Informal interactions about health: connectedness, surveillance and the construction of a moral identity

A thesis submitted to the University of Manchester for the degree of PhD
In the Faculty of Medical and Human Sciences

2013

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Abstract

This thesis is about the informal interactions about health that take place between friends and family. An important distinction of this study is that these connections are conceptualised as interactions rather than as helping, caring or support and so, as well as larger scale help, the study is also concerned with conversations about health and small-scale, fleeting or incidental interactions about health. It is argued that only by combining all of these types of interactions is it possible to begin to understand broader issues of sociological importance about the ways that people relate to one another, and how a seemingly personal task such as managing and maintaining one’s health becomes enmeshed with the input from and connections with other people.

Drawing on literature from both the sociology of health and illness and the sociology of personal life, the thesis analyses the way that people present moral narratives of their informal interactions about health and engage with the moral meaning of these health interactions, whether as part of a moral project of the self, an obligation to follow moral norms or out of a sense of moral emotion. It engages theoretically with the individualization and connectedness theses and asks whether health interactions challenge the individualization thesis.

An interpretive approach was taken and 25 qualitative interviews were conducted with a sample of people with either heart disease or mild to moderate mental health problems.

Examples of a range of health interactions were identified, which included practical, emotional and advice giving interactions. These were often gendered, not always welcomed or positive, and often involved monitoring, surveillance or governmentality. Health interactions were found to be more than a simple transfer of assistance, and relational dynamics going on within the interactions were discovered and discussed.

Moral narratives were also identified, where people used health interactions in a number of different ways to construct a moral identity and as part of a moral project of the self. However, the data do not entirely support the notion that health interactions were moral narratives or served the function of identity building, as there were also clear examples of people engaging in health interactions out of a sense of genuine care and because it mattered to them to do so. This moral concern or moral emotion influenced and underpinned many of the health interactions explored in this thesis.
Declaration

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Acknowledgements

This PhD has been funded by a Personal Researcher Development Award from the Department of Health and additional funds, via the NCC RCD (National Coordinating Centre for Research Capacity Development), which is now part of NIHR Trainees Coordinating Centre (NIHR TCC).

I would like to thank the people who took part in this study, who gave up their time and shared with me their experiences and their insights, upon which this thesis has been built. In order to protect their anonymity, pseudonyms have been used throughout.

I would also like to thank the two GP practices (who are not named here to protect the anonymity of the participants). The practices, and particular individuals within them, helped greatly in securing a rich and carefully selected sample for the study.

I benefited greatly from the intellectually stimulating environment at the University of Manchester and would like to thank colleagues in the departments of primary care and sociology and in particular members of the Self-Management Group (primary care) and the Morgan Centre (sociology) for very useful discussions.

There are also other people to whom I am grateful, for their role in my intellectual and academic development. Chris Dowrick inspired me to do a PhD in the first place. Joanne Reeve and Carol Kingdon offered ideas and comments on the early formulations of my research proposal as well as encouragement and friendship throughout. Jo Hart and Sarah Peters shared with me many happy, productive and very supportive writing retreats, where ideas, approaches and dilemmas of all kinds were chewed over in the breaks, together with packets of chocolate cornflake bites.

As the subject of this study is interactions, I would like to highlight here my appreciation for the interactions that I have been part of during the course of this PhD. I have had many interactions with friends and relatives about my own health, the health of others and also about the experience of doing a PhD. These interactions have kept me going and not only provided support and kindness, for which I am extremely grateful, but they also inspired reflections and insights about the subject of this thesis. There were many people among my friends who sparked ideas and new ways of seeing my data or of analysing the themes that were being developed in this study. These include Jo Cochrane, Ashlyn O’Dwyer, Henry Papworth, Lydia Papworth, Debbie Quinney, Tracy Quillan and Nicolette Taylor – thank you, this thesis is now richer and better because of the conversations and experiences we shared.
Other people showed great care, support, kindness and encouragement in a range of different ways, all of which sustained me during this process and I am extremely grateful to them. This includes Tracy Bowles, Susannah Crump, Alexandra Lethbridge, Ann Papworth, Helena Papworth, and Gillian Seymour. Particular thanks go to Cath King and Julia Segar whose terrifically kind and valuable encouragement and support helped immensely. Last but not least my sister, Sarah Foster, was supportive and encouraging throughout the personal and professional challenges faced during this time and also bought me a beautiful vintage bike that got the wind in my hair and my head cleared, just when I needed it most.

I thank them all, who in different ways, have kept me going and helped get me to the point of writing this today.

Finally, very special thanks go to three people who simply could not be put in the lists above. The first is David Hojman, who has been alongside for each step of the highs and lows of these PhD years, providing every kind of support and sanity, and who has even begun noticing health interactions wherever he goes! The other two are my incredible PhD supervisors, Professors Anne Rogers and Jennifer Mason, from whom I have learnt an immense amount and to whom I am very grateful for their generous and invaluable intellectual support and encouragement.
List of Abbreviations

EPP    Expert Patients Programme
DoH    Department of Health
NCC RCD National Coordinating Centre for Research Capacity Development
NIHR   National Institute for Health Research
NIHR TCC National Institute for Health Research Trainees Coordinating Centre
Preface

One of the many intellectual puzzles that led me to this study was a desire to investigate how much friends (and others) become involved in our lives and how, in what ways, and why. Here I think I was influenced by the ten years I spent working in developing countries, mostly in Africa. Cultural practices there seemed to encourage significant engagement in each other’s activities, higher levels of support and reciprocity, and thus in most cases strong ties. I also became interested during my time working in developing countries in village healers, traditional birth attendants, and lay health workers. All of these were people from the village, who took on informal roles of helping with the health of the village in place of formal health services. I was interested in who took on these roles, and why. I developed this interest further in my MSc dissertation, and threads of this can be seen in the interests I have in the current study.

This has been very much an interdisciplinary endeavour, combining the sociology of health and illness with the sociology of personal life. This was a deliberate strategy to try to respond to the questions that interested me and that seemed to be important in exploring these issues. It has involved the bridging and blending of two bodies of literature and conceptual frameworks. I believe that this has brought a greater richness to the thesis and enabled a distinctive and novel perspective on issues that have been subjected to significant debate separately in the two subdisciplines, but not put together.

At a mid-way point in the thesis, just as I was beginning to analyse the data, I was diagnosed with early stage breast cancer. This brought with it for me all of the biographical disruption (Bury, 1982) that as sociologists we have come to expect. It also brought powerful insights and experiences of exactly the type of health interactions that I am studying in this PhD. Despite this, I have not taken an autobiographical approach to the thesis; however, I have included reflexive material on my experiences (in text boxes) where they are pertinent to the argument being made. This occurs mostly in Chapter 8 (on the relational dynamics of health interactions), where the reflexive material is treated almost
as an additional source of ‘data’, influencing, as it has, the themes, argument and perspective of this thesis. The experience of having cancer, of the treatment and of the interactions with my friends, family and others about it, has made a profound impact on my ontological perspective and has inevitably found its way into my thesis.
PART ONE

SETTING THE BACKGROUND FOR THE STUDY
Chapter 1: Introduction

On the face of it, when people interact with friends, relatives, neighbours or colleagues about their health, the main reason is to contribute to better health and management of health. Indeed, there has been a longstanding recognition of the importance of social support for health (Thoits, 1995) and more recent acknowledgment of the significance of social networks for management of health (Vassilev et al., 2011). However, there is also a sociological literature from non-health sources which suggests another way of seeing things. This study explores people’s engagement with others’ health, from the perspective of the sociological literature on moral identity construction, and builds on this to analyse the study of health interactions in a different and novel way.

This thesis engages sociologically with an understanding of health interactions, influenced by Bourdieu’s notion of ‘practice’ (1977) and by Morgan’s ‘family practices’ (1996, 2011). Thus the study focuses on what is involved in the ‘doing’ of health interactions on a day to day basis, creating the lived reality of lives and relationships, while at the same time analysing this in terms of the meaning it contains, particularly for the construction of a moral identity. The thesis analyses informal health interactions as a set of practices with whomever they happen, including friends, neighbours, colleagues, even acquaintances and strangers as well as family. This is the reality of the informal ways in which people’s health is managed, and it recognises the fluidity of the terms ‘family’ and ‘friend’.

Defining health interactions

Informal health interactions are outside the formal NHS services and are lay health interactions, rather than interactions with health professionals of any sort. The term ‘health interaction’ is used in this thesis to describe any form of informal, lay interaction, contact, communication or exchange between two or more people, that is either loosely or directly related to health in its broadest definition.

A health interaction, as viewed here, can take a wide variety of forms ranging from large-scale, ongoing and quite demanding care or support for someone
with a medical condition to, at the other end of the health interaction continuum, a fleeting enquiry as to someone’s health or the sharing of a brief conversation or snippet of information about a health condition or experience. It is the inclusion of these latter types of health interactions that make this thesis novel, as most studies looking at people’s involvement in others’ health have looked at more demanding forms of caring (Munro and Edward, 2010; Fonseca et al., 2010). So, it was felt to be important in this study to encompass the widest possible range of ways that people engage with each other over matters of health, in order to try to understand, not only the specific detail and practices of what it is that people do, but also to understand the meaning that this has for the links between people, and to explore what it is that health interactions can tell us about the way human beings are connected. This will also allow an exploration of the breadth of possible ways that other people influence how we deal with our health, to better understand the shared ways that health is managed.

As a broad term, the notion of ‘health interactions’ encompasses a number of other expressions used to describe people interacting about health, such as social support, emotional support, advice giving or lay consultation (see Chapter 2 for a discussion of these). All of these types of interactions are included here, but also included are other, much more small-scale, fleeting or incidental interactions about health. It is only by combining all of these types of interactions that it is possible to begin to understand broader issues of sociological importance about the ways that people relate to one another, and how a seemingly personal task such as managing and maintaining one’s health becomes enmeshed with the input from and connections with other people.

*Moral identity*

This study is a sociological exploration of the negotiation in everyday life of the practices of engaging in the health problems of others we know, and through this an attempt to analyse how we build our moral identity and engage in the construction of a moral self. Therefore, this study is about the ways people interact informally about their health, involving descriptions of their practices and the meanings they hold. It is also about the ways that people use these health interactions as moral agency to build a moral identity.
The argument presented here is that informal interactions about health can be viewed as 'identity work'. This involves people in actions to construct or maintain a certain type of identity as their 'self'. The type of identity work referred to here is the actions people take in engaging in informal interactions about the health of their friends, relatives, neighbours or others in their social networks. This kind of work has a moral imperative and can be seen sociologically as the 'moral work' (Radcliffe, 2011) or the 'moral agency' (Smart, 2001) of building an identity as a moral person.

This thesis is concerned with the presentation and construction of self and the way health provides a perfect vehicle for this. More specifically, this thesis aims to examine the practices of health interactions and to use insights about these exchanges to inform theory. The focus is not only on health (how health is managed), but also on relationships (what are the connections that link people) and how people use these to present a moral narrative. This means that the conceptual focus of the study is an analysis of the presentation and construction of self as moral and virtuous, through health interactions. What is more, this may lead us to question or redefine what is understood by social support.

Questions about moral behaviour are hardly new, but in the sociological literature there has been recent interest in moral work in managing or overcoming what could be seen as a 'spoiled identity' (Goffman, 1963). Researchers have examined moral narratives and the importance placed on moral virtue (as discussed further in Chapter 3), but their main focus has tended to be on the way moral narratives are used to defend lifestyles that others may perceive as wrong or immoral. For example, May (2008) and Radcliffe (2001) show how it was important for mothers with a 'spoiled identity', such as lone or drug using mothers, to strive to build and present an identity as a 'good mother'. This literature demonstrates the importance for people of a moral identity and of the presentation of the self as good and moral. However, little is known about how moral narratives are used in situations where there is not a 'spoiled identity' to recover from. For example, when people are 'helping the sick' they are not defending stigmatised lifestyles as drug using mothers may be, so this thesis
will explore the sociological meaning of if and how, despite this, people decide that it matters to them to work to construct a moral identity.

The literature from the sociology of health and illness has long emphasised, for people with an illness or chronic condition, the importance of presenting a moral identity as trying to be healthy, or as not responsible for their illness. Sontag (1978) argued that illnesses are morally ‘ranked’ by the extent to which people are perceived to be blamed for them, and Williams (1993) identified that it is common for good health to be characterised as moral and as a ‘virtue’ and illness as a sign of immoral ‘sinfulness’. These ideas have been taken further by Brown and Whittaker (2003), who emphasise the importance of the presentation of a moral self by people with chronic illness through their study of people with diabetes. They demonstrate the negotiation of moral identity through monitoring, self-discipline and the use of ‘control’ type language, and show how a sense of controlling diabetes is ‘intimately related to moral understandings of individual responsibility to be as healthy as possible’ (Brown and Whittaker, 2003). This work emphasises the point that will be made in this thesis of the importance of moral identity. However, work such as Brown and Whittaker (2003) and Williams (1993) describe the importance of moral identity to the individuals who have the illness or chronic condition. But in this thesis the importance of moral identity is explored from a totally different angle – not from the perspective of the person with the illness, but from the perspective of other people around them. It explores the moral agency and identity work of the people who interact with, care for or support others who are ill. This is not about the morality of being healthy as described by Sontag (1978) and Williams (1993), but about the morality of caring for others, or ‘helping the sick’.

The sociological as well as the philosophical literatures also stress the importance within society of being a moral actor. Goffman (1959) argues that this is crucial for participation in social groups, and that social life is intrinsically moral. So, if this is the case, people need to be able to present themselves as moral in order to be an accepted part of society. Thus, this becomes a dominant discourse, and the need to be moral becomes a shared understanding within social life. We can see this in the narratives of moral motherhood provided by May (2008) and Radcliffe (2011), where as described
above, the mothers seemed to feel compelled to present themselves as ‘good mothers’, or as trying to become good mothers. They were not able to challenge this dominant discourse, or argue for example that a drug using mother could be a good mother, or that being a good mother was not necessary. The strength of the shared moral code of good motherhood disallowed any dissent. This thesis asks whether there may be similar ideas operating in the arena of health interactions.

**Moral narratives**

The perspective taken in this thesis is that people’s accounts when being interviewed are narratives, which are often presentations of a chosen identity. So the work, or ‘moral enterprise’ (Radcliffe, 2011), that is going on in a health interaction, can be seen as a ‘presentation of self’ (Goffman, 1959). This thesis seeks to explore sociologically if and how people feel the need to present themselves as moral, and what this tells us about our social world. If these narratives are presentations, it would not imply that they are of no use to the study. Presentation of self can tell us a lot sociologically, for example about the seemingly inalienable importance of ‘being moral’, or about social attitudes to illness and to the care of people who are ill, or whether illness can be viewed as a site for morality to be played out, or about societal attitudes to ‘helping’, or whether it matters to people to be seen by others (through one’s presentation of self) as ‘moral’ and as having a moral identity.

What seems particularly important to consider here is what is going on when people want to engage in this moral identity work, and what is the significance to people of presenting themselves in the interview as moral. It may be easier to understand the rationale of the participants in the studies by May (2008) and Radcliffe (2011), where people were trying to use the narrative in the interview to rebuild ‘spoiled identities’, but in the present study none of the participants started from the position of having a spoiled identity (at least as far as became evident in the interview). So, the need for participants to present themselves as moral here tells us something new and different. Beyond the importance of moral identity work for people with a spoiled identity, it can tell us about the way
that in our social world there is a very strong shared discourse, a dominant discourse about being a moral actor.

The study set out to ask about people’s practices in their interactions with friends, relatives, neighbours and others, at times of health concerns, illness or suffering. This provided an opportunity for a presentation of self as a moral actor, since ‘helping the sick’ is an iconic notion in our society. It is loaded with potential for moral identity building and feel-good interactions, and for the presentation of those interactions. Thus, sociologically ‘helping the sick’ may be a dominant discourse in our society, with a powerful shared code of behaviour, like ‘good motherhood’, that compels people both to try to adhere to it, and to present themselves as adhering to it. So, with this in mind, it is possible to see how it could become very important for people to present themselves, in the interviews at least, as being caring, helpful and supportive in their health interactions within their informal social networks.

This thesis is divided into three parts. The first part (chapters 1 - 4) outlines the purpose, approach, perspective and methodology of the study, and gives a critical review of previous analyses of the issues. It is argued in this part that some of the most convincing sociological analyses of moral identity work have used examples of ‘spoiled identity’ requiring repair work, and in this thesis this analysis will be extended to explore identity work which is engaged in cases different from those of spoiled identity. This part of the thesis argues that there is a need for research into identity work and moral agency, in situations which are not ‘spoiled’, to explore and provide material for a broader critical assessment and sociological understanding of moral agency and the construction of a moral self.

The second part presents and explores the themes emerging from the data. It is based largely on empirical data generated by 25 qualitative interviews with people with either heart disease or mild or moderate mental health problems. This part contains four chapters (5 – 8) and it uses the data to construct an
analytical account of the practices and meaning of informal interactions about health. Of particular importance is that it presents and develops the concepts of presentation of self, moral narratives, moral identity, moral agency and moral self, as well as providing descriptive and analytical material on informal interactions about health. These materials are presented in a way that adds to the existing literature by including fleeting or superficial health interactions and health interactions with friends, neighbours, colleagues and other more distant connections, as well as with family members.

The third part comprises chapters 9 and 10. It builds on Part Two, but presents a different level of theorising and abstraction. By analysing informal interactions about health in relation to moral narratives and identity, this part is able to explore sociologically the presentation and construction of self through everyday practices. Part Three also contains a Conclusion, in which the arguments of the thesis are pulled together in a reflection of some sociological themes and implications of this research.
Chapter 2: Understanding the context of health interactions

Having introduced this thesis by outlining the rationale and the questions which the thesis seeks to answer, this chapter will now turn to the literature upon which this thesis has been developed.

The aims of this literature review were to identify existing knowledge on informal lay interactions about health, to determine the gaps in knowledge and competing perspectives within the literature, and to explore useful insights and concepts to help inform the study’s research questions.

Conducting the literature review

A comprehensive and thorough review of the literature was conducted, the stages of which are described below. A decision was taken that a systematic review of the literature was not best suited for the research questions addressed in this study. Some authors consider systematic reviews to be at the top of the traditional ‘hierarchy of evidence’ (Sackett et al., 1996), which ranks different types of information by the strength of evidence they provide. Studies which seek to prove that one particular intervention or treatment (e.g. a new drug or clinical intervention) works better than another place considerable importance on systematic reviews. However, this thesis did not seek to provide evidence to develop a new drug or clinical intervention, but to offer a sociological understanding of people’s views and experiences of interacting with others about health.

Conceptual mapping was used to identify the topics and sub-topics of relevance to the review. Conceptual mapping consists of the use of a visual approach, in this case mind maps produced manually in an A3 notebook, to assist in the process of identifying relationships between concepts, topics and ideas. Through mapping them visually, it was possible to begin to understand how ideas are grouped (Centre for Reviews and Dissemination, 2009). The process
of identifying the sub-topics was iterative, as shown in Figure 1, and it continued throughout the duration of the study.

Figure 1: The iterative process used to define sub-topics to search for in the literature review

![Figure 1: The iterative process used to define sub-topics to search for in the literature review](image)

*Some examples of new sub-topics introduced at a later stage of the literature reviewing process included contemporary neighbouring, surveillance, and humour as a form of peer communication about health.*

Conceptual mapping was also used as part of the process of identifying the keywords for the search. This was conducted following the process described in Figure 2. This was also an ongoing process that was revisited when new topics became relevant as the study progressed.

Figure 2: The three-stage process of identifying the study keywords

![Figure 2: The three-stage process of identifying the study keywords](image)

1. The topic was broken down into sub-topics: for example friendship, interactions about health, caring, support, social networks, self-care, health and illness behaviour, lay health knowledge, lay health workers

2. Keywords were brainstormed that represented the area of study, using the sub-topics but also thinking broadly of different ways the topic may be seen or described by authors (conceptual mapping was used for this). Also used were: synonyms (e.g. self care and self management), terms that may be outmoded (e.g. folk knowledge), terms that may be used in different countries or contexts (e.g. physician, family doctor), Web of Science author keywords and 'KeyWords Plus'

3. The process of identifying keywords was iterative. For as long as the search and the review continued, different words used to express the topics of the study continued to be identified, so new keywords were added and new searches conducted
Inclusion and exclusion criteria were decided upon. The Web of Knowledge database was used as the key source (see Appendix A which outlines the characteristics of the Web of Knowledge and its suitability for this review). Supplementary search methods were also used to ensure that the review was as comprehensive as possible and did not miss any literature that had not been identified through conventional methods. The supplementary electronic methods used included searches by key authors (e.g. Freidson, Stoller), searches of journals which, based on previous searches, had proved to be central to the research questions (e.g. Sociology of Health and Illness, Social Science and Medicine) and searches via a mainstream search engine (Google) to identify grey literature. Manual reference list searching was also conducted.

Figure 3, on the following page, summarises the stages of the process of conducting the literature review.
The traditional hierarchy of evidence (Sackett et al., 1996) was adapted to apply to study the research questions. Types of evidence to be used for the review were based on the research questions: largely research studies (range of methodologies) and theoretical and policy pieces.

Sub-topics were identified at the outset, based on research questions. New sub-topics were identified iteratively throughout the review.

To ensure the review focused on literature needed for the research questions. See Table 1 for the inclusion and exclusion criteria used.

Several databases were considered for the search. The Web of Science (using the ‘All Database’ search) was used as the key data source, as it incorporates all the databases identified as relevant for the study.

Three stages were used to identify the keywords to use for the search (see Figure 2, above).

Phase 1 - search and retrieval by ‘topic’ of article (led to unmanageable amount of hits). Phase 2 - search by keywords in title only. Boolean operators used where appropriate. In latter stages, ‘refine’ control was used to limit search to Sociology (which did not exclude medical journals). The search for latest literature was ongoing throughout the study.

To identify additional relevant literature and ensure comprehensive coverage. This was conducted and recorded systematically.

Abstracts (not the title alone) were used to decide upon relevance. When it was not possible to assess from the abstract and title, the full paper was read and assessed. The research questions and inclusion and exclusion criteria were referred to in the assessment for review. The decision was recorded in the appraisal form (see Appendix B).

Literature was reviewed on paper (rather than electronic) to guarantee thoroughness and allow highlighting and critical review notes to be made in margins. If not possible, documents were reviewed online.

References were recorded and managed using an appraisal form (see Appendix B), recording each of the articles assessed and its relevance for full review, as well as critically reviewing e.g. theory, methodology, suggestions for further references to review.
Studies of all methodological approaches which were directly relevant to the research questions, and which related to interaction between two or more lay people about health, were included (subject to quality assessment). Studies were excluded if they had not been published in English (see section on language bias, below), or which were off the subject of the study. This included interactions that were not about health and interactions between or with health professionals in the formal health service.

Table 1: Inclusion and Exclusion Criteria used in the Literature Review

<table>
<thead>
<tr>
<th>Inclusion Criteria</th>
<th>Exclusion Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Used to identify the scope of the study and ensure that the literature remained focused on the research questions</em></td>
<td><em>Used to ensure that the literature review did not get sidetracked into areas of less direct relevance to the research questions and to create boundaries on the scope of the literature review for reasons of feasibility</em></td>
</tr>
<tr>
<td>Topics that were directly relevant to the research question:</td>
<td>Topics that were not directly relevant to the research question:</td>
</tr>
<tr>
<td>- Refer to some form of interaction between two or more lay people about health</td>
<td>- Health interactions between lay people and health professionals (the focus of the study was on informal health interactions that take place <em>outside</em> of the formal health services, so interactions with health professionals e.g. in formal health facilities such as hospitals, clinics, surgeries, community care at primary, secondary or tertiary levels were excluded)</td>
</tr>
<tr>
<td></td>
<td>- Interactions between people that are not related to health</td>
</tr>
<tr>
<td>All relevant studies in English language covering any country, population, condition or age group</td>
<td>Literature published in languages other than English (though where possible abstracts were reviewed for papers published in other languages. Had an important paper been identified in another language efforts would have been made to translate it)</td>
</tr>
<tr>
<td>All years: earlier literature was included as there was a strand of medical sociology research on lay beliefs, dating back to the 1960s (e.g. Freidson’s work on lay consultation). It was important that classic works such as this, or commentary on them, were not excluded</td>
<td>Unpublished research (but grey literature and policy documents were included)</td>
</tr>
<tr>
<td>All study designs and types of methodologies including both qualitative and quantitative studies (documents were assessed for methodological rigour)</td>
<td></td>
</tr>
</tbody>
</table>
Minimising bias

Steps were taken to minimise the bias in the process of conducting the review. Bias is defined by the Centre for Reviews and Dissemination (2009), in their guidance for conducting systematic reviews, as a deviation from the ‘truth’ or a systematic error in the inferences made or the results used. There were a number of ways that the process used could have biased the literature review. The steps taken to avoid this are discussed below.

Publication bias - Grey literature, including unpublished research, was included in the review in order to ensure the review was not subject to publication bias. Publication bias arises from the fact that research which reports findings which are statistically significant is more likely to be published than studies whose findings are negative or inconclusive (Centre for Reviews and Dissemination, 2009). The importance of avoiding publication bias is more relevant to reviews which seek to evaluate the impact of a treatment or intervention, where publication bias is seen to potentially exaggerate the effect of a study intervention if publication is influenced by the results of the study. However, despite the fact that this is not the type of study reported in this thesis, it was felt important to include both published and unpublished material, in order to ensure that the review was comprehensive. This is particularly the case as much of the total volume of research conducted is not published (Sindhu and Dickson, 1997), for reasons that include small sample size or negative results (Rosenfield, 1996; Droogan and Song, 1996). According to Hughes (1996), only between 25% and 50% of research studies are published.

Language bias - In the literature review reported here, only English language studies and documents were included, based on availability of foreign language journals and the cost of translation to the high standard required. A fully comprehensive systematic review would include all the existing evidence that was relevant, including documents in all languages in order to avoid language bias (Centre for Reviews and Dissemination, 2009; Magarey, 2002). For research written in languages other than English, studies with statistically significant results are more likely to be published than those without (Centre for Reviews and Dissemination, 2009; Egger et al., 1997). In addition, Vickers et al. (1998) claim that research in some countries show unusually high percentages of positive results. However, despite these concerns about language bias, it is also recognised that often translation may be outside of the
boundaries of feasibility and affordability (Centre for Reviews and Dissemination, 2009). This was the case in this single-handed PhD study.

Bias in the process of selecting papers for review - One of the ways in which bias was avoided in the selection of documents for this literature review involved critically assessing the methodological quality of the studies, as the inclusion of poor quality studies would have affected the quality of the review. It was considered important to use a thorough and consistent approach to selecting the literature to review, as without this the inclusion could be biased through being affected by pre-existing attitudes to the research. An appraisal form was developed (see Appendix B) for assessing suitability for inclusion. This was important in recording materials assessed and reviewed and helped to identify any failings in the papers, as well as ensuring that the review was consistent and systematic (in the sense of methodical and comprehensive) about minimising bias. It was considered important to assess the methodological rigour of the studies being reviewed, to ensure that they were not methodologically flawed or biased in their approach. This need differed according to the type of study reviewed (Magarey, 2002). For example in randomised controlled trials (RCTs), the assessment aimed to identify whether there was any selection bias, performance bias, attrition bias, detection bias or reporting bias, as inclusion of biased studies would lead to bias in the review.

Strengths and limitations

Limitations of the literature review conducted for this thesis included the fact that it was constrained to English language publications. There may have been documents in other languages which illuminated or provided examples or alternative conceptualisations of health interactions. In addition, unlike in a systematic review, where a team of reviewers assess each paper for relevance (Paterson et al., 2001), as a PhD study this was done by the author alone, which could potentially have affected the rigour in the process of assessment for review. However, notwithstanding these possible limitations, the process used for the literature review has important strengths as described below. A very important and novel feature of the literature review conducted for this thesis is its interdisciplinary character, combining as it does two previously separate bodies of literature: the sociology of health and illness, and the sociology of personal life. This, while generating extra challenges for the
review, also created considerable strengths. New insights and ways of seeing and interpreting would have been impossible without it. An additional strength was the careful, iterative process used to define keywords and sub-topics to search for in the literature review, making use of previous reviewing and also conceptual mapping (or 'idea webbing').

Quality appraisal: Criteria used to assess quality of work reviewed

A system was developed to assess the quality and methodological rigour of the studies being considered for inclusion in the review. The two options which are generally proposed in the literature for the process of quality assessment (particularly for systematic reviews) are either to make use of checklists or to use scales which give a score for each study (Centre for Reviews and Dissemination, 2009; Moher et al., 1996). The former approach was considered more appropriate for this study. The appraisal form (a type of checklist) which was used to assess and record the judgements about the quality of each document can be found in Appendix B. The checklist was based on and adapted from the guidance issued by the Centre for Reviews and Dissemination (2009) for systematic reviews. The criteria used to assess quality included appropriateness of design, bias (e.g. selection bias, performance bias, attrition bias, detection bias or reporting bias), which differed according to the type of study, and rigour of analysis (quantitative or qualitative).

However, these criteria proposed by the Centre for Reviews and Dissemination (2009) are intended for conducting systematic reviews. They assume that the reviewers will be using the ‘hierarchy of evidence’ (Sackett et al., 1996) and will be reviewing mostly randomised controlled trials (RCTs) or studies based on other quantitative approaches. Due to the nature of the research questions in this thesis, a large proportion (though by no means all) of the documents assessed for inclusion in the literature review used qualitative approaches. Although there is no clear consensus about the method of quality assessment for qualitative studies (Centre for Reviews and Dissemination, 2009), there are a large number of qualitative research appraisal tools (see for example: Popay et al., 1998; CASP, 2006; Spencer et al., 2003; Dixon-Woods, 2004; Long and
Godfrey, 2004; Walsh and Downe, 2006). These appraisal tools were examined and the tool developed by Popay et al. (1998) was found to be most useful for this study. This tool was found particularly helpful as it recognises the different ontological and epistemological foundations of qualitative and quantitative approaches. It is based not solely on techniques, but on the nature of the knowledge created by qualitative methods and its philosophical underpinnings. The assessment criteria that are recommended by Popay et al. (1998) are privileging subjective meaning, responsiveness to social context and flexibility of design, evidence of purposeful (described in this thesis as purposive) or theoretical sampling, adequate description, data quality, conceptual and theoretical adequacy, and ability to assess typicality (Popay et al., 1998). These criteria were used in an adapted form in the process of quality assessment of documents for inclusion in the review.

It is generally assumed that no one checklist will be appropriate for all types of study designs (Centre for Reviews and Dissemination, 2009). Nicholas et al. (2006) have shown that most researchers using qualitative appraisal tools found them difficult to apply in their totality and often adapted the tools for the purposes of their studies. This was the case in the review reported here. For the final appraisal form used, see Appendix B.

As this was a PhD thesis, there was only one researcher assessing the quality of the studies for review. This has been noted above as a potential limitation of the review, as having two or more researchers seeking to reach agreement about the quality and inclusion of the studies could have strengthened the rigour of the process.

The literature review

This review of the literature is organised around the three points which make health interactions an important area of study: Firstly, that informal health interactions can affect health. Secondly, that health policy about self-care is based on an individualised model and a possibly erroneous assumption of
individualised self-care. Thirdly, that interactions about health connect people with each other, so health interactions have the potential to affect not only health, but also relationships and social ties.

People connect over issues of health. These connections are important because they can affect people’s health. They have the potential to improve, or indeed worsen, the health of those involved and this study aims to examine the mechanisms and practices through which this happens. The impact of these connections, or health interactions as they are referred to in this thesis, may be profound or fleeting and they may be valued forever or readily discounted.

**Health interactions can affect people’s health through the informal sharing of health knowledge**

One of the things that this thesis will explore is how and if, through health interactions with others, people become better informed about their own health. This section will discuss existing literature on the sharing of health knowledge.

**Lay health knowledge**

This thesis argues that health advice giving among friends or relatives is both important for and influenced by interactions with others (Morgan and Spanish, 1985; Shaw, 2002). Lay health knowledge is taken to refer to knowledge that is not professional, medically trained knowledge. The following quote from Popay et al. (1998) emphasises the way that lay knowledge is seen to come from the life-world of people:

> ‘Lay knowledge differs from expert knowledge in the sense that it has an ontological purpose, orientating behaviour in terms of an understanding to the individual’s place in their life-world (Popay et al., 1998)

Lay knowledge is seen to be rooted in lay beliefs, which an early (1968) quote from Hughes defines as:

> ‘Those beliefs and practices relating to disease which are the products of indigenous cultural development and are not explicitly derived from the conceptual framework of modern medicine.’ (Hughes, 1968).
However, more recent work (for example Shaw, 2002) has highlighted the debate within the literature about the extent to which lay beliefs can be seen as something totally outside of and separate from medical knowledge as suggested above by Hughes. Shaw (2002) argues that lay knowledge is inevitably informed by biomedical knowledge.

Research on lay knowledge focused on lay understandings of illness and their origins (examples of early work include: Blaxter, 1983; Morgan and Spanish, 1985; Pill and Stott, 1982), as well as on the health effects or outcomes of forms of lay health knowledge (Hughner and Kleine, 2004; Lawton, 2003). It tended to present stark differences between lay and medical knowledge (Kleinman, 1978) which have now been questioned (Shaw, 2002). In this thesis, the informal health knowledge which people have is not viewed as an almost fully structured body of knowledge, but as a complex and nuanced understanding which contains, in a similar way as described by Shaw (2002), sources and types of knowledge on a continuum in terms of its relatedness to medical knowledge. It is seen as having a fluid overlap with medical knowledge (or other health related knowledge bases). So, as people’s health knowledge may be informed by medical knowledge (amongst many other sources), medical knowledge may also be informed by ‘lay’ perspectives and knowledge. This is different from the early strand in medical sociology which viewed lay health knowledge as opposed to medical knowledge, and considered them in a binary relationship, rather than something multiple and fluid. Rogers and Pilgrim (2005), discussing lay perspectives on mental illness, highlight that lay health understandings may at times take the same perspective as medical knowledge (for example in a study of anorexia nervosa reported by Lee, 1997), but it may also at other times take a very different perspective. Maternity care is an area where there are strong differences between lay and medical perspectives, due largely to the fact that there is a very strong lay expertise and knowledge about maternity care, which results in a powerful lay critique of the role of medicine in decision making about maternity care (Oakley, 1984). Furthermore, lay health knowledge is located within a very different context from medical knowledge, the former emphasizing the immediate context of the illness such as place or time, and also the role of the illness in the biography of the person (Rogers and Pilgrim, 2005). For Cornwell (1984), who distinguished between lay public and private
accounts of health and illness, private accounts tended to incorporate a wide range of personal, social and structural issues that affected people and their health. In contrast, public accounts were selective and tailored to be acceptable, they tended to be in line with formal medical knowledge, and were compatible with uncritically following medical advice.

The moral imperative to health is an area which has not remained untouched in the sociology of health and illness literature. Moral judgments that people make about being healthy have been documented, for example, by Sontag (1978), Williams (1993), Brown and Whittaker (2003) and Cornwell (1984). Cornwell described people having a strong concern about the moral aspects of health and illness. Her work gives accounts of different categorisations of illness, which bring with them different degrees of moral culpability. An example of this is illnesses which were described in Cornwell’s study as ‘health problems that are not illnesses’. These included depression, asthma and allergies, which carried a sense of blame and moral responsibility for the illness, as opposed to other types of illnesses which were viewed as if they could not be helped and were therefore morally acceptable. Backett (1992) also highlighted the moral evaluations that people made about their ‘healthy’ or ‘unhealthy’ lifestyles. Similarly to Cornwell (though based on a middle rather than working class sample), Backett argues that these health moralities result from people’s construction of good health as at least partially ‘achieved’, which becomes linked to moral evaluations of being ‘good’ or ‘bad’. This sense of moral obligation extends to the good management of health, as shown by Townsend et al. (2006) in their study of people with multiple chronic illnesses, which identified a moral imperative to manage their conditions well and to present themselves as having a morally worthy identity. They describe this as ‘moral work’ and present it as part of the ‘lines’ of illness work depicted by Corbin and Strauss (1985). These accounts provide us with a sense of the moral underlay of people’s construction of health and illness. However, in this thesis the moral work that will be discussed relates, not to people’s sense of a moral duty to try to be healthy themselves, but to a moral desire to engage in other people’s health problems or needs, and so construct a moral identity through helping others.
Davison et al. (1991) have suggested that lay perspectives can become a kind of 'lay epidemiology'. They cite, for example, the way lay observers question the medical idea of 'candidacy' (such as coronary candidacy), because they are aware of the anomalies which health educators ignore in their attempts to create a simple health promotion message. ‘Lay epidemiologists’ may perceive the likelihood of a health problem, such as a heart attack, subtly but importantly differently from medical orthodoxy, for example in terms of luck rather than risk (Davison et al., 1991). Lay health knowledge has led to challenges to the medical establishment, for example in the case of the development of a new disease known as ‘miners’ lung’ (pneumoconiosis) (Bloor, 2000).

