding' social capital was therefore by no means experienced as unequivocally positive amongst participants, enmeshed as they were in relations of familial power, particularly in childhood with little option to fully understand or successfully resist. The patterns of experience in relation to such issues predominantly concerned relations with women, whether mothers, sisters or wives, reflecting dominant social arrangements.

*Receiving support and care*

Whilst some participants highlighted the role of harmful family dynamics in illness, for others such issues were downplayed or dismissed. Alex framed his chronic illnesses more as physiological entities. Whilst he also could not remember a time when he was not chronically ill (again with asthma) the matter did not carry the same resonance in being weaved together with negative long-term family relationship issues in his narrative. Rather, he conveyed information about his early childhood illness that had been communicated to him in the family context, filling in for a lack of memory of early childhood years. Whilst he, like Steven, had missed school with his mother's permission, the responsibility for this was located in his own ability to manipulate his mother, rather than in any shortcomings of hers.

Alex: I skived off school when I shouldn't have, I learned to play my mum in particular that I was ill when I wasn't, and a lot of that time spent off school I could have gone and if my mum would have been harder and I was honest, I probably would have been in more and I can certainly remember playing the system to my own benefit and I suppose even as a kid you are aware that you can get away with slightly more than a kid without a problem because they are aware of it and I don't know if more doting is the word, but because of the fact that they spend so much time trying to worry about you or addressing the fact that you are ill and I suppose if I am truthful I am aware that when I was younger I did play the system in a way to benefit me.

(Alex, Interview 1, 120-139)

Such talk was reflected in the more harmonious family relationships that many participants spoke of. Within men's social networks, people such as close family members were described as exerting influence on participants to 'look after themselves', to call upon help and support appropriately. When Tony fell and broke his wrist, for instance, his son mildly berated him for driving himself to hospital rather than asking for a lift.



Tony: I was on my way to my daughter's house, about a mile away, I tripped over a kerbstone, I just went flat. Of course instinctively you put your hand out like this, so, if I hadn't of done that I would have broken my face I should think. (laughs).

Tony: And er, this I did, but er, having had words with my son, ha ha, before about various things I've done, I came home with him. Cos I drove there with difficulty... I could move the gear by working my hand in a certain direction. And erm, he ran me out there, and we were there, four hours I think. But I mean this time, it wasn't their fault.

Int: Right. When you say you had words before, can you elaborate?

Tony: Well I'm very independent, I tend to do things on my own if I, you know.

Int: Right. So words about..

Tony: Oh very good words, "behave yourself", something like this [laughs].

Int: Right. So telling you to be more careful, is that what you mean?

Tony: Er partly, partly, yeah. I mean such, such, they could happen to anybody couldn't they?

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(Interview 1; 29-52)

Independence as an aspect of dominant masculinity ideals, and its implications for health has been widely discussed (e.g. Courtenay 2000). As hegemonic masculinity is not a set of personality traits however the process by which demonstrative independence is implicated in asserting power and authority must be considered. It may be interpreted here as a form of social distancing, and to a disconnectedness that eschews reciprocal obligations for caring and emotional support that typifies father-son relations as represented in Western cultural-historical discourse. Weakness and vulnerability allow for ruptures in authority-based relationships, whilst emotional connection allows for negotiation, compromise and avoiding causing harm physically or verbally.

In the context of social relatedness the ways in which this is negotiated and fluid become highlighted however. Tony's ambivalence, or reluctant acceptance, of his son's exhortations to avoid risk-taking behaviours may reflect the way that they symbolise the growing limitations of his ageing body. Connell (2005) notes that ageing is influential in social processes of gender, so that specific meanings about masculinity are generated through the interplay of age and gender (Mac an Ghail and Haywood, 2007). Given the contemporary cultural focus on the body, the once privileged position of older men as experienced and powerful may no longer be tenable (Hearn, 1995). Growing older may be experienced by some men consequently as entering 'marginalised manhood' in relation to dominant ideals of masculinity based on the bodies and lives of younger men (Comeau and Kemp, 2007). As Spector-Mersel (2006) argues, this trajectory may represent a challenge to identity in later life. The development or exacerbation of chronic illness during later life is only likely to intensify this process, and narratives such as the above exemplified the renegotiation in social relations takes place as part of such processes.

Relating to an ideal of independence was also often set within family or other social stories, where men who exemplified this ideal in relation to health matters were discussed. Tony, for instance, related an incident when his father had broken his arm and similarly had been reticent to call upon prompt assistance (Interview 2, 610-621).

Tony: Oh no. He broke an arm, on ice, when he first came to us, and erm, I offered him help but he wouldn't he just refused, he put his arm up like this and walked home. He was a tough man, you know. And er, waited for me to take him to the hospital when I came home from work.

Int: How long was that?

Tony: Oh only about er a couple of hours, it was about er but he still had his own house by this time.

Int: And what did you say to him?

Tony: Well it was just useless quite honest, it was like talking to a brick wall. So you know, I was alright, you know. But again, I

get this instinct as well with my sons you see, although we get on far better, I mean whether we would living together I don't know, it's a tricky thing.

In narrating this depiction of his father as a stubborn 'tough man' Tony acknowledges a habitual alignment towards these sorts of practices, but also distances himself from them and describes being in the position of offering help to his own father. An instinct within that he seems to acknowledge as being problematic, but that he may not entirely have overcome. This may be seen as represents a discursive orientation to hegemonic ideals via exemplary cases. Authority and dominance issues are implicated then in the matter of accepting help.

Whilst some men were parents of young children, their children also were often supportive of them at times of acute illness. Barry described for instance his young son's understanding attitude to him (Interview 1, 500-509).

Int: What about with your son, is he aware that you are unwell?

Barry: Oh yes, sometimes when I am not so good he brings a blanket and says, 'don't worry Daddy, I will look after you!', its sweet, he understands that Daddy is poorly some days and I think children are quite robust in that way, probably when he gets to be a teenager he will be upset about it!, He'll be like 'useful old Dad", but he's got a few years to go yet

Men did often received a great deal of support within their families, indeed for many men family relations were a central positive influence on them in modifying unhealthy behaviours/adopting healthy behaviours. Tony gave up smoking when his grandchildren were born and his son and son-in-law stopped smoking at that time due to their interest in providing a healthy environment for their children (Interview 2, 857-861).

Int: What was it that prompted you to give up smoking then?

Tony: Young kids I suppose because my son and my son-in-law when their kids were born they're all twenty three down to twenty now but when they were babies they were both told to stop smoking and they did and they have never gone back to it all

In contrast to that of Tony, the norm in Alex's family was one of heavy drinking and smoking, and a fatalistic acceptance of the potential health consequences to these behaviours. Alex had close family members (his wife and his mother-in-law) who worked as health care professionals, and the onset of Reynaud's syndrome and its management constituted regular dinner table conversation amongst them. His young daughter had been critical of him smoking, conveying information she had acquired through her school education about detail on the risks of smoking. Whilst this had not influenced Alex to stop smoking, it had influenced how he smokes, in that he no longer smoked within the house, instead smoking at the back door. He and his wife have discussed the possibility of quitting smoking, and whether it would be wise for them to both stop at the same time, so as to assist each other with the process. As a result he had delayed any attempt until his wife finishes her university nursing degree. It had not been the norm to discuss health matters in Alex's biological family, in contrast to the situation existing within his wife's family. This had changed somewhat however since his mother had developed arthritis. His mother often inquires about how his asthma is doing, whilst he has told his sister about his Reynaud's syndrome. In fact he told both his mum and sister well before he attended a G.P. about the symptoms of Reynaud's. He did not feel able to smoke openly in front of his mother as he knows she will disapprove because of his asthma.

Several behaviours associated with lifestyle-related illness were identified by men as being associated with masculinity performance. Heavy drinking was one of these; Alex had been a heavy drinker for several years and had become concerned enough about the consequences to undergo a liver test.

Alex: Yeah because I am aware that I have drunk fairly heavily for a consistently for a number of years. It didn't worry me having the test because I always thought that even if it comes back and they say oh there is a problem with your liver at least then you have that knowledge that you can change what you are doing. So it didn't in any way worry me in any way having the test I saw it as a good thing. A bit like an MOT to see how your body is doing. I looked upon it as being a good thing that it was being tested it didn't worry me. It was

pleasing that it came back as being perfectly fine. I had a celebratory drink after that result

(Interview 2, 102-111)

He recalled celebrating the outcome of the test (positive in the sense that his liver was undamaged) by a binge drinking session, and that he had openly discussed this with friends and acquaintances in the pub as illustrating his ability to 'take it' – to drink 'like a man' and his liver being able to stand it. In terms of Alex's wider circle of friends, he discusses Reynaud's only with close friends, and has discussed with these the possibility of quitting smoking, but cites a norm of respecting individual's choices amongst his friends' as a reason why nobody has attempted to influence him to quit.

#### *Family homemaking practices and illness*

Men with partners in full time employment often saw themselves as largely responsible for domestic chores, but were sometimes limited in their abilities to perform these by illness. Barry described the accommodations that are made between himself and his wife in terms of daily domestic tasks [Interview 1, 481-498].

Barry: Well she understands the problems and she lives round it like I live around here doing her job, so I try and not impose too much because she has got enough on without me and she worries enough without having, she's a worrier so you try and avoid, and some days she knows I can do things and some days I can't.

Int: What kind of accommodations have to be made then on an everyday basis?

Barry: Well basically sometimes she has to get food in for the evening because I am too tired to do it or sometimes she has to look after James by herself and I am too tired to do it at the weekend basically, or cook a bit more, really she goes out to work and I am at home and I should do the cooking but sometimes she does it, and I don't drive anyway, you can do things or you don't enjoy doing it and you are not well as well.

One of the gendered processes by which masculine identities were potentially challenged by chronic illness (Charmaz, 1995) was exemplified in this pattern. Culturally the 'househusband' is represented in terms of a marginal and socially disqualified masculinity (Chopra, 2014). Nonetheless empirical research has also illustrated a shifting contemporary landscape between domesticity and masculinity in which men may experience increased emotional wellbeing (Gornann-Murray, 2013) and a sense of pleasure as changing practices of homemaking re(figure) masculine identities (Meah, 2014). The changing nature of paid work and its gender relations are for Connell (1995) the most important driver of change in and renegotiation of masculine identities. Whilst 'breadwinning' may still be a core component of hegemonic masculinity, for Demantas and Myers (2015) unemployed men who are unable to engage in paid work recentred their domestic work as being essential for the family, so that "women's work" became redefined as "men's work" (Demantas and Myers, 2015). Tony exemplified this well in terms of reframing domestic work within a professionalised and even competitive discourse:

Int: So, so how did you find it, these changes to becoming a caregiver?

Tony: The caring came very easy, because I'd always participated in the house, well I, when I retired, I took over the washing and the shopping 'cos I was a rep, in food, so supermarkets never faze me. I can go to a supermarket and run rings round everybody. I'm not being big-headed but I know the job.

Tony (Interview 1, 725-732)

Participants with M.E. were however often unable to consistently or fully meet the demands of domestic work due to fatigue, and this line of discourse was therefore less available to them. There was certainly no evidence of resentment towards women in the face of participants' economic dependence. Retreat from the public realm was not necessarily seen by participants as stigmatising or negative:

Int: How did this affect your personal and social life at the time?

Barry: Not a lot really, because I am a home person anyway, I am quite happy being at home, people who are slightly deaf can never pick things up and making small talk about football or cars or whatever, yes I can do it when you have to but I find it a strain, even when I was well I found it a strain.

(Interview 1: 372-380)

Barry's slight disdain for such topics and seeming ease of adjustment may be seen in the context of his middle class professional background, university education, and left of centre politics. He at least did see more relaxed attitudes towards aspects of being a househusband as being associated with similar backgrounds to his own, and this was important in his maintenance of a social network via his presence at the school gates with his son:

Barry: Because I do the network more than Liz because I'm the one picking up and dropping off James.

Int: Right

Barry: And there's gossip as much as any school there are some women who aren't fazed by having a man pick up his son or whatever, and.

Int: Yeah

Barry: Usually tend to be professional people rather than nonprofessional people so

Int: Yeah

Barry: Who went to university so mixed you know and understood and as a child or whatever and you find they are more relaxed about having a man in there rather than

Int: Yes, right.

Barry: Even so I don't know if you read in the guardian a long time ago it's a male journalist or a female journalist her husband was a house husband said she learnt in one, she took two weeks off and learnt more in those two weeks than her husband learnt in the previous eighteen months (laughs)

(Interview 2: 301- 320)

Barry's retelling of a newspaper piece here does position women having a greater aptitude for domestic work nonetheless. This takes the form of self-effacing humour in which the househusband is a rather incompetent figure in domestic spaces. Steven's wife's health restricts some of the activities around that she can do around the house, so that domestic labour is parcelled up into tasks that are feasible in the light of their respective illnesses.

You know I am trying to sort my study out and there are things that my wife can't do like changing beds and so forth which I do on a Saturday. I actually find that quite pleasing in a sense because you know you change a bed, the dirty washing is there, and it is nice and square and you have done it.

(Interview 2, 437-442).

Again the default or implied position here is that this is woman's work, at the same time as it is accepted as an activity that Steven undertakes out of practical necessity. This pattern might best be characterised as a complicit enactment of masculinity therefore.

### *Chronically Ill Family Members*

For a number of men their partners were themselves suffering from a chronic illness, and so interdependence issues in health and illness were particularly highlighted. Steven for instance has worried about the health of his wife, who has diabetes.

Steven: I am trying to think if there has been anything else desperate, my wife's health has not been good which has been worrying, she is fairly unstable on her feet and err, you know worrying about her health has not helped. Recently she has been put on injecting insulin which has been a new experience and again that seems to be settling down so hopefully that will sort itself out

(Interview 2, 128-133)



Since his wife is disabled and the geography and nature of the built environment prevent the use of her motorised scooter, one of the ways he reciprocates care and support is by assisting her to where she wishes to go:

There are no complaints about the people the problem with the area in so far as there is a problem is in my wife being, disabled and this being a very hilly area. She has one of these motorized scooters and at first we, had hoped that she would be able to get out of the house on her own. But because of the varies slopes on our drive and the slopes on the footpaths in fact the narrowness of the footpaths and so forth she really can't get out on her own so I take her out where she wants to go.

(Steven, Interview 2 475-482)

Tony's wife developed Alzheimer's disease and this had led to her moving to a Care Home by the time of our interview. Her illness had impacted upon Tony, whose asthma resurfaced after a period of being asymptomatic following his retirement from work:

Tony: But when I retired, it all practically disappeared again. And of course it's come back, I had a stroke in eighty five, and had to retire, erm, and from then on it was quite good, and then of course, Kath, you know she had Alzheimer's don't you?

Int: Yes.

Tony: And the incessant worry of that has caused it to come back again really. Not too bad but I'm very susceptible, I mean this started as a simple cold, I've had a flu jab, and it's erm, it's went onto my chest and er, it's just erm, difficult, of course the weather's not good really, it's one of those things. And cold weather, you know, hot to cold.

(Interview 1, 279-292)

Chronic illness impacted upon men's family lives in numerous ways. Men discussed the ways in which relationships with their partners had affected and been affected by illness. This was often narrated as a process of adaptation and adjusting expectations. Steven considered that he and his spouse are well

matched in light of their both being chronically ill, since he would not be able to keep up with a more active partner. Over the course of their partnership he described how his spouse had adjusted her expectations of him in light of his illness and consequent lack of energy. At an earlier time in their lives this did cause some problems in their marriage with his low energy levels affecting his ability to engage with his wife's disabled daughter:

When we married, I think she was fitter and more energetic than I was but she did have a grown up daughter who was severely handicapped to look after I think my lack of energy did considerably irritate her but we stayed married and she put up with me. I think eventually that we partly because of my lack of energy and partly because Mary has got older you adjust your expectations and you know you can do what you can do and you have to get on with it (Steven, Interview 2: 514-521)

Steven: I think someone of my own age who was fully fit I couldn't keep up with

I: Right

Steven: I think they would lose their temper with me very quickly and depart. I am you know too slow to catch a cold at times that doesn't mean actually that, that doesn't annoy me I don't think it means that it doesn't annoy her you know it does but there are obvious compensations to stay. You know sufficient compensations not to lay the blame, no we never got round to that. You get on with what you have got you have to play the hand you are dealt and so obviously she must have felt from the beginning that there was sufficient reward to put up with my slowness of doing things you know. I remember complaints when we moved house at various stages that I didn't help with the packing as much as I ought to have done and left too much to her and so forth. But probably that applies to most people anyway

I: Yeah

Steven: Of course the men are supposed to eat and sleep and lie there aren't they, that is what they are supposed to do

(Steven, Interview 2: 532-550)

Steven normalises his illness-related limitations by stating that their consequences here are entirely within the spectrum of behaviours that should characterise men. Illness consequences that are potentially identity threats may be reframed then in line with discourses of masculinity.

### **Bridging Ties and Illness Experience**

Networks of people beyond family members were also important in providing men with assistance at times of illness, although this was not a prominent feature of most men's accounts. Barry described being assisted by peers taking notes for him at university when he became ill with ME/CFS. Such support was important in enabling him to complete his degree successfully [P19-1, 25-35]. As he describes it, the support extended to feeding him during the time he was incapacitated there

Barry: 1990, the 8<sup>th</sup> term, that's not counting the two years I had out, so in my 3<sup>rd</sup> year, the Spring of 1990, but there were people feeding me and people taking notes, it was a nine week term and I had five weeks off, so I had to go into top gear and catch up as much as I can and got my degree which was a 2:1 and I was quite chuffed with because I was a mature student, then I got a job with Bradford Council and then I got struck down again, I knew what it was because quite a few people at university had it, and the symptoms were all the same so I more or less told the doctor I thought I had it and he said I think you have

The onset of illness was constructed for some men in relation to a context of social support, in Barry's case from a network of friends at university. This is described in as meeting his practical needs for food whilst he was bedridden, and emotional aspects of support were downplayed greatly. Indeed his emotional response is reduced to anger (at the situation) and the need for emotional support, or its implicit presence in the practically supportive actions of friends over the 6 month period was denied [120-140]:

Int: What kind of support did you have during that first episode?

Barry: Medically zilch really because I was in bed but I had support from friends and have some friends across the road, I was in Halls of Residence but the people across the road made sure I was fed!

Int: What about family?

Barry: Well I was in my thirties then and my parents were in their late seventies and living seventy miles away, because I was at university, but they sent me a food parcel once or twice, there was nothing they could do when they got here at that age.

Int: And were you married or engaged?

Barry: No, no I was living in Halls of Residence.

Int: So how did the support that you had help you to cope?

Barry: Well the only thing I needed was basically being fed, I was in one room so there is no much to look after.

Int: And how did it affect you emotionally?

Barry: I was pissed off! But nothing really.

Int: And did you get emotional support or talk about it a lot to people, or did you not feel the need?

Barry: No, well it's like breaking a leg isn't it, it's something that happens to you, I got better after a month, I mean I was there for six months, in bed for six months, I did go home to my parents for the fifth week when I was better, to recover and have a break.

Notwithstanding the lived experience of men who divorced illness onset from emotional life, these accounts also narrate into being more culturally dominant versions of masculinity based upon stoicism and discounting emotions. Men may internalise such constructions so that they do become their conscious experience of illness onset, as represented in internal dialogue (in the Bakhtinian sense, as Vitanova (2010, p.25) writes “..the dialogue that selves are carrying on within themselves, but in the context and with the awareness of the larger society”) later externalised in social settings such as the interviews.