Lay consultants – are health interactions a form of lay consultation?
Freidson (1960) developed the idea of ‘lay consultants’, which are described here by Becker:

‘[Freidson] introduced the term “consultant,” borrowed from medical practice, to name the people a sick person turns to for advice and help. In the professional medical community, one doctor calls in another with specialized expertise to assist in the diagnosis and treatment of a case (to “consult”). Freidson generalized the term to refer to anyone a sick person called on for advice or treatment, whatever their professional status’. (Becker, 2006)

A symbolic interactionist perspective on the sharing of health knowledge presents people acting as ‘lay consultants’ for their family and friends (Freidson, 1960, 1961, 1970). Freidson addresses these ideas within a more general debate about the medical profession and professional power and dominance. His interest in ‘lay consultation’ is very much linked to its relationship to a respective ‘countervailing force’ (Becker, 2006), which Freidson saw as the medical consultation. Freidson’s work spawned a body of mostly quantitative work using the concept of lay consultation (Furstenberg, 1985; Furstenberg and Davies, 1984). There have also been more recent usages of the concept of lay consultation such as Stoller and Wisniewski (2003). However, in general, in the older work on lay consultation the concept could be seen to be rooted in a particular period when functionalist and interactionist thought were popular, and
it has in some ways been replaced in contemporary literature by work on social support (see below) and social networks (see for example Vassilev et al., 2011).

The studies that have used the concept of lay consultation present very high levels of lay consultation, sometimes as high as 70% of illnesses involving a lay consultation (Fleming, 1984; Suchman, 1965), or higher for certain conditions (Strain, 1990). Lay consultation is used more, and differently, by women (Furstenberg and Davies, 1984; Stoller and Wisniewski, 2003; Unruh and Ritchie, 1999). About 80% of lay consultants are partners (Stoller and Forster, 1992; Strain, 1990). Some of these studies are now quite dated, and although Freidson was part of the Chicago symbolic interactionist group, there are hints of functionalism in the way he presents lay consultation as a part of a system, a cog in the wheel of improving people’s health. For example, Freidson’s work outlines a ‘lay referral system’ (Freidson, 1961, my italics) and a hierarchy of referrals, within which lay consultations play their allocated part (see section below for a discussion on lay referrals). Although both Strain (1990) and Furstenberg and Davies (1984) refer to everyday conversations about health, much of the work by Freidson and others has tended to treat the concept of ‘lay consultation’ in a fairly formalised way, for example by asking people to recount the number and identity of people whose advice was or would be sought. This thesis will take a very different perspective. Superficially, lay consultations could be seen as very much the same that is being explored here as ‘health interactions’. Yet the perspective taken in this thesis, represented by the use of the term health interactions, is very different, viewing health interactions as fluid, multifaceted and valid in their own right, even if no health benefit is obtained.

The original notion of lay consultation was developed in a different period and theoretical terrain from more recent work. The contemporary concepts of risk and the risk society (Beck, 1992), for example, may influence the content of health interactions or people’s willingness to engage with them, or the health professionals’ concerns about them. Governmentality (Foucault, 1979) provides us with a perspective from which to consider the possibility of being controlled by others, through the advice and prompting of health interactions, this is discussed in the next chapter.
Lay referrals – is this one of the ways people interact about health?

Referring people to seek medical advice (from a doctor or other) is one of the ways that health interactions may be enacted which will be explored in this thesis. ‘Lay referral’, which happens when people suggest to a friend, relative or someone they know that they consult a doctor or other medical professional about a health problem, is part of the ideas developed by Freidson (1961, 1970) which were discussed above, including ‘lay consultation’. Lay referrals are most commonly given by partners (Cornford and Cornford, 1999) or children, but also by other relatives or friends (Schoenberg et al., 2003). They tend to come about as a result of primarily non-health related conversations (Cornford and Cornford, 1999), which are gendered in the sense that men tend to have these conversations with men and women, whereas women have them largely with other women (Cornford and Cornford, 1999). Lay referrals may function differently now that people have access to internet health information (Hardey, 1999), which may prompt them to decide to seek a medical consultation. Lay referrals may be seen as linked to functionalist thought, as they may be interpreted as part of a system which is the ‘pathway to the doctor’ (Zola, 1973). In that perspective, the referral is valued for the part it plays in the overall system, and not viewed solely as an end in itself, as it would be in this thesis, where a lay referral would be considered a health interaction in its own right.

In ‘Pathways to the Doctor’, Zola (1973) described five triggers that lead to people seeking medical help. One of these five triggers is ‘sanctioning’, that is other people, for example friends or relatives, communicating their view that medical opinion should be sought, which legitimises a visit to a doctor. This legitimisation can be important, as there is a moral element to seeking the advice of health professionals, since people are wary of being a ‘time waster’ (Goode et al., 2004). Although Zola’s ‘Pathways to the Doctor’ was published almost forty years ago, Nettleton and Hanlon (2006) have conducted research that indicates that this still has validity in the 21st century. They argue that, although there is a greater proliferation of ways of accessing formal health care than when Zola was writing, people still adhere to norms and values about the
use of health services, and are guided by their sense of what it means to be a ‘good patient’.

The use of the term ‘referral’, like the use of the word ‘consultation’ discussed above, places these ideas within a medical model and implies that people may be acting, not as friends or relatives in their own right (as considered in this thesis), but as substitutes for a doctor or part of a medicalized process that ends up with the doctor. There are strong arguments supporting the view that people are never really divorced from the world of medicine and medical knowledge (Cornwell, 1984; Shaw, 2002). Lay referral and lay consultation assume a medical model with the objective being the path to the doctor, but it is possible to see many other potential types of paths (or non-paths) which do not always imply that either the problem or the solution require medical intervention.

A number of assumptions are being made in the concept of lay referral which may not be accurate (or may not be accurate in contemporary society). There is an assumption that people with a health problem will want to consult a doctor, but some may not (for example people who prefer to use complementary and alternative medicine, Segar, 2012), some may want care or empathy, or may not view their problem as a medical problem. There is also an assumption that people will view seeing the doctor as a positive experience, which not everybody shares (Turner, 1995). The theory of lay referral also seems to assume that illness equals acute illness, rather than (the more common now than in 1973) chronic, ongoing or mild illness, which in some cases people may neither define as an illness nor want to engage with health professionals about it.

In addition to the practical function of the referral, something that this thesis will add is consideration of other levels at which lay referrals may operate. At the most obvious level, and regardless of whether a lay referral helps or does not help health management, it may also affect the relationship between the two people. There is yet another level at which lay referrals may operate, that is the level of moral power which is operating, where the referrer may gain or be trying to gain some moral power or build a moral identity by the referral, which would place them in a powerful position. This thesis will explore whether people might
feel good and might feel a sense of power and authority that they are helping others.

These ideas of lay referral, like the ideas of lay consultation discussed above, are very similar to the interactions about health examined in this thesis. However, because of the way that health interactions are conceptualised here, lay referral is actually viewed as something very different from health interactions. As described above, lay referrals are part of functionalist thought that see lay referral (and lay consultation) almost like a machine that has the function of putting the patient onto the 'path to the doctor'. In contrast, in this thesis health interactions are seen very differently, as more fluid than rigid and static, and possibly an end in themselves rather than only important as part of a system. The health interaction may result in a referral to a doctor, but that is only one possibility. It could equally well result in advice, support, information, or it may be totally ignored by the 'patient', who is seen here as far more agentic than as conceptualised in lay referral theory.

*Health advice – are advice-giving health interactions a help or a hindrance?*

One way that health interactions could affect people’s health is through the giving of advice to others about health. It has been suggested that advice giving can be a gendered activity, with men more likely than women to give advice and women more likely to interact in other ways (Mason et al., 2007). The literature on advice does tend to focus more on advice giving between women, for example advice from mothers to adult daughters (Moseley et al., 2011), from adolescent daughters to their mothers (Mosavel and Thomas, 2009; Mosavel, 2009), or between adolescent girls, for instance the sexual health advisor roles played by friends (Fallon, 2010). Often intended and sought or received as kindly and benign (Henwood et al., 2003), advice giving can also be presented or perceived as monitoring or meddling (Lamm et al., 2008; Rooyen et al., 2011) and tinged with hints of criticism, blame or attempts at guilt creation (Crossley, 2003; Reid et al., 2010; Williams, 2005). For these reasons, the expression ‘horizontal advice’ (advice from peers) is preferred by some (Lamm et al., 2008). The recipients of advice do not always appreciate it, and can
perceive it as control or unwelcome involvement (Lavender et al., 2005; Reid et al., 2010). Some recipients or ‘targets’ of health messages may respond through forms of deliberate transgression, rebellion or resistance (Williams, 1998), through which they eschew the moral imperative implied by the health advice (Crossley, 2002, 2003; Rooyen et al., 2011). Others may simply be unwilling to take any advice that has not been checked or is not from a medical professional (Hauck and Irurita, 2003).

What matters for the present thesis is that this literature tells us, not only that informal health advice is exchanged and amongst whom, but also that health advice giving is not always positive. This is important as it raises questions that will be explored in this study about whether or not health interactions more generally are seen by the recipients as wholly positive in a range of ways.

Advice giving is viewed in this thesis as operating at more than the obvious level of the transfer of advice. The perspective taken here views advice giving and receiving as influenced by choice and agency and the thesis will explore ways that health interactions may operate at the levels of, for example, personal power, control and identity building.

**Self-help groups – how are they different from the health interactions studied here?**

People also share health knowledge and advice through a range of ‘informal but formalised’ systems, via face to face or online self-help groups. While self-help groups are often condition specific, this is not always the case, and there are also generalist self-help groups such as the Expert Patients Programme (EPP) which is discussed later in this chapter. There are big differences between diverse types of self-help groups (Williams, 1989), with some closer to health interactions as discussed in this study, and others more ‘quasi-formal’.

Some self-help groups are moderated and become semi-professional. Although many self-help groups are ‘lay-led’, this may not, according to Taylor and Bury (2007), need to imply that they will result in improved health outcomes
for the participants. The Expert Patients Programme took the notion of lay knowledge further, by presenting the patient as ‘expert’ (Taylor and Bury, 2007) and emphasising the participants’ self-efficacy (Kennedy et al., 2007; Rogers et al., 2009) over the acquisition of self-management knowledge.

Self-help groups are an important part of the background for this thesis, as they have many similarities to the interactions about health discussed here and can illuminate issues that might be relevant for the analysis of health interactions. Both self-help groups and health interactions as explored in this thesis are lay exchanges, using lay health knowledge (although Munn-Giddings and McVicar, 2007, highlight the experiential knowledge used in self-help groups in particular). Both self-help groups and health interactions provide advice and information (Avis et al., 2008, Sandaunet, 2008; Malik and Coulson, 2010), emotional support and empathy (Munn-Giddings and McVicar, 2007; Blank et al., 2010; Malik and Coulson, 2010). Herzlich and Pierret (1987) suggest that self-help groups may act as a substitute for a doctor in the same way that health interactions could be seen to function (see discussion above on lay consultants). Another similarity between self-help groups and what health interactions may offer is that the reciprocity or mutuality that is experienced through the self-help group is another way in which they have meaning for people (Munn-Giddings and McVicar, 2007; Avis et al., 2008; Malik and Coulson, 2010). Drentea and Moren-Cross (2005) propose that social capital is being built through online self-help groups involving instrumental and emotional support as well as ‘community building’. Whelan (2007) claims that these groups form epistemological communities of shared experience.

However, self-help groups are also different in a number of ways from the health interactions explored in this thesis. Munn-Giddings and McVicar (2007) argue that one of the advantages that participants found in self-help groups is that they are with strangers and provide some ‘space’ from friends or family who may be carers or attempting to provide support which is unwelcome or ill targeted. Another difference from health interactions is that self-help groups are often formed by people with a shared health condition, whereas in the informal health interactions studied here, the friends and family offering support are less likely to have the same condition themselves, so they will be coming from a
different perspective. There may be different gender dimensions to self-help groups, Blank et al. (2010) report that women use online self-help groups more for emotional support and men for informational support; however this finding is not confirmed by Seale (2006), who found that online support groups generally took a style of communication more commonly associated with women, and that both women and men prioritised emotional support over informational support. Self-help groups may be entirely lay initiated and lay led, but some are initiated or led by health professionals (Stang and Mittelmark, 2010), which gives them a quasi-formal nature not present in the health interactions studied in this thesis.

Another way in which self-help groups are very different from health interactions is that they may have a broader, more collective purpose in the form of a type of lobby group or social or protest movement, in opposition to medical policy or discourse (Herzlich and Pierret, 1987; Gillett, 2003). Williams (1989) points to the tension in self-help groups between self-reliant individualism and a collectivism that emphasises mutual aid. So, the literature indicates ways in which self-help groups have similarities to health interactions as viewed in this thesis, but also that self-help groups are very different from health interactions, so while the self-help literature can inform this study of health interactions, it also highlights that what is being studied here is something different.

Friends and relatives provide practical and emotional support at times of ill health

Over the last thirty years social support has emerged as an important area of research and debate. Social support has been defined as:

“Information leading the subject to believe that he is cared for and loved, esteemed, and a member of a network of mutual obligations.” (Cobb, 1976)

Some of the health interactions explored in this thesis could be viewed as forms of social support, although the concept of health interactions, as used here, covers types of engagement which may not be strictly defined as social support.
There are two different perspectives on the importance of social support for health. The first is what is referred to as ‘structural support’ or social integration (Wills, 1991; Barth et al., 2010). From this stance, the important thing about social support is that there exists a supportive network, surrounding the individual. Social relationships can affect, for example, whether negative life events such as illness are likely to bring about depression (Cooper, 1999; Mirowsky and Ross, 1989). Cohen et al. (1997) go as far as equating the magnitude of the health risk of having limited networks with that of smoking. This is not the type of social support that has parallels with the health interactions discussed in this thesis, as here the concern is not so much whether or not people have supportive relationships, but what, in practical terms, those relationships do, or what goes on as part of them. So health interactions are more akin to the second perspective on social support, known as ‘functional support’, which emphasises the importance of the functions played by social support (Uchino, 2004), including a range of ways that social support can contribute to a person’s life, for example through practical (or instrumental) support, emotional support or advice giving. These three types of support are part of the health interactions examined in this thesis and are discussed below and in Chapters 5, 6 and 7.

Social support may also be negative for health (Rook, 1992; Thoits, 1995). This can happen, for example, through support which is also demanding (Seeman, 2000). Just as with positive social support, this has implications both for the relationship as well as for health and wellbeing.

Some of the ways that social support is seen is as playing a protective role for health (Reblin and Uchino, 2008), are by acting as a ‘buffer’ against stressful life events (Thoits, 1995), such as the shock or ‘biographical disruption’ of the onset of serious illness, and protecting against the impact on both physical and mental health of stressful events by assisting with coping mechanisms (Seeman, 2000; Thoits, 1995). Thoits (1995) suggests that support helps people cope through things such as reinterpreting situations, or encouragement towards bolstering identity, which may itself help to increase a sense of competence. With echoes of social capital, Thoits (1995) described this as a type of ‘fund’ available to be used to help coping at times of stress. So, from this perspective social support
is beneficial at times of stress (Cohen and Wills, 1985; Thoits, 1986; Taylor, 2011).

A different perspective considers the impact of social support as beneficial at all times, rather than just at the time of stressful life events. From this perspective, the everyday engagement with others through conversations or interactions can have the effect of regulating feelings and emotions and so creating an improved sense of emotional well-being. Lakey and Orehek (2011) have referred to this as ‘Relational Regulation Theory’ and the nature of the social support given would be that of the everyday aspects of a relationship, rather than any specific support targeted at a stressful event. Health interactions could be seen as part of both of these types of social support and future chapters will provide examples of this.

It has also been argued that what is beneficial about social support is not the actuality of receiving it, but the perception of it being available (Thoits, 1995), since it is this perception that may act as a protection against stress.

In this thesis, what is being explored as health interactions could be viewed as ‘functional social support’ (Uchino, 2004). Yet there are two main ways in which this thesis on health interactions is different from the social support literature. Firstly, health interactions are conceptualised here to encompass not only elements of health related functional support, such as practical and emotional support and advice giving, but also more transient, fleeting type of interactions over health. That is why the study is entitled ‘health interactions’ and not ‘health support’. The second difference between the social support literature and the health interactions discussed in this thesis is that here, these same actions are viewed differently. They are not seen as ‘functional’, as a means to an end or as playing some kind of utility role. They are viewed as relational and as part of the fine mesh of what goes on in a relationship between two (or more) people. So, to give an example of an interaction about health - somebody taking a neighbour with depression out for a game of cards - in the social support literature this may be viewed as a form of functional support, as it may assist the neighbour with depression to recover. However, in this thesis we are exploring, not so much whether or not the trip to the game of cards may or may
not help with the function of improving or ameliorating the depression, but what that tells us about the relationship between the two people and how that is experienced by both parties. This leads to reflection on the fact that much of the social support literature (this is aside from the more contemporary sociological social networks literature) is written from a psychological perspective and aims to understand how social support works for the individual who is in receipt of the support. However, this thesis is a sociological study and it views the importance of social support, not for the individual concerned, but as an indicator of ways that people in our social world relate to each other and manage illness, often not as individuals but as connected to other people, who, in a wide variety of large or small ways, may engage with each other over matters of health. This gives us a picture of patterns of responses to ill health as one of connectedness.

Periods of ill health often involve difficulty in sustaining the activities of daily living. There has been a long history of accounts of practical support at these times given by family, friends or others, from Young and Willmott (1957) to more recent examples such as Richardson et al. (2007). The latter point out that the practical support can be from the person with poor health, as well as to them. But this literature fails to recognise the more minor, sometimes seemingly trivial, sometimes fleeting forms of practical support that are also included in this thesis, and which often take place between people who know each other less well, or are less tied by familial obligations. These acts of support, while often small, can be hugely important in their role in cementing a friendship or developing a bond.

Practical support is often gendered. The caring literature has typically presented support at times of illness as most commonly done by women (see for example Stacey, 1988; James, 1992; Bracke et al., 2008). However, in this thesis what is emphasised is the greater complexity of the gendered nature of health interactions. While it may be true that the largest part of major caring is done by women, and forthcoming chapters will confirm the important role that women play in interactions about health, the study also identifies ways in which men get involved in providing support at times of illness, and an understanding of this is one of the important contributions that the present thesis makes. This
confirms research conducted in the 1980s on men as carers by Arber and Gilbert (1989), who argue that men play a larger role in caring than is commonly recognised. They found that, while the majority of carers were women, among carers living in the same household one third were men, whom they describe as ‘the forgotten carers’. Later research by Arber and Ginn (1995) found that, in care for people outside of the household, more women (13%) than men (10%) were involved as carers. Other authors suggest that within caring roles, men take different tasks than women (Campbell and Martin-Matthews, 2003), play a range of roles (Harris, 1998), and caring responsibilities are affected by a number of other factors as well as gender (Campbell and Martin-Matthews, 2000). Ungerson (1987) suggests that male carers are motivated to care more by ‘love’ and women by ‘duty’. Although this distinction has not been explicitly explored in this thesis, gendered differences in health interactions will be analysed. Later work by Ungerson (2000) highlights the way that gendered roles in domestic care have influenced paid production of care, which she argues creates and perpetuates inequalities between women as well as between men and women. There is also a study by Seale and Charteris Black (2008), which presents men as less willing than women to draw upon available support.

An important aspect of this thesis is that it analyses health interactions that are distinct from ‘caring’ as described in the literature discussed above. Caring has been presented as an ongoing, permanent, often demanding and frequently challenging form of support for close others who have a usually quite serious or debilitating health problem (Fine, 2005, 2007). In contrast, when exploring health interactions this thesis is also looking at more fleeting, minor or advice based inputs, so, while the literature on caring can provide some useful insights for the study of health interactions, in this thesis something quite different is being considered.

That friends and relatives provide emotional support at times of ill health is well known. Informal emotional support is given by relatives and friends for a range of life challenges such as relationship problems or breakdown, professional difficulties, financial problems, and periods of ill health. This thesis engages particularly with the last of these (although it also illustrates how they are
integrated) and shows how emotional (as well as other) support at times of illness or distress is one of the ways that people connect with each other, as well as contributing to the experience or management of the health, emotional or personal difficulty or distress.

One of the ways that the health interactions discussed in this thesis differ from formal medical health services is that the way formal health services are organised creates boundaries between physical and mental health. However, interactions with friends or family as explored here are not constrained by these boundaries or training backgrounds and can provide emotional support by encompassing distress caused by a range of physical, mental, emotional or social causes or by interactions between them. Indeed, in the interviews (reported in detail in following chapters) it was clear that people were integrating different types of distress as, for example, when asked about support for health related distress, they would often talk about a range of other types of distress caused by social or relationship problems. This is aided by the fact that informal health interactions are not medicalized. Emotional health problems are often medicalized by the formal health service as ‘mental illness’ (Bendelow, 2010). However, the emotional, personal or social distress that people may be feeling is not interpreted by friends or relatives in a medicalized way. So, interactions can help to reclaim some parts of the human experience from an overly medicalized treatment, and can be a way of redressing the medicalized response to emotional distress.

Friends and relatives also provide emotional support in coping with physical health problems (Fallon, 2010; Thoits, 1995). This could be related to coping with the shock of a diagnosis, or its implications for life, which Bury (1982) has described as the ‘biographical disruption’ caused by the onset of an illness. This thesis will explore ‘emotion work’, which refers to the work involving emotions that is done in private and personal life (and is akin to, but distinct from Hochschild’s, 1983, concept of ‘emotional labour’; both of which are discussed in Chapter 6). The thesis seeks to create a nuanced understanding of the levels at which health interactions operate, over and above the ‘giving’ of emotional or other forms of social support.
This chapter is devoted to presenting and discussing the existing literature on three areas which make the study of health interactions an important area of research. In the first section, above, the point has been illustrated by reference to the literature on ways that informal health interactions can affect health. The chapter now moves on to examine another of the concerns underpinning this thesis, namely that health policy about self-care is unduly rooted in an individualised model of how people manage their health.

Is self-care policy rooted in a false assumption of individualised self-care?

A development in UK health policy (as well as in other countries) has been ‘self-care’, also known as self-management (DoH, 2004; 2005). Self-care policy in the UK was developed as a method of ‘downward delegation’ to patients (Rogers et al., 2009), in response to a perceived need for ‘demand management’ resulting from an aging population and an increase in chronic illness. However, whether a connection has been established between the increase in the aging and chronically ill population and an increase in demand has been questioned by some (Gray, 2002; Rogers et al., 2009; Taylor and Bury, 2007). Another influence on the development of self-care in the UK is the lay-led chronic disease self-management programme developed in the USA by Kate Lorig at Stanford University (Lorig et al., 1985, 1999, 2001). Tellingly, Lorig’s work was strongly influenced by the psychological approaches developed by her colleague Albert Bandura, and in particular his theory of self-efficacy (Bandura, 1986). This is important as it helps us to understand, at least in part, the individualised approach taken by self-care policy which is challenged in this thesis.

Despite the less than convincing outcomes of early evaluations of the effectiveness of the chronic disease self-management programme in the USA (Newbould et al., 2006; Rogers et al., 2009; Taylor and Bury, 2007), the programme was adopted in the UK in 2001 as the Expert Patients Programme (EPP) (DoH, 2001; Donaldson, 2003; Kennedy et al., 2007). EPP has formed a dominant part of self-care policy for much of the last decade.
Although self-care support policy documentation mentions the importance of networks, a lot of self-care policy has assumed that the individual ‘self’ operates independently, or largely independently, to produce its own care. Such autonomous approach is in stark contrast with collective approaches to care. This tension is seen, for example, in some self-help groups (Williams, 1989). Measures to encourage self-care are directed at individual patients and self-care policy assumes that patients are acting autonomously as independent units. This thesis aims to illustrate ways in which these assumptions can be misguided and unhelpful, as people’s self-care efforts are often the result of shared efforts of a number of other people close (and sometimes not so close) to the patient.

Self-care policy is based on an idealised model of a confident, competent, empowered and self-activated patient (DoH, 2000, 2004; Donaldson, 2003). Patients are expected to act as consumers (Calnan and Gabe, 2001; DoH, 1991; Rogers et al., 2009). They are expected to be knowledgeable (Lorig et al., 1999), fully informed and involved, and to exercise choice (DoH, 2000). Whether this informed choice does actually result in greater empowerment has been challenged by, for example, Henwood et al. (2003), who argue that the self-activated patient may rarely exist in reality, either for reasons to do with the patient (lack of desire for responsibility or weak information gathering skills), or to do with the doctor-patient partnership, such as doctors’ unwillingness to accept patients’ (informed) perspectives. This thesis will demonstrate how very commonly the ‘activation’ comes as a result of shared efforts, both at motivational and practical levels. So, to build health policy on an individual model is to negate much of what, in reality, makes ‘self-care’ work.

Through their ‘empowerment’, it was envisaged that patients would take responsibility for their own health (Michaillakis and Schirmer, 2010). This approach, although presented as ‘patient control’ (DoH, 2005), may also be seen as part of a wider retreat of the state from the provision of welfare services, and as attempts, as described above, to manage the fear of impossible-to-meet demand for health services (Rogers et al., 2009).
In some of the self-care policy documents, reference is made to the ‘supporting’ role of others (DoH, 2005). However, in practice this acknowledgment has tended to be ignored or marginalised, and in reality the focus remains on the patient as the sole creator of their own self-care. This of course is part of a wider sociological debate. The way health policy is evolving reflects not only political and fiscal priorities, but also the general trends of society in late modernity. The informed choice promoted in health policy documents can be seen as a direct parallel to the ‘reflexive consumer’ (Giddens, 1991).

Self-care policy also tends to assume that patients are highly agentic (and so have a strong capacity to act and create change in their world) and can and will take an active role in their own health. This both ignores and diverts attention from the structural causes of ill health (Taylor and Bury, 2007). Instead, it assumes that, if only people become more active and self-efficacious, they can improve their health (which may be a result of poverty, inequality or environmental factors). Thus, there are hints of victim blaming in self-care policy (Taylor and Bury, 2007). This view is linked to self-efficacy (Bandura, 1986), which is based on the principle of ‘you can if you believe you can’. The sociological critique of self-efficacy theory has been vociferous. However, it remains an influential psychological theory, and it has been very powerful in its incorporation into policy, which may at least partly be because of its fit with the dominant individualised model (Kendall and Rogers, 2007).

Self-care policy anticipates that a very active role is to be played by the patient in creating his or her own (health) destiny. The discourse of the self-management policy is American. Its roots in ‘rags to riches’ mythology could be read in the context of an ‘illness to health’ trajectory. However, it is important to remember that the American health system and more importantly the cultural aspects of American society (Lasch, 1979) are very different from the UK’s. The history and expectations of the relationships between central government and the health service, and between the health service and the patient, are totally different.

Self-care can also be seen as a form of governmentality (Foucault, 1979; Rose, 1989). People are expected to ‘internalise control’ (Rogers et al., 2009) and be
resourceful and take responsibility for their own health. They are expected to assume responsibility for controlling themselves as part of the project of the self (Giddens, 1991). This is ‘the enterprising self’ which works on itself in order to improve itself (Rose, 1996).

There is a challenge to this individualised health policy from the sociological literature, which has documented family care at times of ill health. Although not fully incorporated into health policy, the sociological literature has long documented the ways in which health care is managed within families. The literature on caring depicts the involvement of family members (and in particular female partners) in caring at times of, for example, acute illness (Chattoo and Ahmad, 2008), end of life (James, 1992), or chronic illness (Drentea et al., 2006). There are also many accounts of the ways others act by accompanying patients to medical appointments (Binder et al., 2010; Brown et al., 1998; Buchbinder, 2009; Eggly et al., 2006; Hughes and Leary, 2008; Ishikawa et al., 2005; Repetto et al., 2009; Schilling et al., 2002; Street and Gordon, 2008; Wolff and Roter, 2008). So we can see that, while the sociological community has been aware that care is not done by the self alone, this has not become fully integrated into health policy.

The third area to be addressed in this chapter is the fact that health interactions may affect not only health, but also relationships. The chapter now moves on to this third area of concern.

*Interactions can affect not only health, but also relationships*

In this thesis, health interactions are examined, not only because of the effect they may have on health, but also because of the way they can contribute to the building (or dismantling) of bonds between people. When we think of what builds relationships between people, it is often seemingly small aspects of the sharing of life experiences that creates or strengthens links. For example, people may develop a new friendship, or make an old friendship stronger,
through a shared history or shared specific experiences, including the shared experience of an illness. Bonds may be strengthened through sharing good or bad times, such as a time of illness, or the diagnosis of an illness, which may lead to the development of ‘hidden solidarities’ (Spencer and Pahl, 2006). Connections between people may be established or reinforced through doing things together. This could include doing health-enhancing activities together such as going for a walk, swimming or attending the gym (Crossley, 2006), or less obviously health-giving or even health-damaging things such as drinking (Kiuru et al., 2010; Overbeek et al., 2010) or taking up smoking (Lakon et al., 2010; Simons-Morton et al., 2001). Relationships can also be built or reinforced by kindness shown at times of illness, when people often show care, love and support for others.

While health interactions may affect relationships, and examples of it will be presented throughout this thesis, this effect is not always positive. Just as bonds can be built and strengthened, they can also be weakened or destroyed. Health interactions can worsen relationships, as well as improve them. This may happen in a number of ways, as will be shown by examples in this thesis. Relationships can deteriorate as a result of lack of disclosure of an illness or health problem. Or people may offer or impose health support or advice that is not wanted or welcome. Advice may be perceived as being too pushy (Rosland et al., 2010) or excessively protective and smothering (Thoits, 1995), or indeed it may be more for the benefit of the giver than the recipient.

*A lot is already known about friendships, but we do not know much about friendships and health*

In this section a range of sociological literature will be examined, emerging largely from the sociology of personal life, which sets the background for the argument made in this thesis that friends can play an important part in health interactions. Literature will be explored about how there is a blurring of boundaries or a ‘suffusion’ (Spencer and Pahl, 2006) between friends and family and about the nature and roles of friendship, including the role of friends.
in the construction of identity, which has parallels for the construction of illness identity.

One of the ways that this thesis is distinct from much of the other work on support and care at times of illness is that here the aim is to incorporate health interactions with whomever they happen. This may often be with relatives, but this thesis aims to stress that it is important also to recognise much more fluid patterns of engagement and fuzzy boundaries about who interacts with whom over matters of health. Friends are an important source of interactions about health and we will see below ways in which friends engage over identity support, particularly illness identity work. However, friends may also interact in other ways over health and illness, both trivial and profound, as family members may. Roseneil and Budgeon (2004) argue for a ‘decentring’ of the concepts of the family and the heterosexual couple in sociological analyses of care and intimacy, which they illustrate with examples of contemporary care and intimacy practiced among friends, co-residents who are not partners, or partners who are not co-resident. These patterns are presented by Roseneil and Budgeon as ‘at the cutting edge of social change’, which echoes Giddens’ (1992) description of same-sex relationships as the ‘harbingers of change’. Roseneil and Budgeon present these lifestyle choices as being made as a part of a ‘life project’ people are engaging in, which places them as both in tune with the spirit of the individualization thesis, but also at the same time emphasising connectedness and patterns of interaction and bonds that challenge traditional views of the arenas in which intimacy and care are enacted. Roseneil and Budgeon provide examples of the importance of friends in support and the provision of care, which they argue can become ‘heightened’ at times of personal crisis such as illness. In their sample this happened even among people who were not cohabitating with a partner. This is important and the present study will explore it further. Roseneil and Budgeon argue that, if the sociological study of intimacy and care continues to emphasise primarily interactions within the family and heterosexual relationships, it will be missing the meaning that practices of care and intimacy may have to people at the ‘cutting edge of social change’. They depict care and intimacy as a ‘flow’, which is how it is being seen in this thesis.
Friendship is often depicted as a voluntary relationship. Unlike family relations to whom connections are prescribed by blood ties, friends are seen to be a matter of choice. Giddens (1992) describes friendship as a relationship of free will, and this fits very well with the transience and contingence of what he describes as the ‘pure relationship’ (referring to contemporary individualised relationships between sexual partners). But if friendship is a relationship of free will, does that free will extend to the freedom to make choices about if and how to support friends who are ill, for example, or whether to engage at all with friends over the subject of their health? Roseneil and Budgeon (2004) argue that friendship operates as an ‘ethical practice’ which involves a sense of obligation, and so they disagree with the idea that people are free to choose to ignore friends’ health problems. This will be explored in this thesis, which will ask whether and how people feel about being free to engage with or ignore friends’ illnesses. Related to this is a further question that will be explored namely, if friendship really is a voluntary relationship, does that make any difference to the meaning that this has for people in terms of engaging in health interactions? Does the voluntary nature of the relationship somehow influence the way people see their engagement in health interactions?

But is friendship a voluntary relationship? The notion has developed in recent years, both in the academic literature and in common parlance, that ‘friends are the families we choose’. Some of the few published examples of people supporting and caring for sick friends are to be found in the literature on gay friendships (Weeks et al., 2001). It is argued that, when family relationships have broken down (sometimes due to the inability to accept others’ sexuality), friends can and do take on ‘family-like’ roles which include care at times of ill health. Weeks et al. (2001) give the example of a man who cares for his friend (not partner) who is dying of AIDS. In many cases it is the family who provide the immediate caring support. However, there are also examples of practical support given by friends (Arora et al., 2007; Matt and Dean, 1993), neighbours (Buonfino and Hilder, 2006), acquaintances (Morgan, 2009) and even strangers (Ignatieff, 1984). But does this mean that friends, if seen as family or ‘family-like’ (Spencer and Pahl, 2006), are playing roles that previously might have been seen as roles that family members ought to perform, such as care for a serious illness? Roseneil and Budgeon (2004) give an example of a woman
who has breast cancer and is cared for by her friends, not her family. Could support at times of illness be seen as a ‘family-like’ activity? Or is that privileging the notion of ‘family’, as it has been argued above, based on the work by Roseneil and Budgeon, and this is one of the bases of this thesis, that there is a flow and fluidity in who engages in health interactions, whether family, friend, or other.

In the research reported in this thesis, it was decided not to limit the data to interactions among friends alone. This is because there is a great deal of boundary blurring, complexity and cross-over surrounding the definition of family. In common with Spencer and Pahl (2006), there are examples in this thesis where friends are described as family, and blood relatives are described as not being family. Spencer and Pahl identified these as ‘friend-like’ and ‘family-like’ patterns of friendship, with each pattern including both family and friends. This redefining of the boundaries of the ‘family’ (Mason and Tipper, 2008; Weeks et al., 2001; Weston, 1997) has led some to use the term ‘personal communities’ to refer to personal ties which were reported as important, as opposed to other which were not (Pahl, 2005; Spencer and Pahl, 2006; Wellman, 1979, 1982, 1993; Wilkinson, 2010). There are suggestions in the literature that the time may have come to ask whether a fusion of the concepts of ‘family’ and ‘friend’ is emerging. Spencer and Pahl (2006) suggest that there is what they call a ‘suffusion’ between the categories of family and friends, a pattern that they explore together with the extent to which separate or similar roles are played by friends or family. Spencer and Pahl (2006) identified both kin and non-kin practices in ‘personal communities’ and analysed these as ‘friend-like’ and ‘family-like’ patterns of friendship, with each pattern including both family members and friends. Personal communities are identified not in the strict, bounded sense of either ‘family’ or ‘friend’, but as ‘families of choice’ (Weeks et al., 2001; Weston, 1997), ‘elective affinities’ (Beck-Gernsheim, 1998), ‘elective communities’ (Bellotti, 2008) or ‘elective families’ (Weeks et al., 2001). From this perspective, as Carsten (2004) puts it, ‘kin is whom you define as kin.’

The question of who gets involved in health interactions is an interesting one. This thesis will show how it is not only family, but also friends, colleagues,
neighbours, acquaintances (Hiscock, 2007) and strangers. Furthermore, as we have seen above, the definition of what constitutes ‘family’ is very much contested, blurred and full of grey areas.