*Bridging capital and illness management.*

A number of participants had been involved with groups that impacted on their management of ill health. Men had participated in groups undertaking courses (e.g. the NHS Expert Patients Programme) that were organised through the health services specifically to facilitate optimal illness management. Through such groups men had developed social connections to others who were living with long term health problems. The chance to talk and share experiences with others appeared as being particularly valued, often more so than the content of such courses.

I don't know if you've heard of the expert patients courses, I went on that and I met a lot of people who had chronic illnesses, all different sorts of people, erm, and that was interesting although I found the actual course a load of bollocks, er, actually as virtually everyone on the course did, but I think it must have been our lot who were particularly bolshie because I've heard that other people found it useful, but a lot of the people there you see, they've had illnesses all their lives and they know how to get through life, you know, they went there I suppose looking for something new and they were, and people left because they felt patronized, you know the girl who was doing the training, she was ill, she had, can't remember, a form of arthritis really quite bad, and she was getting people to do these little exercises and things like this, and there were people there who couldn't even do those, and she was trying to encourage them to do it, look, you know, they knew, they know what they can do, anyway a lot of them didn't come back. (p05 – Sean)

'Being patronised' undermined men's sense of masculine identity. Demonstrating being able to cope was an important part of the presentation of men's illness narratives. Participation in such groups was thus presented positively where it illustrated men's active coping, rather than inability to cope. Men did not generally relate that a management course had helped them to cope with illness, and their accounts valued the people they had met and their interactions with them to a greater extent. The groups did function as an informational resource for men, however, and men developed continuing

relationships with other group participants, perhaps constituting networks of support.

One participant had also participated in a group that aimed to provide lay input to the health services. Participation in this group was used to demonstrate that Raymond was willing and able to contribute to public life in relation to his illness experiences. Through such participation, he was also able to gain a better understanding of how the health services worked, that related to his own experiences of dealing with health professionals:

Interviewer: So what led you to become involved with the patients forum then?

Raymond: Well I wanted to help, basically, erm, if nobody gives them feedback then how can they know what patients want? What their experience of the services are. So to have some input, representing, if you like, the voice of patients.

Interviewer: And have you found any benefits to you personally from being involved?

Raymond: Well yes, I know my way around the system now, I understand if there's a long delay in me seeing the consultant why that is, it makes it easier for me to negotiate my way through the process of being a patient.

Raymond, Interview 1 (675-683)

Participation may have added to Raymond's confidence in dealing with health professionals, however it also seemed that the kinds of resources that he already had as a middle class man were involved in his participation in this group. To 'represent' others in this public sphere bolstered his ability to 'do masculinity' despite his enforced retirement from the world of work. His participation implied some sense of confidence in talking to health professionals initially, and also was presented in a way that suggested a degree of power and status (i.e. being a 'representative').

For several participants their involvement in this study was similarly motivated by a desire that the experiences of chronically ill men should be understood,

researched or publicised in some way so as to in some way benefit other men in similar situations.

Barry used the ME society as source of informational support. He had not participated in local meetings of the groups however:

Int: And was it quite early on that you joined the ME Group?

Barry: Oh yes because I wanted to make sure I kept my job and got the support.

Int: And what kind of support were you able to get?

Barry: Just basically finding out, at first the doctors referred me to the ME Unit at Leeds and its things like that, the practical support, I never went to any of the meetings because that would really depress me, a lot of people suffering from ME, I just use it as a resource.

(Barry, Interview 1, 236-245)

Clearly for some men the prospect of mutual support in the form of meeting and in-person discussion was not perceived positively. The value of cross-cutting ties in facilitating access to information and other resources has been emphasised in relation to processes linking social capital and health (e.g. Ferlander, 2007). For chronically ill men such resources supplemented information provided by health professionals and were seen as assisting them to negotiate interaction with the health services. This was important as many of the men had complaints about the processes of diagnosis and treatment they had undergone. Charitable organisations therefore were both independent and promoting best practice in relation to illness. The same applied for Barry in relation to discussing illness with a neighbour:

Int: Talking to other ME sufferers have you found that's a common cycle?

Barry: No I read it, there is only one other ME sufferer that I can talk to and I don't really get on with him, we are sociable, he is the chap across the road, he has ME, he had to give up his job as well, I mean I read a lot but not extensively, I haven't read a recent report about this gene or whatever but I tend to read, I would much rather talk to

people anonymously or on the phone, sitting and having heart to hearts is not my thing.

(Barry, Interview 1, 360-370)

Whilst some non-employed participants had adjusted and expressed contentment at being restricted to the domestic sphere, this seemed to some extent a function of their having the companionship, support and focus provided by their partners. Tony had moved to resume community group participation that he had previously undertaken in company with his wife as her Alzheimer's disease had progressed to the point where she eventually entered a care home on a permanent basis:

I used to go out shopping and things like this you know, and actually took on other jobs that I'd done previously, cos we used to do lunch in Ray Court in Dockton, for the WRAS, I was in the Fifty Plus club, and then the [inaudible] club and I went back to them all., I went back to them all, er, only a couple of miles at a time, you know, on days when she was either in care or in bed, you know, so you have to gamble with this, some people get so knotted up, I mean I tried to avoid this, but the worst part of it strangely enough, was when she went into care, I felt like a lost, lamb shall we say, you know, just, my time had been so, planned, and I was really really efficient, and everything sort of moved around quite nicely, and suddenly there was nothing, a void, you know, and erm, it's one of those things that erm, it's erm, you know, I'm getting over it now, it's two years now but, as I say I have a friend, but er, it's erm, it's very hard but erm, you feel lost and sort of er, I know you say this business of post, post marriage again you see, it's one of those things you see...

Tony (Interview 1: 759-780)

For a man like Tony who does want to participate it seemed that an acceptance of a gender imbalance was important in their continuing to attend:



Tony: But yeah men do, they're a pain in the arse quite honestly men, and they don't join, I mean this fifty plus club there's two men in it, all the rest are women, I mean my wife was in it, with me, and apart from the odd men, they look round at all these women and think, 'god I can't stand this' and get out. And why? What's wrong? You know.

Int: Yeah, so you find it, you find it great to be...

Tony: Very good, yeah, yeah, yeah.

Int: So does that reflect on your general view on relations between men and women?

Tony: I think so yes.

Int: Has that always been the same?

Tony: Well I can communicate, a lot of the buyers are women, you know, you've got to be able to, erm, communicate between the sexes, I mean a lot of men are put off, I mean maybe it's a sheltered life they've worked in business which was male orientated, my age group, and er never contacted women, and probably didn't see their wives awfully frequently, you know, it's one of those things, but I mean, as I say before, my wife was my friend and, it's one of those things that's er.

Int: So that's helped you in communicating with women.

Tony: Absolutely, yeah, yeah.

Int: Has that helped you cope since your wife's gone into care. Has that helped you cope?

Tony: Well yes because I can talk to people, you know, it's one of those things, it doesn't bother me talking to people. If you go round shops you see men on their own, like, trudge, trudge, trudge round the shop, you know. I'm weird, you see. [laughs].

Int: You say weird, do ever feel that other men look at you in that way?

Tony: Maybe, but I was in the commandos [laughs]. But I have quite a few friends who have very close relationships with their wives, you know, it's one of those things, it's er, I'm not alone in this sphere.

Tony (Interview 1, 787-825)

Tony linked his ease with women with both the nature of his marriage and the professional environment of his previous career. He sees that as a point of difference between him and many if not all men. His time as a commando is a discursive resource for demonstrating masculinity that inoculates him against attributions of feminisation or 'weirdness', embodying as it has historically an elite male-only environment. The military has been identified as "one of the most obvious arenas of men's social power" and is deeply implicated in hegemonic processes (Hearn, 2012, p.35) relating to both internal and external hegemony. The use of the past as a discursive resource typified narrative as a defensive, performative resource (see Sean above in case study analysis). Whilst illness and ageing challenge masculine identities, one of the ways in which that challenge is met is to rely upon such narrative reconstructions that legitimise a masculine sense of self, so that inability or disinclination to engage in masculinist practices in the present may be recontextualised within the life story. De Visser et al (2013) find that masculine capital accrued in one domain can effectively be "traded" to compensate for behaviour not considered masculine in another. The narrative approach of the current study allowed for the temporal aspect of such processes to be highlighted.

It is interesting here also how Tony represents men who have more exclusively inhabited male-dominated professional environments and socialised little with women as rather sad figures trudging around the shops on their own. Successful ageing for him is affiliative and whilst it would seem more realistic to discuss the gendered nature of his social network participation in terms of 'mosaic masculinity' than to argue that he actively challenges hegemonic masculinity ideals, he is clearly able to both resist censure and construct a dominant and confident masculine sense of self.

#### *Involvement in health-related groups*

Several of the men interviewed were participants in health-related groups, linking them with health professionals. Tony was a member of a Stroke Support group, and the local Primary Care Trust. Being ill had created both an interest and investment in participating in such groups. Men benefited from the social outlet and feeling that were participating in something important, as well as

increased knowledge of how to manage illness and access to health professionals.

The majority of men interviewed who discussed their participation in such groups spoke of using them as an informational resource. For instance membership of illness related charitable groups such as the M.E. association gave access to a newsletter and useful articles about the condition. Tony had been invited to join a stroke support group through informal social ties (his partner's family). Participation had led on to his joining other health-related groups linking with the local NHS Primary Care Trust and he was one of the most active participants in terms of formal community participation. There was some discussion of the status of these groups and the linking capital that accrued from membership – in the Stroke Support group for instance health professionals were perceived as unhelpful, whereas the PCT group was attended by more senior health professionals and participation was more satisfactory. Tony described himself as a life-long 'joiner' of groups, and referred to his army training and presentational experience in his past career as a salesman fitting him well for speaking in committees and playing an active role in such groups. He had acquired skills that other participants did not all share therefore and was perhaps better equipped to negotiate linking ties.