The idea that we ‘choose’ who to see as family, or indeed friends, has been considered by some to be a fallacy, as the principle of homophily means that we ‘choose’ friends who are similar to us (McPherson et al., 2001). This happens because the friendships we ‘choose’ to build tend to be with people who share similar structural characteristics with us, such as class, ethnicity, age or level of education. This means that there are structural boundaries within which we can choose our friends. The concept of homophily is described by Bottero (2004):

‘… social characteristics (class, gender, race etc.) are systematically embedded in these social networks, and the people closest to us also tend to be socially similar to us …’ (Bottero, 2004, p166)

We know that there are different types of friendships and diverse roles played by friends. There have been reflections on this from Aristotle in Classical Greece, or in contemporary times Simmel (1908), to Spencer and Pahl (2006), whose research emphasises not only the diversity of types of friendship but also the diversity of the circumstances and contexts that mould them. Pahl (2002) believes that there is a need for a definition or qualification of what is meant by the term friendship, as it is currently ‘being forced to do too much work’. Differences in friendships may also be influenced by class (Allan, 1998) or gender (Allan, 2001; O’Connor, 1998; Oliker, 1998; Allan, 1998), which may in turn affect the way health interactions are conducted, so one of the things this thesis will explore is whether health interactions are enacted differently by men and women, or are influenced by social class. Spencer and Pahl (2006) identify what they call ‘friendship repertoires’, where people have different types of friends and there is also variety in which friends they would or would not include in their personal communities. They also describe ‘friendship modes’, which is the way people form, maintain and loose friends over the life course. Some of the friendship types described by Spencer and Pahl, such as helpmate, comforter or confidant, may play a part at times of physical or mental illness.
Upon diagnosis of a chronic or serious illness, a process of developing an illness identity may need to be embarked upon. This is usually not a simple or easily adopted process. More commonly it is negotiated, struggled with and sometimes outright rejected. However, friends, or some friends, can play an important role in a transition to an illness identity, providing support, advice, reminders of old identities or encouragers of new ones. Friends may also make the transition to an illness identity more difficult (Allan, 2001), wishing their friend to remain as their old self. Life course theories of friendship may also be of relevance here. Antonucci el al. (1995) present friendships as a ‘convoy’ that we go through life with. We could see that, as we journey through life with our convoy, different friends may be more involved at certain life stages – and periods of illness could be one such stage. Some friends, for example with a shared illness experience, may become new or closer friends at times of illness. Others, who may be uncomfortable with our new illness identity, may leave our convoy permanently or temporarily. While age may be described as a contextual factor in friendship, life course factors tend to be highlighted more in the literature. The life course theories of friendship can also be seen as related to the role of friendship in supporting the life project and identity formation. Thus, at different stages in their lives, people will want different types of identity support and different types of friends to provide that.

It is possible to imagine that, while the individualization theorists present the ‘life project’ (Giddens, 1991) or ‘project of the self’ as something very personal, in actual fact it is likely that others, friends as well as family, very often become involved in its creation, implementation and modifications. This has parallels in the way people engage in shared practices of managing health and illness. A diagnosis or a period of illness, particularly serious or chronic illness, is a time when life plans and outlook may be destabilised or forced to change considerably. This is what Bury (1982) refers to as ‘biographical disruption’. It is likely that friends and relatives play a part in this biographical disruption and become involved in support for this transition and for the possible subsequent ‘reconstruction’ (Williams, 1984). This involvement in biography or identity at a time of illness is similar to the way peers are considered very important for young people, who are also going through a period of transition and identity formation or reformation. Bury’s (1982) disruption, caused by the diagnosis of a
long-term illness or condition, generates a dislocation or rupture in our life trajectory (although others have suggested that the rupture may be less severe, Carricaburu and Pierret, 2002; Pound et al., 1998; Williams, 1984). Spencer and Pahl (2006) found that one of the things people want out of friendship is a ‘biographical anchor’. This suggests a role, not in helping to create new identities, but in providing a reminder of old (or more permanent) identities. This is the way old school friends, for example, become reminders of roots and early identity.

An important aspect of the reflexive project of the self is the ability to maintain a sense of the coherence of the ‘life project’ and a continuity of the accompanying biographical narrative (Gauntlett, 2002). So, when an illness is diagnosed which ruptures the stability of the biographical narrative, the impact is significant. When ‘biographical disruption’ occurs, interactions with other people form one way in which people’s life narratives are held in check and are forced to align with reality. Health interactions may perform this (possibly uncomfortable) function and may support the re-modifications of the life project (Williams, 2000). Theories of the life project (Giddens, 1991) involve the creation and continual recreation of a reflexive self, which requires ‘identity work’ to be defined from the multiple lifestyle choices available. Friends can help to interpret, accommodate and resolve dilemmas (Allan, 2001) encountered during periods of illness. Allan (2001) argues that, far from becoming peripheral as a result of individualization, informal relationships such as friendships are likely to play an increasingly important role in the construction of self-identity and help deal with personal problems or dilemmas, which could include health problems or health decisions. Friendships can act as ‘identity supports’ and, Allan (1996) argues, if macro-level change is leading to individualisation and the personal project of construction of identity, then other types of relationships such as friendships will be affected as well as the intimate relationships referred to by Giddens (1992) as the ‘transformation of intimacy’.
Contemporary neighbouring

As discussed above, this thesis is not limited to examining health interactions as they happen between family or friends, but explores interactions with whoever they occur, so also explored here are any interactions over health with neighbours. Due to the sampling decisions taken in this thesis (see Chapter 4), a high proportion of the sample were based at home during the day, either because they were retired, on long-term sick leave, or unemployed. So because of this it will be particularly important for the thesis to explore whether neighbours may be an important group with whom health interactions are enacted (in a similar way that colleagues might become important for people in employment). The thesis will also ask whether neighbours are engaged in different kinds of health interactions, or at different times, or in different ways from health interactions between family or friends, and what this can tell us about shared management of health and about relationships of support, obligation or reciprocity.

Crow et al. (1994) argue that there is some skill required in being a neighbour, in getting the right balance between being there if needed and maintaining a respectful distance, a middle ground they refer to as a ‘friendly distance’. In a similar way as was discussed above about friendship, interactions with neighbours, whether about health or anything else, can be seen as ‘voluntary’ and not a compulsory part of local solidarity or residence (Suttles, 1972). So, for Crow et al. (2002), as people’s views will differ about what is acceptable or desirable levels of neighbouring, this creates some uncertainty and delicate work in managing the extent and way any neighbour interactions are enacted. This will be explored in the present thesis and the concept of careful work to get the right type of health interaction, whether with neighbours or others, will be examined. Crow et al. (1994) identified what neighbours tend to describe as a ‘willingness’ to help if need be, this will be explored in relation to health interactions, to see if this same description as ‘willing’ applies in relation to matters of health.

As part of the individualization thesis, there is an argument that a sense of local community and closeness between neighbours is in decline, being replaced by
privatized and individualized lifestyles (Beck, 1992). However, a number of studies have suggested that interactions between neighbours are more important, far-reaching and stable than is suggested by this ‘privatization model’ (Crow, 2002; Crow and Allan, 1994; Devine, 1992; Procter, 1990; Richards, 1990). This is confirmed by Charles et al. (2008), who, in a ‘re-study’ of a 1960 study of a community in South Wales, found that positive attitudes to neighbours had increased since 1960, and that ‘not noticing their neighbours very much’ had declined.

Crow et al. (1994) maintain that contemporary neighbouring is an interplay of forces where people have both freedom from the kind of ‘control’ that a monitoring type of neighbouring may have represented in the past, and at the same time the possibility of not being totally individualized or isolated in a way that would suggest that neighbours are superfluous. Crow et al. (1994) refer to this as the ‘busybody/nobody dichotomy’.

Conclusion
This thesis is about the ways that people connect over matters of health. This chapter has reviewed the literature in order to demonstrate that health interactions are an important area of study. It has discussed a range of literature which report on lay involvement in health and different types of social support, which, although not the same as the health interactions explored in this thesis, do indicate that connections with other people can affect health (negatively as well as positively). It has also shown that health policy about self-care has tended to be based on an assumption of individualized self-care. The literature on friendship and neighbouring has been reviewed to provide a context for the way that this thesis examines interactions about health with whomever they happen, and has shown that the notions of ‘family’ and ‘friend’ are increasingly seen as fluid categories. This underlines the importance of the approach taken in this thesis to focus on the level of ‘practices’.

This review of the literature has suggested that, both in some individual responses to ill health and particularly at policy level, the reflexive autonomy of
the individualization thesis is a powerful influence. These ideas will be picked up in the next chapter, where they will be discussed in contrast with what Smart (2007) calls the ‘connectedness thesis’, which emphasises the importance of the connections that people make with each other.
Chapter 3: Sensitising concepts: health interactions as connectedness, moral agency and surveillance

The title chosen for this chapter is ‘sensitising concepts’, because it engages with some of the key theoretical constructs that have been used to start thinking about the subject of health interactions. They are referred to as ‘sensitising’, as they have been important in providing points of departure (a sensitisation) for the reflection and analysis, they were applied at all the stages of the study, and will be explored further in forthcoming chapters. Three sensitising concepts will be discussed in this chapter. However, as will be seen in later chapters, there were also other key theoretical concepts which became relevant during the research process, and which are incorporated into the data chapters (5-8) as emerging concepts.

This chapter begins with the first sensitising concept, which is the individualization thesis (and the opposing ‘connectedness thesis’). This was clearly an important body of theory to inform a study about interactions and connections between people, as in many ways this thesis could arguably be seen as a challenge to the individualization thesis. The second sensitising concept explored in this chapter engages with issues of morality and moral agency, as a central tenet of this thesis is the moral stance that people take in their interactions with others about health. However, it is also possible that behind at least some of the health interactions are notions of surveillance and control, and so this becomes a third sensitising concept to be explored here.

Connectedness and Individualization

This section will discuss two contrasting perspectives which have become arguably part of the most influential debates about social interaction in recent years, animating both academic and policy discussion and analysis, and addressing whether, in late modernity, society and social relationships are connected or individualized. The individualization thesis has received a
significant critique, part of which has influenced the development of a contrasting theory of connectedness. This section will explore both of these perspectives, which are underpinning concepts for the analysis of health interactions as they trigger a number of questions about the practices (or absence of practices) of interaction about health.

The ‘connectedness thesis’ – are health interactions examples of connections? The questions that this thesis will explore are informed by a perspective that Smart (2007) has called the ‘connectedness thesis’, which was developed as a challenge to the individualization thesis and to counterbalance the fairly influential mindset of individualization. The connectedness thesis is a way of looking at contemporary personal life, which emphasises the significance of the connections that people make with each other. Health interactions could be seen as an illustration of the connectedness thesis. Smart (2007) draws attention to the ways that personal connections happen, involving for example love, commitment, the imaginary and memory, and the influence that these types of meanings and emotions have for the way personal life is lived and experienced. In Smart’s approach, these factors should be given attention in the same way that cultural and structural aspects are taken to be important influences on social life and experience. In this thesis health interactions will be explored as connections at the level of those more hidden connections that Smart refers to, such as meanings and emotions, as well as the more obvious or tangible face to face physical connections.

Smart (2007) stresses that the concept of connectedness in the ‘connectedness thesis’ is not a normative category, and that connectedness is not inevitably good, which is illustrated with examples of what Smart calls ‘everyday unhappiness’ such as hurt, anxiety or disrespect in relationships in the ‘families we live with’ (Gillis, 1997). It will be important in this thesis to be mindful that health interactions, as a form of connectedness, are not always necessarily positive. The thesis will ask about the impact and meaning that health interactions have for people and will explore ways in which these are negative as well as positive. It will also be discussed later in this chapter that the view taken in this thesis is that health interactions are not normative.
Smart argues that one of the roles that the ‘connectedness thesis’ can play is as a heuristic device to make us rethink the way that we conceptualise personal life. This could also be applied to this thesis, where interactions about health can be viewed as incorporating the smaller scale, more fleeting types of interactions involving many of the things that the connectedness thesis refers to, such as meaning and emotion.

The individualization thesis – do health interactions challenge the individualization thesis?

The individualization thesis portrays social interaction as in serious decline (Beck, 1992). This individualized world is presented as inward looking, almost narcissistic and untrusting and being lived out in private (rather than public) spaces (Giddens, 1991).

The individualization thesis as portrayed by Beck (1992), Beck and Beck-Gernsheim (1995) or Bauman (2001) takes a particularly negative perspective on the impact of an individualized social world. Beck (1992) presents a very pessimistic picture of social relationships in late modernity, with fragile relationships which are un-embedded and dislocated from any bonds and boundaries. Bauman (1994, 2001, 2003) presents individuals as wafting around, limited to engaging in superficial, ‘liquid’ relationships. He argues that what he perceives as a shift from fixed systems of family structure to elective relationships based on affinity, not kin, is a negative social change.

There are significant differences (Crow, 2002; Smart and Neale, 1999) between the individualization thesis as presented by Beck (1992), Beck and Beck-Gernsheim (1995) and Bauman (2001), and the perspective taken by Giddens (1992). Although still identifying social life in late modernity as more private and insular than before, Giddens is somewhat more positive about the implications of this, and argues that the ability to redefine ourselves can be advantageous as it can contribute to increased democracy and equality. Giddens also sees same sex relationships as ‘harbingers of change’ (1992), leading the way for heterosexual as well as same sex couples towards more democratic styles of relationships. Giddens’ work on individualization at the level of intimate relationships, in his book ‘The Transformation of Intimacy’ (1992), has claimed
that changes parallel to the individualization thesis have been occurring in intimate relationships. In The Transformation of Intimacy (1992), Giddens argues that twentieth century society saw a transfiguration of couple relationships with a rise in the concept of romantic love, and an idealising of the importance of love and intimate relationships, which he refers to as the ‘pure relationship’. Giddens presents the pure relationship as confluent, open and reflexive, and expected to fulfil all needs. If it does not, since it is a contingent, transient type of love, it can be dissolved. The pure relationship has been criticised for two main reasons, the first that it arises from a white, male, middle-class perspective, ignoring structural constraints such as class and gender, which means that it is not easy for everybody to engage in a reflexive project of the self (Jamieson, 1999; Crow, 2002; Ribbens, McCarthy and Edwards, 2022; Smart and Neale, 1999). A second critique of Giddens’ work is that it tends to operate at a level of grand theorizing (Smart, 2007), which could be useful as a heuristic device but is more problematic when attempting to apply it to everyday life. Part of the thinking behind the individualization thesis, particularly as proposed by Giddens (1991), is that in late modernity people are engaged in ‘life projects’, choosing how and who they want to be. As we will see later in this chapter, this is one way in which health interactions could be interpreted, that engagement in health interactions could be part of the ways in which people develop their life projects and identities as moral and caring beings.

These ideas of the decline of social life have been widely challenged around two main areas of contention. The first is historical accuracy, Spencer and Pahl (2006), Allan (1996) and Devine (1992), argue that society prior to late modernity may not have been as united, cohesive and communal as the individualization theorists would have us believe when they emphasise relatively recent change to a more atomised contemporary social world. The individualization thesis has also been critiqued for its ‘broad brush’ theorizing, which is not based on empirical evidence (Brannen and Nilsen, 2005), as there have been a number of empirical studies which present social interactions as much less private, transient, and ‘liquid’ than depicted in the individualization thesis (Smart, 2007; Smart and Shipman, 2004; Gross, 2005; Duncan and Smith, 2006; Crow, 2002; Lewis, 2001). This can also be seen, as has been illustrated in the previous chapter, in the renewed interest in the sociology of

The previous section described how this thesis is located within the connectedness thesis, which means that an understanding of the individualization thesis is an important foundation for the thesis. Do health interactions provide an example of a challenge to the individualization thesis? Do people refuse to engage with others about health, preferring to manage their health in a private or atomised manner? Or are there illustrations of health interactions where people are clearly not atomised? Are they relying on each other rather than experiencing the type of decline in trust that Beck (1992) refers to? This thesis will also provide an opportunity to explore whether, as Bauman proposes, social interactions and in this case health interactions are fluid and ‘liquid’, by considering both their durability and the sustained support they represent. However, there is a degree of complexity here, as this thesis will also explore whether interacting about health can sometimes also be transient, fleeting or fluid.

The moral meaning of health interactions

Is there a moral dimension to health interactions? Are interactions about health underpinned by moral understandings or moral agency? As this thesis will seek to examine these questions, in this section three different types of moral perspectives are discussed, each offering a possible explanation of what is going on, from a moral perspective, when people engage in health interactions.

Firstly, moral norms will be discussed to provide background to the question of whether people may engage in health interactions out of a sense of ‘should’ or ‘ought’. The second perspective is a more instrumental one, which proposes the idea that people engage in practices such as health interactions for their own purposes of constructing, or presenting, a sense of a moral self. Lastly, a third perspective is outlined, which suggests that people feel ‘moral emotion’
which leads them to engage in moral actions, such as health interactions, because it matters to them.

*Moral norms – people should help the sick*

Engaging in health interactions could be seen as normative. Norms are prescriptive and indicate a shared expectation of culturally appropriate and acceptable behaviour, such as ‘helping the sick’. In this sense they serve as a set of unwritten and informal rules and regulations demonstrating the almost universal expectation of engaging in other people’s health problems. Normalising judgements could be used as a way of punishing those who do not conform, and so it is the threat of negative sanctions that enforces the norms. Likewise, it is the possibility of rewards in terms of social acceptance which encourages people to conform to norms. This is discussed in the section below, where it is argued that one of the things that could be going on when people engage in health interactions is that they are constructing a positive self identity. Norms are associated with social regulation and social order and can be seen through a functionalist perspective (Durkheim, 1938; Parsons, 1951). This perspective is discussed below and explored elsewhere in this thesis, where it will be asked whether people find it possible to negotiate and ignore the social norm of ‘helping the sick’. From a functionalist point of view, a compulsion to ‘help the sick’ could be interpreted as a social norm which governs the way people act. From this perspective, participating in health interactions could be seen as obediently or almost blindly following powerful norms that exist in our society. Moral pressure may be felt from a wide range of sources impelling people to engage in health interactions and support others when they are ill.

The notion of ‘moral voices’ (Hekman, 1995) may be another way in which these societal norms control our behaviour. People may be unaware that they are responding to a friend or relative’s illness, or caring for their neighbours, as a result of moral voices and norms which create for them a sense of ‘ought’. ‘Helping the sick’ is a very powerful normative force in our society (and indeed not just contemporary or Western society). A question that will be explored in this thesis is the degree to which individuals follow the dominant norms of
engaging in health interactions, and whether or not they are aware of a normative compulsion to do so.

In functionalist thinking, society is viewed as systems-oriented and norms are a part of an interconnected cohesive social system or social order, where all parts of society function as organs or components of an overall whole. A biological analogy is often used by functionalists (Parsons, 1951), where the workings of society are compared to the workings of the different parts of the human body. Functionalism views the different functions performed by component parts of society as contributing to the maintenance of society as a whole (Durkheim, 1938). So, from this perspective health interactions could be seen as performing a utility function required by society; this function is caring for the sick or providing lay healthcare, support or advice at a level outside the formal health service.

Durkheim, in his *Rules of Sociological Method* (1938), takes a highly non-agentic view of social life, viewing society as something distinct from individuals and where individuals’ actions are shaped by society and not the other way around. Thus, people’s participation in health interactions from a Durkheimian perspective would be a result of compliance with social norms essential to maintaining a working and ordered social system (Parsons, 1951). One of the questions that this thesis will explore is whether people’s engagement (or its absence) in health interactions is a result of agency or social norms.

Critiques of the idea of social norms tend to focus on a view of social life as being more negotiated, flexible, complex and diverse than the concept of social norms suggests. This raises the question whether everyone conforms to the norm of ‘helping the sick’, or whether some people challenge, negotiate or develop their own variations on it. Sayer (2011) believes that people do not automatically follow norms and that norms are not necessarily universal, but differ according to variations in settings and relationships. Also in opposition to functionalist theories, Bauman (1995) argues that society in late modernity is about diversity, so there is now less authority for ethical and cultural norms than before, as social life is now much less uniform. A question that this thesis will ask is whether society is becoming diverse about attitudes to ‘helping the sick’
in the same way as it is, for example, about family structures, or whether ‘helping the sick’ is beyond social change, beyond societal transformation? What Bauman (1995) would argue in response is that, it is not that moral principles no longer have a place in postmodern society, but that what is rejected is the way of controlling or enforcing these moral practices through norms and ethical judgements. Bauman argues that the extent to which we engage in moral actions is now a matter of our own choice, rather than the ‘moral pressure’ of societal norms. It will be interesting to explore in this thesis whether and the extent to which people describe following a generally functionalist model through following norms, or they have free choice and are able to exercise that choice in deciding whether to provide support for someone they know who has a health problem.

Radcliffe (2011) and May (2008) discuss identity work in the context of the norms surrounding being a good mother, which result in drug using pregnant mothers (Radcliffe, 2011) and single mothers (May, 2008) feeling compelled to try to define themselves as ‘good mothers’. They argue that it was impossible for these women to take an alternative, challenging or defensive stance, as none of the women would consider the option of not being a good mother. They all subscribed to the dominant societal norm about being a good mother. Are societal norms about ‘helping the sick’ similarly strong? In this thesis the question will be asked of whether there were people who felt that they did not want to engage in health interactions with others, who may have felt either that social norms did not apply, or that they could opt to challenge or ignore them.

May (2008) argues that, because of the strong social norms about being a good mother, people try to present themselves as such. This may have parallels in health interactions as ‘helping the sick’ is such an iconic notion of doing (and being) good, that people may want to present themselves as engaging in health interactions. So one of the things that this thesis will explore is whether this social norm compels adherence which results in the health interactions studied here.

As was discussed in Chapter 1 (Introduction), an at least partial similarity between the contexts referred to by Radcliffe (2011) of ante-natal drug use and
by May (2008) of single mothers, and the health interactions explored in this thesis is that, whereas drug using or single mothers may be operating within a potentially critical and moralising social climate influenced by traditional and normative views about family structure, helping the sick has been a powerful social norm for centuries.

*Moral project of the self – health interactions as instrumental moral agency*

The previous section outlined a perspective on health interactions that sees them as inevitable, almost compulsory responses to strong moral norms around ‘helping the sick’. A second perspective will now be discussed which takes a very different slant on what is going on when people engage in health interactions, by presenting this as instrumental work which people do in order to build a sense of self as moral. This may be done for presentational purposes, in the interview or elsewhere, or it may be done for people’s own sense of self as a moral actor.

This perspective is rooted in the ideas of the ‘reflexive project of the self’ (Giddens, 1991), which views people as highly agentic and free to define and create and recreate their selves. So health interactions could be used instrumentally, as a way to contribute to people’s projects of the self, by providing them with opportunities to develop a moral aspect to their selves. The critique of Giddens’ approach focuses on the individualism implied. What is criticised is the emphasis on benefit solely for the individual, and the purely agentic notion that this takes place outside of any context of society (so opposite to the social norms described above) or social structure. These criticisms, particularly of the individualistic focus, would also apply to this perspective on health interactions.

One of the aspects that this thesis will explore is health interactions as the moral work involved in constructing or presenting a moral self. Many people care deeply about being viewed, either by others or by themselves, as moral. In the two articles about motherhood referred to above (May, 2008; Radcliffe, 2011) it was important for mothers with ‘spoiled identities’ (Goffman, 1963, see discussion of spoiled identity below) to strive to build an identity as a ‘good mother’. In a similar way, this thesis will ask whether the study participants
could be seen as using health interactions to work towards an identity as a good person, a moral actor, or a good friend, neighbour or relative, through their engagement in health interactions. This ‘moral work’ (Radcliffe, 2011) can also be seen as a type of ‘moral enterprise’ (Radcliffe, 2011), where people are working to prove themselves as moral actors. Health interactions could provide good opportunities for people to present themselves as moral actors, which Goffman (1959, 1971) argues is crucial for participation in social groups, so there could be a strong pull to engage in moral work and to present oneself as moral. ‘Doing morality’ (May, 2008) takes place as part of daily ‘lived practices’ (Radcliffe, 2011) and so it is fitting that this thesis will examine this and other issues at the level of practices.

Both May (2008) and Radcliffe (2011) explore moral agency from the perspective of people who feel that their behaviour may be something that could be considered to be outside of societal norms (single parenthood and ante-natal drug use), which they both equate with a ‘spoiled identity’ (Goffman, 1963). Spoiled identity is when people act ‘outside’ of social norms and consequently are not fully accepted in society, or are stigmatized (the term ‘spoiled identity’ originates as part of Goffman’s, 1963, work on stigma). The moral ambitions of those engaged in health interactions discussed here could be seen as the opposite of a spoiled identity. Here health interactions are used as a way of preventing a spoiled identity or of building such a strong positive, ‘pure’ identity that it could never be seen as ‘spoiled’.

*Moral emotion – concern for others matters to people*

In the previous sections, two perspectives have been outlined on why people engage in health interactions. A third perspective will now be presented, influenced particularly by Sayer (2011), which is that people engage in moral actions, such as health interactions, because it matters to them to do so. Sayer argues that social science needs to reconceptualise moral concern. The current approaches of seeing it as either soft and romantic or crude and rationalist do not capture what is important about moral concern. He argues that people are motivated by virtue, human concern about others and ‘moral emotion’ (Sayer, 2011; Bauman, 1993, 1995; Pritchard, 1991). These are what
eighteenth century philosophers referred to as ‘moral sentiments’, which include emotions such as compassion, sympathy and benevolence. It is these types of moral understandings, or ‘moral emotions’, that Pritchard (1991) argues play an important part in influencing people’s actions and sense of self and identity. Bauman (1993, 1995) and Hekman (1995) point out that we have a choice about whether and how to respond to these moral emotions, including translating them into ‘moral practices’.

Sayer’s (2011) argument, that what matters to people is concern, virtue and human feeling, could be applied to health interactions, which could be motivated by this type of human kindness. The counter argument to Sayer (presented in the previous section) is that people engage in health interactions for instrumental reasons, in order to be able to present a moral narrative or presentation of self as moral, so from this perspective health interactions are seen as motivated by an instrumental desire to build a moral identity. These two positions are not mutually exclusive and this thesis is positioned somewhere in between them, viewing health interactions as both a result of human virtue, feeling and concern, as well as an instrumental project to build and present a moral identity.

To sum up this section, three different perspectives, all underpinned by (albeit very different) senses of morality, have been discussed to help illuminate what is at stake when people are engaging in health interactions. The main differences between these perspectives are rooted in the theoretical positions from which each of them originates. The first perspective is that people are compelled to engage in health interactions in order to comply with a dominant social norm about ‘helping the sick’, a viewpoint which has its foundations in functionalist thought (Durkheim, 1938; Parsons, 1951) and assumes a society that functions like a well-oiled machine. The second perspective has developed from ideas almost diametrically opposed to the functionalist social norms, namely that we create our own self and are highly agentic and indeed quite instrumental in doing so. Health interactions in this perspective become part of the reflexive project of the self (Giddens, 1991) and involve constant change and re-examination as part of the work of construction of self, so in this light
people engage in health interactions, not because they ‘should’ (as in the first approach), but because they choose to as part of their own ‘project’. So while in the first perspective health interactions are for society, and in the second perspective health interactions are for the self, in the third perspective health interactions are done, not for oneself but more genuinely for the other, based on a sense of morality. There are overlaps between these three perspectives, which imply that there is a relationship between them and that these viewpoints are not entirely separate, but rather more complex and intertwined.

Of these three perspectives, social or moral norms, instrumental construction of a moral self, and moral emotion, the view taken in this thesis is that people have some instrumental interest in the construction and presentation of a moral self, but at the same time they possess a sense of moral virtue or moral emotion, which means that helping others is important to them.

Narratives and identity: are health interactions a way to construct identity?

One of the ways to view the health interactions studied in this thesis is as a series of narratives. The narratives that people present will be interpreted not simply as ‘truth’, but as how people present themselves, and what this tells us about health interactions, and possibly more broadly about illness. In this section, drawing particularly on the work of Lawler (2008), the concept of narratives and identity will be reflected on, and the role that narratives play in our understanding of health interactions.

Radcliffe (2011) has referred to what she calls ‘language as a social action’, where people are trying to actually do something with the interview. They are not just there to answer questions for the researcher, they are trying to do or achieve something for themselves. Thus, it is important to take narratives into account in this thesis because health interactions may link to people’s identity and moral presentation of self which can be understood as narratives that people wish to present, informing us not only of the content of their narrative but of the often complex reasons surrounding it.
Allusion has been made in recent years to a ‘narrative turn’ (Atkinson, 1997), which refers to an increasing interest in the narrative form, and which is often taken to suggest an uninterrupted, solitary voice, uninfluenced by situated context, or by the research process. However, narratives do not appear from thin air, they are socially and historically constructed, so the narratives that people tell draw on broader cultural attitudes which are themselves another form of narrative (Lawler, 2008). When people are telling a narrative about a health interaction they may be influenced by, or ‘borrowing’ ideas from, other narratives (Lawler, 2008). Stanley and Morgan (1993), when considering why there has been a growth in interest in biography and autobiography, suggest that one reason is an interest in intertextuality, where people’s narratives are influenced by other narratives, texts or life stories either in their lives, others’ lives, or in fiction. Memories are also drawn upon in the construction of narratives; however, memories are also products of the social world and of other narratives, our own and others (Lawler, 2008).

What do narratives do for us? Lawler (2008) describes the functions that narratives play, one of them being to help people understand the world and their lives, both in the abstract and the immediate. However, for Lawler identities constructed through narratives do more than clarify the world, she feels that they create a relationality, a connection or link between an individual and other individuals living in society.

The narratives that people present can be seen, not only as linked to their identity, but as creating their identity (Lawler, 2008), so it will be important to examine in this thesis both how people present a narrative of themselves about their engagement with health interactions, and also how these narratives serve more than presentational purposes, and whether narratives about health interactions seem to also be part of people’s identity construction work. This thesis will examine talk about health interactions and will explore whether individuals are narrating accounts which took place because of their (pre-formed) identities, or whether they were actually building identities through the process of articulating the narratives they gave in interviews.
Lawler (2008) argues that identity emerges through the development of the narrative, which makes identity ‘profoundly social’ through continual interpretation and reinterpretation, so in this way we have a sense of our identity through this repeated interpretation. Identity is produced or constructed through narratives, it is not something that is ‘there’ waiting to be discovered or narrated. This, Lawler argues (based on Ricoeur, 1991), means that the reason that there is a view of the self as a ‘solid’, durable thing that lasts over time, is that people have an ongoing narrative of stories which, by their telling, produce a sense that this self has a permanence to it, which is not actually a permanence but a continual recreation (Ricoeur, 1991). Giddens (1991) has pointed out that people redefine themselves by using autobiography, by describing their lives, thereby reconstructing themselves. So the research interview about health interactions is being used by study participants to aid their identity work, or maybe it is their identity work.

Postmodernists argue that we live in a world where identity is fragmented, fluid, contradictory or unstable (Bauman, 1994). They disagree with what they see as the modernist sense of a single, stable and unitary self as somehow ‘static’ or prescribed. From postmodern perspectives, this view of the self and indeed the concept of the self itself is seen as a product of modernity, and use of the term ‘identity’, rather than ‘self’ is preferred (Hall, 1992). Viewing identity instead as pluralistic and many faceted is again in disagreement with the notion of a single, unitary self.

Another aspect of the postmodern perspective is that people’s identities are a matter of their own choosing (Bauman, 1994), so people are seen as choosing what identity they would like to adopt or they work to construct their own identities of choice. This notion has been criticised (Woodward, 2000) for failing to take into account the structural constraints which prevent people from choosing certain identities. Exploring whether people are engaging in the work of health interactions in order to try to construct a certain type of identity is at the root of the question of whether the reason for participating in health interactions is an attempt to build a ‘moral identity’.
Social Selves – health interactions as part of the construction of our social selves

In this section self and identity will be explored. How are health interactions part of a process of construction of self? How does engaging in health interactions play a part in identity formation? To what extent is it possible that people might be instrumentally using their participation in health interactions to build a certain type of identity? The concept of the social self will be examined to provide an insight into these questions, drawing heavily on Burkitt (2008) and Mead (1934), an argument that will be explored further in Chapter 8.

There are many ways that the notion of the self has been conceptualised; this section will focus on just one of these perspectives, which is of a ‘social self’. Mead (1934) viewed the self as formed through engagement with others, that is, people come to experience their self by seeing how their social group responds to them. This also happens the other way around, through viewing other people’s selves and experiences people imagine their own. To what extent does this apply to health interactions? Could it be that part of the way that we form our social self is through the way we respond to and interact with others at times of ill health, and that by noting the way others respond to our engagement in health interactions, we come to understand our ‘self’? Burkitt (2008) follows Mead’s perspective of the self as social and argues that it is through interactions with others that we find and construct our self, which is why he refers to the self in the plural as our ‘social selves’, as he believes that the construction of self is not a solitary activity, but a social one, involving interactions with others. Burkitt (2008) has two reasons for arguing that the self is a social self. Firstly, people are born into a social structure, culture and set of social relations which influence the way they are – these are social influences. Secondly, in trying to define our self we often do this through what we do, which is invariably social, so Burkitt sees the self, not as pre-set waiting to be discovered, but as something which is created and developed through our activities. This could include the engagement we have with others who are experiencing health problems.

Macpherson (1962) referred to Western individualization as ‘possessive individualism’, meaning each person being creators and owners of their own
capabilities and talents, and that none of these are attributed to the influence of or interactions with others. By contrast, Burkitt (2008) argues that the social self runs counter to individualism (see the earlier part of this chapter for a discussion of individualization), and that there is a temptation to assume that the ‘self’ is somehow inside of people, an internal, private thing, what Burkitt (2008) describes as ‘like a pearl in its shell’. He argues that viewing the self as an isolated atom ignores the connection with others, which is what creates the self. In this light, the interactions about health that are studied in this thesis could have a very important role to play in the creation of self.

Mead (1934) saw the self as the interaction between ‘I’ and ‘me’. This is central to understanding the social self. The ‘I’ is the attitude of others who observe us, and the ‘me’ is the object that is observed (Burkitt, 2008). The self is both the ‘I’ and the ‘me’, but particularly it is the interaction of ‘I’ and ‘me’. In health interactions, the way others observe us (the ‘I’) engage in health interactions will influence the production of the ‘me’, the self that we enact.

There is another level at which Mead foresaw that the self was formed through engagement with others. As well as responding to others’ responses to us, we may also respond to their imagined responses. Then it is those imagined responses which become the ‘I’. This is particularly relevant in the context of the way people interact about health, as they may decide to engage in a health interaction due to the ‘imagined’ response it would get from others.

There is a strong critique of these ideas of social self, for example the way it is presented as rationalistic and cognitive and lacking in any sense of the emotional side of the formation of self through social engagement (Elliot, 2007). It also leaves no room for conflict between the self and society, and assumes that individuals will passively or unquestioningly form their sense of self based on the perspective of others or of the society around them. To allow us to explore this further, this thesis will consider whether there were people in the study sample who challenged the perspective of others reflecting on their role, or lack of it, in health interactions. The concept of the social self has also been criticised for not giving credit to the fact that the construction of self may be defined or constrained by social position and other structural factors – so in
order to try to address this, this thesis will seek to understand the nuances of power and control which could be implicit in health interactions. Mead’s concept of a social self also assumes that social interactions are positive engagements and that there is a helpful, constructive relationship between the views of others and the formation of self. By contrast Foucault (1975) highlights ways in which social interaction can be very damaging through repression, monitoring, surveillance or control of the less by the more powerful. This tension will be raised later in the thesis by exploring how health interactions can be destructive or used as a form of control, as well as constructive, and whether, if health interactions do contribute to the development of a ‘social self’, this is obtained through domination of one person by another.

The concept of the social self is important for this thesis because it suggests that while engaging (or not) in health interactions, people may be doing more than trying to help someone they know with a health problem. From the perspective taken by Mead and Burkitt, individuals may also be developing and learning who they are, through the response of others to this health interaction.

**Monitoring, surveillance and governmentality – are health interactions controlling us?**

Having discussed the importance for the study of the individualization and connectedness theses, and having explored different ways that health interactions could be a form of moral agency, this chapter will now move on to the third sensitising concept which provides an alternative way of seeing health interactions. This is as a form of monitoring or surveillance, or what Foucault (1997) has called ‘governmentality’.

Foucault (1997) has described governmentality as ‘techniques and procedures for directing human behaviour’. Foucault as well as others who have developed his work (Rose, 1989; Dean, 1999), argue that in the past power and discipline were maintained through strong institutions such as hospitals, schools, prisons or psychiatric institutions. However, Foucault argues, there has been a de-centering, or dispersal, of power. The method of exercising power has shifted
from the state to the individual (Rose, 1989). People are expected to be self-governing, and regulation of their actions and behaviour comes not from the state but from within themselves. In terms of health this would mean that, rather than the state telling people that they should do exercise, for example, individuals internalise the discourse about exercise and health and they discipline themselves to exercise. The responsibility therefore for discipline shifts from the state to the individual, something that can be seen reflected in the UK health policy initiative of ‘self-care’ (Lemke, 2001), which triggered some of the ideas for this thesis.