Practical support also derived from membership in such groups, in the sense of help with navigating the healthcare system. Men were often ambivalent about and/or tended to value less the aspects of group membership that would involve fellowship with other illness sufferers [Barry, 234-245].

Int: And was it quite early on that you joined the ME Group?

Barry: Oh yes because I wanted to make sure I kept my job and got the support.

Int: And what kind of support were you able to get?

Barry: Just basically finding out, at first the doctors referred me to the ME Unit at the hospital and its things like that, the practical support, I never went to any of the meetings because that would really depress me, a lot of people suffering from ME, I just use it as a resource.

## **Linking Ties and Illness Experience**

A number of themes are relevant to the concept of linking social capital, which is concerned with the vertical dimension of social relatedness where people interact across explicit, formal or institutionalised authority or power gradients (Szreter and Woolcock 2004). Networks of trusting relationships, norms of respect and reciprocity between people in vertical relations are theorised to characterise positively productive settings and facilitate the receipt of ideas, information and resources. Amongst participants the workplace, and healthcare institutions were important settings in which such processes had impacted in the lived experience of chronic illness.

### *Workplaces and Linking Social Ties*

Relationships across workplace power gradients were narrated in ways that largely focussed on the struggles men had faced in negotiating employment whilst chronically ill. Workplace cultures had tended to militate against men's ability to continue working, and retirement or sickness absence were linked with inflexible regimes and 'long hours' cultures.

### *Negotiating Accommodations*

Beyond statutory mechanisms of support such as paid sickness absence, men talked about their need for and attempts to negotiate appropriate workplace accommodations to chronic illness. Linking ties however were sometimes helpful and sometimes not. Obtaining workplace accommodations had proved difficult for participants. Both negative aspects of masculinist workplace culture and positive benefits of linking social networks across a power gradient were evident in Tony's narrative regarding his experience with colleagues who were above him in the workplace hierarchy. This concerned a period of workplace absence due to illness, the possibility of returning to work in a changed role, and his eventual early retirement [478-502].

Tony: I mean I was with the Brookshaw company, they're a Quaker firm and good, look after their staff and this sort of thing, but, I was told

by a gentleman who I'd known for many many years, I was on grocery he was on confectionary on this area, and he came to see me and he said 'well you know Tony, you come back fit or you don't come back at all.' I said 'charming John'. So that's the way the company's gone, but of course it has, these days, there's no sympathy, I mean there would have been a job in a depot in Langton, or job in the office in Pullford, just doing minimal things, in the old days, but all that had gone of course. So I mean I had a friend who, in Franley, who I'd known very well who was a senior manager, and I rang him up one day and said, 'what do I do about this? Do I take sick retirement or early retirement' which was going at the time, 'take early retirement but this conversation never took place.' [laughs] were his very words. So I did it and when it all percolated through the system Pete Newham who was a peculiar sort of bloke really, he sort of said 'oh you're going are you?' 'about our conversation' 'oh well I didn't really mean it' you see he started panicking like this, in case I talked to somebody. But erm, you know it's erm, but he said 'you come back fit or you don't come back again.' So my doctor said 'if you go back you'll kill yourself.'

As a long term employee of the company, his access to powerful colleagues in this case enabled him to negotiate the situation and the company's retirement policies advantageously. The narrative positions Tony himself in a number of ways, as simultaneously somewhat vulnerable, and subject to potential injustice, but also as 'well connected' and able to actively shape the outcome positively via such connectedness.

### *Workplace norms and illness-related disruption*

For some men a long hours work culture had made life with a chronic illness especially challenging. This was the case for Steven, who reported that within the church ministry it was seen as a virtue to overwork regardless of personal circumstances or family life, such that his decision to reserve one day per week from work had resulted only by conscious decision to reject this norm after attempts to meet it took a toll on his wellbeing. Steven described reorienting himself towards a position of some resistance to the long hours workplace

culture as a result of it's personal consequences. He had then taken some steps to achieve a more realistic work-life balance in light of his own chronic illness and caregiving responsibilities.

Steven: And I think the other problem is particularly with colleagues that I think you get amongst congregations, you get more sympathy in those terms than your colleagues who are also underpaid and overworked but you do I think within the ministry get a higher proportion of workaholics than you do in many other jobs. Of people who see it as a virtue to work themselves into the ground I am not quite sure why whether you become a workaholic when you go into the ministry or whether it is people are already workaholics going into the ministry I don't know. You know I think even if I were entirely fit with my particular take on things I think I would be somewhat aghast at what some of my colleagues get up too. A good number of them I have known literally go to work seven days a week morning afternoon and evening never have a day off I insist on having my day of simply as self-defence. Plus time off to look after my wife and do things around the house. But because I went through a phase of picking up this way of doing things from my colleagues in the church you know I would try and do the seven day business but you can't you just crumple. Particularly in my situation, you crumple a lot quicker.

245-263

Oksanen et al (2013) argue that an aspect of "dark side" social capital in work settings involves the reinforcement of health-damaging behaviours where they are defining characteristics of the work community and Steven's experiences may be seen to exemplify the phenomenon. Downplayed or ignored in much of the literature on social capital in the workplace however is the way in which configurations and practices of employment have been strongly coupled with notions of hegemonic masculinity (Pini and McDonald, 2008). Workplace expectations of long hours may be seen as enforcement of hegemonic masculinity, hindering men whose commitments to sharing household labour and childcare reflect new forms of contemporary masculine subjectivity (Pini and McDonald, 2008; Smith and Winchester, 1998). Acting in ways that do not

accord with such recognised masculine ideals in the workplace becomes a struggle (McDonald and Jeanes, 2012). For chronically ill men in such a context an inability to meet these expectations due to illness may be seen as reduced 'masculine capital' (e.g. Coles, 2009).

Support from employers had often seemed limited however to those statutory provisions such as sick pay; like Tony, Steven found that despite there being some institutionalised benefits an inflexible approach to working practices had characterised personal interactions with more powerful colleagues:

Steven: So you get a certain amount of sick pay and you do get sort of housing and I think you get a proportion of your retirement pension if you retire under those circumstances. But in terms of ministers with disabilities the church is a confounded nuisance actually I don't think there is any great official policy on this. My, in my experience is you either function or you don't function you know there is no sort of halfway house which I find very weird. For instance when I was in Colne and got very depressed and had three months off, I remember towards the end of that talking to the chairman of the district who had authority over me and suggesting that it would be useful if I could perhaps you know go off assisting an old minister for a week or two and you know take a few services with him. So if I couldn't cope he could take over No. no, no you either do it or you don't do it you are either sick or you are not. So I was sick until a particular day and the next day I had full responsibility for everything. Which shows a tremendous amount of lack of understanding, which I find bizarre I do find in the church the church teaches its ministers and its lay pastors to you know; be kind, listen, and understand people and do the best for them. But it does not seem to have anything like that same attitude to people in the system. Which I find tremendously hypocritical so again this tends to make me a little bit defensive I am afraid.

(Steven, Interview 2, 320-342)

Such inflexibility towards accommodating his illness can constitute a marginalising process. Interacting with colleagues across an upwards power gradient could produce unsatisfying outcomes due to such issues as personal disposition, lack of understanding, or conflict between the chronically ill employee and institutional goals. Inflexibility of work and a lack of understanding amongst co-workers have previously been noted as an important domain within which low back pain sufferers experience workplace challenges (Tveito et al, 2010) but such issues are liable to be relevant to a range of chronic illnesses. In greater depth, Smith-Young et al (2014) discuss the theme of 'constant negotiation' in relation to social psychological processes amongst men with chronic musculo-skeletal disorders in the workplace. They found that their participants also talked about dealing with supportive and unsupportive managers, with men having various degrees of success in negotiating workplace implications of illness, resulting in a spectrum of experiences from satisfactory to feeling victimised. In constructing a Grounded Theory model of 'negotiation strategies in gaining control' Smith-Young et al identified 'feeling in control of the situation' combined with negative/positive workplace support as key issues in determining negotiating options and victimisation/workplace partnership outcomes. For men such as Steven a masculinist workplace culture and relationships with more powerful work colleagues detracted from their ability to feel in control. Therefore whilst Smith-Young et al (2014) do not interpret their findings in relation to gender constructions, issues of control and negotiation in a masculinist workplace may be usefully related to the wider social context beyond dyadic social-psychological processes.

A further issue concerned the specific position of seeking help when one is oneself in a 'helping profession'. As Steven described it, a prevailing attitude within the workplace was that as a member of a 'helping profession' one should not require help oneself. Having problems of one's own that necessitated help was instead seen as meaning the person was unable to do the job.

You know they have this psychology that sees the world divided into the helpers and helped. If you are helper you are supposed to help you can't actually go and get help because you are the wrong side of



the divide I am sure some psychologists have produced a theory in this probably works with doctors as well but we won't go into that  
349-354

Work on role identity theory has developed in relation to the issue of barriers to help-seeking amongst helping professionals such as social workers, psychologists, and pastors (Pooler, 2011), theorising that psychological identification with idealised helping-professional roles and social comparison processes lead people to neglect to seek help themselves when needed. However Steven's perspective touches on discourse and normative practices related to his role, which he has had cause to question.

Perceived pressure came from congregations also, so that the recipients of his services as well as colleagues were seen as demanding.

But equally I think there is a difficulty with people you are working with when this is your congregation or colleagues see you as being paid to do a job and then seeing that you are not actually fit to do the job and I think that I have been fairly sensitive too that. There is an issue that is not really to do with this condition that I find congregations are very demanding they assume that since they pay your wages they can virtually can rule your life, I am sure that medical workers find exactly the same thing you are owned by them because they pay your wages. The fact that ministers even more than medical people are not terribly well paid is entirely beside the point you know you have got to be available twenty four hours a day seven days a week you know and they look at you sideways if you say you are going on holiday. Well this is not everybody but a sufficient number to make you quite sensitive to criticisms of not working  
228-243

Linking social capital is conceptualised as existing across formal/institutionalised power gradients and it is interesting here that unhealthy working practice is reinforced from both 'above' and 'below' in the church

hierarchy. Perhaps not surprisingly in this context like many of the men interviewed Steven had tried to hide symptoms of chronic illness. Whilst Dilorio et al (1996) argue that disclosure within the workplace is necessary in order that practical support, role adaptations and perhaps improved social support may be provided, it has also been noted that for disclosure to be beneficial both parties must be willing participate in 'disclosure encounters' (Hagedoorn et al, 2011).

### *Linking Capital & Health Professionals*

Participants talked about relationships with health professionals, a topic that also may be explored in relation to 'linking social capital', i.e. relationships across power gradients. Health professionals held power to diagnose and legitimise illness experience, and acted as gatekeepers both to treatment/management interventions, and to relief in the form of welfare benefits and medical absence from employment.

Several men described a fraught process of struggling to be diagnosed. Amongst participants with CFE/ME such experiences were particularly prevalent. As an illness with a history of disputed aetiology, men with M.E. related narratives in which their difficulty in obtaining a diagnosis was intertwined with attributions by healthcare professionals of their symptoms to psychological causes, notably depression. Men had sought a diagnosis that involved some physiological component and none of the men interviewed accepted M.E. as being caused by emotional illness. Barry summarises this in a generalisation about medical professionals that 'if you can't find a medical cause then it's all in your mind, that's their approach.' (216-232).

I managed to settle back into university I was struck down with ME so it was a bit of a bugger, so I played the Health Service and I got sent to ----- for tests and it wasn't anything physical that could be diagnosed, and I was perfectly alright they put it down to ME so the doctor wrote to work in around 1992 after about a year of plaguing them and they sent me to the ME Unit and that was crap because they

think it is all psychological and Doctor Lynch there who wrote one of those books about ten years ago and said it was all associated with depression, but of course you get pissed off if you are ill! You know I am sure they fitted the characteristics quite perfectly, one of the sayings in the doctors is 'profession ----- conspiracy -----', I think it's more understood now, it's what medics do isn't it? If you can't find a medical cause then it's all in your mind, that's their approach.

In the case of limited medical acceptance of the condition the need for men's active agency and persistence was discussed, in order to have their illness legitimised with employers.

Such episodes of ambiguity and seeking meaning must also be related to the wider context in which CFS/ME has had the status of a medically disputed illness. Steven's narrative typifies the experiences of many men with this condition; diagnosis was a lengthy process, his GP was unsure for a considerable time about what he was suffering from, and indeed as a result communicated to him that there was nothing medically amiss. This could be conducive of self-blame for the symptoms of CFS/ME amongst men, and indeed depression. Steven had felt that after treatment with various antidepressant drugs he was simply left floundering. In fact, in contrast to the expectations he had that investigations would be pursued until the definite cause of his symptoms was ascertained, this proved not to be the case. [610-634].

P: Because when you don't know what it is and you have been to doctors and they tell you there is nothing wrong with you, you tend to exclude that you then have only two options either that you are in some sort of built in sense lazy not by choice but simply by manufacture. Or that you are playing games with yourself, you know I know a bit about psychology, and that you are playing games with yourself and you are not in a situation you actually want to be in but are not admitting it. And you keep wondering around things

all of which produce guilt and the guilt does not help you know it tends to make the depressions and so forth worse Yes I am very disappointed really about doctors you know you go with a problem they try one or two things like antidepressants. They make sure you are not diabetic and your thyroid is all right according to their rules. And they try some antidepressants so you go through three or four of them with various side effects and they don't work and that is it and then you know you are sort of left floundering. I find this, of course, what you want is oh this is an interesting case we will send you to hospital spend thousands of pounds taking you to pieces but of course this in reality is not going to happen.

Clarke & James (2003, p.1393), taking a Foucauldian perspective on CFS conclude that: "The medical profession provides, through power and knowledge, legitimacy for the way the person is feeling and the body is operating. The lack of a clear and generally accepted diagnosis in the case of CFS means that the self is without the legitimating discourse from the powerful medical profession". For other men who were more readily diagnosed with a chronic illness the inability of health professionals to provide effective treatment was an issue; it is in the nature of chronic conditions that they are not curable, and amelioration of symptoms via medical/drug treatment is of course possible to different degrees for different illnesses. There was some frustration with health professionals, often linked to a seemingly insufficiently concerned attitude in combination with a lack of effective treatments. Barry's comment exemplifies this: [176-182].

I went to the doctor but it was like, 'take two aspirins and go to bed', type of approach, that was all they could do, and then I never shook it off, after the first bout I was back to square one basically, I thought that was it, I thought the ME might have been the flu or a cold but in October 1990 it came back again and I was back to square one.

Men also identified a lack of information about effective lifestyle changes coming from healthcare professionals as an issue of concern. Steven for instance suffered from migraines, but was later disappointed to discover for himself that certain foods might be triggering these episodes, and that the various doctors he had spoken to had not raised pointed this out to him, and it was a counsellor that did offer him this information.

### *Gatekeeping and linking social capital*

Another aspect relating to relations with healthcare professionals was their role as gatekeepers and adjudicators on the legitimacy of illness, fitness for work, and entitlements to welfare and pensions provision. Barry described some negative experiences in this regard [463-477]. Barry described some negative experiences in this regard:

Int: Up until the time when you had left work, how had your relationship with health professionals developed?

Barry: Oh appallingly, because I am trying to get a pension, my GP is perfect but the occupational doctors were appalling, one was a nasty piece of work who said the reason was I was on contract and trying to get something out of it, the second person was [anonymised] who sat in Bisford and kept sitting on the fence and said I might be ill, I might not be ill, I might get to work and I might not get back to work, my local doctors sent me to the ME Unit at Leeds and a very nice young girl, a specialist there said, 'well he might get better', so it was like pension down the drain, I mean the bloody doctors sit on the fence, so my views of doctors haven't changed!

There is a lack of trust and problematic 'linking' ties evident here, with health professionals' gatekeeping preventing and devaluing men's experiences. Marginalised identities were evident in such circumstances, marginalisation was described as a process, proceeding via such socially mediated experiences and difficulties. In common with employers relationships, active negotiation or following up was often discussed, but where health professionals seemingly bought into non-existence arguments regarding CFS/Me this was a frustrating

process for men. Men were constrained then in their opportunities for technical/professional domination in dealing with powerful health professionals.

For some men participation in support groups that directly linked them with health professionals had provided them with more access in non-clinical settings.

### *Uncertainty and Masculine Sense of Self*

For some participants the thread weaving past and present was speculative in the sense that experiences which earlier were not recognised as 'symptoms' were reinvested with meaning at a later point in life when a long term condition had been recognised.

P09 48-71

The basic problem from probably beginning to end is that no-one has been very clear about what's wrong with me and that has covered the whole experience. As I say, I went to school between five and eleven, and I remember 7 years into that, an irate teacher coming to see my father and saying, 'do you realize that this child has lost two thirds of his school', now the pattern was on the one side I had everything that was going, you know, mumps, measles, chicken pots, I don't think I had scarlet fever but most of the things that were going round, I had frequent colds, and I remember drinking gallons of, you won't remember it, pink penicillin, it came in bottles, they coloured it pink so you would like it, but it tasted revolting, which suggested that I then had recently had two infections, I had two respiratory infections, so that is one side of it but that doesn't account for two thirds of school life. The rest of it is simply accounted for not feeling I wanted to go to school, I don't remember particularly being anxious about this, I don't remember throwing tantrums or anything, I simply remember not being well enough, being tired, lethargic, headaches and things like this, it's all a while ago but this is what I remember, and I was simply not wanting to go because I felt I couldn't cope.

Even from the perspective of being diagnosed with M.E at the time of interview, a participant such as Steven is left to conjecture regarding the nature of such problems and connection with his now diagnosed illness. For a condition that would not even have been recognised during his childhood, and has passed through various degrees of debate about it's ontological status historically, the nature of such experience becomes problematic and the life story's unsettled, contestable, malleable nature and openness to new meanings that alter one's sense of self are particularly apparent.

## **Reflexive Analysis**

### *Myself as a researcher*

I am a white, 46 year old married man, from a working class background. I am employed full time as a Lecturer in Psychology at Manchester Metropolitan University. I grew up and have lived in the North West of England where the interviews were conducted for the majority of my life. My interest in researching masculinities came about initially through my undergraduate psychology dissertation on the topic of men's friendships, and then developed through involvement in other research projects. I am (pro)feminist in outlook and this also informed the development of my interest in gender issues. Such interest has coincided with exciting growth in theory and research on 'men and masculinities' during my time in academia, related to wider social change and interest in gender relations and which has shaped the research process throughout including research questions and interpretation of interviews..

My interest in social capital came about as a result of my participation in a research project looking at social capital in a deprived community. At a broader level the timing of such work reflected an environment in which the concept was both developing a very large literature, met with the interests of the Research Institute for Health and Social change at MMU, and was valorised by the New

Labour Government of the time. This context influenced my ability to gain an RIHSC bursary to support the research.

### *Meeting and interviewing the participants*

Amongst many of the participants I think that understanding of the role of a researcher or psychologist was quite limited at the outset, and participants sometimes addressed me as a medical or healthcare professional (sometimes making assumptions about a level of clinical medical knowledge, or psychological insight into their personalities), that were not accurate. For instance, Steven communicated to me his perception that psychologists either “run rats round mazes” or “walk away with your life in a bag”. I saw the implications of that as being linked with themes of authority and power that permeate qualitative interview research such as this.