This thesis suggests that there is an extension of the ‘governing of the self’. It is not only that people are governing themselves, but they are also governing their friends. This becomes a kind of ‘technology of the other’ or ‘technology on the other’. The way this happens is through surveillance and monitoring each other’s health or health behaviour.

The ways this type of control is conducted in practice have been referred to as disciplinary power, or technologies of power (Rose, 1999). People discipline, or act on themselves, through training, self-control and other self-improvement techniques. Rose (1996) has referred to this as the ‘enterprising self’. As part of the technologies of the self, there is a role for experts. These can be doctors, for example, who tell us what it is that we should do in order to achieve our targets – such as a fit body. This thesis suggests that these ‘experts’ could also possibly take the form of friends and family who provide advice and implicit governing.

Care and support from friends at times of health problems is loaded with feel-good moral high ground. Viewed differently here, I suggest that we could consider it, not as care, but as a tool of surveillance, that people have come to govern not only themselves, but also each other.
Conclusion

This chapter has continued the process begun in the two previous chapters, of setting the scene for this study of health interactions. Whereas the previous chapter mapped the range of literature relevant to the thesis, this chapter has moved to a greater level of depth and has focused on the theoretical ideas that have been influential in the conceptual thinking and analysis of the thesis. The chapter has engaged with concepts which will be used in future chapters to understand and interrogate the data and which suggest possible areas of interest including health interactions as a challenge to the individualization thesis, health interactions as a form of moral agency and identity construction, and health interactions as monitoring and surveillance.
Chapter 4: Methods – researching health interactions

The previous three chapters have provided the intellectual and theoretical background for this thesis. The objective of this chapter is to build on that and to direct the focus of attention to how and why, given that background and the research questions, the study was designed to not only answer the research questions but also to enable exploration of the theoretical constructs described in the preceding chapters.

The chapter begins by presenting the research questions, which is followed by an account of the rationale for the choice of approach to answer these questions and by a critical reflection on other methodological approaches considered, with reasons for their rejection. The chapter then moves on to describe the methods used in the study, beginning with a description of the sampling methods and following with descriptions of recruitment, data generation and analysis. The chapter ends with the ethical considerations taken into account in the study and by summing up the rationale for the methods used.

This study seeks to understand the form, nature and meaning of informal interactions about health. The research questions are:

1. *In what ways do people interact over matters of health?*
2. *Who becomes involved in health interactions, who does not, and how?*
3. *What is the meaning that interactions about health have for people?*
An interpretivist approach

This study was embarked upon in order to understand how people interact about health. It sought to understand the different ways that people connect with each other over matters of their health and the meaning that these connections have for them. This interest was motivated partly by a desire to understand how these interactions might influence people’s approaches to their health. It was also motivated by a desire to understand whether and in what ways people felt a sense of connection (or distance) through health interactions and whether people felt that these interactions strengthened or weakened their social bonds. Given these aims, which evolved to become the study research questions, a number of methodological approaches were considered which might have provided the kind of understanding that was sought.

Ethnography was the first potential approach that was explored. It was felt that, by observing people’s practices of health interactions, it may be possible to answer at least the first of the study research questions. This process is described in greater detail below but an ethnographic approach was ultimately rejected. Conversation analysis was rejected for the same reasons as ethnography, which is that they both require naturally occurring data (which were felt to be impractical to gather, see below). Discourse analysis was also a possible approach and indeed it became an important influence on the form of interpretivism taken in the study, because large parts of people’s accounts were analysed as ‘narratives’ (see below for a fuller discussion of discourse analysis).

After researching this range of possible approaches, it was decided that what was necessary to answer the questions that this study posed was to talk to people. It was felt that only through obtaining people’s firsthand accounts would there be an opportunity to understand, not only the fine mesh detail of the ways people interact over health, but also the meaning that this has for them. So it was through this process that it was concluded that an interpretivist approach was needed for this study.

However, the exploration of other methodological approaches and the identification of much of value in some of them, led to the belief that the
interpretivist approach which was needed was one which was uniquely
designed for this particular study, incorporating some aspects of both the
ethnography and conversation analysis approaches, where they helped to
answer the research questions. So, a broadly interpretivist approach was
adopted which prioritised access to people’s meanings.

Interpretivism was also chosen for this study, because of the nature of the
research questions, which required the possibility of providing nuance, depth
and richness. In order to answer the research questions, it was necessary to
understand health interactions through understanding the meaning that people
themselves ascribe to them, ‘in their own terms’ (Fay, 1996). This is a key
factor in the choice of interpretivism over ethnography or discourse or
conversation analysis, as it was felt important to obtain people’s own accounts
of and perspectives on the ways they interact about health and the meaning
that this has for them. Just observing health interactions would not have been
sufficient to answer the research questions about the meaning of such
interactions. It was felt that it was only going to be possible to access the ‘fine
grain’ insights on meaning and perspectives needed for this thesis, through
reported accounts.

The roots of interpretivism are in idealism, a belief that our knowledge of the
world is filtered through our minds, making it impossible to know the nature of
the world except through our perception of it (Williams and May, 1996). It was
this that led to the choice of interpretivism, as it was people’s perceptions of
health interactions that were sought, not merely an assessment of whether or
not and how health interactions existed. Thus, what was wanted from an
interpretivist approach was an emphasis on the ways that health interactions
were understood and experienced, from what Blaikie (2000) refers to as the
‘insider view’, rather than enforcing an ‘outsider’ view. To get those ‘insider
views’, an interpretive approach was required.

In sociology, the origins of the interpretivist approach are associated with Weber
(1968), and before that Dilthey, with the concept of ‘verstehen’ (an
understanding of people’s actions). Blaikie’s description of interpretivism as the
‘insider view’ is similar to the emphasis that Weber (1949) put on people’s
subjective meanings as the starting point of social analysis. Weber was
influenced by the late nineteenth century work of Dilthey, which stressed the importance of people’s lived experiences and of ‘understanding’, which Dilthey first referred to as verstehen. For Dilthey, this was part of a separation of the cultural and natural sciences (Murphy et al., 1998). Weber built on Dilthey’s ideas. However, Weber diverged from Dilthey in that, rather than separating, he sought to link interpretivist approaches with positivist ideas (according to Hammersley and Atkinson, 1995, a tradition that continued until the 1940s). Weber aimed to develop a science of society that had the same levels of objectivity as the natural sciences (Murphy et al., 1998). He has been highly influential in legitimising the notion of verstehen and an interpretative approach to the study of the social world (Murphy et al., 1998).

There is a vociferous critique of interpretivism, which needed to be considered in the decision to adopt an interpretivist approach for this thesis. Some authors question the practical use, value and possibilities for generalisation of interpretivist research. Williams (2000), for example, coming from a positivist perspective, depicts the use of an artist’s brush to paint a building as an analogy for the utility of interpretivist approaches. Some have argued that these characteristics of interpretivism link it more closely with art than science (Frisby, 1992a, 1992b). Williams is critical of interpretivism for this reason and portrays the difference between interpretivism and positivism as the difference between ‘a Sisley painting and a surveyor’s photograph’ (2000). This was an important consideration for this thesis, which spans the boundaries of medicine and sociology, and will thus have medical as well as sociological and positivist as well as interpretivist audiences.

The choice of an interpretive approach for this study worked well. The focus on people’s accounts meant that it was possible to access not only the meaning that health interactions have (or do not have) for people, but also the presentation of self (Goffman, 1959) and the importance of moral narratives and the construction of a moral identity, all of which are discussed later in the thesis.
Discourse analysis

The broadly interpretivist approach used in this study of health interactions has incorporated some elements from discourse analysis. However, the focus of discourse analysis is on the study of discourse or talk (and also texts) and does not take the accounts given to be reality, but views them as socially constructed (Silverman, 2005). Wilkinson and Kitzinger (2000), for example, are unsympathetic to the way they see much social science research uncritically accepting study participants' self-reports as reflecting reality, and assuming that the participant's objective in an interview is to give an accurate report to the researcher. They argue that discourse takes place within a social context and should be analysed as such, rather than in what they refer to as a 'social vacuum'. This thesis' approach is a combination of accepting the accounts given, as well as reflecting upon them as narratives. The latter makes it close to the approach used in discourse analysis.

In discourse analysis, careful attention is paid to discursive practices and the varying ways that the social world is constructed through talk (Potter, 1997). In this thesis, a similar approach was taken through reflection on what was happening in the talk, as recorded in the interviews, in terms of identifying elements of the talk as 'narratives'. The type of discursive practices that tend to be the subject of discourse analysis include performances, linguistic style and language used, rhetorical devices, and talk systems for competing accounts (Silverman, 2005; Tonkiss, 2000). Also included in discourse analysis are formulaic devices and idioms, which are the subject of the above mentioned study by Wilkinson and Kitzinger (2000). They argue that, when the participants in their study used the particular idiom being researched ('feeling positive' in the face of cancer), those participants were appealing to a commonplace, taken-for-granted understanding. This can be seen as similar to the way in which, in this thesis, people used what are described as narratives such as 'helping the sick'. Here, accounts given in interviews are viewed as an opportunity for people to present themselves as moral, through their roles in other's health. Similarly, Wilkinson and Kitzinger (2000) illustrate, in their use of discourse analysis, how accounts of 'positive thinking' by women with cancer are viewed as 'talk as a form of social action', where talk plays an interactional role. From this perspective, talk is not a simple report of an experience or feeling, but a
‘conversational device’ which does certain types of ‘work’ in facilitating interactions.

It could be argued that there is a certain arrogance in the approach of discourse analysis, which, by the way it emphasises the discursive tools and the social context of the talk, presumes to rewrite the self-report of study participants. For example, Wilkinson and Kitzinger (2000) argue that, when people with cancer talk of ‘feeling positive’, this should not be taken at face value to mean that they are indeed really ‘feeling positive’. This view, whilst methodologically interesting, does seem to be something of an imposition of theoretical assumptions onto people’s own personal accounts. Another example could be from this thesis – where people talked on the theme of the importance to them of helping others who were ill. A discourse analysis approach might view this as a discursive tool that should be taken in the context of the social meaning of ‘helping the sick’. However, a concern with this perspective is that it implies that the researcher knows better than the study participants themselves what they think and feel. This concern is rooted in the principles of idealism and the epistemological position that knowledge of the world can only be obtained through people’s own perception of it (Williams and May, 1996).

Although discourse analysis has been rejected as an overall methodological approach for this study, nonetheless some elements of the principles of discourse analysis have been incorporated. The most important of these are the occasions when participants’ accounts have been analysed, not as straightforward reports, but as narratives that people use to achieve a certain moral identity.

Conversation analysis

Conversation analysis was also explored for possible use in this study of health interactions. It was recognised that some health interactions take the form of everyday, often fleeting or seemingly trivial parts of people’s lives. Garfinkel (1967) calls these the ‘seen-but-unnoticed’ informal everyday practices which include taken-for-granted, often tacit, actions or routines (Murphy et al., 1998).
This element of commonality could suggest the use of conversation analysis as a methodological approach for this study.

However, a key aspect of conversation analysis is that it uses naturally occurring data. It is based on an in-depth analysis of talk or naturally occurring social interactions between people (Murphy et al., 1998). The aim of conversation analysis is to be able to capture and analyse a picture of the complexity and richness of social life and interaction as it occurs, what Heath and Luff (1992) have called ‘a microscope with which to study human life.’ However, a microscope to study human life, or social interactions, was not what was sought in this thesis. Although here an aim was to understand how people interact over health, there was also the intention to understand the meaning this has for people, and to understand how people see things as well as how they do things. Conversation analysis focuses only on the latter (Maynard, 1989).

Another way in which conversational analysis could have been viewed as a possibly appropriate choice of methodology is that it is concerned with social interaction and uses data of interactions between two or more people. This thesis is also about interactions – interactions about health. However, the similarity ends there, as this study was not limited to seeking to understand the health interactions but, importantly, it also sought to understand participants’ reflections, narratives and accounts of those health interactions.

This relates to another reason why conversational analysis was not adopted here, which is that it aims to identify interactional practices (Murphy et al., 1998), such as rules of interaction, conventions or procedures, or what Silverman (2005) has described as the methods people use in ‘the organisation of talk’. This thesis had different aims, which were to understand, not the form of the interaction but its content and, importantly, to include people’s perspectives on the meaning that health interactions hold for them.

Indeed some critique of conversation analysis focuses on the fact that there is often much more happening in an interaction than is contained in the talk (Murphy et al., 1998). There are also things which go on inside people’s heads, which would not be recorded by conversation analysts but, importantly for this study, could involve thoughts and reflections on interactions about health.
There was also a practical reason why conversation analysis was rejected as a methodological approach to be used in this study. There was a concern that, due to the often fleeting and occasional nature of health interactions, if naturally occurring data had been used, the amount of collected data relating to health interactions would be miniscule, compared to the vast and unmanageable quantity of unrelated data which would have to be collected in order to get the few snippets of data related to the study aims. This concern also applies to ethnographic approaches, which are discussed below.

So, in sum, conversation analysis would have been a possible approach for this study, based on the shared focus on interactions and everyday ‘taken-for-granted’ practices. However, this possibility was finally rejected, as this thesis sought to understand meaning and participants’ perspectives and reflections, and not be limited to what was actually said in an interaction. In addition, as conversation analysis uses naturally occurring data, it would have been practically impossible to record enough data of health interactions in order to provide a workable quantity of data to answer the research questions. However, the thesis has been inspired by the ideas of researching the ‘seen-but-unnoticed’ (Garfinkel, 1967) which stem from conversation analysis and these ideas have influenced the form of interpretivism used in this study.

Grounded theory

Grounded theory (Glaser and Strauss, 1967), which has been reported to be the most extensively utilised interpretive framework in qualitative social science research (Denzin, 1994), was also explored as a possible methodological approach to be used in this study.

Similarly to this thesis, grounded theory is based on underlying principles of close observation of the social world. Like this study, its focus is also on the actor’s perspective (Alvesson and Skoldberg, 2000). The aim of grounded theory is to generate theory, and although this was not an explicit aim of this thesis, it did seek to develop a greater theoretical understanding of health interactions and how they affect both management of health and the connections and relationships between people.
There is a systematic approach to both gathering and analysis of data in grounded theory (Denzin and Lincoln, 1998). Glaser and Strauss (1967) have described this as ‘a general ... [constant] comparative method.’ Data collection and analysis are conducted simultaneously. In a cyclical pattern, the data are coded using an approach known as ‘theoretical coding’ (according to Alvesson and Skoldberg, 2000, this is the hallmark of grounded theory). The initial categories are developed, based on the coding, and then further data are collected and compared in order to see whether they fit, or do not, or they extend the emerging theoretical categories (Charmaz, 1990). Denzin and Lincoln (1998) have described this process as a constant interplay between analysis and collection of data. The grounded theory method of choosing further ‘critical cases’ to study is referred to as ‘theoretical sampling’. It is an iterative process where cases are sampled for their potential to test the emerging theoretical constructs (Charmaz, 1990):

‘Theoretical sampling is the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyses his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges. This process of data collection is controlled by the emerging theory, whether substantive or formal.’

Glaser and Strauss (1967: p45)

Through this progression, initial hunches are backed up or disproved and theoretical sampling, through continuing to add new cases, is maintained until a point of ‘theoretical saturation’ is reached. This is when no further insights are obtained by the addition of new cases.

A critique often raised to grounded theory is that it assumes that a research study begins with a ‘tabula rasa’ and it fails to recognise the implicit theoretical perspectives that influence the initial stages of research work (Silverman, 2005). However, Charmaz (1990) has argued that this is a misunderstanding of grounded theory. In her own social constructionist version of grounded theory, she recognises that researchers bring to the study their own perspectives and disciplines.
After consideration of the approach and principles of grounded theory, described above, the option of a wholesale adoption of it as the methodology for this study was rejected. This was based largely on a practical consideration, related to the decision that had been made on the recruitment method to be used. As the study participants were recruited through GP practices, it would have been impossible to use the iterative form of theoretical sampling. This was because, for reasons of patient confidentiality and data protection, it was the GP practice administrators who selected the sample (based on criteria given to them) and sent out the invitation letters. Neither the patient characteristics nor their names and addresses could be passed to the researcher. This meant that, as the recruitment relied upon the goodwill of the practice administrators, it would have been impossible to request them to use theoretical sampling. The researcher did not have the patient information which would have been needed for theoretical sampling.

However, in other ways grounded theory was not fully rejected, as it was influential in the interpretive approach used. A number of elements of grounded theory were incorporated in the study. This was done firstly through the development of theoretical sensitivity (Blaikie, 2000) and use of ‘sensitising concepts’ (Denzin, 1970). Secondly, the interplay which is part of grounded theory between the categories developed through analysis and the sampling for new data (Denzin and Lincoln, 1998) was not implemented in this study. However, there was interplay within the analysis process, where emerging categories were compared with newly analysed data rather than newly collected data. In a similar way, cases which disproved the emerging theory were also sought in the analysis process. This has parallels with the act of searching for ‘disconfirming cases’ (see for example Nelson et al., 2012), which is also a feature of grounded theory. Thirdly, to a certain extent in this thesis the data were analysed during the data gathering phase. Two examples are given here. The first is the way that the very first interview was reflected on and discussed immediately after transcription, and before other interviews were conducted. The importance of gender issues became apparent here and remained an important analytical focus throughout the rest of the study, including the subsequent analysis of the rest of the data set. The second is the use of memo writing throughout the analysis stage. Memos were written in Nvivo while
analysing and used to record conceptual or thematic observations and reflections. This is akin to the use of memos as part of grounded theory, where they help to record ideas on the emerging theory. This is a key way in which the researcher engages with the data, that makes the resulting theory ‘grounded’ (Bryant and Charmaz, 2007). Interview notes were also written at the end of interviews, which recorded observations on the interview and emerging thematic reflections. The interview notes were used as a form of early analysis during the interview phase, and fed informally into future interviews. Although the formal methods of grounded theory may seem quite prescriptive, there are arguments in the literature for the modification (May, 2001) or flexible application of grounded theory principles (Charmaz, 2006), as has been done in this thesis. Alvesson and Skoldberg (2000) recommend integrating parts of the grounded theory approach and building on the ‘inspiration’ that it provides:

‘Another path is quite possible: without paying too much attention to the whole, researchers could make their own choices according to individual taste, appropriating individual tips and techniques from the rich material on offer – provided that these can be integrated into an overall interpretive awareness.’ Alvesson and Skoldberg (2000: p34)

A grounded theory approach was not used in this study. However, some of the principles of grounded theory were used to build ‘sensitising concepts’, reflect on ‘disconfirming cases’, and engage in various forms of analysis during the data gathering phase, which fed into further data gathering and analysis.

**Ethnography**

At the outset of this study, an ethnographic approach had been envisaged as the obvious approach to adopt. Extensive research into a range of different ethnographic techniques was conducted. Various possibilities for participant observation were explored in depth. Options such as ‘go along’ interviews, passing the day(s) with study participants, or being based in possible locations
of health interactions such as clubs or community venues were thoroughly researched and discussed. However, it was finally decided that to gather observational or naturally occurring data on health interactions would not be feasible.

In this study, the focus of interest was interactions, so an approach such as ethnography that emphasises exploring processes, social dynamics, interactions and actions (Murphy et al., 1998) seemed to be a promising option. Ethnography is based on the epistemological perspective that culture can be known through taking the viewpoint of the people or situation being researched (Silverman, 1993) and seeking to understand people’s own ‘real-life’ social or cultural settings (Murphy et al., 1998; Mason, 2002). It was of interest to this study to understand the cultural practices surrounding interactions about health. However, there was also concern that the kind of understandings that were sought could not be ‘captured’ (Mason, 2002) in the way advocates of an ethnographic approach suggest they may be. One of the questions which were faced in deciding on a methodological approach was how, methodologically, to learn about some of the more fleeting or routine patterns of everyday interactions about health. These patterns may pass people by unnoticed and so they may not be reported in an interview. So, in this sense an ethnographic approach could have been useful in accessing this kind of understanding, which may have been inaccessible to other methods (Silverman, 1993). In ethnographic approaches the analytical categories are not identified at the outset, but begin with an open focus which progressively focuses in (Murphy et al., 1998; Silverman, 1993). This makes ethnography a good approach for studies where not a lot is known about the topic at the outset (Murphy et al., 1998), which in some ways was the case of this thesis.

However, there were two important disadvantages in adopting an ethnographic approach. The first is epistemological and the second practical, and for these two reasons it was rejected. There are different traditions within ethnography (Murphy et al., 1998), but in the ethnomethodologically influenced tradition (Silverman, 1993) the interest of the researcher is clearly focused on what is observable. This makes it unsuitable for this study of health interactions, as some of the research questions of the study seek to understand the meanings that health interactions have for people. These are not observable, and can
only be obtained through interviews. Some ethnographic approaches do include interviews and other methods as part of a broader ethnography (Atkinson et al., 2001; Mason, 2002). But possibly more important is the second reason why an ethnographic approach was rejected. This is the same practical reason offered above, when explaining why conversational analysis was not used. An ethnographic approach requires ‘immersion’ in the research setting. A number of ideas were developed of how and where this could be done. However, the essential problem remained, which was that health interactions are likely to be a very small part of people’s daily activities. Any health related conversations or interactions may occur infrequently, and may often be very short or fleeting. Because of this it would be ineffective to use an ethnographic approach, where a vast amount of data would be gathered and processed, which would be highly labour intensive and costly in time and research budget (Murphy et al., 1998). Of this large volume of participant observation data, only very small proportions would be of relevance to the study.

So, an ethnographic approach was rejected for this study due to practical considerations. But epistemological considerations also applied since, in order to answer the research questions, particularly the question about the meanings that health interactions hold for people, merely observing would not have been adequate. A research approach which gathered people’s accounts was essential.

**Social network analysis**

As this is a study of people’s interactions about health within their social networks, it might have seemed obvious to adopt a social network analysis (SNA) approach. This possibility was investigated carefully through the literature and also through participation in the Manchester social networks research group (The Mitchell Centre). SNA is based on the identification and examination of connections or ties (Freeman, 2004; Scott, 2000), to provide relational data which give an understanding (and often also a visual illustration
in the form of sociograms) of the structures which are built from these connections (Scott, 2000). A number of approaches can be taken to SNA, including qualitative approaches (see for example Heath et al., 2009). However, formal SNA involves quantitative mapping to accurately measure and present ties according to a number of features such as strength, frequency, direction and intensity (Knoke and Yang, 2008).

Although one of the study research questions sought to explore who becomes involved in health interactions, other research questions aimed to understand the meanings and practices of health interactions. This could not be explored through SNA which, at least in its most formal sense, seeks to tell us that there are ties and connections, but not what these ties mean for people, or how it is that health interactions happen within these ties. In a way, it is the lines between two connecting points (nodes) in a SNA sociogram that are of importance to this study, but what we really want to know is not that the lines exist, but what they contain.

To conclude this section on the methodological approach used for this study, the form of interpretivism which was adopted incorporated elements from discourse analysis, conversation analysis and grounded theory. The influence from discourse analysis is to analyse participants’ accounts, not necessarily as straightforward reports, but also as narratives that people use to construct an identity as a moral self. From conversation analysis, the study has been inspired by the ideas of researching the small, fleeting, taken for granted and ‘seen-but-unnoticed’ (Garfinkel, 1967) aspects of everyday life, which many health interactions seem to consist of. Some of the elements of grounded theory which were used included ‘sensitising concepts’ and the engagement in analysis during the data gathering phase of the study, which fed into further data gathering and analysis.
A purposive sample was chosen

The research questions were the most important guiding factor in the choice of the sample and this was the starting point of the sampling process. In order to be able to fully explore the research questions, the thesis used purposive sampling, where the sample was deliberately chosen to reflect the features (described below) that would help to answer the research questions. This purposive sample was not intended to be statistically representative, rather a range of study participants was purposely chosen to reflect certain characteristics.

The sample was checked to try to ensure a range in terms of the other sampling criteria outlined below, particularly ensuring that there was an approximate balance between men and women. The approach used is similar to maximum variation sampling (Yin, 1994), but clusters were used to assist analysis, rather than getting a wide range of single cases.

The study participants were members of the public, recruited through primary care, who had either heart disease or mild or moderate mental health problems. This was the primary sampling criterion and it aimed to ensure that the study participants did have some health problems about which they could interact with others, and also to illuminate the way different types of medical conditions may influence informal interactions about health.

It was important for the thesis to include in the sample individuals in the population who challenged the researcher’s own personal assumptions about the thesis, as well as those who reinforced them (Mason, 2002). For example, if it was believed that people do interact about health, an attempt should be made to include in the sample people who were anticipated to be less likely to do so (e.g. men and people with mental health problems – see below), so that an ‘obviously’ highly interactive type of sample group was not selected.
example of this can be found later in this chapter where it is discussed how people who did not interact about health were responded to in the interviews, to ensure that this perspective was fully embraced in the study. What was being done here at the same time was ensuring that ‘negative’ cases were included in the sample (Mason, 2002), this is based on the ideas of ‘analytic induction’ (Denzin, 1989) which argues for the inclusion of cases which are contradictory to the emerging analytical perspectives. This was done through sampling decisions about two groups of people. It was hypothesised, based on the literature, that both men and people with mental health problems may interact less than others about their health. So in order to ensure that the study would be able to fully explore this, steps were taken to ensure that the sample included a sufficient number of men and people with mental health problems. As it was also felt that these two groups would be harder to recruit, they were over sampled (by 50%) in the recruitment process. This worked very well and resulted in 15 out of 25 study participants being men. This was considered a particular achievement of the thesis, as men tend to be poorly represented in samples of research on health or personal matters, and having a good proportion of the sample being men meant that the gendered nature of health interactions could be fully explored.

The final sample achieved can be seen below in Table 1. What drove this choice of sampling frame were considerations of who it might be that interacts about health in one way, or a different way, or not at all, and so on. This relates to the discussion of sampling principles described above, ensuring the sample allows illuminating comparisons to be made. The sampling criteria which were considered to be of greatest potential relevance to the thesis were health condition, age, gender, severity of condition, household composition, employment status and socio-economic status. Each of these is considered in turn below, and their importance to the thesis is discussed.
**Sampling criteria**

*Health condition* - The sample comprised individuals with a health condition. The two conditions which were selected were heart disease (broadly defined) and mild to moderate mental health problems. The definition of heart disease used for this study is any disorder that affects the heart. This includes a wide range of heart conditions, varying from very serious (e.g. heart attack – myocardial infarction, or heart failure) to less serious. Heart disease was chosen for the sample, precisely because it would allow a sample to be selected of both severe and mild conditions, which meant that the thesis could explore ways in which severity of condition might have an influence on health conditions. The definition of mild to moderate mental health problems in this thesis included mood disorders, anxiety and mild depression. The rationale for this sampling approach was two-fold - first, methodological utility and second, policy priority. In terms of methodological utility, these two conditions offered scope for the research to explore health interactions of a range of types including prevention, advice, information, care of mild conditions and recuperation from episodes of illness. These two conditions also had the advantage that they are very different from each other. It was felt that exploring health interactions of people with such different health needs may illuminate or challenge patterns emerging from the data and help with the development of themes. Mental health was an interesting condition to include because it was felt that people with mental health problems may have different types of networks given the stigma associated with mental illness, may be less likely to have wide or strong social networks, or may find interactions or giving or being given support to be challenging, thus potentially offering negative cases and challenging the researcher’s assumptions (Mason, 2002). Both heart disease and mental health were designated as Department of Health priority areas for both research and clinical care, and therefore they are important areas in which to understand the ‘fine mesh’ detail of how and with whom these conditions are managed.

*Age* - Although different age groups were likely to interact differently and about different health related matters, it was intuitively felt that the importance of age was that it was more related to life stage than to age by years. Life stage was of particular relevance because of the differing access to social interaction.
Two age clusters were chosen, firstly people 45-55, to avoid the childbearing years and to capture the late 40s / early 50s as a time when people may be beginning to see more health related problems among their social networks, but who also are still working. It was felt that pre and post natal issues could dominate quite a lot of the health related interactions for women between their mid twenties and their mid forties. As the focus of this study was not on childbirth or parenting, the best way of avoiding a predominance of data on childbearing issues was to avoid those age groups. The second age cluster was people aged 70-80. So, by selecting a sample which included two age clusters of people in middle age and in older age, this meant that in the analysis the thesis could explore the ways either life stage or age may influence engagement with others over matters of health.

**Gender** - It was felt to be important to have a more or less equal split between men and women, in order to explore the suggestion in the literature that women and men interact differently about health. Recruitment of the sample was actively managed in terms of gender, as there was concern that, if it was left to chance, it would be most likely that the study would have more women than men, as women may be easier to recruit, both generally and for this study in particular, which may have been perceived as ‘women’s business’. As described above, men were deliberately over-recruited, resulting in a sample of slightly more men (15) than women (10). So, by choosing a sample which included a good proportion of men as well as women, an analysis of gendered patterns of health interactions was possible.

**Severity of condition** - The thesis did need to explore all kinds of health interactions, so, although severity of the condition was not a priority sampling criterion, it was hoped that there would be a range of severity of condition within the sample. It was felt that people with more severe conditions would have withdrawn from some social situations (such as paid work), and so would have less interaction about health outside the family and formal health services

**Socio-economic circumstances** - It was felt to be important in the sampling and the analysis, to be aware of how socio-economic circumstances map onto other factors such as locality (e.g. inner city / rural etc) or cultures of relating. It was decided to select two contrasting areas, which represented different
geographical regions of the country, but also and importantly, different socio-economic deprivation levels. The Index of Multiple Deprivation was consulted and two contrasting areas were selected, one was among the least deprived (in Yorkshire) and the other (in Liverpool) was among the most deprived in the country. The Index of Multiple Deprivation uses a range of indicators, to combine social, economic and housing circumstances into one deprivation score by small area.

Recruitment was through GP practices

It was decided to conduct the recruitment via GP practices, using informal contacts to identify two suitable practices willing to participate. The advantage of recruiting through GP practices was the potential, because of the information held by GP practices, for a high quality sample that would provide the range of sampling criteria which, as discussed above, were felt to be important to address the research questions. The disadvantage of this method of recruitment was that it was reliant upon GP and practice staff goodwill and there was only limited scope for controlling the quotas, which risked slow progress. However, on balance this proved to be a very effective method of recruitment and resulted in a strong sample which was efficiently recruited.

Sample size was 25

Sample sizes in qualitative research are usually small compared to those of quantitative studies. What is important in qualitative research is to be able to interpret and access the depth of data necessary to answer the research question, or to ‘allow interpretive access’ (Mason, 2002) to contexts which will illuminate the research question. In this thesis, the sample was kept small enough to allow a full and in-depth interpretive analysis of the data. It was felt to be important not to recruit too large a sample, as this could lead to an overwhelmingly large total volume of data, which would have been unmanageable and may have remained under-interpreted. In identifying the sample size for this study, a combination of intellectual logic and pragmatism was used. The intellectual logic was to identify a sample which had sufficient of the range of characteristics (discussed above) to answer the research questions.
and to understand sources of variation on certain sociologically interesting criteria.

As this method of recruitment involved giving a quota to a third party (a GP practice administrator) to select the sample, a decision was taken in favour of intentionally over recruiting, by increasing the quota of groups which it was anticipated would be hard to recruit (specifically men and people with mental health problems).

The target for the total sample was 24, 12 from each of two GP practices. It was assumed a 10% response rate in general, and a 5% response rate from men and people with mental health problems, as it was felt that these would be the hardest to recruit groups. It was also thought desirable to recruit larger numbers in the 45-55 age group, in order to make sure that there were sufficient numbers of people in paid employment, who will be largely absent in the 70-80 age group. As a result of all these considerations, it was requested from each practice to send out recruitment letters to 240 people, making a total of 480 recruitment letters. See Appendix D for a record from one of the practices of the search process used.

Limitations of the sample

The approach used in this study was analytically strong, but it was not a representative study. It used a small, purposively selected, qualitative sample which was carefully composed (as described above) to make sure that the sampling prioritised characteristics that could be important to explore in answering the research questions. So it is possible in the study to identify patterns, but the sample is not representative in a statistical way. However the study has followed a careful qualitative analytical approach and its strength lies in this.

There are at least two limitations in the sample. Firstly, the sample did not include many people who are currently in employment (9 people out of the total
sample of 25 were in paid employment). This means that the possibilities to explore health interactions among colleagues in the workplace were limited. However, possibly as a result of this, there was plenty of opportunity to explore health interactions among neighbours, which may act as a substitute for colleagues for some people who are at home during the day (due to retirement, unemployment or ill health). The second limitation of the sample was that it did not include any young people. The two age clusters (45-55 and 70-80) were deliberately chosen to ensure that there would be sufficient health problems (among the study participants and their peers) to talk about in interviews. However, with a greater understanding of the topic that comes with hindsight, and after a discussion at a conference presentation of this work, this researcher has come to believe that young people do engage in health interactions, albeit on different types of health issues. Exploring health interactions among young people is proposed below as a possible area for future research.
Table 2

Total final sample achieved

<table>
<thead>
<tr>
<th></th>
<th>Liverpool</th>
<th>Yorkshire</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>6</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>Women</td>
<td>6</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>45-55</td>
<td>8</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>70-80</td>
<td>4</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>Live alone</td>
<td>6</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Live with others</td>
<td>6</td>
<td>13</td>
<td>19</td>
</tr>
<tr>
<td>In paid employment</td>
<td>6</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Not in paid employment</td>
<td>6</td>
<td>10</td>
<td>16</td>
</tr>
<tr>
<td>TOTAL</td>
<td>12</td>
<td>13</td>
<td>25</td>
</tr>
</tbody>
</table>

Notes:
1. The sample was recruited via GP practices, which were not able to release information about participants’ diseases (or any other personal information), which is why the health condition of the participants is not shown on the table. Information on health condition was gleaned from the interviews, when participants chose to give this information about themselves.
2. The ethnicity of all 25 of the sample was white.
3. The socio-economic status of participants is not shown because no measures of class or other socio-economic measures were taken. The way that the thesis sought to include people with contrasting socio-economic circumstances was by sampling from two contrasting areas of the country, one (Liverpool) having a very high score on the Index of Multiple Deprivation and the other (Yorkshire) a very low score.
Conducting the interviews: data generation through qualitative interviews

Interviews were chosen for the data collection method, because of the nebulous and relatively uncharted territory of the nature of the subject matter. In order to answer the research questions, it was necessary that people recounted their stories of interactions, so the data generation for the thesis could not use a questionnaire, qualitative interviews would need to be used and the interviews had to be semi-structured.

The interview context offers an ideal opportunity to present or perform a moral identity. Radcliffe (2011) refers to this as ‘language as a social action’, where people are trying to actually use the interview, they are not just there to answer questions for the benefit of the researcher, but are trying to do or achieve something for themselves, to use it as part of their own identity work. Giddens (1991) has pointed out that people redefine themselves by using autobiography, by describing their lives they are reconstructing themselves. So the research interview plays a role for research participants in defining, or constructing, their identity. This moral work is engaged in during the interview, to persuade either the interviewer or themselves of their moral worth. For example, as will be shown in the following chapters, some people tried to present a strong image of themselves as a ‘healthy specimen’, or as leading healthy lifestyles, or as being ‘caring’. May (2008) links the moral narratives that she was told by divorced and single parents, and the source of those data (anonymously submitted written life stories), arguing that the method may have been a contributory factor to the women presenting a positive and moral picture of themselves. This thesis was, however, based on interview data, which gave people more of a chance to assess the interviewer’s response to their presentation and to shape their narratives to their interpretation of that response. The narrator’s moral position could be undermined if the interviewer gave the impression of not agreeing with their interpretation of morality (Frank, 2002), although in the case of a topic such as interactions about health they may have felt secure that the interviewer would be supportive of their moral narrative.
Data generation was conducted during the summer of 2008, with a total of 25 interviews which explored people’s experiences, to get a picture of the nature of health interactions in practice. The interviews lasted about one and a half hours each and were conducted in the participants’ homes (unless they suggested another venue). A topic guide was used to direct the discussion (see Appendix E). Various approaches to the opening of the interview were tried in the early interviews, and are discussed below. Immediately after the end of the interview, ‘interviewer’s notes’ were recorded which were later transcribed along with the interviews. These reflected on the methodological and substantive issues relating to the interview and the participant, to act as an aide memoire, improve future interviews and assist with early thematic reflections and analysis.

Various approaches to the opening of the interview were experimented with in the early interviews, until the best approach was found. These approaches are referred to here as the social networks opening, the critical incident opening, the warm-up question opening, and the other people’s health problems opening. These diverse approaches are described briefly below, as it was felt that the way the interview was opened may have an influence on the quality and content of the interview and the data generated. The social networks opening (example: Julia: ‘So if you could just tell me a little bit about the other people that you know’) was tried in the first interview. But it was not used after that, as it was felt that it may be confusing for people who have been invited to participate by the GP’s surgery, so they are expecting the interview to be about health, so it was in danger of setting the interview off on a confusing path. The second approach to the opening was the critical incident opening (example: Julia: Just to get started, could I ask you to tell me about one time when you had a problem with your health?) After trying this type of opening, it was felt that this was again not a good way to start, because it gave participants a wrong impression of the focus of the study, as it may have suggested that the focus was on the details of their own health problems. The third approach used was the warm-up opening, in which people were asked to say a little bit about themselves, with some prompts. However, it was decided not to use this as an opening approach, as it was rather vague and it asked lots of things at once, people did not know which question to answer, and it put the onus on the participant to define the question and decide what to answer, which requires
confidence. All this was not helpful for the social dynamics of the interview. The final approach tried was the other people’s health problems opening. It was decided that this was the best way to start the interview, as it gave people a sense of what was the central focus being explored in the interview. An example of this opening is:

Julia: ‘… the study’s about how we interact with other people, about health, so could you tell me, can you think of a time when you’ve got involved in a friend’s health problems or a friend has had some health stuff going on and you’ve got involved in any kind of way with that?’

There were two types of particular methodological challenges that were encountered in the interviews. These were, first, learning how to respond to people who were very private and did not engage in health interactions, and second, trying to generate some depth of data in situations where people seemed to be blocking that. It was a challenge for the researcher to think what her research question was, as it related to people who did not interact. What was wanted to find out from those people? The interview with Mike (the first interview of the thesis) in particular taught the researcher that she had framed her study from the perspective of people who do interact, and about those interactions. This was therefore a very important aspect of this interview, to be reminded that not everybody is like that. And to have to explore what was wanted to learn from those people. The researcher’s instinct was to try to explore why Mike did not interact, but it was an important lesson to learn that this would be ineffective. Also unfair, as it seemed possibly unethical to keep pushing him and coming from a perspective that the ‘normal’ thing to do is to interact about health, which would be adopting a normative judgement about participation in health interactions. It was decided to deal with this firstly by continuing to think about it, as it was important to reflect on the ‘non-interactors’ and what was wanted to find out from them. In addition, it was decided to deal with the non-interactors in interviews, by firstly asking about their observations of health interactions going on between other people (i.e. not involving them). That would then allow discussion of their views about health interactions more generally, which may offer a sense of their positioning and attitudes towards health interactions. Then they were asked about non-health interactions. What is the ‘stuff’ that goes on between people (i.e. not just health)? Finding out what
they do in their interactions might help to explore differences between health interactors and non-interactors. As the analysis progressed, it became clear that people who did not interact about health were incredibly important to the analytical potential of this thesis. So, it was very valuable that this had been discovered in the first interview, which forced a reflection and critique of the tacit assumptions that seemed to have been present in the early days of the study.

A second challenge faced in some interviews was trying to get at some depth. The response ‘that’s just the way I am’ was encountered more than once and tended to act as a block, maybe signalling to go no further. In the end it was decided that, where further depth was not forthcoming, not to pursue it any further. In any case, their motivation was not the most important factor in what is a sociological study of health interaction practices, and may have indicated more about the researcher’s own perspective and expectations. Another way of responding to this challenge was to explore the gendered factors. For example, the interview with Mike was highly gendered, impression management seemed to be very important to him, and he also seemed to be taking a morally superior position. So in response to this, after the interview had been transcribed, two men were asked (one male colleague and the researcher’s partner) to look at the transcript and to give a man’s view of it, to see what they thought. Their views contributed to the early stages of reflections and analysis on the gendered nature of health interactions.

A number of difficulties had been anticipated with the interviews. It was expected that data on health interactions would be hard to access from the qualitative interviews. Aware of the intangible nature of health interactions and the difficulty of getting people to focus on the fleeting nature of health interactions, there was concern that people may not have noticed them happening, far less be able to recall and recount them. These potential difficulties were addressed by starting the interview by talking about something tangible, for example about an illness which they had had, or something specific that had happened. This was an attempt to make them think of evocative things, to transport people into the right frame of mind, creative ways to encourage people to remember interactions about health and of transporting people to what they were expected to talk about (see Appendix E for the study topic guide). This worked well and it was found to be quite easy to move fairly
rapidly into accounts of health interactions and the meaning that they had for people.

What was found with hindsight was that the interview context, focusing on reported accounts, offered an ideal opportunity for the participants to present or perform a moral identity, as mentioned above, thus confirming previous research work (Radcliffe, 2011; Giddens, 1991; May, 2008; Frank, 2002).

Overall, the choice of qualitative interviews for the data generation was very effective and generated rich data, not only about health interaction practices and their meaning, but also the narratives that people choose to present.

**Analysis, first through case studies and then thematically**

**Case study analysis**

Before embarking on thematic analysis of the data, some analysis of part of the data set was undertaken, using case study analysis. The main reason for deciding to do this was that it was felt that there may be some important themes or explanations which would only be evident by looking across whole cases. By cutting the cases cross-sectionally into chunks of data which would then be organised with like chunks of data from other cases (as was later done), the data would no longer be in context and some understandings may have been missed, which were only illustrated by one individual case as a whole. A second reason for analysing case studies was to improve the decisions to be made about the coding structure for the thematic analysis. The case studies were read interpretively (Mason, 2002) and looked at for meaning and higher level themes to be used in the analysis of cases. As the entire data set was going to be analysed cross-sectionally later, the case studies aimed to identify particularly those issues which would have been missed by the cross-sectional, or thematic, analysis. The aim was to try to identify the health interaction practices that ran through the entirety of the case.
The four cases selected were Edward, Margaret, Trish and Steve (not their real names). The four case studies were chosen for two reasons. Firstly because they raised interesting themes and contrasts, and secondly, based on the principles of analytical induction (Denzin, 1989), cases were deliberately chosen which provided negative instances or contradictory examples from both those cases which had been analysed previously, and the explanations that were being developed as the case studies were conducted. So Margaret, and then in a different way Edward, were chosen to provide a contrast with Trish and Steve. The idea here was to help with the testing of explanations, and if need be to modify them or develop alternative explanations.

**Rationale for conducting case studies**

The rationale for conducting case studies prior to the coding was that in the data set there were some empirical aspects and theoretical categories which could not be coded. They were instead found in the data in subtle ways, often spread throughout the whole of the transcript, making it impossible to code. Therefore, four case studies of individual study participants were conducted, to try to identify these aspects and categories and to ensure that they were not lost.

There were several advantages to writing case studies at the outset of the analysis. It provided an insight into themes in the data that could not be organised cross-sectionally. It helped with the construction and modification of codes. It also assisted with the development of theoretical thinking, or thinking about the data in a conceptual and analytic way.

The decision was taken that four case studies would be conducted. This was because the main part of the analysis was going to be thematic (cross-sectional), so four case studies would be sufficient. The case studies were conducted before beginning the thematic coding. This was in order to use the case studies to inform the process of deciding on the codes.
Choice of study participants to use as case studies

Analytic induction was used to choose the cases. The choice of cases included both similar and differing cases, and also included negative instances. The objective of this was to explore why there were differences and to try to explore how they arise. For example, if a theory was beginning to develop, an attempt would be made to try to look for a case which falsified it. It was also considered important to include cases that were different in terms of their conditions of existence (e.g. age, life experience, class). For example, Trish and Steve were in the study’s younger age group (45-55) and Margaret and Edward in the older group (70-80). While Margaret lived in quite poor conditions of material existence, Edward lived an affluent lifestyle.

Elements taken into consideration in conducting the case studies

Conducting more than one case study offered an opportunity to compare across the different case studies. Each case study was compared and contrasted with the others, during its completion and after. This was to facilitate reflection on the emerging themes, commonalities and differences across the entirety of the case studies.

In conducting the case studies, it was felt that the complete story of that participant’s health interactions was needed. So, care was taken not to miss out relevant parts of the story (a particular temptation was to exclude bits that would be captured in the cross-sectional analysis). It was also felt that later it would be useful to contextualise the lives of the case study participants and link with biographies. That involved including information in the case studies about the ordinary aspects of their lives, such as biography, circumstances, place and habits, which helped with the process of understanding the meaning of their health interactions.

An explicit attempt was made in the case studies to integrate underlying theory and key concepts, linking the themes that were emerging from the case studies, with the key theoretical concepts of relevance to the study. Examples of these are theories of habitus, identity, friendships and networks.
The themes that had been identified and the content of the case studies were discussed within the supervision team. This was felt to be important as it provided more than one perspective on the cases.

It was felt that the use of case studies at the outset of the analysis process was invaluable, as it allowed the development of theoretically informed analytical ideas early on, and meant that the Nvivo code choices were analytically informed.

**Thematic analysis**

There were two parts to the thematic analysis process. The first was organising the data, and the second was interpreting the data.

*Organising the data into codes*

The first stage of organising the data for analysis was familiarisation and (re)immersion in the data through active re-reading of the transcripts. The data were then coded into ‘themes’ or like categories. This process was essentially a classificatory task, akin to putting sheets of paper into separate files in a filing cabinet. However, the initial decision on the categories into which the data were organised was an important one and given a lot of careful thought. It was intended to keep these categories as simple organisational categories of ‘like material’, rather than move to higher levels of abstraction at a very early stage.

It was decided to do the initial coding using free nodes only (in NVivo), because of the flexibility that this allowed to define, redefine, collapse or merge the codes. An initial long list of codes was developed from the case studies for use as free nodes. However, it was later decided to compress this into a much shorter list of free nodes. This process was guided by the research questions. The process of identifying codes was also guided by how useful a code would be to retrieve data, and by how easy a code would be to spot when going through the transcripts.
At an early stage of the coding, a number of issues were observed and attended to. Firstly, some of the revised codes looked very similar to each other. This would have created a problem in the coding. If they were not sufficiently different from each other, everything that was coded under one would have ended up being coded also under the other. Secondly, some nodes were not sufficiently explicit, so it was necessary to encapsulate exactly what the circumstances of interest were. Then those circumstances became a code. Thirdly, it became clear that some codes would benefit from renaming. For example, the code entitled ‘reciprocity’ was to be used to code both issues of balance / imbalance in health interactions, and other forms of ‘reciprocity’, so the word ‘reciprocity’ was considered vague or ambiguous.

A number of practical techniques were used for deciding on the coding. For example, it was felt that it would be useful to have a mix of ‘big’ and ‘small’ codes. The big codes were broad descriptive codes. They may also represent large categories, where it was clear from the outset that they were important to know about. They had the function of catching data. The small codes were used for interesting or important things in the data, for example leads which appeared useful to follow up and explore whether other people said similar things. It was decided not to add in possible, abstract codes just in case they might be eventually needed in the future.

Some important topics, such as gender, were difficult to code for. For these it was decided that any relevant observations should be recorded while going through the transcripts. An NVivo memo was created into which observations and ideas were recorded while going through each transcript. This also illustrates the benefit of having conducted the case studies, which aimed to ensure that these difficult to code themes were not lost.

Once the initial decisions about the codes were made, they were tested out on some transcripts and modified where necessary. In addition to trying out the coding, this also proved to be a useful exercise in order to view the output of the nodes to understand whether a code was working well.
For some discarded codes which were too large and incorporated too much data (such as ‘examples of health interactions’), a grid was developed, organised by case, into which a record was made of different types of health interactions, as they were mentioned in the transcripts. This prevented basic descriptive information from being lost.

The following are examples of codes. The table illustrates the way the codes were considered carefully for their strengths or weaknesses as codes, and were tweaked where necessary:

Table 3 Examples of the process of checking the usefulness of the draft codes

<table>
<thead>
<tr>
<th>Draft code</th>
<th>Checking the utility of the codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workload</td>
<td>This was viewed as a good code as it came straight from the data.</td>
</tr>
<tr>
<td>Gender</td>
<td>It was felt that this would be difficult to code, as people do not actually say the word gender or talk explicitly about it</td>
</tr>
<tr>
<td>Formal health services</td>
<td>It was felt that as a code this might not be needed, as although people did sometimes refer to formal health services, it was not directly related to the research questions.</td>
</tr>
<tr>
<td>Examples of health interactions</td>
<td>It was felt that this code was far too big. The point of coding was to facilitate the retrieval of bits of data organised into meaningful pieces. A code this big would not have fulfilled that function. Using this code the pieces of retrieved data would not be helpful as they would be huge.</td>
</tr>
<tr>
<td>Weak ties</td>
<td>This was felt to be a good code, as it was easy to spot.</td>
</tr>
<tr>
<td>Presentation of self</td>
<td>A problem was identified with this code, as almost everything could have been coded under it.</td>
</tr>
<tr>
<td>Hierarchy of illness</td>
<td>This code as it was phrased was not sufficiently explicit. It was felt to be important to explore what underpins this code, e.g. Stigma.</td>
</tr>
<tr>
<td>Speed of reaction to health problems</td>
<td>This was felt to be a code that would be easy to spot.</td>
</tr>
<tr>
<td>Hospital visits</td>
<td>This was seen also as a code that was easy to spot.</td>
</tr>
</tbody>
</table>
Use of computer assisted qualitative data analysis software

An informed decision was taken about which computer assisted qualitative data analysis software (CAQDAS) package to use. A course was taken at the University of Surrey, investigating the comparative merits of three different packages. These were AtlasTi, MaxQDA and NVivo7. The package choice was informed by several facts. AtlasTi had slightly less useful features and was slightly less user-friendly than the other two packages. MaxQDA was a neat, easy to learn package which fulfilled all the likely needs of this kind of project. However, its drawback was that very few people use it. This means that there are fewer training courses available and fewer people to ask for advice. The package which was decided upon as the most appropriate choice was NVivo (at that time the most recent version was NVivo7). It has a very wide range of features and it offers most things that are likely to be wanted from a CAQDAS package (in fact, it offers many more features than most researchers are ever likely to use). Secondly and possibly most importantly was its growing popularity. This means that there was a wide range of support available, and it is likely to be the most useful package for team or collaborative work in the future.

Interpreting the data

Once the data had been organised or classified, the next stage, interpreting the data, began. This started with a thematic analysis using the material organised into the codes. Here what was looked for were themes, patterns and clues to help answer the research questions. The interpretation was guided by the research questions and interpreted in the light of the bodies of theory which underpin the study, and analysed according to the criteria which were deemed at the sampling stage to possibly have an important influence on health interactions (see above for discussion of sampling criteria).

Semi-quantification

The preliminary stage of interpreting the data was a process of ‘semi-quantification’ (Clark, 2003) within each code. This involved counting incidents,
for example types of health interactions, and who does them. This was found to be useful as one way of knowing the content of the data. An example to illustrate this is advice giving. The semi-quantification revealed that there was a lot of advice giving, more than many other forms of health interactions. This led to a need to try to understand why this was so, and if and why people found giving advice and tips easier than other forms of health interactions. By counting the numbers of advice giving incidents and counting who did the advice giving, a process of unpacking the meaning of the advice giving was begun. This therefore informed the process of looking for patterns in the data and following through lines of enquiry.

It was also felt that semi-quantification was useful to provide the reader of the thesis with an understanding of the shape and content of the data and by helping to make the data appear less vague.

This semi-quantification was undertaken only after a considerable amount of methodological thought and discussion, due to concerns about using numbers in analysing or presenting data generated from a qualitative sample. However, it should be emphasised that this semi-quantification was not to make numerical claims beyond that which the data could hold. It was more of an occasional exercise with the dual function of assisting with the interpretation process and giving the reader a more concrete sense of the data. The results of this semi-quantification were recorded in a number of formats including tables, lists, patterns and grids.

Thinking theoretically

An explicit attempt was made to ‘think theoretically’ about the data. This type of conceptual thinking involved asking ‘what is going on?’ and ‘how can it be explained?’ Thinking theoretically also involved making links with theories in the literature. It was felt to be important to engage with theory through thinking theoretically while immersed in the data, rather than from a position of standing back, removed from the data.
There was a conscious effort of trying to bring sociological imagination as well as theoretical thinking to the analysis of the data. Through trying to use the sociological imagination (Mills, 1970), the intention was to look afresh at the possibly commonplace things in the data, as if it was something unusual, and to take a broader viewpoint by attempting to step outside both the researcher’s and the participant’s personal viewpoints. Here the aim was to reflect on how the actions and perspectives that were being read in the data reflected larger societal issues and how these influences shape the lives of the study participants and beyond.

In bringing theoretical thinking to the data analysis, heavy reliance was put upon Coffey and Atkinson (1996) and in particular their suggestion to focus on ideas. It was aimed to both bring ideas to the analysis and use those ideas in the analysis. The process of trying to ensure ideas were brought to the analysis was really about providing an opportunity to respond to the data creatively, with a spirit of discovery and exploration. This included trying to explore aspects of the data that appeared surprising or puzzling or which seemed to highlight something bigger than itself. It also involved speculation in trying to explain the things seen in the data. For example, asking ‘why?’ and trying to offer possible answers. This is essentially a creative process which Coffey and Atkinson (1996) point out is an important part of the intellectual craftwork that is done in research and scholarship. It was aimed to generate ideas about the data inspired by as many sources as possible: academic, non-academic, metaphors and personal experiences. The academic sources used tended to be from sociology or the sociology of health and illness, but they could have been from other disciplines or traditions. The most important source of the ideas was the inspiration provided by the data.

Analytical notes were written in NVivo memos during the process of conducting the analysis. These included reflections, observations, thoughts, themes, concepts and explanations, and they developed and evolved over time. They were an important element of the analytical interpretation.
Reflexivity in the data interpretation

The data analysis was approached by first trying to develop reflexivity about the way the data were being thought about whilst analysing. What does it mean to have taken a reflexive approach? There are four main ways that taking a reflexive approach has affected how the process of conducting this PhD research was enacted. Firstly, by trying to rethink the priority in the study from the empirical data, to the process of interpretation and reflection. It was also felt it important to develop a conscious awareness of the researcher role as part of the process of constructing knowledge (Jorgensen, 1991). Attempts were made to explicitly recognise the situated nature of the knowledge that was being produced throughout the PhD process. Examples of this could be the gendered nature of the health interactions, or the gendered, social and cultural impact of health interactions on the heart or mental health problems of the study participants. Secondly, it was sought to actively incorporate reflection and interpretation at each stage of the research process, not just at the analysis stage. This happened through engaging reflexively at the stage of reviewing the literature, formulating the research question, preparing and planning the fieldwork, recruiting participants, data generation, and analysis, writing and presenting. Thirdly, there was an active reflection on the researcher role and the impact both on the study and on the people who are participating in the study (for example the effect on the narratives of the prompting done in the interviews), how this has shaped and influenced the interactions which were narrated, and also how the interactions have shaped and influenced the interpretations of the accounts.

It was mentioned in the Preface that a reflexive approach was taken through the latter half of the study, as a result of a diagnosis of breast cancer midway through the PhD. The analysis of data was therefore inextricably linked to the experience of having breast cancer, and in a cyclical way, the experience of doing the PhD affected the experience of having breast cancer. Because this study is about interactions about health, all the (many) interactions with friends, family or others during this time were powerful observations on the subject of the thesis, and both formally and informally have found their way into the arguments developed.
The study has aimed to produce ‘thick descriptions’ (Geertz, 1973) of the context around the participants’ interactions and its situated nature. That means that it has tried to go beyond the analysis of the immediate circumstances, to look at the way the participants situate themselves. This has included reflections on how and within what constraints people exercise agency, what shapes or facilitates their agency, and how does structure (for example class, gender, ethnicity) mediate their agency.

In sum, the methods used for the analysis fitted well with the requirements of the research questions and facilitated rich analytical insights which are discussed in the following chapters.

**Ethical considerations**

As with many topics for which qualitative methods are employed, there is a possibility that some people could have found the interviews upsetting, which would be unethical if people had been put in an uncomfortable position, or were unable to get out of it. Interviewing styles were used which offered people control of how they wanted to proceed, if they appeared to become upset or to be finding the interview difficult in any way. For example, in the interview with Ray, the interview was stopped when he became upset and he was offered the opportunity to end the interview at that point or to continue after a break. He chose the latter.

In the writing of the thesis, publications, presentations and in the use of quotes, pseudonyms have been used throughout and careful thought has been given to ensuring that true anonymity is respected.

The study was given NHS NRES ethical approval from Liverpool and Yorkshire ethics committees and also from the University of Manchester ethics committee. Research governance approval was also obtained from the respective Primary Care Trusts in Liverpool and Yorkshire.
Conclusion

This chapter has built on the rest of Part One, which provided the intellectual and theoretical foundations for this thesis. Here, a description and rationale were presented of the way that the study was designed to answer the research questions and to explore the theoretical constructs described in the preceding chapters. The sampling, recruitment, data generation and analysis were all designed to generate a depth and richness of data to understand the form, nature and meaning of informal interactions about health, including the ways that people interact over matters of health, who becomes involved, who does not, and the meaning that interactions about health have for people. These will now be discussed in Part Two of the thesis.
PART TWO

EXPLORING HEALTH INTERACTIONS IN THE DATA
Introduction to Part Two

Part One has provided the context and background on which this thesis is based. The next four chapters, Part Two of the thesis, will introduce the study data to illustrate the form and meaning of health interactions and the ways that this thesis analyses them. Health interactions are viewed here as distinct from the realm of lay ‘systems’ such as lay consultation, as I have argued in an earlier chapter. Here data are presented on interactions about health that are largely or solely within the informal social arena. Because of this, the analysis incorporates dynamics and considerations that would be expected in an interaction, as opposed to a more one-way act of support or help. There could be a number of different dynamics going on in any one interaction, involving not only the ‘recipient’ of the health interaction, and this thesis will try to tease these out and to be cognisant of the multiple layers of meaning that are packed within a health interaction.

Another feature that will be illustrated in Part Two is the conceptualisation of people’s accounts of health interactions as not only about ‘doing’, but about interacting. The data that will be presented will demonstrate how, although health interactions do include ‘doing’ type activities, the term is much broader than that since it also includes a range of forms of connection that do not involve practical ‘doing’ of things for others. This will be seen particularly in Chapter 6 on emotion work, but it is present throughout all the chapters, as an important part of the argument of this thesis is that an interaction about health is operating at a number of levels and in a number of personal and interpersonal ways, of which impact on health is only one.

The forthcoming chapters will also illustrate how health interactions can be small, fleeting or transient, as well as larger or more obvious as in forms of support or caring. These types of interactions about health are often overlooked in the literature and the data which will be presented will demonstrate that they do hold a relevance and meaning for people and operate, not only to help people manage their health, but to forge, strengthen, damage or destroy relationships and connections between people. Similarly, health interactions can also take the form of conversations and this will be explored in the light of ideas on narratives that were outlined in Chapter 3. Although people
were presenting a narrative to the researcher in the interview, the health interaction itself is also a form of narrative between two (or more) people.

Since these types of connections are interactions, they can have an influence on relationships, and they can create a connectedness (or distance) as a result. This will be explored particularly in the chapter on relational dynamics, but throughout the thesis an important part of the argument is that health interactions are not merely an informal route to improved health management, but are entwined with relational dynamics and the way that personal life is experienced.

Lastly, Part Two of this thesis will more simply illustrate the way the notion of health interactions is used in this thesis with examples from the data, and will demonstrate that the study participants were able to incorporate the notion into their own narratives.
Chapter 5: Practical interactions about health

This chapter will begin the process of mapping the terrain of health interactions and show what health interactions go on, how they are enacted and who gets involved in them (and who does not). This will demonstrate the conceptualisation of health interactions used in this thesis using examples from the data.

This chapter begins by illustrating forms of health interactions that do involve ‘doing’; practical actions that people take as part of interacting with someone over matters of health. It will be demonstrated how, although people are, in practical terms, ‘doing’ something for another, at the same time there are a number of other levels at which the dynamics of the interactions are functioning. This chapter addresses a number of intriguing questions. These are questions such as, what exactly is it that people do when they interact with others over matters of health? How do they do it - how do they communicate about health and what sources of knowledge do they use? Between whom do health interactions happen (and between whom do they not)? What is the meaning that these interactions about health have for people, both for their health and for their perception of their relationships with others?

Table 4 provides data on the type of practical interactions about health that people in the sample engaged in, and also allows us to see who gets involved in which kind of interaction.

*Please note in Table 4 (below) that these are numbers of different examples or activities mentioned, not numbers of people who mentioned them.*
Table 4: Practical interactions about health: domestic support

<table>
<thead>
<tr>
<th>Activity</th>
<th>Relatives</th>
<th>Friends</th>
<th>Neighbours</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Errands and shopping</td>
<td>5</td>
<td>1</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>Housework</td>
<td>6</td>
<td>1</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>Baby-sitting or dog-walking</td>
<td>2</td>
<td>6</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Providing food</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Domestic problems or crises</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>When people away/in hospital</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>‘Opening up’</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Gardening</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Taking out the bins</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Lifts</td>
<td>2</td>
<td>1</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td>‘Checking on’</td>
<td>2</td>
<td>0</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Involvement in emergencies</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Practical help at times of bereavement</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>32</strong></td>
<td><strong>11</strong></td>
<td><strong>51</strong></td>
<td></td>
</tr>
</tbody>
</table>
The way health interactions are conceptualised in this thesis includes a very wide range of types of informal engagement with others’ health. In this chapter practical health interactions will be described and it will be demonstrated that as *interactions* they are operating at much more than purely a practical level.

A large proportion of the practical interactions described by participants in the study were forms of domestic help at times of illness. This, described by Corbin and Strauss (1985) as one of the ‘lines’ of illness work, is one of the ways that people help each other to manage long term conditions or during specific periods of illness.

When people were ill or unable to get out themselves, others offered both to do food shopping for them and to run local errands. As shown in Table 4, it was mostly neighbours who did this. The relatives (all women in this case) tended to offer to do the shopping and the neighbours the errands, reflecting the proximity of the neighbours and the greater opportunity to offer errands. This is also interesting in the light of the literature on contemporary neighbouring as discussed in Chapter 2, as Crow et al (1994) also describe neighbours’ willingness to help if ‘need be’, so maybe times of ill health could be precisely when ‘need be’. Errands and shopping were gendered activities, insofar as the examples of doing shopping or errands for others were not only from women but also in the older age group (and from the Yorkshire sample). It was mostly male study participants who gave examples of errands or shopping being offered *to them*. Being offered assistance with shopping and errands was much more common in the inner-city, deprived Liverpool sample than in the rural, less deprived Yorkshire sample. This could reflect the relative affluence in the Yorkshire sample, and it could suggest a certain ‘habitus’ or local culture prevalent among the Liverpool sample. Whichever the case, it provides empirical data which challenges the individualization thesis by showing that at least some of the people in the sample became quite heavily involved with others’ lives, which suggests a considerable degree of connectedness (Smart, 2007).
A number of participants did housework for people experiencing illness or incapacity. It is interesting to consider why people might do housework for others who are temporarily unable to do so; it could be useful to draw on the competing theories of morality which were discussed in Chapter 3. Earlier it was suggested that one perspective of why people engage in health interactions is as a moral project of the self, to construct a moral identity or moral self. Maybe cleaning somebody else’s house could contribute to a sense of moral identity. Or the argument made by Sayer (2011), that people engage in health interactions out of moral concern and compassion for others could be useful here. As this is a highly gendered form of health interaction, understanding it may also be rooted in gendered identity and a gendered form of moral agency, and these questions will be returned to later in the thesis, particularly in Chapter 9.

### Table 5: Housework: who does housework for people who are ill?

<table>
<thead>
<tr>
<th>Task</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleaning</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Laundry</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Changing the bed</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Other*</td>
<td>0</td>
<td>1*</td>
</tr>
</tbody>
</table>

**TOTAL**

|       | 10 | 1* |

* This was an example given by Ray, who had depression and was an alcoholic. His daughter did most of the domestic tasks for Ray, but he said that ‘even’ his son would empty the ashtrays, emphasising his gendered surprise at this by adding ‘and he’s a lad’.
The gendered nature of this activity is very clear. In this sample, it is women who go to clean for others. Yet they may equally well be cleaning for other women who are unable to do it, as for men. The gendered nature of domestic work within the household is well known, however it is important to note that this extends beyond the household to a community form of domestic labour.

The following example from Lorraine, a care worker from Liverpool who was asked by a neighbour who had depression to go and do her housework once a week, is pertinent. This lasted for six months. After Lorraine left the neighbour’s house each week, the neighbour would go up the road and clean her (60 year old) nephew’s house. When asked whether the nephew could have come and cleaned his aunt’s house himself, Lorraine’s reply was ‘it’s no good asking lads’. Another interesting aspect of this story is Lorraine’s reflections on why her neighbour wanted her to come and help her with the housework. Lorraine’s guess was that the neighbour wanted company ‘and the cleaning was a way round it’. This is an interesting idea that has broader applications – some people may use practical support as a route to emotional support, which is discussed further towards the end of this chapter. Another interesting aspect is that this account from Lorrraine shows the importance of studying these connections between people as interactions rather than as support or help. We can see here that, in an interaction such as this, the relational dynamics are operating at a number of different levels at the same time and a lot would be missed if we merely analysed this as an example of Lorraine’s provision of housework for her neighbour.

In 1974, Ann Oakley discussed housework in relation to gendered inequalities. In this thesis, doing housework for other people was seen not only as gendered, but also related to class or material conditions. The examples given of doing housework for people who were ill tended to be from people who had fewer resources. It may be that people who have more material resources would pay for someone to come and clean the house at times of difficulty such as illness, or indeed may have a regular cleaner.

Another way in which people interacted with each other triggered by a health problem was to offer babysitting or dog-walking. Dog-walking help tended to be
offered when people had been ill, had had treatment or had a temporary mobility problem. The babysitting offers tended to be to provide an opportunity for friends (or their children) to take a break, which was more common in the sample of people with mental health problems. While these are examples of practical, ‘doing’ type interactions, they are also important as interactions over and beyond the act of walking the dog or babysitting, as they contribute to the relationship between the two people and also act at the level of identity building and sense of self. All of the examples of babysitting or dog-walking came from the Yorkshire sample and were from people in the younger age group (45-55). For the babysitting this could be explained by life stages, with people in Liverpool tending to have children earlier and so by the age of the sample they would no longer have young children. It was also mostly neighbours who provided dog-walking and babysitting, and so this provides us with another example of neighbouring which possibly challenges Crow et al.’s (1994) concept of ‘respectful distance’ maintained by neighbours, as in these cases the neighbours did not exactly maintain a distance. However, the argument made by Crow et al. (1994) as well as others (Devine, 1992; Proctor, 1990; Richards, 1990) is that interactions between neighbours are more active and substantial than suggested by the individualization thesis (Beck, 1992), which is what is observed here.

There were a number of cases of people delivering home-cooked food to others. These are also taken as examples of health interactions and illustrate well the way that interactions about health can be small scale as well as larger interactions. In Steve’s example, he described how his wife prepares a Sunday lunch every week, which he delivers to an elderly woman in the village. All the other examples of sending food were smaller scale ones, and were in circumstances where the person had a short term illness (e.g. Patrick who had just had an operation), or had a long term condition and the normal system for provision of food did not apply (e.g. Barry, who had had a serious stroke and his wife was away).

*I mean like Ann [Steve’s wife] is very caring, I mean she cares for old people in the village, she doesn’t even charge them, I mean there is old Betty, we take her her Sunday dinner, every bloody Sunday I get in the
car, take her dinner down to the village, and then we take one from the pub if we don't organise it, you know.

Steve

Many a time we open that front door and there is a basket of goodies on the door handle, freshly cooked scones and stuff like that.

Barry

I go with my sister in October to North Wales for 3 or 4 nights … Jane brings him fish and chips.

Pauline

In some cases taking food to people was a way of showing that they cared, or of opening the way for emotional support, such as Fiona taking food to a neighbour who she was aware was having a hard time.

Like the other forms of domestic work described above, the provision of food was highly gendered. Except for Steve above, it was most commonly women who sent food and men who received it. Ray is a good example, he was sent some stew (scouse) by Sheila, although he wants to convey the message, in the interview if not to Sheila, that he did not want it.

You know, little Sheila …she had made too much scouse, so she went 'here you are, a bowl of scouse'. I don't even like scouse.

Ray

The dominant part played by neighbours in the provision of food needs to be stressed. This can be understood in terms of proximity, of being on the spot, making it easier to deliver ready-cooked food and also possibly allowing more awareness of when people may be ill and when food may be needed. Again these are examples of the way that neighbouring is more important in contemporary society than the individualization thesis would argue.

Another form of health interaction was when people helped with domestic or household problems or crises. In all of these cases it was relatives that people turned to. This could be because it is easier to ask a relative and it may suggest that there are moral norms or obligations around responsibility for domestic or household maintenance or repair, and that, despite the arguments
about suffusion of the concepts of family and friend (Spencer and Pahl, 2006), in such situations it is the family who are expected to step in. It is also important to note that, unlike the other examples described above, this is something that has to be requested rather than offered:

She [Margaret’s sister] rang me and said ‘my kitchen is flooded, will you come in?’ So I went in and it was her, she had unplugged her freezer, and it had just left, overnight, and it was, literally, it’s a wonder the woman underneath wasn’t drowned. And she has got a back problem, she has got osteoporosis, she is very stooped. She is as tall as me, but she stoops. And so I get down on my hands and knees and I am cleaning it all up … She will ring me if she is in bother, or the lights have gone out, or ‘my microwave is not working’ and she hasn’t plugged it in. And you know, it’s silly things.
Margaret

Interactions were also described which involved the provision of help when others were away or in hospital. All of the examples of help given when people were absent from their homes due to hospitalisation or holidays were given by men, who described themselves as the person providing the support, which included things such as checking the house and taking the mail in. This type of health interaction is important in outlining the range of activities that are considered in this study as health interactions. This is a relatively small-scale type of interaction, and in fact it does not even necessarily involve a face-to-face interaction, and yet it is argued here that this has relevance, not only for the person in hospital whose affairs may be taken better care of, but also for the dynamic of the relationship between the two people. It is also relevant for the moral work that is part of the act of engaging in this type of interaction, as can be seen in this quotation from Jack:

If anybody goes to hospital, there’s always somebody looking after – is the house locked up? Is the lights out? And all that … I have keys to four people’s houses.
Jack

This suggests that health interactions can play a large role in identity formation, the telling of a moral narrative and a moral presentation of self. Jack seems proud that he has ‘keys to four people’s houses’. These types of interactions were all conducted between neighbours and they can be understood as another
example of the way proximity between neighbours affects engagement in health interactions.

Another type of support that was only provided by relatives was practical help at the time of bereavement. Examples included Alison who cleared out her late brother-in-law’s personal effects in order to help her sister, and Bev who arranged a holiday for a bereaved relative. Again, this was highly gendered work, done by women. It was also done by women who were not in paid employment, so had more time.

There were examples of a form of health interaction that people called ‘opening up’, this was done by neighbours and all of the examples were from Liverpool. These were cases where people were ill, post-operative or old, and a neighbour would come to their house in the morning to check on them and open the curtains. In some cases they would return again in the evening to close the curtains. Here is an example from Mary:

Mary: I used to go in every morning and open the blind, turn all the alarms off, you know. And shout, “Are you alright?” She would say, “Yeah.” I would say, “I am coming up with a cup of tea now”, make a cup of tea and a piece of toast and I would take it up to her. By that time she’d have been into the bathroom and washed around and then I would sit with her for half an hour or so, and then I would go out in the afternoon and get a scone or something, come back … I would come back with a scone or custard or something you know, and I would sit with her for another half hour. Well and then at night I used to go in about nine o’clock, draw all the curtains, put the alarm on and go up and talk to her … I done that every night.
Julia: Every night for how long?
Mary: Oh about, I’d say about three years.
Julia: And what made you do that for her?
Mary: ‘Cause I loved her. She was a lovely person, a good person.

This can be reflected upon in the light of the theories of moral agency discussed in Chapter 3, as it is a type of health interaction that could be quite demanding and it is interesting to consider why people might do this and which of the three possible explanations offered in Chapter 3 might apply – whether people feel they are following moral norms in doing this, or are building for themselves a moral identity or sense of a moral self, or whether it is out of moral concern or
affect, as suggested by the last line in the quote from Mary above. Whichever it is, it is certainly an example of ‘hidden solidarities’ as suggested by Spencer and Pahl (2006), because if these types of things are going on, then relationships in our social world are far from individualized. ‘Opening up’ may also be used as an excuse to spend some time talking with the ill person, or bringing them some food, which suggests other levels at which this is operating as an interaction and supports the argument taken in this thesis that it is important to view these connections as interactions and not limited to the simple level of the help given.