There was also an apparent readiness to see me as ‘on participants’ side’ as a gatherer and publiciser of information about their experiences which assisted with the development of rapport. Some participants clearly viewed me, as a researcher, as somebody who could make a difference regarding illnesses that are stigmatised such as CFS/M.E. In considering the function and status of a PhD thesis it was difficult for me to reconcile that perception with the reality of a vast literature and politicised arena of media discourse and public policy debate into which publications stemming from this research would make a relatively small contribution. I was often conscious of being careful to represent the nature of the research and it’s likely impact realistically, or to dispel any perception by participants that I was in some way psychoanalysing. This was important in maintaining authenticity of communication with participants.

There were few instances of sexist and other offensive talk from some participants, and undoubtedly instances of hegemonic masculinity construction. I did not challenge hegemonic masculinity signifiers in order to facilitate rapport and to not inhibit participants by being oppositional, respecting their generosity in taking time to participate in the research, their hospitality, and that I was largely interviewing men in their own living rooms.



An overriding consideration for me was to listen and facilitate the gathering of extensive narrative accounts of men's lives and experiences. I have taken the position in this research that, as Cowburn (2007) argues, it is not the researcher's role to challenge the story that is being presented by participants, but to document and interpret it. I therefore did not approach the interviews as a site for contestation or policing of participants' talk, which might be appropriate in other contexts. This of course has shaped the resultant interviews. Critical distance therefore was expressed later in my analytic writing.

I do not share therefore the stories of the majority of participants in suffering from a serious physical chronic illness with its many implications for everyday living. I am in good physical health; although I am a diagnosed asthmatic it has little impact on my adult life aside from insuring I have access to an inhaler which I use infrequently. In that sense I do not see myself as an 'insider' to chronic illness. Whilst my political and social values have informed the research, had I myself been greatly affected by chronic illness the research would likely have been influenced by that, assisting me perhaps in both insight into participants' experiences.

## **Chapter Nine: Discussion and Conclusions**

In this chapter I summarise the rationale for undertaking the research, before providing an overview of the findings in which I discuss them in relation to recent relevant literature. Limitations of the methodology employed are discussed. Implications of the research for policy, practice and research are reviewed. Subsequently I make recommendations for future research to follow from this thesis, and make some concluding comments.

### **Summary of the Research**

This thesis has explored the experiences of chronically ill men with a particular focus on issues of masculinity and social capital. Semi-structured qualitative interviews with individual white, working and middle class men were analysed. A multi-level narrative analysis (Murray, 2000) informs the interpretation and conclusions of the study. The participant narratives have illustrated close links between processes of masculinity construction, chronic illness experience and social relatedness.

I introduced this thesis with an outline of health psychological research and theory, attending to critiques of what has been termed a 'mainstream' approach and contrasting this with developments in critical health psychology that have relevance to chronic illness experience. I argued that research grounded in the experiences of chronically ill people can be usefully approached from the pluralistic perspectives that acknowledge and attend to interpersonal and sociocultural aspects that impinge on accounts of chronic illness experience. I further argued that men's experiences of chronic illness are intimately bound up with conceptions of masculinity, and reviewed developments in work on masculinities and men's health and illness that inform the study. Gendered sense of self then is considered as an important informing aspect of illness experience that links with men's practices in complex and varying ways. Relational aspects of illness experience were central to the investigation. In further observing that masculinities and their enactment amongst chronically ill men call for examination of social and community processes I then reviewed work on social capital which pointed to the benefits of critically engaging with the concept to produce a gendered analysis of the processes linking it with chronic illness experience.

## **Rationale for undertaking the research**

Whilst a growing literature on men's health and illness has developed, a gap in research exists regarding a gendered perspective on 'illness narratives' of men. Despite the increasing popularity of multi-perspectival qualitative studies, few of the studies linking masculinities with chronic illness experience systematically take this approach. Similarly both gendered and narrative perspectives on social capital are relatively lacking in the vast literature on the topic and more specifically in relation to studies exploring links with chronic illness experience. The rationale for the current study has therefore been derived from a review of the literature with the aim to contribute to addressing the research gaps identified.

In two case study narrative analyses a holistic view of chronically ill participant biographies was constructed. In cross-case analysis using interviews from a further four participants commonality and divergence in themes around issues of chronic illness experience, social capital and masculinities was explored and interpreted.

This chapter describes the contribution to knowledge produced by the study regarding lived experience of chronically ill men in relation to masculinities and social capital.

## **Overview of the Research Findings**

The research used semi-structured interviews to investigate the lived experience of six chronically ill men. In the longitudinal design employed men were interviewed twice over the course of approximately one year. Consistent with the pluralistic approach to interpretation, the interview process was seen as involving co-construction of narrative accounts and resulting in material that can be viewed in relation to personal experience, interactional processes, and sociocultural discourses. The findings of the analysis reflect my interpretations of the interview material and aim to contribute to current debate around the study topics. The findings are specific to this group of men, however there may

be transferability or generalisability of issues to similarly socially located men. The relevance of the findings to non-heterosexual, non-white men may be limited.

The thesis has addressed the following research questions:

1. What processes link social capital, masculinities and experiences of chronic ill health?
2. What are the experiences of men in their use of social capital in relation to chronic ill health?
3. How do participation in community life, relationships with friends and family, shared group norms, trust and reciprocity work to mediate men's experiences of chronic ill health?

This section of the chapter briefly summarises key findings of the study. Issues of masculinity construction, social capital and chronic illness experience and the processes by which they were linked are summarised below.

The meaning of chronic illness in various settings was seen to be open to disputation, reflecting links with social relatedness. Causes or exacerbation of illness for instance were disputed amongst family members for instance, linked in with family conflicts. One participant had discontinued contact with a parent, another with an in-law as a result of conflicts that had crystallised around issues related to their illness. As Årestedt et al (2014) find, families co-create a context for living with illness. Their research highlighted some of the productive ways in which families work together towards increased wellbeing. Whilst they illustrate how conflict linked with frustration and fear may be aroused by clear manifestations of illness, the current study illustrates some of the alternative ways in which illness may result in or be a 'lightning rod' issue for family conflict.

Gender is not an issue highlighted in Årestedt et al's (2014) research but a gender-sensitive approach as in the current study highlights the way that (in this case) masculinities may be linked with experiences of conflict within families around issues of illness. Men who were unable to work due to chronic illness

sometimes found that their inability to meet with masculinist expectations about 'breadwinning' led to criticism and shaming for instance.

More generally gender is often ignored as an issue or with minimal analysis of the processes by which it links to illness behaviours and social support or social capital; Tay et al (2013) for instance in recently summarising links between social relations, health behaviours (including chronic illness self-management) and outcomes barely mention gender. Rosland et al (2012) in a recent large scale systematic review of the impact of family behaviours on chronic illness outcomes discuss gender as a moderating variable. In contrast a critical gender-sensitive lens has allowed for the processes linking masculinities and illness experience to be explored in a more in-depth way. Whilst research such as that of Årestedt et al (2014) focusses on lived experience using an exclusively phenomenological approach, the multi-level approach employed in the current study has facilitated contextualising experiences beyond the micro-level of family systems usefully.

Reciprocating care and support within families was a feature of many participants' lives. As Rosland et al (2012) argue, family behaviours may be particularly important in influencing outcomes for chronic illnesses that require active, ongoing self-management. For most of the participants in the current study who were cohabiting with families some degree of active self-management was required and the interconnectedness of family members was both complex and emotional, encompassing behaviours perceived as supportive and non-supportive often over long periods of time. It was not uncommon for men's partners to similarly be suffering from some chronic illness and the degree of severity and nature of their respective conditions influenced the manner and form of reciprocal care and support.

Workplace stress, and sometimes its connections with wider social changes affecting employment appeared prominently in men's narratives about causes or exacerbation of illness. Similarly social relations in the workplace context appeared often featured in narratives dealing with difficulties of negotiating productive courses that were positive for men's wellbeing and supported their continued working. Men's reticence to admit to or seek assistance, as well as

unsatisfactory outcomes of seeking accommodations were apparent. This was often related more to the masculinist context of workplace cultures than individual men's own wishes to 'do masculinity' by struggling on however. The concept of 'masculine capital' (e.g. Coles, 2009) was relevant here and useful in conceptualising the processes linking masculinities and social relations at work. Again in broadening the focus beyond individual experiences to examine the way that masculine ideals shaped these the findings of this thesis add to and elaborate on research such as Oksanen et al (2013) and McDonald and Jeanes (2012).

Men's experience of illness then played out in the context of attributional discourse around social, cultural and political contexts. Issues such as the above are likely becoming more highly charged as the discourse around long term conditions, employment and welfare provision has become both increasingly harsh and as recent policy changes reflect that in focussing on issues of functional limitations of people with perceived impairments to a greater extent than inequalities in the way that work is socially organised (Garthwaite, 2011).

Positioning themselves in relation to such issues often provided justificatory force for their narrated actions (here resigning from work, or cutting a family member from their social network were examples). Emplotment weaves together events and actions with the actor's logic and argument. Experiential perspectives such as provided in this study can assist in understanding lay rationalities that inform the actions of chronically ill people. Issues of policy attention such as the pattern of those becoming chronically ill rapidly leaving the labour market, and the stigmatisation of such people by governments and media as 'scroungers' are often represented without reference to the voices of the chronically ill. Where the voices of chronically ill people are presented they may lack richness, and gendered understandings are often simplistic or non-existent.

The interviews illustrated the narrative construction of illness worlds often characterised by disruptive impact. This notion of biographical disruption was relevant both to men who had been chronically for large proportions of their

lifetimes, as well as to those who became chronically ill more recently. Sudden disruptive change did occur over the course of lives marked by early onset of illness as symptoms fluctuated or worsened, and often as additional chronic illnesses developed; co-morbidity was common amongst the study sample. It was also relevant for men who had experience material hardship. The sense of illness experienced as a 'normal crisis' was less apparent, with the complexity and ambiguity of experiences of loss and transition in relation to illness however being marked.

Expectations about family life had often changed as result of illness, sometimes causing relationship difficulties. In some families such as those of Barry and Tony non-employed chronically ill men had engaged more in regularly cleaning, cooking or caring for children whilst their partners' employment provided a source of income.

Healthism (e.g. Crawford, 1980), a web of discourse and practice that individualises and attributes moral responsibility to health-related behaviour and its consequences is a relevant context to contemporary illness narratives. One participant (Sean) jovially related an account of drinking and heterosexual pursuit that resulted in injury and other attendant health consequences. Whilst accepting responsibility for these, there was a presumed rapport and attendant esteemed identity performance in his delivery that illustrated well how accounts of personal experience can perform hegemonic masculinity. For a man who is largely housebound, socially isolated and single the episode constituted a strong narrative resource in which the negative health consequences illustrated the extent of his heterosexual libidinal drive or motivation. The interactional level of narrative discourse was particularly pertinent to such instances of masculinity construction.

Although a stoical approach to illness was claimed by many men this did not necessarily preclude help-seeking. Indeed even those who seemed to orient themselves most strongly with hegemonic ideals of masculinity positioned themselves as active and questing for advice, diagnosis and treatment. Sean for example framed this as a rational project entirely in line with his generally masculinist outlook.

Similarly men sought and valued supportive social relationships with partners, friends, neighbours and other community members that helped in attempts to reconstruct esteemed identities and with many aspects of everyday life. Men's stoicism then related to talking about emotions and in particular of emotional vulnerability. The successful regulation of emotion was valued in this respect, in multivocal narratives that performed the former function within a wider cultural context of masculine ideologies and exhortations to positivity. Men's narrative accounts concerned with seeking of information, advice, diagnosis and treatment regarding chronic illness were all framed within a consumerist and rational problem-solving approach that aligned with wider discourses increasingly attributing responsibility for illness self-management with individuals. This accorded with ideas about the reframing of illness in line with masculinity ideals, as a technical problem to be solved. The use of chronic illness support groups often reflected that also, with men valuing the informational resource they provided but downplaying the value of shared emotional support or the opportunity to express themselves amongst fellow-sufferers.

A high proportion of participants were M.E. sufferers, and it was apparent that the condition was seen as stigmatising in a gendered way in being culturally represented as somewhat feminised, and relatedly, associated with emotional-mental health difficulties in the form of depression. This in turn linked to historical medical debates about its status as a physiological or psychological entity and the representation of women as more prone to emotional-mental problems.

Fit between participants and the places they resided was an issue that linked with their experience of illness and social capital. Many participants were present in their residential neighbourhood through weekday daytimes when most other people around their age would be working, and spent more time there than their employed peers. Places that were characterised by a mix of people including retired people opportuned friendships. Activities such as dog-walking that facilitated engagement with local community members were enjoyable and even led to supportive friendships. These tended to be either



friendships with men who themselves were retired, and often older than participants, or with couples (again often older than participants). For some participants, such as Sean, however a poor fit between themselves and their neighbourhood was described, and whilst this did not preclude some supportive friendships, generalised trust and reciprocity were absent, and indeed identities that were oppositional to the general character of people in the local community were constructed based on othering and difference in terms of social class and/or lifestyle.

### **Limitations of the method**

In this section I will present a brief account of the main limitations of the current study.

Qualitative investigations have been criticised for their use of non-random samples that are small and lack generalisability to a wider population (Onwuegbuzie & Leech, 2010). The sample size in the current study is relatively small compared with quantitative survey studies due to the restrictions of this PhD and the laborious, time-intensive analytical process employed. The current study is concerned however with analysing rich data in depth as opposed to focussing on breadth. Rather than obtaining a study sample that statistically represents the larger population of interest in order to achieve generalisability, a differing logic informs qualitative work.

One approach is to employ 'thick description' to address the particularities of experiences in specific settings in place and time. In the current study a combination of in-depth case study is combined with cross-case analysis to produce a rich picture of the experiences of study participants. Looking beyond the current study the question of transferability links to its wider usefulness and implications. Transferability is enhanced by both detailed description of particularities and good theoretical analysis to allow readers to assess credibly what is likely relevant in other contexts and settings (Green & Thorogood, 2014).

Considering the sample in the current study, it is apparent that it is weighted towards older, white men identifying as heterosexual. Further all participants were living in the North West region of England. A greater diversity of participants in terms of ethnic/cultural background would have enhanced the study, however the methods for accessing participants that I selected did not bring forth such. Perhaps the targeting of different community organisations or specific local areas could have facilitated this and helped to more fully address research question two regarding the experiences of chronically ill men.

Chronic Fatigue Syndrome/M.E. sufferers were highly represented whereas many other illnesses which may have specific implications in relation to the study focus did not affect participants. The study is likely therefore to have some level of transferability across similarly socially located men. As Payne and Williams (2005) argue, the reader must exercise discerning judgement in assessing the extent to which findings transfer to men beyond this sample.

Both information and nuance become to some extent degraded as the oral material generated in qualitative interviews is transcribed to written text. Peoples' self-report accounts also should not be seen as simply mirroring their experiences (Polkinghorne, 2005). The relation between experience and its description in language remains an issue of philosophical contestation (Devitt & Sterelny, 1987). Nonetheless language remains our primary access to people's life experiences and attentiveness to some of the central issues involved in that has been facilitated here through the pluralistic approach to analysis employed. In interviewing participants twice over the course of approximately a year I gained the opportunity to follow up further on issues that were judged to merit expansion from the initial interviews as well as discuss with participants their experiences in the intervening period. Other researchers may have wished to probe different or additional issues following from the initial interviews of course.

### **Implications of the study for policy, practice and research**

It is a feature of recent White Papers relating to health and social care policy (DoH 2004, 2006, 2010) that chronically ill people should be supported in being independent. Similarly a discourse of 'choice' has featured strongly in recent

public health policy documentation since the then Labour government's (2004) White Paper 'Choosing Health'.

Ideas of independence and choice fit with a neo-liberal ideology of individualism, and notions of the 'responsible consumer' (Marks et al, 2014) whilst also creating a space also for the 'Irresponsible consumer' to be targeted (Marks et al, 2014), making attribution of blame for the consequences of choices that impact negatively on health a matter of policy concern (and perhaps laying the ground in future for reduced support or sanctions for those who make health-damaging choices, such as adopting lifestyles that negatively impact on chronic illness management).

At the same time the large body of health inequalities research (e.g. Marmot) showing the patterning of choice according to indicators such as socioeconomic status, ethnicity, gender etc. is acknowledged in policy discourse. There is a recognition that "we do not have total control over our lives or the circumstances in which we live. A wide range of factors constrain and influence what we do, both positively and negatively." (2010, p.29). Whilst such policy developments are described as 'new' (2010), in fact this statement is similar to that of the previous New Labour government. Reid (2006) for instance recognised that 'Existing health inequalities show that opting for a healthy lifestyle is easier for some people than others.' (p.6).

The health policy White Paper (2010), Health and Social Care Act (2013) under the Conservative/Liberal Democrat coalition and NHS Constitution (2015) continued the theme in arguing for a central aim of making policy that "empowers individuals to make healthy choices and gives communities the tools to address their own, particular needs." (2010, p.2). There is a corresponding obligation of individuals envisaged; 'All capable adults are responsible for these very personal choices.' (2010, p.29). To the extent that a logic of rational choice informs public policy, the desire to make healthy choices, such as positive illness self-management steps, becomes a moral responsibility for chronically ill people.

As Oldman (2003) notes, ideas about independence and increased levels of choice may seem difficult to take issue with. There is a long history of advocacy for independent living and patient choice for instance that has grown out of disability movements and is related to the social model of disability. One of the tenets of this movement was that health service users should be liberated from bureaucratic and professional dominance and empowered to make their own choices (e.g. Williams, 1983). However health inequalities may be obscured by a rhetoric of choice (Bell et al, 2011) which fits with a neoliberal agenda and policies that fail to address constraints on and inequalities affecting choice, or a rhetoric of independence which fails to recognise the value and necessity of interdependence. Goodley et al (2014) have recently discussed such issues in relation to 'neoliberal-ableism'.

The Government is positioned as enabling and guiding more healthy choices through policy actions, however the extent to which social determinants of health inequalities are reduced is likely to be limited by domestic economic and social policies such as selective austerity programmes impacting the poor (Shreker, 2014) and the growing influence of large corporations on health promotion initiatives (Marks et al, 2014).

Not only are health-impacting choices patterned in ways reflecting health inequalities, they are also arguably influenced as much by emotions and habit as by rational decision making. As Hoggett argues (2001, p.40):

'Choice, then, is not simply something which occurs after rational deliberation, most choices we make are made on impulse in urgent and contingent encounters in which we have to make on-the spot decisions as our own and others' needs, expectations and phantasies and feelings press in on us.'

Independence similarly is a socially constructed concept, and is therefore likely to vary in meaning across cultures, class and gender (Stephenson et al, 1999). Gignac and Scott (1998, p.740) have argued that the terms independence and dependence 'are generally treated as antonyms both in their valence and their definitions' and devised a model of independence and dependence that

specifically concerns chronic illness and elucidates numerous complexities in the nature of both concepts.

Planners and policy makers have acknowledged the importance of interdependence and social connectedness (Public Health England, 2015). The context of care and illness management within families has to some extent been recognised in policies that aim to support both chronically ill people and carers (e.g. HM Government, 2010; NHS, 2014). Government has also sought to advance patient participation in healthcare and management of illness, through the NHS Constitution for instance. The healthcare system however has been subject to large scale changes recently however and support for illness self-management needs to be considered in that context.