Gardening was another form of health interaction which was done mostly by relatives, for people who have mobility problems. This was a feature of the Yorkshire but not the Liverpool sample. It could be that, as people in the Liverpool sample generally had fewer material resources, fewer people had gardens or had sizeable gardens. It could also be related to culture or habitus as gardening may be an activity associated with relative affluence. It is interesting to consider why it may be mostly relatives that did gardening, as in the discussion above neighbours were often the ones who engaged in other types of practical tasks due to proximity. This suggests that there are other dynamics at play, such as types of obligations applying to certain types of tasks but not to others, or applying to family but not neighbours.

Taking out the rubbish bins for people who were unable to was a form of interaction which was done exclusively by neighbours. This does emphasise the importance of proximity for certain types of support. It is also an example of small scale, almost hidden types of health interactions that may often be overlooked in studies of social support, but which are nonetheless important, not only to help people manage their health, but also for the relational dynamics that are created.

Other forms of practical support
A number of examples have been discussed above of types of health interactions that involve ‘doing’, or practical tasks. However, an important element of the approach taken in this thesis is that health interactions involve
much more than ‘doing’. As illustrated above, even the ‘doing’ interactions simultaneously operate at other levels. However, there are a number of other types of health interactions which are more than practical, ‘doing’ type tasks that are considered important for the effect they have not only on health management, but also on relational dynamics and on moral agency and identity construction.

For example, there were a couple of cases of people getting involved with others in a quite personal manner when they were incapacitated in some way. An example of this is Mary, an 80 year old highly community spirited woman who lives alone in Liverpool. Mary gave the example of a time when her neighbour, who also lived alone, had a problem with her arm:

*Her daughter used to wash her hair, but we used to comb it for her of a morning you know, when she was going to work and that … I would say, “Come here Masie,” and I would comb the back of her hair. And put her stockings on.*

Mary

This is interesting in its ‘family-like’ (Spencer and Pahl, 2006) nature. We may expect that personal care of this type is done by partners or family members. Yet where people live alone, and as they age have more health problems which may inhibit their ability to do things for themselves, it is not surprising perhaps that this type of more intimate support is also provided by non-kin. This confirms somewhat the suggestion by Spencer and Pahl (2006) that there is a suffusion of the concepts of family and friend where, as we have seen here, neighbours may act ‘like family’. It is also interesting as it appears to breech the careful balancing act described by Crow et al., (1994) which neighbours play in ensuring they keep the right distance and become ‘neither busybodies or nobodies’.

Participants gave a number of examples of health interactions where people ‘checked-up on them’ to make sure that they were alright, particularly when they had been ill or were post-operative. Typically people would pop in or phone. It tended to be the people in the older sample group (70-80) whom people checked up upon. Although it did also apply to some of the younger group who
were quite ill – such as Barry who has had a severe stroke and has diabetes and Ray who is an alcoholic and appeared to have the most serious depression in the sample. With the exception of Ray, it was people with heart problems rather than mental health problems who tended to be checked up upon. This notion of ‘checking-up on’ runs counter to the individualization thesis, but in Foucauldian terms it could also be interpreted as monitoring and surveillance.

_We make sure that we meet up, take her out for lunch every few weeks and so forth. We feel conscious that she may feel lonely because she is on her own, her husband died some years ago._

Geoffrey

Ray: She [Linda, his daughter] will be here at 12 o’clock and Tommy will come like, he is not working at the minute and he is looking for work, but when he is home, Tommy will come down 3 or 4 times a day so will Linda.

Julia: And why do they pop in just to see you or…?

Ray: Well, I have that, what do you call it, erm, you know that, what is I have got, this thing I get upset and that like and so I have good days and bad days, bad days and good weeks.’

Ray

This study is based on a small, non-random sample, so the connections identified could be chance, but there does seem to be a pattern indicating some relationship between affluence and ‘checking up on’, as the more well-off participants, such as Geoffrey and Philip, tended to talk more about the checking up on they did for other people. Whereas the less affluent participants, such as Ray, talked more of others checking up on them. Taking up a role in ‘checking up on’ may also be a type of project which can be afforded only when other basics of life have been met. Men are checked up upon more than women in this highly gendered form of support. Checking up on also appears to be an activity which is done mostly by neighbours, again the proximity and ease of access facilitates this. It is clearly not something which is commonly done by friends.

In the case of most urgent type of medical emergencies (heart attacks, serious falls) it was neighbours who invariably became involved, as they were on the spot. This confirms Crow et al.’s (1994) argument that, in their role as neighbours, people are keen to ‘be there if needed’. There is an excellent
example of this from Jack, who was taken to hospital with a heart attack and although the neighbours, being close by, played the major role in calling the ambulance and providing immediate support, it was important to the neighbours to ensure that Jack’s son was called and they facilitated his journey to the hospital. This was despite the fact that Jack did not have a particularly close relationship with his son, and Jack’s accounts of interactions about health were all related to neighbours, friends or fellow church-goers, but not his son.

Being on the spot also applies to strangers and Terry and Bev both described their assistance to strangers in road accidents. There may be some presentation of self here, as the number of people describing their involvement in others’ emergencies is much more than those admitting to needing or receiving emergency help themselves. Both Terry and Bev presented themselves in the interviews through a ‘good Samaritan’ type of moral narrative.

Giving lifts was another form of health interaction. Lifts to hospital visits or to hospital or doctor’s appointments were not as commonly mentioned as general lifts, which were given because people were seen as old or frail or not in good health. Lift giving was dominated by neighbours. This is easily understandable in terms of convenience and ease of access. Although the very low numbers of lifts arranged between relatives or friends is perhaps surprising. This could possibly be a product of the sample, which was dominated by people who were not in paid employment (retired or out of work commonly due to ill health). Lift giving involves much more than practical assistance in terms of relationship building and connection, as well as other health and non-health sharing of information, advice and ideas, than the simple transporting of a person from one place to another. The quote below from Philip suggests this and a narrative of a ‘moral community’.

*Philip: taking them back and forth to hospital, a neighbour across there … providing transport for his wife to visit him … because he was in hospital at Hull, which is sort of 30 miles from here, a bit difficult to get to otherwise … his wife felt a bit unsure of driving, never knowing what she was going to expect when she got there. But he is ok now.*

*Julia: Good. How often did you do that, how regularly?*

*Philip: Oh, I suppose 3 times a week.*

*Julia: Yes, for the 4 weeks?*

*Philip: Yes*
Julia: That’s quite a lot of driving isn’t it.
Philip: Well you do that kind of thing, they would do it for us, and that’s how, we are very much a self-help cul-de-sac here actually. Yes.

Philip

The people who were given the lifts were all in the older age group (70-80), except for Barry who was younger but unable to drive due to a serious stroke. They were also all people who had heart as opposed to mental health problems.

There seemed to be some difference according to material conditions, with people with more material resources, such as Philip, being more likely to describe themselves as offering lifts, and people with fewer material resources being more likely to be in receipt of lifts. This is an example of structural disadvantage as it suggests that people with less material resources are not only denied material goods, but also moral goods. In this case they are denied the moral capital of being able to offer lifts, and through that to build and present a sense of self as a moral actor.

Advocacy was another form of health interaction, it was identified mostly in Liverpool and mostly from the mental health sample. This typically tended to involve trying to get benefits or other support for people.

Little Elsie, what did I do for her, oh she had a, the DHSS had messed her pension up, and I went to the citizens advice on Brook Road and asked them could someone come out and see little Elsie because she wasn’t too clever on her pins. Just little things as regards like I mean these people do more for me than I do for them.
Ray

There was a trend mostly between friends, but also neighbours, to take people for outings or ‘treats’ when they were ill or having a hard time. This activity was found mostly in the Yorkshire sample and amongst the younger age group (45-55). The examples included a trip to see the cricket, a drive in the country while in hospital receiving chemotherapy, or being taken out for a meal, or on holiday.

I was having chemo to begin and then I was having radiotherapy … she used to come over and take me … a little drive round and it was brilliant, it
did more that hour because the rest of the time you are in sort of you are in with everybody else and there is a lot worse than what you are.
Margaret

Jane was going through a very, very hard time with her husband at the time, and I said why don’t we all go for a holiday, why don’t we go away … Jane said I can’t afford it, we just can’t, I said look it’s my treat I am paying it, let’s go somewhere for a few days …
Fiona

It was among people with more material resources and the younger age group that examples were given of doing health promoting things together. This included meditating, giving up smoking, walking, going to the gym or accompanying to alcohol meetings.

Oh she loves meditating with me … Our canteen has been disbanded … and it’s just an empty room that we can still go and sit … and Lucy and I would go down and meditate.
Bridget

Both this and the ‘outings and treats’ (see the quote from Margaret above) are examples where it is easier to see the way that interactions that are ostensibly conducted to deal with another’s ill health, also have a number of other impacts as they are interactions and not one way transfers of help or support. So, by going on a trip together, or to the gym or a shared meditation, people could be strengthening their relationship and also benefiting personally from the experience, whilst at the same time being able to gain some sense of moral authority or moral identity. Also, from the perspective of the ‘receiver’ of the help, it may be a form of help that feels more reciprocal or shared.

The public health literature (see for example Thoits, 1986, 1995) is quite clear that, as well as social support being an important indicator for improved health, it is also the perception of social support that is important. The data from this thesis show something similar. It seemed important to people to have a perception that help and support was always there if they needed it. Or at least to report in the interview that it was always there if needed. People often talked in hypotheticals: ‘if need be’ (Jack); ‘they would do anything for me’ (Trish); people are ‘always there if you want help and vice versa … we are very lucky
really’ (Barry). This is interesting in its emphasis on hypothetical reciprocity, which seems to help people feel that they are not the ones who are doing all the giving all the time. It would also be possible to view this as presentation of self (Goffman, 1959) or identity work, as it could have been that people felt that it was important to them to present that narrative in the interview.

Ray presented a slightly different picture, which illustrates the complexity of this issue. Ray’s narrative below is one of broken promises and the unreliability of offers of help and support. This shows that strong and positive support narratives are not universal. Ray had depression and during the interview he was the most visibly distressed of the entire sample. In the quote below, he describes his perception that he did not really have even the level of support that his friends implied they were offering. This is in contrast to Jack, Trish or Barry, all cited above, for whom it seemed important to have, or present, a sense that they were well supported and that help would be there if they needed it. Ray put forward precisely the opposite narrative: support would not be there, even if it was offered. This suggests that for Ray there was no compulsion to make a positive presentation of self, which may be related to the extent of his depression. This is also interesting in that it reinforces the argument (in a negative sense) that it is the perception of social support that is important (Thoits, 1986, 1995).

... anyone will offer, anyone who has got a pint of lager down them, I will give you the world when I have got a pint of lager down me, and the next day you won’t get it. You know, you get to learn that one as well.

Ray

People talked both of always being there if others needed help or support, and of knowing that others were always there for them. Sometimes the same people said both. This could have been people trying to present a narrative which showed that people cared for them too, this importance of presenting oneself as cared for is discussed in the next chapter. It tended to be people in Liverpool and with less material resources who talked in these terms.
Opposition to practical health interactions

This chapter has emphasised the various forms of practical interactions which people engage in with others in times of ill health. But it would be wrong to imply that this is a universally good and wholeheartedly appreciated thing. There are people who described how they did not like receiving practical (and often other forms of) support. These attitudes were to be found slightly more in the Liverpool than the Yorkshire sample. They were much more common among people with heart problems. They included both materially deprived and advantaged people and they were balanced in terms of age and gender. It is interesting to reflect on the fact that this included as many women as men, as it challenges notions that this is a male, macho way of responding to support over matters of health. The type of concerns that people had or related to are outlined in the following paragraphs.

Some people, both men and women, felt quite passionately that they wanted and needed to be self-reliant. It was important for them to feel that, despite their health problems, they could function independently and did not need to rely on other people.

Strong feelings about the importance of self-reliance seemed to be related to a belief that there is a loss of power or control that goes with allowing others to help through practical support. This echoes work in the sociology of health and illness about self-reliance and stoicism in the management of health (Williams, 1993). It suggests that there are other social dynamics which are taking place at the same time as health interactions, dynamics of authority or identity. Indeed, some of the examples from other people who wanted to provide practical support did hint at both control and identity or presentation of self, such as Terry who stated that he and his wife ‘get people sorted’, or Margaret who was very critical of her sister’s (a diabetic) diet. Pete describes below the individualized, almost atomised approach he takes to his life:

*It’s as if you needed help and a person was here, say it was like your brother or sister or friend or someone like that, you would turn round and say, “No, I’m all right. There’s nothing wrong with me, I can do it,” ... when you couldn’t, you know what I mean? ... It’s not a pride thing or anything like that, it’s just within yourself ... No it’s not a pride thing, it’s ... er; I think a lot of it is within your own mind, you know, you think, “I can do this, I don’t need help*
with it," when clearly at times you might have done … you don’t see yourself
as failing or anything like that …
Pete

The quotes above from Lorraine and Pete suggest a link between accepting
support and threat to identity. Fiona, for example, said that help ‘gives you the
feeling of having a label up here that says you can’t do things’. Fiona is
indicating here that her sense of self and identity is affected by the receipt of help.

Some people equated their disinclination towards practical support with some
kind of sense of the constraints of a modern, individualized world where people
did not have time for each other, echoing a kind of idealised or popular version
of the individualization thesis. Mary (who was 80) pointed to the fact that her
daughters all had jobs, and so could not be expected to be involved in providing
her with support. This could be interpreted as Mary tailoring her expectations to
reality. But it could also, from a sociological perspective, be possible to view
Mary’s description here and in the quotes below from both Mary and Pete as
what C. Wright Mills would call ‘private troubles’ which should be understood as
part of wider ‘public issues’ (Mills, 1967). The quotes below, for example, could
be read as suggestive of the type of individualized or atomised lifestyles that
some individualization theorists (see for example Beck, 1992) depict. However,
it was Mary who also gave a number of examples of acting in a way very close
to the connectedness thesis (Smart, 2002), so it is interesting to note that when
talking about support for herself, rather than for others, Mary uses much less
connected and more individualized terms. Someone who more clearly locates
himself within the individualization thesis is Pete (who was in the younger age
group but with serious heart problems), who for example was fearful of
providing support for others because of the time demands it would place on
him. He was also fearful of others’ providing support for him, based on a strong
sense of privacy. He felt uncomfortable about them encroaching on his territory
and looking around and being nosy in his home.

Plus a lot of people now the way life is anyway, they've all got their own
stuff to do anyway, you know, people are working longer and you know,
longer hours at work … Because I mean a lot of people don’t really like to
encroach on other people’s territories if you know what I mean … Plus also a lot of people might think if they get too involved how much time is it going to take or how much of my time is it going to take up?
Pete

You see I know that my daughters have all got jobs and kids you know … and I wouldn't want to be a burden on them.
Mary

For a number of people, the basis of their disinclination to accept practical support was that they felt strongly that they did not want to be a burden. This is linked to the ideas of identity and self-reliance mentioned above.

In this chapter, health interactions that involve practical activities have been discussed and a range of types of interactions about health have been illustrated in order to demonstrate the breadth of types of connections that are viewed in this thesis as health interactions. The chapter has shown that it is not only large-scale or practical, ‘doing’ type interactions, but also smaller scale or temporary interactions that have meaning and importance for people and their sense of self and personal life.

This chapter will now move to reflect on some themes which have recurred throughout it and which merit a deeper discussion because they illustrate the layers of complexity within which health interactions operate. They also remind us of the argument made in this thesis that it is simplistic to think of health interactions as a straightforward, one-way form of ‘help’ or ‘support’, and that as interactions they also involve relational dynamics. These will be unpicked here in relation to the practical health interactions described in this chapter, by looking firstly at who does what in terms of practical health interactions, which will be followed by another way of looking at this involvement of neighbours which is as monitoring and surveillance. The chapter will conclude by exploring
the implications of the data for the relationship between practical and emotional health interactions.

The data presented in this chapter suggests that there may be something gendered going on in the dynamics of health interactions. The ways described above that women and men participated in different health interactions (for example women’s dominant role in domestic housework for neighbours who were ill), and in the same health interactions but in different ways, suggest patterns of gendered practices, or what Hagemann-White (1987) referred to as ‘gendered modes of behaviour’.

The dominant role played by neighbours in practical support is also interesting. Possible explanations have been discussed in the chapter of the significant role of neighbours in practical health interactions. These included: convenience, proximity, being ‘on the spot’, ease of access, and being closely in touch with neighbours’ needs. There is a literature (Crow 2002; Crow and Allan, 1994; Devine, 1992; Procter, 1990; Richards, 1990; Charles et al., 2008) maintaining that neighbours do play a much larger and more important role in present-day society than suggested by the individualization thesis (Beck, 1992). The argument made by Crow et al. (1994) is that contemporary neighbouring exhibits what they call a ‘busybody/nobody’ dichotomy, where neighbours engage in a task of some skill in trying to get the right level of not interfering, and yet being there if needed. Because this study is about times of health problems, there have tended to be accounts of how neighbours have become involved, as these have been the times when the ‘if needed’ comes to fruition. This suggests that neighbours play a more active role than implied by Crow et al., although this is unevenly spread across gender, age, locality and social class.

However, it is possible that some of the roles played by neighbours could have been, with a little planning, played by relatives, and although this does happen in a minority of cases, it is interesting that it is quite rare, and may be suggestive of a number of things such as moral identity building by neighbours, or moral norms or obligations which imply that relatives should become involved in certain types of health interactions but not necessarily in others. The
dominance of neighbours in the practical health interactions described in this chapter could be a product of the sample which is predominately people who were not in paid employment, so colleagues could (and did) play the role of neighbours for people who were employed. The considerable engagement of neighbours in practical health interactions could also be attributed to or influenced by the particular social history of the Liverpool sample, many of whose recent ancestors had immigrated from Ireland. The Liverpool sample was recruited from a highly deprived inner city area which had previously been largely tenement buildings and had been part of an urban redevelopment scheme to rehouse the tenement occupants. Many of the roles taken on by friends and in particular by neighbours could be seen as ‘family-like’. To some extent, there appear to be different roles for different types of relationships – for example relatives are asked for help with domestic crises, whereas neighbours become involved with the provision of food at times of illness.

There is, however, another perspective that could be taken on the role of neighbours in practical health interactions as described in this chapter, which is less kindly and benign and suggests that it could be seen not simply as help or assistance, but as monitoring or surveillance. As has been seen in this chapter, what people actually did that could most commonly be interpreted as surveillance was regular checking that the person who might be ill, experiencing a difficult time or having an emotional problem, was alright. A good example of this is Richard’s description of his wife’s friend, who:

...would provide lots of support for my wife, but it was done on a whole host of levels but mainly just sitting, talking to her, sitting with my wife, calling her to make sure everything was ok, even when she was away. Richard

To phone to check up on somebody while you are yourself away on holiday, suggests either a high level of worry about the person, and/or a need to manage and control the situation.

The surveillance that has been observed in this thesis happened primarily through someone monitoring a friend, or friends’ monitoring each other (though this was not necessarily reciprocal). Earlier this chapter outlined a number of
examples where people ‘checked up’ on friends or neighbours with health or other problems. To give a very literal illustration of this, we can look at the examples described in this chapter, where people would pop in on a neighbour a couple of times a day. This was described as ‘opening up’, and it did involve opening the curtains. However, it was actually more than that. It was used as an opportunity to check that the person was alright, and in some cases get them going for the day. Whilst presented by the study participants as caring, ‘checking up on’ is, by definition, a form of monitoring or surveillance. It could be seen as a lay extension of the ‘clinical gaze’ (Armstrong, 1983).

These examples of health interactions that may be seen as monitoring or surveillance could be analysed within Foucault’s (1977) framework, described in Chapter 3. Much of Foucault’s work on discipline and control was based on historical research on the major disciplinary institutions of the nineteenth century, particularly prisons, but also including hospitals, where he referred to ‘hospitalised bodies’. Today there are comparatively fewer large-scale institutions and more care is conducted in the community. In the same way, it could be seen that the control of these institutions has also been passed to the community in a form of ‘post-hospitalised bodies’. So our neighbourhoods, our friends and family could be seen as providing an extension of the disciplinary role played by the hospital in surveillance and monitoring of our health. This can be done through the type of health interactions discussed in this thesis. In a literal sense of ‘post–hospitalised bodies’, there were also a number of examples of friends or particularly neighbours playing a role in people’s health immediately after they were discharged from hospital. An example of this is Patrick, whose neighbours came in to help him at least a couple of times a day for a few weeks after his heart operation. Another example is an illustration from Philip, who was particularly active in engaging in his neighbours’ and others’ health problems. As quoted earlier, Philip described himself as living in a ‘self-help cul-de-sac’. The circular image of a cul-de-sac conjures up the image of an almost perfect ‘panopticon’:

… that’s how we are, very much a self-help cul-de-sac here actually. Yes … we have got my wife will do the shopping for a 95 year old, I look after her tax, she is visited by, the old dear is visited by the next door neighbour from that side, ourselves and one other, and that is the other
one who has just had a new hip so she can't get out at the moment. We take her shopping, generally, that's her … That's the 95 year old … She lives just the first bungalow on the right as you go down. And likewise if anybody is ill or wants help in any way, running to the station and so on, then there is always somebody here will take you to the station and pick you up, or whatever.

Philip

Philip’s description of his self-help cul-de-sac could be seen as a contemporary community version of the great institutions of the nineteenth century, where we conduct surveillance from our homes on our neighbours. Philip described how he had been ‘watching’ his neighbour’s drinking habits at a party, and monitoring the number of times a fellow golfer urinated in the bushes. Philip’s use of the term ‘self-help cul-de-sac’ is very interesting, because it could be seen as very much like Jeremy Bentham’s panopticon, described by Foucault (1979). The shape of a cul-de-sac, which is often round and from where one can physically see all the neighbours coming in and out, is ideally suited for surveillance, in the same way as is the design of a panopticon.

**The relationship between practical and emotional support**

As we have seen above, there is a range of different ways in which people engage in practical health interactions with others at times of ill health. We have also seen that it can be a mistake to take an act of practical support as simply that, as often there are layers of complexity within a health interaction. A particular layer of complexity is that there is an interesting relationship between the giving of practical support as presented in this chapter, and the giving (or not) of emotional interactions (which will be discussed in the following chapter). What concerns us here is the relationship between practical and emotional health interactions.

Engaging in practical health interactions seemed to be easier than engaging in emotional work. This could be because offering emotional support can sometimes be frustrating and unrewarding, as we shall see in the next chapter. People may shy away from offering emotional interactions, in the sort of way that Simon describes here:
I think if you are in a position where you might be able to offer somebody mental or moral support just be a bit of a pillar for them … you can’t just say hey I am a really good friend and I would like to help you with this mental difficulty … you can say hey look I am here if you need me to help you put the coal out or clear the bins, because your arm is broken … or would you like me to mow the lawn is a practical help you can give to somebody with a broken leg, but when their head is broken it must be very, very difficult to say, you know hey I am here, you can trust me, I don’t know what I can do but if there is something I can do I will do it for you … and I think it’s also difficult to ask for help because the help isn’t tangible.

Simon

Is Simon talking here about stigma? Or is it, as he mentions, something about the intangible nature of emotional support? Or the difficulty of knowing what to offer? An example of the latter could be Geoffrey’s offer to help a friend with house-hunting. Geoffrey’s friend had moved away from the village to live in Wales, where he became very unhappy and developed depression. Geoffrey wanted to help. He wanted to do something to ease his friend’s problems, yet it was something practical and tangible such as house-hunting that he felt able to offer.

I think if somebody is going to talk about their problems it has to come from them rather than you try to drag it out of them. We talked about his overall situation, yes he would talk about all the problems … we would listen sympathetically and try to sort of, you know help with suggestions and what have you in that way, but there is not much you can suggest … We offered to help as much as we could … any help we can give you for looking for a house here, we would be only too pleased …

Geoffrey

It seems that it is also easier to request practical than emotional support. Ray, who appeared to be one of the most depressed people in the sample, was able to ask for practical support, but when what he wanted was emotional support, the practical support felt inadequate:

I don’t think people can help me in the way that you mean. Because your mates will do you know, I mean, ‘Charlie do us a favour cut that grass’, ‘yes here you are’. You know they will do that. But as regards just sit and listen, they might do you know, I think if my mates or my family was to listen to me waffle on, I think like at first you get the sympathy vote, which is all right but you don’t really want that.

Ray
It is interesting to consider how people frame what support they ask for. Why is it that people do not ask for emotional support? Ray does seem to be suggesting in the above quote that people would have a limited amount of patience for listening to him ‘waffling on’. However, why does he feel that he can ask his friend Charlie to cut the grass, when he cannot ask him to sit and listen to him? Is it stigma? Is it gendered? Is it difficulty in expressing emotions? Is it difficulty in identifying that it is emotional support that is needed? Some of these ideas may be related to the themes of morality raised in Chapter 3.

Where people find it difficult to request emotional support, they can ask for it under the guise of practical support. There is evidence of the way that people mask the presentation of emotional needs in medical consultations, which is referred to as the ‘somatization thesis’ (Sheehan et al., 2003). This was the case of Lorraine, described before, whose neighbour asked her to come and do weekly cleaning of her house, but which Lorraine felt was really a request for some emotional support. Another example is Richard’s local vicar, who suggested they go for a bike ride together, which was really an opportunity to talk to him about his problems. This is also an example of the multiple levels at which health interactions operate, with relational dynamics becoming enmeshed with moral agency and a sense of moral concern.

Wanting practical support is also easier to admit to than wanting emotional support. There may also be gender and presentation of self and identity issues here, as in the example below from Richard, who, with echoes of the ‘rational, stable man’ and the ‘neurotic woman’, denies receiving emotional support from local friends, but says that his wife does.

Richard: But in terms of the work guys no I wouldn’t have expected them to do that kind of thing. But you can’t get through those kind of situations without people like that really.
Julia: Practical support or emotional support?
Richard: Well a bit of both, but I am talking about practical support really because most of the friends we have local will provide, well as far as I was concerned they provide practical support not emotional support.
Julia: The friends locally didn’t provide emotional support?
Richard: Not really, they do to my wife I know with her problems but not with me no.
Conclusion

This chapter began the process of mapping the terrain of health interactions. It provided illustrations of how health interactions include practical, ‘doing’ type activities, but also other, smaller scale interactions. It was also demonstrated how, although people are, in practical terms, ‘doing’ something for another, at the same time there are a number of other levels at which the dynamics of the interactions are functioning. These include relational dynamics such as the gendered practices of health interactions, or the important role played by neighbours. They also include dynamics which could be imbued with a Foucauldian type of monitoring or surveillance, which brings into the health interaction aspects of power and control. The health interactions discussed here also suggest the importance of moral agency and the presentation of a moral identity, which, it is beginning to appear, may possibly have as much meaning for people, as the contribution to health management that health interactions can make. This thesis argues that what goes on between people when they connect about health has impacts at many levels, and that a great deal more is going on in the interaction than a simple transfer of assistance.
Chapter 6: Health interactions as emotion work

This chapter continues the process of mapping the terrain of health interactions and using examples from the data to demonstrate the range and nature of the conceptualisation of health interactions as used in this thesis. Having illustrated the nature of practical health interactions in the previous chapter, this chapter will engage with health interactions that operate at the level of emotional rather than practical connection. This will continue the process of showing how health interactions operate in terms of relational dynamics as well as health management.

In the Introduction to Part Two of this thesis, it was described how health interactions include not only ‘doing’, but also interactions that do not involve physical or practical ‘doing’, as well as smaller scale or fleeting connections. This chapter will illustrate how health interactions can take the form of connections between people at the level of emotion and interactions about emotional distress involving conversations, understanding, and more intangible but nonetheless important forms of interaction such as ‘being there’ and showing care and concern. These forms of health interactions will be discussed and developed further in this chapter and will contribute to building a growing sense of the nature of health interactions, the multiple levels at which they impact and the fact that health interactions are more than ‘donations’ of help, but are two-way relational processes.

The chapter begins by outlining a number of types of ‘emotion work’ which were undertaken by study participants. It then explores this in relation to themes of emotion work, such as feeling rules, emotional investment, an informal emotion industry and the gendered nature of emotion work.

The term emotion work is used in this chapter to refer to the work involving emotions that is done in private and personal life, sometimes as an individualised process and other times, as will be shown in this chapter, shared. Emotion work is similar to emotional labour, a concept developed by Arlie Hochschild (1983), who used the term to refer to the commodified
work that is done at an inner level of emotions in order to promote the commercial interests of an employer (in Hochschild’s, 1983, study, an airline). There are examples of emotional labour in paid employment in this thesis, such as Trish, who gives advice and ‘health talk’ over the bar during the course of her daily work with customers in her pub and finds herself in the role of listening to customers’ health (and other) talk:

‘I’m a psychologist, I’m a nurse, I’m a lawyer, a marriage guidance counsellor, I’m a specialist in child psychiatry and I don’t even like them.’

Trish

However, as this thesis focuses on informal interactions, it is the emotion work that goes on within the relationships between friends, family and other social connections that comprise the majority of the data upon which this chapter is based.

**Types of emotion work**

Table 6 indicates what people provide in terms of emotion work.
Table 6: Types of emotion work

Note that these are numbers of different examples or offers mentioned, not the number of people who mentioned them.

<table>
<thead>
<tr>
<th></th>
<th>Relatives</th>
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<th>Neighbours</th>
<th>Colleagues</th>
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<td>6</td>
<td>0</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Showing care</td>
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<td>3</td>
<td>4</td>
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<td>14</td>
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Understanding

One of the types of emotion work health interactions that is covered in this chapter is showing or developing understanding for the other. This is a type of interaction that is very different from the practical, ‘doing’ health interactions that were discussed before.

Showing understanding may require the development and use of skills which may be unrecognised and often undervalued. For example, as shown below, in the case of Ray’s friends, learning to recognise and understand the signs and ‘codes’ that Ray uses to express the current state of his depression is quite skilled work:

But my mates, my kids, and my sisters understand that you know, if you are on a bad one, just leave him. If he is tired it’s time to go. If he wants to waffle on, let him waffle on … there is no fuss, there is no lift him up, they are not like that … when I say I feel tired, they understand you know.

Ray

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I mean my wife there, she can tell every day what I am like. You know, she can read me like a book.

Joe

One form of emotion work which people engaged in was trying to understand the health related needs of others. This was described solely in relation to trying to understand others’ mental health problems – depression, stress, feeling down. It was not mentioned in relation to heart disease or other physical conditions. Understanding others’ health needs was mentioned more by the younger age group, more by people who lived with others than alone, more by people in the Yorkshire sample and also more by men who, as in the two quotes above, often described the understanding by others of their needs and health problems.

People who talked about the work of understanding the needs of someone with a mental health problem, tended to refer to it in the context of having had a similar experience themselves. So it was this shared experience which helped them to understand and engage with others with that condition, and it is an illustration of the way that health interactions are not simple cases of one person donating help to another, but the interaction is likely to have meaning for both (or all) parties involved.

At this very moment, a good friend of mine that does work for me on a contract basis is suffering from major depression, like I had … he said bloody hell it’s exactly right, that is exactly how I feel … and it was just basically his symptoms were identical to how I felt.

Steve

I helped a colleague whose wife was also a manic depressive, and he was finding it really difficult to cope and I spent quite a bit of time with him, describing what I did, sort of coping with my wife’s problems … I just described to him some of my coping strategies I suppose. And also, some of the things I did to try and manage my wife’s mood swings whenever they occurred.

Richard

Joanne [his wife] has given me space as well in my life, she has had ups and downs and been in and out of care for one thing and another, she suffered from eating disorders all of her life really, which I have had to
deal with and help with, but then when I needed help she was fabulous and didn't know what to do, or how to do it exactly but again just understood that I needed something.
Simon

As shown in these examples, people’s emotion work was often facilitated by people’s own similar experience. It was more frequently the case that people described trying to understand others, than needing the understanding themselves. This is in keeping with the general theme seen elsewhere in the data, that people preferred to present themselves as ‘givers’ rather than ‘recipients’. However, the example below is rather different, since Ray was the only study participant who described needing people to engage in emotion work to understand him. Ray, who was the most obviously depressed in the sample, described how he tried to get his friends to understand when he was feeling bad, by using signs to indicate when he was experiencing a bad bout of depression, and he appreciated the fact that his friends recognised these signs, and understood and responded to them. So it makes sense to see connections like this between people as interactions, rather than one way processes. Ray’s friends had to learn new skills of understanding mental illness and understanding their friend, and the way they enacted their friendship with Ray was altered as a result. It suggests that possibly this type of health interaction could create a deeper level of connection than the practical health interactions described in the previous chapter. This also shows how something very personal or private such as mental health problems or emotional feeling can become, through the interaction, shared and public (Bendelow and Williams, 1997).

My mate next door … if they knock, and I go, they know I am not too clever and they take off … If I feel iffy playing cards, you know you can sometimes you can feel this thing coming on … they know like that and Charlie will go like, or Ronnie or Gary you alright, I feel a bit tired, that is what I say to them, and they know and go well here are, leave that, we will run you home.
Ray

For Ray and also for Fiona, who described the stress of a possible visitor when she was low, the pressure of friends trying to ‘lift him up’ (Ray) or
having to get dressed and be sociable (Fiona) was strongly objected to, and friends or family who understood this were deeply appreciated.

There were also examples where people actively did not try, and did not want to try to engage in emotion work to understand others’ health problems. Diane referred to her irritation with people she saw as hypochondriacs. She described in the quote below how she only tolerated them to a certain extent, or teased and ridiculed them. Diane was suggesting maybe that she herself wanted to avoid taking on the stereotypical role of a ‘health moaner’ or hypochondriac, or as in the example below an attention seeker.

*Well there’s one girl, Lucile, she’s got pains everywhere, I’m tired, I’ve got bad back I said, “If you were a dog you would be put down,” that many aches and pains, but I think like really it’s attention … I just laugh at her.*

Diane

*‘Being there’*

Another type of emotion work interaction which people engaged in was ‘being there’ at times of ill health, bad times or life crises. Women did this type of emotion work more than men. It was more common among people from the younger age group, people living in Yorkshire, and people who lived with somebody else rather than alone. As with most of the emotion work described here, it was the people with mental health, not heart problems, who tended to engage in work involving ‘being there’ for others.

There were two ways that people talked about ‘being there’. The first was physically transporting themselves to be with a friend or relative. There were examples of this being done for people who were ill, distressed or bereaved. It seems that people felt that there was some power in proximity, or wanted to demonstrate care and love by physically going to be with the person.

An example of this involves one of Trish’s closest friends, Helen, who had been diagnosed with leukaemia. Upon hearing the news of the diagnosis,
Trish travelled immediately to see Helen, who lives about five hours drive away. This required some complicated arrangements to have Trish’s pub looked after. However, Trish described that she was prepared to ‘drop everything because it’s a life and death thing’. To make this kind of immediate visit may or may not be common practice among good friends. But nonetheless it is interesting to consider why it is done. In Trish’s case, it could have been, as she suggests, because cancer is understood as a very serious and life threatening illness. As such, it brings with it urgency or a sense of crisis. There may have been a clear understanding that that was expected or desirable among Trish’s friends. It could also have been related to Trish’s own emotional need to see her friend at that time. It is worth considering whether the rush to visit was primarily for Helen or for Trish. For example, Trish may have felt a need to show or demonstrate something to Helen or to herself about the friendship, or to construct for herself a sense of moral identity. Viewing the visit as more for Trish than for Helen, the support for people who are ill can be interpreted as support for the ‘supporters’ as much as for the ill person, and it shows this to be an interaction with impacts on both people.

It is also worth pointing out that Trish had the resources and lifestyle to be able to do this. Not everybody would be able to ‘drop everything’. Trish also went to visit Helen when she was in hospital having chemotherapy, despite Trish’s inflamed throat and croaky voice. Both the hospital staff and Helen were concerned that Helen may catch an infection. Trish was convinced that this was not the type of inflamed throat that Helen could catch an infection from, although the medical cause of the inflamed throat had not been finally determined. This is interesting as it is possible that Trish was taking a risk that Helen would catch an infection. This suggests that possibly Trish was driven to visit her friend in hospital by something other than, or as well as, a simple desire for Helen to get as better as possible as soon as possible. It could be identity work as suggested above, or a sense of moral norms or obligations, or a sense of moral concern (Sayer, 2011). When it is fairly clear that we are unable to help much in practical terms, it is interesting to consider why it is that we visit people in hospital. It is presumably to try to bring some comfort or show some care to the patient, or
to engage in some moral agency work for ourselves. As illustrated by Trish’s example, people seemed to value being physically close to someone they cared about, who was having a hard time. Even friends of Trish’s who did not know Helen wanted to go to the hospital, to be with Helen. When asked if they had wanted to go for some particular reason, Trish replied ‘because she [Helen] has been diagnosed with this. They wanted to go and show their support.’

Helen herself had acted similarly when Trish’s father died: ‘I rang Helen and she was down in two hours forty five minutes, she flew down the motorway’. Trish explains this need to physically ‘be there’ for a friend:

I mean, long term friends, good friends um, they all bail you out of things and you’ve been there for each other through so much, through thick, through thin it’s just a normal reaction. To go and be with your friend who’s in distress … always gonna be there, but they’re there for me if I ever need it …
Trish

Simon talks of a similar need for proximity when his previously estranged sister had had a car accident which left her disabled:

… she found … who she felt she could confide in, and that’s really what I did. I wasn’t really aware at the time what I was doing. I just felt the need to be near her for a while.
Simon

As hinted in this quote from Simon, there is a second way in which the emotion work interaction of ‘being there’ was manifest. While involving being physically present, the priority here was on ‘being there’ by taking time for the other, to listen and show support.

When we had the problems that we had, ... she would provide lots of support for my wife, but it was done on a whole host of levels but mainly just sitting, talking to her, sitting with my wife, calling her to make sure everything was ok, even when she was away.
Richard
Conversely, failure to ‘be there’ when needed could be experienced as a serious lack of care. For example Margaret’s husband rarely came to visit her when she was in hospital with cancer, and Bev’s husband stayed in the car in the hospital car park when Bev was receiving her diagnosis of multiple sclerosis. These may suggest a failure to follow what Margaret or Fiona saw as the moral norms and obligations of being a husband, they both seem to be suggesting that it reflected a lack of moral concern.

*Showing concern and care*

In this section a slightly different type of emotion work health interaction is discussed, which is how participants depicted the ways they showed care and concern for others at times of health problems.

However, it is also important to be aware that the accounts given in the interviews are narratives which are also a participant’s presentation of self (Goffman, 1959) and possible attempts at developing or presenting a moral identity. It shows how health interactions operate at a number of different levels at the same time. People were describing two types of concern, firstly concern about the other and secondly concern about their own engagement with their moral identity or presentation of self (Goffman, 1959), or their construction of their self in a particular role.

Participants described a range of ways in which they demonstrated concern or care when others were unwell. Fiona, for example, developed systems such as leaving a plant or a note for her friend who was suffering from depression, to show that she cared about her, recognising at the same time that her friend may not want to respond at that time. Fiona’s systems were designed to show care and concern (and also possibly control?), while also trying to avoid bothering and burdening somebody who was already feeling low, and at the same time not wanting to appear ‘pushy’, which may be seen as an stereotype that people wanted to avoid.
Much of the emotion work which people did for others at times of health or emotional need was described similarly to Fiona’s, in terms of ‘showing concern’ or showing that they cared about a friend, relative or colleague and their wellbeing. These relatively small scale interactions demonstrate that health interactions do not need to be large scale, major episodes of caring or support, but can be simpler acts that nonetheless have relational importance for both parties and also act as a form of moral agency, in this case for Fiona.

There were more or less equal numbers of examples in the data of participants showing care towards others, as there were of others showing care towards them. There were slightly more from the younger age group and from the Yorkshire sample. There were also slightly more men than women who gave examples either of giving or receiving this demonstration of care. This is an interesting contrast to some of the gender roles in the previous chapter about practical health interactions, where it tended to be the women who reported producing most of the practical (which was often domestic) help. This suggests that it may be important for men to present themselves, at least in the interview, as caring. It also suggests that there is a fluidity of gender identities, rather than rigid or static boundaries of feminine and masculine identities. It is also interesting to note that all of the people who gave examples, either of showing care to others or receiving it themselves, were people who lived with a partner or partner and children. None of the people who lived alone talked about this.

It was with colleagues or ex-colleagues that this type of emotion work health interactions seemed to take place more than with other groups. This is interesting as throughout the rest of the dataset people referred mostly to their health interactions with friends, neighbours or relatives.

*Like this morning I had an e-mail from someone who I used to work with, but just making sure I was ok, and health wise you know, how are you going at the moment, but at the same time there is I have got to have an operation on my elbow written in there, so you know, I will e-mail back and say what are you having done with your elbow and you know, obviously to offer support if they need it.*

Bev
At that time, a lot of the text messages were you know like more like, thoughtful from a point of you know, like … how are you doing today Champ like, are you feeling a bit better or, you know, you know look you know, money isn't everything … I suppose it makes a bit of difference … it's nice to know somebody cares, people care about you as well I think.

Steve

As well as indicating concern and thoughtfulness, people such as Mike, below, felt that others were worried about him and wanted to reassure themselves.

Julia: I was just wondering what kind of difference that made to you, that they showed that concern?

Mike: It's nice, it's nice to know that people are concerned about, about you and I think that would happen in any walk of life, you know even though I am a quiet and private person, it's still nice to know that people are concerned, show that much concern about you ... and they are worried and they would be worried about you. It's just that I wouldn't like to give them the opportunity to be worried and, and that it's just it's primarily in work; they do know I've been to the doctors for something ... so they show that, and that it's not prying, it's showing a concern ... It's not prying it's them showing a concern and I fully appreciate that, you know within the context. And I think it's nice for people to show concern, it's just that I particularly am not a type of person who would accept it with open arms.

Mike's comment that 'it's not prying' is interesting, as that challenges the Foucauldian ideas about monitoring and surveillance. It would be possible to juxtapose this quote with the quote from Bev above, as she clearly enjoys people showing her concern, whereas Mike does not. However, in general being shown concern and care was appreciated. The quote above from Bev suggests that she felt in some way special and wanted and cared for. Bev also mentioned, as does Pete in the quote below, that people showing concern for you can cheer you up, which helps you to focus less on your illness. These illustrate the multiple levels at which health interactions are working, over and above a simple aid to improved health.

… the actual people that popped in were good friends you know what I mean, so it was nice to see them from time to time to catch up on a few things … it brightens your day up, you know when you see people. I enjoyed seeing them. I used to have a laugh and things like that with them, so I enjoyed seeing them … it certainly takes your mind off it for a bit of the time … I would say it does make your health a little bit better because you are happier and you have a laugh and you're not thinking about anything else at the time, you know.
Pete

There could also be some self interest in showing care for others. In the quote above from Bev, she suggests that the ex-colleague who e-mailed her to show concern actually wanted to tell Bev about her own problems with her elbow (although this could also be interpreted as Bev's presentation of self). Similarly Steve, below, went to visit an old friend who was ill, but an additional objective for Steve was to prevent himself from going to the pub when he was trying to lose weight.

Gary, a good friend of mine, I went to see him last night, he is a farmer, he is about 70 he had been poorly with like some sort of leukaemia type thing … I had been to Slimming World actually I thought well if I go home now I will be off to the pub, and I thought bloody hell I will nip and see Gary for an hour, so I went straight up road and I went to see Gary and have a cup of tea.

Steve

The giving of gifts was another form of emotion work in which people demonstrated concern for others. This seemed to be a way of giving a signal to the other person that they were thinking of them and caring about them. This is also an example of a small-scale health interaction which could have meaning both for the 'giver' and the 'recipient', and may also have meaning for the relationship between the two.

If they're ill and we find out, go down and you might get a box of chocolates or a Lucozade … or a get well card, that's what it's all about.

Jack

It is worthwhile considering why it is that people engage in these actions of showing concern. What do people feel that they are doing, or trying to achieve when they engage in this type of emotion work? What contribution does it make to the way human beings relate to each other? Or to people's management of their health or illness? The way Jack presents gift-giving in the quote above suggests a one-way demonstration of concern, however Mauss (1922) has argued that gifts are never free, they always bring obligations to repay. By contrast, Titmuss' (1970) concept of the gift relationship argues that people are motivated by altruism, and this, which is
possibly similar to Sayer’s (2011) ‘moral concern’, may be more important to people when engaging in health interactions than a sense that they would be ‘repaid’ in some form.

In some ways showing care may be an attempt to actively help fight the person’s illness, an attempt to prevent them from getting worse. This could be the case particularly with mental health problems. An example of this could be Fiona’s friend and the system she developed to try to make sure that Fiona did not slip too far during the time she had depression:

*So, we had that kind of unspoken agreement if you like you know that, and it was actually quite good. And so if she phoned and I didn’t answer it she would then send a wee text, which was what I used to do, saying I will speak to you later I am going such a place if you want anything phone me, if you want me to pick anything up for you phone me … I think I would have been upset probably if she wouldn’t have got in touch.*

Fiona

There are feeling rules in place here. To what extent, in their emotion work to show concern, are people following some feeling rules, template, obligation or expectation of what should be done when people are ill? Which are the ‘moral norms’ referred to in Chapter 3, where it was argued that it was likely that there was more going on than a slavish, functionalist following of norms? The data presented here seem to support this.

Based on the ideas of the gift relationship (Mauss, 1922), participants may engage in the emotion work of showing concern hoping that it would be reciprocated, and that they will be shown care and made to feel special when they are ill. However, participants reacted strongly against the idea of reciprocity in health interactions, as shall be seen in Chapter 8. An alternative explanation would be that showing concern is an attempt to gain moral power or control, or to build some kind of ‘goodwill capital’ or moral identity. The moral agency work that people do was discussed in Chapter 3 and there have been a number of examples from the data in this chapter and others, where people seem to be constructing a moral identity through health interactions. However, another explanation is that people’s concern is a product of affection and a moral sense of care (Sayer, 2011). For
example, as Mary was quoted as saying, she helped out her neighbour ‘because I love her’.

**Talking it over**

Talking it over, or talking it through, is a slightly different type of health interaction from showing concern. Talking it over is used here to describe engaging in conversation over a health issue, which could be a bigger thing to take on than merely showing concern and it can be more fraught with risks. It also illustrates that health interactions can be conversations, they are not only doing practical or physical tasks:

> I text Mandy and say “bloody daughters” you know, so she will say “oh come round you know we will have a drink”, so I have gone round and we have both had a moan about daughters sort of thing.  
> Jessie

> And to be honest I think everybody in their life, and you will have been through it, everybody will have been through it … I have got a bit of a problem and all I need to do is just talk about it, get it off my chest and I will feel better for it. And that’s what most of the stuff is, that kind of caring is about anyway isn’t it.  
> Terry

Although there were examples, as above, of people wanting an opportunity to talk through their own issues, it was more common for people to describe the way that they offered others an opportunity to talk things over. This did, however, have an impact on the relational dynamics between both people involved and was seen as part of the emotion work required to maintain a relationship or to behave as a moral actor. Where people take this as an obligation, as possibly Geoffrey (and his wife) do in the quote below, they may be acting on moral norms.

> I guess it’s my wife mostly who gets involved in supporting people who have got problems, telephoning them and talking things over. Ok, so her sister who lives in Scarborough, her husband died is it a year or 2 years ago, she talks to her sister every day and it’s been a great help to her sister, to get through this.  
> Geoffrey
People emphasised the emotion work which they did, rather than that which others did for them. ‘Talking it over’ was a type of health interaction, as others, highly gendered and was done much more by women than by men. It was also more common among people with mental health problems than heart disease. As a type of health interaction, ‘talking it over’ seemed to be a product of a more affluent, comfortable position in life. It was mostly the middle class participants who referred to this, they tended to be in the younger age group and all but one lived in Yorkshire (in an area of significantly lower deprivation than the Liverpool sample). All but one lived in a household with others rather than alone. This suggests that a level of satisfaction of the basic conditions of living could be required before people can turn to this form of health interaction, which may be considered a luxury, and may be considered by some as less necessary than the practical health interactions described in the previous chapter.

When people are talking something over, its main effect may be to deepen the relationship between the two people, as these interactions will have an impact on the relationship. But Terry in the quote above suggests a different explanation, that ‘talking it over’ health interactions are a mechanism for stress relief and emotional survival, and that people can resolve issues or amend health behaviour as a result. It is likely that there is some illness narrative work being done here, the talking things over may be playing a role in helping people to define, or redefine, their illness narrative, as suggested by Simon, who spent time with his newly disabled, and previously estranged, sister:

... just talking to her, listening to her, she was coming to terms with not being able to walk again and having to change her life from being very active ... which of course couldn’t happen anymore, so she had to work out what she was going to do.

Simon

There are different types of ‘talking through’ and while most of the discussion above has referred to the lighter type of talk, as in the first part of Simon’s quote below, there are also more serious types of health interactions.
conversations that people can share with each other, and which may have a more long-lasting or profound effect on the relational dynamics between the two people. These types of topics might require careful thought about who is the right person to talk them through with:

_Erm, well blokes are always bitching on about their wives aren’t they, it’s part of life. Can’t live with them, can’t live without them, good patches, bad patches and he has been having a rough time with his missus at the minute … he feels shit, needs to talk to someone, you know, usual answer is “oh ditch the bitch go and get a Thai bride” of course nobody believes it but it’s the sort of things that blokes are supposed to say … we know that we are not going to cure it … next week it will be fine, that’s you know, “have another glass of wine”. So, but if it was something really serious, and I did have a big problem in my relationship with my wife, I don’t think I would go and talk to him …_simon

Richard equated this type of ‘talking things through’ support with counselling.

_I suppose she, in reality she was acting almost as a … she was acting as my informal counsellor._ richard

However, some people did not feel bound to engage in the emotion work health interaction of talking things over with others. They found it boring, irrelevant, or self-indulgent and tried to avoid engaging with others on such topics. The people who felt like this were remarkably similar to each other in their demographic characteristics. All except one were men. All were in the older age group, retired and all lived in Yorkshire with their partners. This is a similar pattern to the demographics of the people who welcomed the opportunity for people to talk things through with them. Both groups were relatively affluent and comfortable, but the big difference is that more women welcomed the opportunity for people to talk things through with them, and in contrast women were not represented (apart from one) in the group who did not like to talk about health matters with others. This is a pattern that has been seen before, that people prefer to present themselves as givers than receivers, and is an example of the strong presentation of self and moral narratives that are themes in this thesis.
**Feeling rules in health interactions**

There was a way in which people described feeling required to, or expected to, manufacture emotions to respond to others’ health problems. These accounts resonate with Hochschild’s (1983) notion of ‘feeling rules’, which although developed to explain a commodified experience of paid employees within a commercialised environment, can also be used to consider interactions outside of the workplace. It is feeling rules, for Hochschild (1983), which guide emotion work and give a sense of obligation to behave in a certain way, or an entitlement to expect certain behaviour from others (Hochschild, 1983). There are parallels to be drawn with the moral norms that were described in Chapter 3 and possibly for health interactions, it is not only a case of managing one’s feelings for public display purposes (as in the case of Hochschild’s flight attendants), but engaging in moral actions that would have implications for other people and oneself.

We can see an example of feeling rules at play in Fiona’s reaction to a possible visit from her friend. Fiona had depression at the time and was not keen to have to make herself presentable and entertain a friend. Yet, she knew that the rule (or moral norm) says that she ought to. She knew that she ought to manage her feelings to create an acceptable response or display. This is what Hochschild identifies as the feeling rules which go between ‘what I actually feel’ and ‘what I should feel’ (Hochschild, 1983), as not only ought Fiona have been prepared to entertain her friend, she should also have felt that she wanted to:

... maybe Jane phoning or turning up and having to be nice and having to get dressed and having to make tea ...

Fiona

Similarly, Ray follows some kind of display rules in making an excuse for his depression in terms of ‘tiredness’:

*When I say I feel tired, they understand you know, I feel a bit tired. See you get to the point with making excuses, and my excuse is I never slept a wink last night, what with the helicopter and you know the police helicopter and the kids, you make excuses for yourself, you know, which is wrong.*

Ray
Ray’s concern about this being ‘wrong’ suggests a concern about lack of authenticity, or the difference perhaps between a presentation of self and ‘backstage’. This was mirrored by Ray’s fears that people’s offers, for example to invite him for Christmas dinner, were for display purposes, to respond to a situation of Ray being depressed and alone at Christmas, but were not authentic. So Ray is theorising that the people inviting him for Christmas dinner were merely following moral norms and that was not their preferred choice of action, however an alternative explanation is that that the invitation was offered out of ‘moral concern’ rather than obligation.

Hochschild (1983) describes the way feeling rules work with the expression ‘a private mumbling to ourselves’. This was shown by Bev, who was mumbling in this case out loud in the interview, about how she should have been more attentive to a friend:

She said I bumped my head, do you think I will be all right, yes, you will be fine. And then when she came on the Thursday she said to me, Bev just look at my bruises and she showed me how badly she was bruised and it was obvious from the bruising that she had had a really, really bad fall, and I felt so bad … Because I had like pooh-poohed it … I should have been a bit more sympathetic I think and said oh dear are you ok and you know … because, she really had hurt herself, she really had and it’s not nice is it when you fall and hurt yourself like that so, I felt guilty. I really felt guilty.

Bev

The use and interpretation of feeling rules can be highly gendered, and Hochschild reminds us that men and women may have different ways of applying feeling rules. Bev provides us with another example, this time of the difference in sense of feeling rules between her and her husband:

My husband doesn’t talk about the illness and I mean there was one really bad … I told him that I could never ever forgive you and I got pneumonia and he just treated me as though I had got a common cold, and I can remember laying on that settee he went to work and everything and I was laying on that settee there and I thought I was dying, I really, I was so ill I thought I was dying and he just didn’t acknowledge … I even remember being ill one night and his brother visited and I was just cough, cough, cough and that and I had lost loads of weight and I couldn’t eat properly and I was just drinking and erm, his brother called in and his
brother said to him oh do you fancy a pint in the pub and he went aye, come on we will go to the pub and he just left me again.  
Bev

Bev felt thoroughly aggrieved that her husband had broken a fairly fundamental feeling rule. She felt the need to remind him and call him to account for not really feeling, and therefore doing, what she felt was obvious that he should have felt and done. So in this Bev is drawing on the moral norms that she believes to be powerful directives of human action (see the previous quote, also from Bev, where she shows that she herself responds to moral norms).

As Hochschild (1983) suggests, there are also feeling rule reminders which come in the form of actions from people who are reacting to the way they think another person will be feeling. This is illustrated by the example discussed above of Ray, who was feeling low and wanted to avoid Christmas, yet others around him were following the feeling rules pertinent to Christmas:

Like Christmas, our Tommy was with his girl and his kids, our Linda was working, so Christmas to me is another day … and our Tommy’s girl comes round with the dinner, and when I told the lads in the Star, you know Micky and Jonesey and them that I didn’t have a dinner, Christmas dinner, all their wives, you know next year you can come and have your dinner with us. And I don’t want to have my dinner with anyone.
Ray

Ray’s response could be seen as what Hochschild (1983) calls ‘misfitting feelings’. The example of Bev’s husband above could also be seen in this light. Hochschild refers to misfitting feelings, particularly in relation to rules about how to do ‘proper grieving’. Both Bev and Alison became involved in others’ grieving processes and one wonders if they were trying to apply moral norms or feeling rules to the situation:

Well two weeks ago my sister’s … husband died and so I have been going over to West Yorkshire to give her some support … I have been trying to help her, not that you can do a lot but just be there and you know … I went over the day he died because she was in the hospital, you know they got him into hospital and so I thought well she can’t be on her own tonight, … she was not good but not you know, I think probably because somebody else was there, she felt better about it, you know a
The gendered practices of emotion work health interactions

Of all the types of health interactions described in this thesis, it was emotion work which was most strongly gendered. Gendered differences have been identified throughout the thesis, and particularly in this chapter on emotion work. What the data seem to be indicating is evidence of gendered practices. Daniel, Joe, Edward and Pete, for example, all depicted themselves as people who do not engage in health interactions. Yet each of them had their health looked after, or managed, by their female partners. These are seen here as gendered practices, as their way of ‘doing gender’ (West and Zimmerman, 1987). However, as can be seen in the quote from Daniel below, the men and women in the thesis were not entirely free in their gendered practices, as they were operating within what Hagemann-White (1987) calls ‘gendered modes of behaviour’. That is, their gendered practices were shaped by the gender order, or structural factors which define and constrain the gendered ways that people could engage in health interactions. Daniel, for example, claimed that he was too busy with work to engage in health interactions or emotion work. He describes the gendered practices which he and his wife adopt:

*Julia:* ‘And so you say that it’s mostly your wife that you’d talk to about health?’
*Daniel:* Mmm ... it’s not a regular thing I don’t think, but you know if I’m not feeling well she’ll know about it ... Well men like a bit of ‘there, there’ don’t they, more than women do.’

In a similar vein, gendered practices were shaped by a ‘gender order’ in the examples from the data of men who almost seemed to be delegating their wives to do emotion work or health interactions. Geoffrey and Philip, both in the older age group with comfortable material circumstances, described how it was their wives who did the caring about others’ health, for example in their local communities, partly on their behalf.
Philip: Well erm, we have got my wife will do the shopping for a 95 year old … Oh well she is on the telephone regularly if she needs anything, we take her to the, my wife will take her to the doctors, the dentists, the opticians, the chiropodist, yes, yes … but on the domestic side there are certain things that ladies need doing and my wife will go and see her and do what she can in that respect … but mostly I would say my wife deals with her day to day requirements, any urgency she will ring up here, first call. And that, it is not, we don’t regard it as time consuming because she is such a lively, mentally alert person, who is very interesting. She is almost like a dowager Duchess really, she is nice … I mean to go to the surgery, you know where the surgery is, that would tax her. So, my wife either walks her or takes her down because the road itself is a vicious road, my wife, she certainly is one of these people who well she likes to help others but she has that sort of leaning towards helping people yes, yes.

Julia: And you?
Philip: If I can, if it doesn’t interfere with, yes, yes, yes.

However, men were not completely absent from emotion work. It seems that men and women do emotion work differently. Hochschild in her classic study (1983) did not only describe the emotion work done by female flight attendants, but also by male debt collectors. Both jobs demanded emotion work, but of a very different nature. In this thesis men mentioned in the interviews, more than women did, the importance both of understanding the situation of others with health problems and of showing care. Even within the same types of emotion work, men and women in the study often enacted these interactions differently, which suggests that gendered practices are fluid, not static, and that through enacting health interactions, people are making and remaking gender as they do so. This has its roots in the ‘deconstructive turn’, and particularly the work of Derrida (1967). Steve felt, for example, that between men and women there were different types of confiding:

Steve: Do you really think that … two blokes confide like two women do?
Julia: What do you think?
Steve: I think they do.
Julia: Do you?
Steve: Yes, I mean I know man and wife should be, sort of like totally, I mean don’t get me wrong, I am not on about anything deceiving but you know I think two blokes are more, more honest with each other about conversation than what a man and wife is sometimes.
There were overall differences between men and women in the volume as well as the type of health interactions engaged in. Men talked more or less in equal volumes about others’ health interactions which were directed towards them, as they talked about their own health interactions towards others. Women talked much more about the health interactions they engaged in that were directed towards others. In some cases, participants such as Bev and Fiona said that giving a performance, or presentation of self as a good listener and someone to whom people come to tell their problems, was very important. Bev and Fiona are both in the younger age group, live with a partner and are comparatively affluent. They used almost identical words:

*I used to travel to work on the bus … I always used to get somebody sat next to me and by the time I had got to the end of my journey I knew all their ailments and half their life story, you know and I used to say to my mom have I got something written on my forehead that says come and tell me your problems, but my mom was the same, and my mom used to just say to me you must have one of them faces lass. You know, come and talk to me I will listen. Or maybe I don’t know, maybe I am just a good listener you know.*

Bev

*I think it must be something about me, everybody comes and tells me their problems.*

Fiona

Identity is important here, and it is not only a moral identity which is being constructed but also a gendered identity, or a moral identity combined with a gendered identity. They both seem to aim to ensure that their gendered practices present an image of their role in emotion work for others, not only as moral and good, but also as part of what Hoschschild calls ‘being charming as a woman’ (1983). This quote from Hoschschild reminds us that behind the gendered practices are ‘gendered modes of behaviour’ (Hagemann-White, 1987), which mould and constrain the ability to engage in some gendered practices.
As well as being gendered, health interactions can also be experienced as monitoring and surveillance, as also illustrated in the previous chapter. In this chapter examples are given where the emotion work health interactions could be and were perceived as surveillance. An example of this is Mike, who is a very private person and did not tell anyone, except his wife, about his health problems. But his work colleagues found out about his diagnosis of diabetes due to his work absences for tests. They therefore became involved in what could be seen as surveillance of his condition:

I had to go to the doctor a lot, but I used to go in work time, because obviously you have to go in work time, but that was only a couple of hours, an hour, so they were aware of that, all the tests that was going on ... this that and the other and all that. And they are very, my work colleagues are very, especially my manager, are very supportive and say, "You need to do this and you need to do that and this and that ... they would enquire what the doctor said and this that and the other, whenever, and, "What are they going to do?" And they say, "Well you need to do that don't you?" And I say, "Yeah," you know.

Mike

Other people, such as Fiona, tended to be more tentative about their involvement and checking up on:

I wanted to annoy her and I wanted to go and knock the door every day and do things like that, but at the same time I didn't want to put her right off altogether, so I would do things like ... say you know I am home from work now if you fancy a cuppa or I might text her on my way home from work and say I am going to be passing your house in 15 minutes, are you at home and if she didn't answer I would just leave it.

Fiona

Fiona later felt herself ‘monitored’ when she had depression:

That worried me a lot ... about you know maybe Jane phoning or turning up and having to be nice and having to get dressed and having to make tea.

Fiona
Other ways of observing and monitoring people with health problems could be paternalistic:

One was a female partner, who you know just happened to take me under her wing I suppose, even though we are the same age group, but she decided that she would you know try and take the strain a little bit by talking to me about the issues, and allowing me to off-load a little bit. I don’t know why she did that, but she did, and it was really helpful. Richard

Trish’s friendships and the importance to her of keeping constantly updated about each other could also be seen as a type of monitoring, with frequent reports about each other:

And they ring me back, how’s your throat and I say don’t be worrying about me. So we’re all, we’re all connected at the minute because some days, I can go like a month without talking to Jan, but I get the information through Glen about Jan, is anything wrong with Jan I immediately phone her or she phones me, you know? ... It’s a constant update of info. Trish

Tension between surveillance and showing care
There is an interesting relationship between showing care, or ‘emotion work’ as described in the previous chapter, and viewing this same behaviour as ‘surveillance’. There are many examples of people ‘checking up’ on each other, often presented in terms of caring and wanting to make sure the friend or relative, often older or with a mental health problem, was not alone and neglected.

We saw earlier in this section a quote from Fiona about her friend’s surveillance (as it could be called) of her during a period of depression. However, one of the interesting things about that quote is that, despite Fiona feeling low and not wanting to see anyone, she would have felt upset if her friend had not been in touch. This suggests quite a complex relationship between showing concern and surveillance. Mike suggests a similar tension:
Julia: I was just wondering what kind of difference that made to you, that they showed that concern?

Mike: It's nice, it's nice to know that people are concerned about, about you and I think that would happen in any walk of life, you know even though I am a quiet and private person, it's still nice to know that people are concerned, show that much concern about you ... and they are worried and they would be worried about you. It's just that I wouldn't like to give them the opportunity to be worried ... It's not prying it's them showing a concern and I fully appreciate that, you know within the context. And I think it's nice for people to show concern, it's just that I particularly am not a type of person who would accept it with open arms.

That Mike refers to people ‘not prying’ is interesting, as it highlights the tensions. Mike is a very private person and does not talk about his health to anyone except his wife if necessary, so we can imagine that surveillance of his health problems could feel uncomfortable to him, it could feel like prying. However, he clearly feels that it is intended as a kindly and caring interest that his colleagues are showing.

Conclusion
This chapter has continued the process of mapping the terrain and conceptualisation of health interactions as used in this thesis. It has been illustrated with examples from the data of health interactions which include not only ‘doing’, but also interactions that involve conversations and emotional empathy and engagement. These, as have been shown, can be smaller scale or fleeting connections. This chapter has illustrated how health interactions can take the form of connections between people at the level of emotion. It can involve interactions about emotional distress as well as conversations, understanding, and more intangible but nonetheless important forms of interaction such as ‘being there’ and showing care and concern. It also contributes to a growing sense of the nature of health interactions, the multiple levels at which they impact, and that health interactions are, more than ‘donations’ of help, but two-way relational processes affecting all involved, as well as the relationships between them.

What has been illustrated in this chapter is that health interactions can operate at deeper levels of connection than may have been suggested in the
previous chapter on practical health interactions. The chapter has illustrated health interactions that operate at emotional as well as practical levels, and through this it is possible to begin to see health interactions as a way that links the inner, private, personal world, with the public (Bendelow and Williams, 1998), more shared world outside of the self. The gendered practices of health interactions and the Foucauldian type monitoring or surveillance, both of which were discussed in the previous chapter, have continued to be important in this chapter in considering the different layers of emotion work involved in health interactions. They add to a developing argument that a health interaction involves a great deal more in terms of relational and other dynamics than provision of help or support.
Chapter 7: Advice giving as health interactions

The last two chapters have illustrated how health interactions include practical, ‘doing’ type interactions and also connections between people at the level of emotion. In this chapter a third form of health interaction will be discussed which is the informal sharing of health advice between friends, family, neighbours, colleagues and other social contacts.

The chapter will illustrate how health interactions are more complex than providing assistance practically or emotionally, and that health interactions are not limited to connections which ‘help’, since they can include interactions which do not necessarily help or do not always help. This chapter will argue that the giving of health advice to others may be as much for the benefit of the advice giver as for the recipient. Nonetheless, advice giving is included in this thesis as a form of health interaction, as what is of interest here is the connection, the interaction between people and how, by using health as a conduit, people develop (or damage) their relationships with others and also their own project of the self.

Types of health advice

The chapter will begin by outlining the range of types of health advice giving. These are divided in Table 7 into less engaged and more engaged advice giving, which is because the levels of meaning and relational connection between the advice ‘giver’ and ‘recipient’ differ a lot among different levels of advice.
Table 7: Types of advice

This table presents reported accounts of types of advice giving health interactions. It illustrates about what people gave health advice in the thesis. It also shows whether the reported account is of advice given or advice received.

<table>
<thead>
<tr>
<th>Type of Advice</th>
<th>Reports of advice given to others</th>
<th>Reports of advice given to them by others</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LESS ENGAGED ADVICE GIVING:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lay diagnosis</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Lay prescribing</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Specific advice re particular operation/ procedure</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td><strong>MORE ENGAGED ADVICE GIVING:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General advice re managing an illness</td>
<td>6</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>Advice re specific health improvement actions</td>
<td>4</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Social advice (health related)</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>23</td>
<td>18</td>
<td></td>
</tr>
</tbody>
</table>

Note that these are numbers of different examples or offers mentioned, not number of people who mentioned them.

The first three rows in Table 7, which have been grouped as ‘less engaged advice giving’, are simple, practical and straightforward types of advice giving where there is no in-depth engagement with the person being given the advice. This type of advice was given more by men than women, which suggests that there may be a gendered preference for types of advice giving. It also tended to be given more by working class people and also by people with heart disease rather than mental health problems. The latter three types of advice giving in Table 7 require more engagement with the recipient of advice and, possibly because of this, they are more likely to be given by relatives or friends. This more engaged type of advice giving was both given and received more by
people with mental health problems than heart problems and was reported slightly more often by middle class people. Thus, in this sample there seems to be both a gendered and a class distinction between types of advice giving. There are also differences in advice giving or advice receiving styles between people with mental health problems and with heart disease. It is also worthwhile noting, as shown in Table 7, that there are differences between the advice that people report as giving to others and the advice they report to receive themselves from others. As has been seen elsewhere in this thesis, people are, in general, happier to report giving than receiving. This could be related to some sense of superiority and control that comes with giving advice and which is surrendered by being in receipt of advice. It is also related to the narratives of self that were presented in the interview, where people sought to give accounts of themselves as moral, kind and not needy or demanding. The most powerful example of this is the giving of what is called here social advice (see below), where people seemed happy to report that they gave others social advice, but rarely reported that they were given it, perhaps because they forgot it, or disregarded and then forgot it, or, perhaps as part of the presentation of self in the interview, did not want to admit to it.

Lay diagnosis has been used here to describe situations where people respond to others’ accounts of symptoms, by giving them their own diagnosis of what their health problem is, which will often be accompanied by advice about a proposed remedy. Lay diagnoses which were given included wheat intolerance, stroke and a prostate problem (as in the quote from Philip overleaf). Examples were only given of giving lay diagnosis, not of receiving it, which may be because it is difficult to remember what lay diagnoses others have given us, and it may be more importance for the ‘giver’ (hence they remember it) rather than the ‘recipient’, as possibly the diagnosis is often immediately ignored by the recipient. Lay diagnosis and the accompanying advice could be seen as a form of lay consultation (Freidson, 1960, 1961, 1970). However in this thesis terminology which mirrors formal medical care, such as ‘diagnosis’, is avoided, as here health interactions are not seen as a lay substitute for a doctor or nurse, but as an interaction which is important in its own right for both the potential health benefit and the relationship dynamics. In the quote below, Philip offered
a diagnosis and advice to a golfing colleague. It is clear from the questioning that the interviewer (Julia) felt that this type of interaction could result in some awkward dynamics between Philip and the fellow golfer.

*Julia:* I asked you whether with that prostate problem that you had actually given that advice to somebody?

*Philip:* Yes, I have. Well, having learnt it from the treatment I have had yes … it was playing golf and he was nipping into the woods quite often.

*Julia:* Did you raise it with him then?

*Philip:* Yes.

*Julia:* And was that awkward?

*Philip:* No, not a bit, not a bit. 'I keep missing you, what's the matter with you, oh dah di dah, do you get up during the night as well, oh yes, I think you might have something like I had, you know and if you do the best thing you can do is get yourself down [to the doctors].

In what is described as lay prescribing in Table 7, people recommended a drug or treatment such as Alka Seltzer for a bad stomach, Glucosamine for arthritic pain, glycerine for healing scars, or dietary supplements such as cod liver oil. As shown elsewhere (Gray et al., 2011), this type of advice is an important influence on people's choices of non-prescription medicines. The examples about lay prescribing are different from elsewhere in this thesis, in that people were happy to report that they have been advised by others to take a certain type of remedy, whereas they were less likely to report that they gave this type of recommendation to others, possibly because the latter would feel silly or trivial (in most other types of advice the converse is true, see below).

*She was brilliant actually, she taught me about glycerine it's wonderful, it's now become the beauty product of the age but I was expounding the virtues of glycerine, 30 well 20 years ago, it's great for scars, you know if you massage your child, anyone really, but if you massage your child with scars it heals the scars up so quickly and pressure sores, just sitting there massaging them.*

*Bridget*

People also gave specific advice about particular operations or procedures, where they had experience or knowledge of a particular type of operation and they gave advice to others about it.
I got information from another man who that already had a quadruple ... so em, it made me more positive then ... I listened to his experience, so he told me what to do and what not to do.

Jack

People also offered general advice about managing an illness or particular condition such as cancer, epilepsy, depression or diabetes. This type of advice-giving was more common among men, middle class people and relatives. The latter could be because of the closer, more engaged, longer-term nature of this type of advice. Diabetes was not one of the sampling criteria of this thesis. However, where people had diabetes it did seem to be common for others to give them advice about it. The advice was typically dietary suggestions, cooking tips, or advice about the care of the feet or eyes. Maybe the prevalence of diabetes made people feel that they had some knowledge of it, an understanding of the symptoms, if not the causes of diabetes.

I don’t give him advice ... I sort of let him know that it’s ok to be weak, in very, very subtle ways usually by you know, displaying one’s own weaknesses or ailments or whatever.

Simon

The quote above is an example of advice given about managing a health condition, as opposed to other advice which may be more general information about the condition. The advice given about specific health improvement actions is different from other advice giving, because it was targeted at a single, specific health action, such as advising someone with a hernia not to lift something heavy, or someone with depression to take an exotic holiday, or someone with a recent injury not to scratch the wound. In the sample it was women who tended to give this type of advice, whereas it was more common for men to give other types of advice. This advice on action illustrates how health interactions can be very small-scale, fleeting, almost transient, as well as larger scale ones, and that these small-scale interactions, such as for example advising someone not to lift a heavy object, can have meaning for the connection even it is a fleeting one between the two people.