The current study has explored the complexity of different forms of social capital amongst chronically ill men, including 'bonding', 'bridging' and 'linking' social capital and found that 'one size does not fit all', i.e. that associating these forms of social capital with entirely positive or negative outcomes or experiences amongst chronically ill men is likely to greatly oversimplify the diverse and context specific processes involved.

Theories and interventions that do not rest on models of unconstrained individual choice are one area in which policy and practice may be useful. One approach would be to focus in public health policy 'on the 'lives' of social practices, treating social practices as sites of analysis and as sites of intervention in their own right.' (Blue et al, 2014). Social practices which are of course gendered and exist in relation to a matrix of intersectional locations.

The current study has illustrated some of the processes linking family interdependence and chronic illness experience amongst the men interviewed. Understanding the experiences and processes involved in family life can assist health practitioners to adopt a perspective that acknowledges the importance of family systems in shaping the experiences of chronically ill patients (e.g. Arestedt et al, 2013).

The current study has also contributed to gendered understanding of community life and participation amongst chronically ill men. Technocratic solutions to raising community social capital are difficult to employ, and this may be heightened as austerity affects local communities and vulnerable people within them in particular. Some of the ways in which community life is a positive part of men's experiences have been discussed in the current study, as well as tensions related to social class and the stigmatisation of local neighbourhoods. The policy ideals of empowerment for chronically ill people link in complex ways with employment patterns and ongoing welfare reforms in England. More than half of working age chronically ill people in the UK are not active in the labour market (Office for Disability Issues, 2012). This may be explained with reference to the pattern of rapid transition from employment to unemployment following the onset of characterises many peoples' experience of long term illness European Observatory of Working Life (2014).

In the current study masculinist workplace cultures had often circumscribed men's choices about whether to continue in paid employment. Inflexibility towards needed accommodations and sometimes more overt negative communications had suggested to participants that their changed health status meant they were devalued as employees. Policy measures such as the Equality Act (2010) requiring employers to consider 'reasonable adjustments' in the case of a 'substantial' disadvantage to people with a disability may improve such circumstances (although the substantiality requirement has been criticised, see for instance Butlin (2011)). Since the interviews in the current study were conducted public discourse around chronic illness has arguably centred on welfare issues in the context of austerity however. As Garthwaite (2011) argues the negative rhetoric around sickness-related benefits may be counter-productive in influencing employer responses to ill and disabled individuals.

I argue that such understandings benefit from a gender-sensitive approach that sees family systems and broader social connectedness within community and work contexts also. The UN Economic and Social Council (1997) has defined gender mainstreaming as "assessing the implications for women and men of any planned action, including legislation, policies, or programmes...so that women and men benefit equally, and inequality is not perpetuated". The current

study feeds into this process via its adoption of a gender-sensitive approach (e.g. Hawkes & Buse, 2013).

As an epistemological approach it has been useful in this study to conduct a multi-level analysis (e.g. Murray, 2000) and the resultant conclusions illustrate the benefits of this in terms of both exploring the experiences of chronically ill men and providing additional contextualisation, considering as a result the shaping of experience by both micro- and macro-level influences. There is limited qualitative research on chronic illness and social capital, and little of this brings work on men and masculinities to bear in exploring illness narratives. Further the timing of the current study in relation to austerity, increasing rates of chronic illness (and increasing rates of multiple morbidity amongst individuals)

### **Recommendations for future study**

Recommendations for future study include the investigation of men's experiences of chronic illness and their links with social relatedness in diverse social locations in regard to ethnicity, sexuality and also age. Such research would redress the representation in the current study being weighted towards an older, white sample identifying as heterosexual. Richer detail may also be garnered on specific issues of interest that the broad focus on social capital and masculinities here did not allow for; for instance, the reformulation of masculinities in family contexts, experiences in illness-related groups, experiences in workplaces would all merit further in-depth investigation. Focus group or joint interview research, for instance involving patient groups or families would be useful in adding to understanding of how illness experiences in such contexts are socially negotiated. Given economic, political and social developments since the interviews here were conducted, updated accounts of chronically ill men in the age of austerity, and the impact of such developments on work, family and community life amongst chronically ill men is needed. The current study has illustrated the benefits of bringing a multi-level perspective (e.g. Murray, 2000) to qualitative research on chronic illness and future research may similarly benefit from the incorporation of a critical approach to narratives of lived experience in relation to this topic.

### **Concluding Comments**

In concluding this thesis I reflect again upon the participants who have illuminated the study with their narrative accounts, highlighting the processes linking social capital, masculinities and the lived experience of chronic illness. It is my hope that the thesis will contribute to a critical health psychological approach to chronic illness that is gender-sensitive, and can inform future research, policy and practice as it engages with issues such as social connectedness and participation.



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## Appendix 1: Participant Consent Form

### Research Consent Form

Researcher: John Griffiths

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Dear PARTICIPANT NAME:

Thank you for agreeing to participate in this study. This form outlines the purposes of the study and provides a description of your involvement and rights as a participant.

#### **The purposes of the research are:**

1. To explore the ways in which men's experiences of chronic illness affect their relationships, with friends and family, at work, and their involvement in community life.
2. To explore the differences and similarities in the experiences of chronically ill men of different age groups and their use of social and community resources.

The research is likely to be used through articles that will be submitted to scholarly journals covering health and social science disciplines. Further, it will be used to fulfil the requirements for a PhD thesis at Manchester Metropolitan University.

#### **The methods that will be used to collect information for this study are explained below:**

I will conduct two interviews with you over the course of a year, likely to last between 45 minutes and one and a half hours each, during which I will ask you about:

- Your relationships with people in your community, including friends and family.
- Your experiences of ill health.
- Biographical information about your life in general.

For some participants who are willing, I will be seeking feedback on my interpretations of the interviews completed with them - if you do not wish to participate in this it will not affect further affect your involvement in the study.

You are encouraged to ask any questions at any time about the nature of the study and the methods that I am using. Your suggestions and concerns are important to me; please contact me at any time using the address/phone number listed above.

I will use the information from the interviews with yourself and other men I will be interviewing to write up the study. **The following conditions will be met:**

1. Your real name will not be used at any point in the written report or transcripts of the interview/s; instead, you and any other person and place names involved in your case will be given pseudonyms that will be used in all verbal and written records and reports.
2. Concerning audio taping of the interview/s, no audio tapes will be used for any purpose other than the completion of the research.
3. Your participation in the research is voluntary; you have the right to withdraw at any

point of this study, for any reason, and without prejudice. If you should wish to do this, please inform me either by email, in writing or by telephone.

4. Upon completion of the research, you will receive a written summary of the findings.

Researcher signature

Date

**Please sign below to indicate that you have read and understand the information above, and consent to take part in the research.**

Participant signature:

Date

## **Appendix 2: Interview Schedule (First Interviews)**

### Turning Points

1. Can you tell me something about the key turning points of your life up until the time you became ill?
2. Can you tell me about the period when you noticed the symptoms of your illness.
3. If there is a particular incident or situation that stands out in which your illness became apparent to you, can you describe it please?

### History of social support

4. Who did you talk to about your symptoms? –
  - a) Family,
  - b) Friends,
  - c) Work colleagues
  - d) Health professionals.
  - e) Other?
5.
  - a) Had it been normal to talk about health, illness in family, work, neighbourhood, friends?
  - b) Has this now changed?
  - c) Would you prefer things to be different (e.g. feel able to talk about it more/less?)
6. Can you tell me about some specific supportive actions that family/friends/work colleagues/health professionals have directed at you?  
  
This includes things they have said as well as done.
7. Can you tell me about some specific unsupportive actions [if there are any] that family/friends/work colleagues/health professionals have directed at you? This includes things they have said as well as done.
8. How has illness impacted upon your family/ social/ working life?

### Issues of trust

9.
  - a) Have issues of trust been important in whether/how you talk about your illness with friends, family, neighbours, work?
  - b) Are there people who you have not trusted to talk about it?
- c. How has your trust for friends, family, work, neighbours, changed over time? Example

### Norms of lifestyle and health

10. I want to ask you about issues of lifestyle that are health related.

As a family, would you say you have a healthy diet?  
Has this changed at all since diagnosis?  
Is your diet similar to that of parents, extended family?  
Similarly – exercise, smoking, drink, drugs.

11. Tell me something about your friends?

12. How do you help each other out? Example

13. Do you share things? Example

14. What do they mean to you?

Could do this for family, etc.

15. What has been the lowest point in your illness?

### **Neighbourhood & Community**

16. What is this like as an area to live in, being ill?

17. Do your neighbours know you are ill?

### **Organisational involvement**

18. Are you involved with any groups or organisations (including church, illness support groups, clubs or societies)?

19. How did your involvement come about?

20. How has your illness has affected your involvement?

21. What your involvement has meant to you, in relation to being ill and social support?

### **Reciprocity**

22. Do you feel that you have been able to reciprocate any support others have given you? If so, how?

### **Issues of masculinity**

23

- a) Do you think there is anything distinct about being a man with your illness (i.e. as opposed to a woman) that impacts on the experience? e.g. issues of masculinity?
- b) Is there a specific experience or situation that has highlighted such issues? Please describe.



24. Do you think there are changes that could be made to better support men with long term health problems? (e.g. work & benefits, health services)

**View of the future**

26. What is your view of your future?

27. What hopes do you have for social life?

**Positive aspects of illness**

28. Have there been any positive aspects to your illness? Example.

29. Do you have any religious or political orientation that has helped you cope with illness?

30. Would you describe yourself in terms of a particular class or class background?

31. Do you think your class background has affected how you have coped with illness?