I had to spend a long time in the hospital with Vincent because it’s orthopaedic surgery ... I met a Hindi woman, and her son ... and she used to have to sit and meditate ... she would make herself very, very
still to what she felt leave a presence of herself with him … and she would say well, sit like this and I will teach you to meditate and he will be very well …
Bridget

These examples of advice giving health interactions have some similarities with self-help groups, which also often offer information and advice (Avis et al., 2008; Sandaunet, 2008; Malik and Coulson, 2010). However, often people in self-help groups are strangers (or begin as strangers), whereas the health interactions discussed here are among people who know each other, so this has implications for the acceptability of the advice and also for the way advice giving affects the dynamic of the relationship between the two people.

People also gave advice which was more social than health related in nature, for example about relationship or family matters or personal advice. This quote from Ray describes his daughter’s advice to him about his personal habits and hygiene, in particular about washing and changing his clothes. The quote below illustrates both the daughter’s wish to encourage Ray to be cleaner, but also Ray’s quite strong resistance to this and the unwelcome nature of much advice, especially perhaps of a personal nature such as this. This quote also suggests that Ray may perceive his daughter as overstepping the mark in giving this kind of advice, or that it is a kind of interfering or surveillance as discussed elsewhere in this thesis, and which will be revisited at the end of this chapter. The last few words of the quote, however, also emphasise the point that Ray was trying to make by recounting this, which was a sense of regret about the way his depression led, or pushed, him towards rudeness to his own daughter.

Sometimes I can’t get a wash of a morning you know … and if Linda or Tommy said Dad you know, do you want to change this t-shirt, no. No, Dad, no … our Linda does my ironing anyway, take them off I will wash them, no you are alright. Listen just fuck off … I said that to our Linda. You know.
Ray

There were a number of examples of motivational style advice giving, where people attempted to encourage others to adopt a healthier lifestyle.
### Table 8: Motivational advice giving

<table>
<thead>
<tr>
<th></th>
<th>Relatives</th>
<th>Friends</th>
<th>Neighbours</th>
<th>Colleagues</th>
<th>Strangers</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Drinking</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Weight-loss</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Exercise</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6</strong></td>
<td><strong>6</strong></td>
<td><strong>1</strong></td>
<td><strong>1</strong></td>
<td><strong>0</strong></td>
<td><strong>9</strong></td>
</tr>
</tbody>
</table>

This type of advice giving was more common in closer relationships such as relatives and friends, but it was not common from neighbours, colleagues or strangers.

...they are always telling us to pack up smoking to be honest with you and I know I should pack up smoking um, you know what type of risk it is at the moment um, and I haven’t yet. But they are always telling me, “That’s one of the first things, you want to get shot of those cigarettes.” … I know they’re right so you can’t say a lot about it … You just tell them, “It is hard to pack up smoking,” you know … I just say to them to be honest, “I’ll pack them when I am ready to pack in,” and that’s it, if you know what I mean, and say, “I will, I will pack it in,” but it doesn’t pressurise me or anything.

Pete

In some cases people talked of this type of advice giving being counterproductive, which has also been highlighted in the literature and suggests that advice can be perceived as monitoring or meddling (Lamm et al., 2008; Rooyen et al., 2011) or involving criticism, blame or attempts at guilt-creation (Crossley, 2003; Reid et al., 2010; Williams, 2005). These responses to an advice giving health interaction may see it as control or unwelcome involvement (Lavender et al., 2005; Reid et al., 2010) and interpreted in the light of Foucauldian theories of monitoring, control and surveillance, which have been discussed in earlier chapters and are explored in relation to advice towards the end of this chapter.
... the family, Phil and the boys, and other people particularly Phil and the boys, I think probably it goes the other way round you know, they get this, they say it so often that you just think oh no, I can't stop smoking I am smoking you know, whether you want me to or not I can't do it you know, so I didn't take a lot of notice of them ... whatever they said I would think of a reason why I shouldn't stop and I wouldn't stop you know ... It didn't make me stop for years.

Alison

A different form of advice presented a challenge to the advice from the formal health system. Many people treated the advice of their doctors and the formal health system as sacrosanct, however there were also a smaller number of examples where people gave each other advice which challenged or deviated from that of the formal health service. This is an interesting form of advice, as it places lay opinion and knowledge in opposition to medical knowledge. This lay-professional interface and the tension created were the basis of much of the earlier medical sociology literature. Most commonly this type of advice involved seeking a second opinion where there was a concern, either by the advice recipient or the advice giver, that the doctor was wrong.

... the doctor said oh yes take these pills you will be alright in a couple of weeks anyway, by Christmas day obviously he wasn't and I said look you know, you can't pussy foot about there is something not right ... I said look get another opinion there is something not right, and eventually he did get another opinion, and the doctor was wrong ... I could see from not having seen him for 3 weeks that there was a change in him and the pills they were giving him, they were co-codamol type painkillers but they weren't, weren't the answer.

Philip

Bridget had taken on a role where she recommended specific doctors whom she felt were good at listening, to other mothers who had children with cerebral palsy. Similar to this was advice to ask the GP for certain treatment, for example Steve, who recommended his friend ask his GP for anti-depressants. However, as can be seen in this quote, this was tempered with respect for the doctor’s authority and knowledge.

I said you are just really depressed and I said you have just got to, you know if doctor won't give you the anti-depressants I said you will just have to try and work your way through it the best way you can ... I said go to the doctors and I said see if they will give you some sort of mild
anti-depressants and erm, and he went twice and they said no, they said you will work your way through it and I said to John, I said if you can it is better because I said you don't really want to take the bloody things if you can help it.

Steve

In a similar way to self-help groups, advice giving health interactions functioned as an informal system of peer education and the advice was offered as an opportunity for people to develop their health knowledge. People (more often women) often played a role in passing on information to friends or relatives who they felt could benefit from it, for example Fiona who gave her friend leaflets about bringing up children with an alcoholic parent, or Trish’s friend who printed out information on leukaemia to help her understand another friend’s illness, and Bev who also researched information on leukaemia for a friend:

An acquaintance … approached me and told me that her mother had leukaemia, and so she said you know I am really worried about her … So, I, what I did was … I came home and looked up the leukaemia society for her and rang her, and gave her the phone number and the address. Now, I did that because I cared enough to do that for her so that if she wanted to contact them she could … but I did that because I cared about her worrying about her mother and thought well this might help to alleviate some of her worries.

Bev

When people were asked to explain the source of the advice they gave, it was often the case that they themselves had been given the same advice by somebody else. It tended to be men more than women who described this. So a Chinese Whispers type system seems to be in operation, where information is passed from one person to another. It is not clear whether, as in Chinese Whispers, deviations and embellishments of the advice took place en route. The notion of Chinese Whispers of health advice depicts links of connectedness or network between people, most of whom will never have met each other but who become connected through the passing on of advice.

If somebody tells somebody for something, do this, by the time it gets to the next one, they will have added something to it, and by the time it gets to me, you know what I mean, what do they say the old wives tale type of thing, by the time it gets to me it’s ... like a bloody encyclopaedia, with the do and the don’ts.

Patrick
The discussion above has outlined different types of advice giving and has shown that the concept of health interactions is not limited to ‘helping’ type activities either practical or emotional, but can also include a wide range of advice giving which can be fleeting or transient connections between people, as well as more involved forms of advice giving, both of which it is argued can have meaning for people.

**The relational dynamics of advice giving health interactions**

This section acts as a bridge to the next chapter and will analyse the relational issues involved in giving advice, receiving advice and adopting advice (or not) and through this the argument will be made that, as a form of interaction, advice giving contains the type of dynamics that would be expected in an interaction, as opposed to a one-way ‘donation’ of information.

In most cases the people who described giving health advice tended not to be the same as those who described being the recipients of health advice. In common with themes throughout this thesis, where people preferred to present themselves as net givers rather than net receivers, there were slightly more accounts of giving health advice than of receiving it. Here it is possible to see the ways people build a moral identity (discussed later in the chapter) and presentation of self as powerful and superior (by definition being able to give advice puts one in a superior position).

As with other types of health interactions discussed before, advice giving is highly gendered, although in a slightly different way here from that described in previous chapters. Men and women gave and received more or less equal amounts of health advice. It is interesting that men played a large role in the giving and receiving, but particularly the giving of health advice in comparison to their smaller role in health interactions generally. This suggests that there are different kinds of gendered practices going on for health interactions which involve advice giving. West and Zimmerman (1987) have suggested that through engaging in everyday conduct, and advice giving could be an example,
people are held ‘accountable’ either as a man or as a woman. This could be seen as underpinning the gendered patterns, both of health interactions generally, and particularly of advice giving. Also, following from the ideas of Derrida (1967), all identities can be seen as unstable, so the gendered identities built around health interactions can be fluid and men can, for example, engage in certain types of health interactions but not others, or not others at certain times.

This thesis is based on a small, non-random sample, so it cannot make claims to be representative in a statistical way, but the advantage of the approach taken is that it allows an in-depth exploration of the workings of health interactions and it means that it is possible to identify patterns. For example, both the giving and the receiving of health advice were more common among the younger than the older age group. The giving and the receiving of health advice was fairly equal across the two types of health conditions in the sample, people with mental health and heart problems. Advice was both given and received more by people who lived alone than by those who lived with others. Could this be to do with being more connected generally? Could it be that people who live alone are more self-reliant, more independent and so do not engage in getting involved in other people’s health problems?

The table below indicates the range of advice giving people engaged in.
Table 9: Who engages in health advice?

This table uses the same categories of types of advice as Table 7, but now information is presented on between whom these types of advice are shared.

<table>
<thead>
<tr>
<th></th>
<th>Relatives</th>
<th>Friends</th>
<th>Neighbours</th>
<th>Colleagues</th>
<th>Strangers</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LESS ENGAGED</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADVICE GIVING:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lay diagnosis</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Lay prescribing</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Specific advice</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td><strong>14</strong></td>
<td><strong>11</strong></td>
<td><strong>4</strong></td>
<td><strong>4</strong></td>
<td><strong>4</strong></td>
<td><strong>46</strong></td>
</tr>
<tr>
<td><strong>MORE ENGAGED</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADVICE GIVING:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General advice re managing an illness</td>
<td>7</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td><strong>13</strong></td>
</tr>
<tr>
<td>Advice re specific health improvement actions</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td><strong>8</strong></td>
</tr>
<tr>
<td>Social advice (health related)</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td><strong>7</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14</strong></td>
<td><strong>11</strong></td>
<td><strong>4</strong></td>
<td><strong>4</strong></td>
<td><strong>4</strong></td>
<td><strong>46</strong></td>
</tr>
</tbody>
</table>

**Note:**

1. These are numbers of different examples or offers mentioned, not numbers of people who mentioned them.

2. The numbers in Tables 7, 8 & 9 do not correspond, as it was not possible to attribute all the health advice giving, as not all reports of advice were given with information about from or to whom they were offered.
We can see from Table 9 that friends and particularly relatives played a large role in advice giving. Neighbours, colleagues and strangers seemed to give much less advice. It is interesting to note the low level of advice giving from neighbours, especially since, as described in Chapter 5, neighbours were very dominant in the giving of practical support. This could perhaps be explained by the fact that some advice giving is quite personal, and requires knowing the person and their circumstances quite well. Crow et al. (1994) suggest that it is important for neighbours not to be either a ‘busybody or a nobody’. In Chapter 5 it was suggested that through their practical support neighbours did at times appear as ‘busybodies’. However, advice giving seems to be different. It appears that, if neighbours were to give advice, they may be acting too much as busybodies to maintain the delicate balance that Crow et al. describe is the work of contemporary neighbouring, because they would go beyond not only practical or physical boundaries but personal boundaries as well. The low level of advice giving from colleagues can be explained by the few people in work in the sample. The number of strangers, although low compared to others, is relatively quite high, as there are not many examples of health interactions with strangers throughout the entire thesis. Strangers usually get involved when sharing the same experience, e.g. in hospital or sharing a treatment or the same operation. It is interesting to consider why strangers may take it upon themselves to give advice to people they don’t know. The reasons may be similar to those explored for health interactions throughout this thesis, that is, a need to build or present a moral identity, or to appear to be knowledgeable (which links with power and status), or a genuine desire to help.

There were a number of people who said, often adamantly, that they did not give health advice and did not want to. This is illustrated in the quote from Margaret below. Margaret’s account suggests a lack of confidence, as she explains her concern that she feels that she is not knowledgeable enough to give advice to others about their health. She is ‘wary’ that she might give wrong advice, with potentially serious consequences. Yet here Margaret illustrates for us the complexity of health interactions, because not everybody reacted like her. Many of the study participants were active, even zealous, about giving advice to others (see for example Philip), despite usually not being expert in the subject they were advising on. Technically Margaret may have been more
'expert' than many, as she was one of the few study participants who did have a clinical training. She was trained as a nurse, although she dismissed this on the grounds that she had not been practicing as a nurse for some time. Still, this might have given others confidence in informal health advice giving. For example Bev, who also had a nursing training, loved to give advice both to people she knew and to those that she did not. Whether or not they had a clinical background, for many people in the study giving health advice was an important part of how they constructed and presented a moral identity. Yet in the quote below from Margaret we see no indication from her of a need to build a moral identity, or to use support advice giving to others as part of her presentation of self. It was also suggested above that strangers may engage in health advice giving as part of moral identity building. These strangers appear not to be concerned, in the way that Margaret was, about the risk of giving the wrong advice. A possible interpretation could be that Margaret's concerns may be relational, a product of the fact that she knows the potential advice-recipient, and she will be around in their life in the event of any negative consequences of the advice. Strangers were not in that position.

However, there is also a different type of concern expressed by Margaret in the quote below. She says that she feels that she has not lived or experienced enough to be in the position to give advice. This could be interpreted as a sense of lack of entitlement to give advice. This follows on from the discussion above about neighbours who also do not tend to give advice. It was suggested that this may have to do with not wanting to act as a busybody or get overly involved in the lives of neighbours. In the same way, Margaret expressed strongly her disinclination to become involved in other people's lives, or their health. She led a self-contained and somewhat isolated life, shared few of the experiences of her own health problems with others, and did not engage with others' health problems. Where she says, in the quote below, that she does not want the responsibility of giving health advice to others, she is presenting a perspective that is very different from many of the study participants, who seemingly were prepared to take that responsibility, as it brought with it for them an element of power and control that is an intrinsic part of advice giving.
I always think if I try to give somebody advice am I telling them what I would do, which might not be the right thing. I do think about it, I wouldn’t like somebody to give me the wrong advice. So I am a little bit wary … I am very wary about giving advice, because I don’t think I have lived, I have not experienced a hell of a lot you know to be in a position to give advice … I would be frightened of being wrong and upsetting making things worse … think I would be more worried about the effect on them if it was the wrong advice I had given them ... I don’t want the responsibility.

Margaret

What makes health advice accepted or not? People described a range of processes through which they evaluated whether or not to accept health advice. In a small number of cases, advice was accepted fairly unquestionably because there was a powerful need for advice. Barry for example, who had some cognitive impairment as a result of a stroke, described how he welcomed advice when he did not understand something himself. Ray described being really quite desperate to rid himself of his depression and being prepared to accept any advice in case it might help.

_The Jehovah’s Witnesses they have got a place up there, I don’t mind them coming in because I will take anyone who can help me. If some lunatic come out of [name of mental health secure unit] tomorrow like this and I have got this tablet and you will be better, I will take it._

Ray

However, this was rare. In general people did not need or seek advice, it was something that was offered (or thrust) upon them and they had to decide whether or not to heed it. This makes health interactions distinct from self-help groups, where people participating are likely to be actively seeking or open to advice, as they also might do in a non-interactive way such as using the internet.

People made their own decisions about which advice to accept and which to ignore. Pete in the quote below described a system he had, in order to decide whether or not to take advice. His decision depended on the type of condition. He viewed health problems as in opposition between those that required expert medical knowledge and those that did not. He described colds or flu as examples of ‘basic illnesses’ for which the medical expertise of a doctor is not
required and so lay advice can be taken. In contrast, he also identified another category of illness which did require the medical expertise of a doctor, and therefore for these health issues lay advice was not acceptable and would be rejected if offered.

*I think the only advice you take and stuff like that is if someone is recommending something, is for, what you call it, a basic illness or colds or flu or something like that, not for anything, I mean you wouldn't take nothing for blood pressure or anything like that, because basically you go to the doctors and get the tablets.*

Pete

There was considerable importance placed on the context in which the health advice is given. It seemed very important to people that, if they were to accept advice, it should be tailored to their own circumstances. Advice that was general or applied to other people was not good enough. It had to match with the context of their own lives. An example of this is given elsewhere of Pete, who argued that people’s advice to avoid cooking with fat for his diabetes was useless, as he did not use frying as a cooking method.

In a related point, it was important for some people, as suggested by Bridget in the quote below, that if advice was to be accepted, it should correspond not only with their own circumstances, but also with their own belief systems, priorities or perspective on health. Bridget appears to be expressing regret over occasions where she accepted advice that did not correspond with her own belief systems:

Julia: ‘So how do you decide which bits of advice to take and which not to?’
Bridget: ‘I don’t know, do you know, I have tried working that out, I don’t know. I don’t know if it’s whether I find it socially acceptable in my little head, if it ticks the boxes or what, because sometimes I have done things and I don’t know how I have been talked into doing them.’

A slightly different reason why advice may be rejected related to concerns that lay advisers may inaccurately conflate two distinct conditions, judging the two different health problems as the same, and so erroneously give advice that worked for one, but not for the other. This is an argument made by Alison in the quote below. Her worry is that taking lay advice that was given because it had...
worked for others could be dangerous, as people’s medical conditions or personal circumstances may not be identical.

I think people can do that, they can say oh I know somebody who has had that but it might be completely different to what you have had, or what you know about and I think it can be a little bit dangerous, because you might think oh, you know, I will do that … I just listen to her and say yes and no you know … unless I know it’s something that will work you know.
Alison

A number of the themes discussed above about the adoption of advice are pulled together in the quote below from Edward. He reinforces the argument from Alison, that advice can be dangerous as it needs to be personalised to the condition of each individual. Health advice that was good for one person will not necessarily be good for another. Edward’s argument also echoes Pete’s views in the previous quote, which depicts a hierarchy of knowledge and a hierarchy of advice givers. Whereas Pete was prepared to take lay advice for ‘basic illnesses’, but only a doctor’s advice for potentially serious conditions, Edward placed the medical profession at the top of his hierarchy of knowledge and was not prepared to accept any advice from others. Bridget’s views in the quote above are also reflected in Edward’s argument, that he himself knows what is good for him and that others’ advice is not helpful as it is not attuned to his own personal health beliefs and self knowledge. Gender issues are reflected in the different ways that Edward and Bridget express this point, but the point is similar. They both refer to a hierarchy of lay knowledge, this time placing themselves at the top of the hierarchy, with greater knowledge than people within their social networks who might advise them.

I think if people started giving me advice, I wouldn’t really take too much notice of it … I would think well, hang on a minute, it might have worked for you but I would rather go to the doc and see what they think and give me some … But without being selfish again or a bit clever or cocky I would think that my experience has taught me what is good for me and what isn’t and people rarely come up with anything that’s, that I take to, or that I haven’t come across previously.
Edward
Some people engaged in a process of checking out advice that they were given. This involved looking things up in a dictionary, encyclopaedia or on Google. It could also involve thinking about how the advice given fits with their own pre-existing knowledge and rejecting it if it did not.

... you know your gum tissue is the same as your heart? ... She told me and I checked it out, it’s true. If you get an abscess in your gums and you leave it, it could travel down to your heart, because it’s got a direct path, it’s the same tissue ... I checked the tissue, the tissue type is the same ... I checked it in an encyclopaedia ... Yes, it is the same. So I went in and said, Yvonne, she said why would you doubt me.

Bridget

Related to Bridget’s comment, people also made evaluations of the advice based on the extent to which they trusted the source. Some people described themselves as naturally trusting and others as naturally critical and unlikely to believe what they hear. For some, trust in the advice was based on the expertise of the advice giver. This could be general expertise or knowledge of the issue or condition (as in the quote below), or direct personal experience of that condition.

My other friend Karen ... her hair is always perfect and she gave me loads of advice and support on my teeth ... she gets all this sort of fancy dentistry done, because she is very into how she looks, ... she does all these very high standard of excellence things, and she will happily talk to you about them because she works so hard at them.

Bridget

Some people were adamant, whether or not they considered the advice to be valid, that they were not going to take it, considering it to be undue interference and control, which is the Foucauldian perspective discussed at the end of this chapter. Those people who were more concerned about the validity of advice and less inclined to take advice generally tended to be the most independent and self-reliant people in the sample. Often they did not want to engage generally with other people’s lives – they did not want to give advice and they did not want to receive it. They also tended to be the same people who did not engage in other types of health interactions and tended to operate in a self contained way.
People often took health advice from others with grace, even though they did not necessarily want to accept it. This was explained as ‘they are trying their best’ or ‘good intentions’. However, cases where health advice is not accepted are important, as they challenge the power and control that is asserted through the giving of health advice.

Having discussed how not all advice is accepted, we will now move on to consider that even less is acted upon. First we will explore what are the characteristics of people whose advice is more likely to be heeded.

Closeness and relational proximity were the most important influences on whose advice people would accept and whose they would ignore. In some cases this meant relatives, as Edward who would only take advice from his wife, or Fiona who felt that she had a right to give advice to her sister. Trish, however, tended to get quite irritated by advice from her mother, describing it as ‘stupidity’. Advice from close friends was also taken seriously. For Fiona, it was not only the closeness of the friend, but also the trust and intimacy that comes with a shared history:

*When I was going through all that stress thing, and there were some days like that I needed a kick up the backside too to do things … She would give me that, and I would take it from her … if you didn’t really know Jane and if you didn’t like her a lot, you probably wouldn’t take that and you wouldn’t like it … But because we have been through so much together and you know there is all that history … It’s only because of the history that we allow for each other I think.*

Fiona

A few people said explicitly that they would place more value on advice from an older person. For Bridget, wisdom comes with age. For Pete, the type of advice often described as ‘old wives tales’, passed through generations, somehow has greater validity:

*A lot of the older advice that comes from older people is quite good … The stuff that maybe has been passed down through the generations and some of them do work … a lot of the older stuff or the older remedies some work, you know, so it’s always worth taking advice off an older person … a lot of them do work.*

Pete
Simon’s perspective was slightly different. He mentioned his high level of intelligence several times. For him, it was important that anyone whose advice he might take was clever generally, with a wisdom and knowledge of the topic which was greater than his own.

I wished I had been born thick. Because that is what it comes down to. What is the point of going to somebody whose opinion you wouldn’t respect or who didn’t know as much as you do, and this might be very, very pompous and self opinionated, and all the rest but I am clever, my sister is clever, our family are quite bright, my wife is incredibly clever. I tend to find people in the community who are clever, and not only clever but lucid and can you know, and that carries a price. You know most people you go to talk to are going to be not in the position where they have wisdom to offer you.

Simon

There seemed to be some confidence in taking advice from people who had background knowledge or professional experience. Bev, who had a nursing background, felt that people were seeking her advice because of that. Edward argued that one of the reasons he took his wife’s and only his wife’s advice, was that she had a nursing background. But others, such as Fiona, dismissed this as a reason. Again, this could have more to do with presentation of self than anything else. Daniel’s ‘scientific background’ seemed to give him some sense of authority and because of it he felt he had the right to give advice:

I always help people out, if I see somebody who is ill you know, I’ll, I’ll offer advice or whatever to them but because I’m from a science background myself you see, so I know a fair bit about the body and how the body reacts to things.

Daniel

People who had or had had the same condition or experienced the same circumstances were highly valued as sources of advice.

If somebody said now that their mother or father is starting with Alzheimer’s, then we would say then that Yvette’s mother had, and this is what we went through and what to be aware of, and that kind of thing, that is passing on again your little bit of knowledge about how it affected you …

Terry
Some people took advice only from others whom they felt comfortable with or on the same wavelength. Bridget felt that anyone whose advice she was to take should share her own perspective on illness.

*I don’t speak to any neighbours about any problems like that … we haven’t been here that long, I don’t feel I know anybody close enough to put that upon them … I would think I would have to be on their wavelength and you know, know that I had got a bit of sympathy from them … I don’t know how they would react and they might think oh she is weird, talking about her health.*

Alison

Trust was also important in deciding whether to accept advice, as discussed earlier in the chapter. Margaret, who is strongly opposed to engaging in health interactions, raised the issue of trust by saying that she would take her son’s advice, as he held a reputable position in his working life and also she was absolutely sure that she could trust it:

*I think, if somebody like, if my son advises me on something I listen to him, because I mean for all he is only young he is, he holds a good position so he, and he is, he knows what he, he is like me he wouldn’t give advice unless he was sure.*

Margaret

But do people always have a choice? Sociologically this may have to do with the different contexts of people’s lives, and may also depend on how much the advice is needed. The example of Ray and the Jehovah’s Witnesses, quoted in the previous section, is relevant. Ray described himself as in a state of desperation. He is an unusual case of someone who actually wants some health advice and is prepared to accept it from anyone, as he says, even a madman. This raises issues about advice as luxury or a superfluous communication technique, not really needed but which does do a lot of other work, mainly for the advice giver (and for Ray). This will be explored in following sections.

The chapter will now move on to ask what it is, sociologically, that goes on when people give health advice and what is accomplished.
I think this is a thing that is within everyone, to offer that advice … Every single person does it. You know, it's just a natural thing to do I think, you know what I mean. Even if someone was fixing a car, they're doing something, somebody will come along and offer advice how to do it, you know what I mean? Somebody will be standing there, "Oh you don't do it this way, you do it that way," or "Why don't you try this?" I think that's what it is about it, I think it's one of those things, why don't you try this and no matter what situation, whether it's someone with an illness, something wrong with maybe with the house or the car, anything, I think it's, "Why don't you try this?" situation. That's what it is.

Pete

This observation from Pete implies a compulsion to give health advice, as if it is impossible not to give health advice. Why should this be? Some possible explanations are explored below.

The first is gender. Gendered patterns of advice-giving have been identified throughout this chapter, which are understood here as gendered practices or ‘doing gender’. West and Zimmerman (1987) have suggested that this involves being held ‘accountable’, either as a woman or a man, and that this leads to gendered modes of behaviour, which shape the room people have to construct their gendered identities.

The second possible explanation for advice giving is that people were presenting moral narratives or wished to build a moral identity through advice giving. Sometimes advice was received gratefully and used and valued, for example the advice about pain-relief and muscle relaxation given to Bridget by another mother of a child with cerebral palsy. However, although packaged as a kindly act to help the other person, it is argued here that advice giving can also be as much for the givers themselves as part of their moral identity building. People’s narratives were often loaded with examples of their advice giving activities, with the implication that they had helped and had done a good thing, so were able to build and present a strong moral identity.

An alternative way of viewing people’s advice giving interactions is as a Foucauldian type of control and surveillance. Several examples in this chapter have suggested that advice giving could be a form of surveillance and governmentality (Foucault, 1979, 1997; Rose, 1989; Rose et al., 2006).
Through observing, monitoring and ‘checking up on’ as described in earlier chapters, but most importantly through advice giving, people were exerting a (lay) clinical gaze on others’ state of health, which was imbued with judgement on what health promoting behaviour was normal and what was not. Through giving health advice, people were exerting power and control and often assumed a kind of quasi-expert discourse. Through encouraging and motivating others to healthier lifestyles, they were anticipating docile bodies, willing to be ‘trained.’

For Foucault (1979), knowledge and power are closely entwined. In this sense, as the advice giver assumes a superior knowledge, it is also a manifestation of power. People may be controlling and monitoring others through advice giving. In this chapter a number of examples of advice giving have been shown which, when reviewed through the lens of surveillance, seem less benevolent. For instance Philip (quoted earlier), who took it upon himself to take one of his fellow golfers aside on the golf course, and point out his concern that the man seemed to be urinating frequently. This could be interpreted as surveillance and control.

Advice givers are using what could be called ‘quasi expert discourses’. They are assuming a superior knowledge. This could be compared to the ‘expert discourses’ used by medical professionals to their patients. Both are overlaid with a power dynamic. Both imply control and management of the other. We can see this, for example, in the advice given to Pete about what he should eat for his diabetes:

… they were all telling me, “You’ve got to look after your feet,” and this, that or the other, and, “I know someone that’s lost a leg through it.” Um, you always get advice on a dietary advice off people you know … “You want to try this and you want to try that,” and, “Don’t be frying stuff and if you’re cooking sausages or anything like that, cook them on the George Foreman grill rather than the frying pan,” and stuff, you know.

Pete

Monitoring and surveillance, and stronger forms of Foucauldian disciplinary power, were most common when people were engaging in what was viewed as classic ‘unhealthy’ behaviours such as drinking or smoking:
… there was one who was regularly over stepping the mark round here … he does it surreptitiously, we all know him and he is coming to this do in a week’s time and we’ll, I shall be watching him … I shall try to steer him away from the booze, but you can’t be watching him all the time … I can’t look after his health, he could go straight home, he is only 2 or 3 doors up here, and get stuck into it again so I mean there is nothing, I can’t control his own actions.

Philip

There is a tension in what Philip is saying. On one hand, this is one of the strongest, most explicit statements of surveillance in the thesis. But on the other hand, underlying Philip’s statement, particularly the last half, is a kind of ‘neoliberal’ sense of individual freedom and responsibility, which may be the antithesis of the surveillance activities described in this section.

Diane described being on the other side of this. It was her fear of being the object of surveillance which she felt contributed to her unwillingness to tell anybody about her health problems:

… if just say, I’m out, and just say to my son … if he knows [about her high blood pressure] and like I had whisky and water or something he would be like you know, should you be drinking that you know … I am saying that would happen … if they knew … cause I don’t like to be told what to do, you know, I mean, the blood pressure is there, but it’s a problem I’m dealing with, you know, I don’t need to be reminded of it, you know, every time, I don’t want it to be taking over my life.

Diane

Steve described how his weight was under surveillance from a friend in the pub:

I went into the pub one night, one Friday night and she said bloody hell how much bigger are you going to get like, … and I thought, yes I think she is bloody right … I said I am going to try and lose a bit of weight … she said why don’t you go to Slimming World, I go. She said it’s on a Wednesday night at the village hall … so I went down on the Wednesday went in through the bloody door, Jen never even turned up so I felt a right plonker … and I thought Christ almighty I know half of these teletubbies, so I signed on.

Steve

In their surveillance, people are exercising what Foucault would refer to as normalising judgement (1979). They are making a judgement of what is normal and what is ‘deviant’, or in the case of this thesis perhaps between what is
healthy and what is unhealthy. So in the quote above from Steve, his friend in the pub was exercising a judgement on what weight Steve should be, either because it was normal, or because it was healthy. Another example is from Mary, who felt the need to ‘normalise’ the behaviour of a stranger sitting in the GPs’ waiting room:

I went up to give blood last Monday and I turned around like that, it was in the waiting room and … my eyes nearly fell out my head, she had a dress on this old lady and none of the buttons was fastened, but she didn't have any clothes on … underneath … So I went up to her and I said, “Excuse me,” not in front of everyone, very discrete, I sat down by her, I said, “Do you know that none of your buttons are fastened on your dress?” She said, “Oh I know, but I don’t bother,” she said, “I leave them like that.” So I said, “No but you can’t leave them like that,” I said, “You’ve got young lads sitting there.” “They can't see nothing, they can't,” I said, “Yes they can.” … So I said, “Do you want me to fasten your buttons for you?” She said, “No I can do it myself.”

Mary

In a possibly similar way, Bridget took the role of mobilising and monitoring her family members after her father died. This was motivated by Bridget’s normalising judgement on what is ‘normal’ and ‘healthy’ grieving:

We kept each other busy. My challenge was to get [my mother] out of the house. I would challenge Anneka … and keep my sisters and brothers, I am the oldest of 7, so keep them connected, one of them got away Colin but he was always going to get away anyway … But the other ones are in, one of them is still very depressed, no two of them, but the younger ones were easy, they were easy, I plied them out.

Bridget

Part of Foucault’s vision is that modernity is defined by surveillance which encourages self-disciplined and ‘docile bodies’ (Foucault, 1975). We can see in this thesis a number of ways by which people tried to ‘train’ or ‘discipline’ their own bodies. But they also did this for and with others. An example of the latter is Bridget’s colleague who tried to encourage Bridget, who was suffering from depression, to go to spinning classes at the gym:

She goes to a gym, and she does this thing called spinning. And she is trying to persuade me to go spinning, I don’t know anything about it, but you know, she is trying to persuade me to do that because it’s so good for cardiovascular workout and stuff like that. And I might try that.

Bridget
In the quote below, we can see Fiona and her friend trying to train their ‘docile bodies’. Indeed it seems that Fiona is the motivating force behind this walking and gym activity, by observing that not only she (Fiona) was putting weight on, but her friend also was. Fiona also ends with the assertion that they needed ‘a kick in the right direction’, which does sound like disciplining their docile bodies:

So that really helped both of us, we used to go out walking a lot, we would meet three times a week and we would walk round the local park at home, that was 3.5 miles, so that is what we would do … We would do that three times a week and we would do it also on a Sunday morning, unless it was very, very wet and we wouldn’t do that. And, unfortunately we both like to eat … We both go for a really good walk and then we would go and have breakfast somewhere you know … the local leisure centre were advertising this get fit programme … you went along and they advised you about your diet, like we needed anybody to do that, but we did need a kick in the right direction.
Fiona

The next quote, from Diane, shows how surveillance can operate. Diane had been talking to a relative stranger, who had observed her cough and decided to admonish her about it.

I’d never had smokers cough or anything like that … and I had this cough and then this lady lives over the other side of the estate, but I was talking to her and I coughed and she said em, she said to me you’ve got to rear that child and it must have been something that just stuck in my mind about it you know, because she had ..., she had a little boy at forty-five, she had like a family then she had and ..., her mother said that to her, you’ve got him to raise, so you better give up them cigarettes, so she said that to me. I must have had the cough and she said that and I don’t know, I didn’t give them up there and then, but it must have been just something that played on my mind.
Diane

... every single time he used to light up I used to say to him, you will die of lung cancer, every single time he used to light up I used to say that to him, and he used to say, c’est la vie Bev, c’est la vie. And I was right.
Bev
Conclusion

This chapter has contributed further to the conceptualisation and mapping of the notion of health interactions as used in this thesis. It has illustrated with examples how health interactions include not only ‘doing’ (as in Chapter 5), or emotion work (as in Chapter 6), but also interactions that do not necessarily involve ‘helping’ at all. The examples of advice giving in this chapter have shown that health interactions are not always for the benefit of the ‘recipient’ and can be as much for the ‘giver’. This has been discussed in the light of the theme, developing through the thesis, of a Foucauldian type monitoring or surveillance. Gendered practices of health interactions have continued to be important in this chapter, and a larger role for men has been illustrated in advice giving, than in the practical and emotion-work health interactions discussed in previous chapters.

Health interactions have been shown in this chapter to be more complex than ‘helping’ either practically or emotionally, and this theme will be developed further in the next chapter, which explores the relational dynamics that are in operation within a health interaction.
Chapter 8: Analysing the relational dynamics of health interactions

The previous chapters have mapped the range of types of practical, emotional and advice giving health interactions in which people engage. The intention in this chapter is to analyse the ways that health interactions affect, not only health (as described in previous chapters), but the relationships between people. The chapter will argue that entwined in the enactment of health interactions are relational practices which are a part of the way we develop our relationships with others and the way we experience our social world.

The chapter begins by exploring the dynamics involved in the disclosure of a health condition, illustrating how interactions about health are imbued with relational complexity. The chapter will then move on to explore who it is that people engage in health interactions, in particular when and if people involve family or non-family in their health interactions, this is explored using ideas of the suffusion of the concepts of family and friend (Spencer and Pahl, 2006). This will then be developed by looking at the example of health interactions with strangers, which offer an opportunity to understand both the fleeting nature of some health interactions and the often momentary, but still important, connections that accompany them. The roles of gender, class and habitus will then be explored to show that health interactions are not entirely agentic and that in a range of ways structural circumstances can affect whether people engage in health interactions and how. This will take us on to consideration of the cases, referred to in previous chapters, of the nine people in the study who preferred to avoid health interactions, choosing rather to be self-reliant. Related to this is the opposition to the notion of reciprocity, which will be discussed next, to develop the points made above in relation to self-reliance, and the importance of not being indebted to anyone, and that people preferred to present themselves as net givers, rather than net takers. The chapter will end by returning to the main theme which is the impact of health interactions on connections between people.
**Telling: the relational complexity of disclosing a health concern**

It may be assumed that to tell others about one’s illness or health condition is a relatively straightforward, practical, almost administrative task. We can picture people confiding in friends about a recent diagnosis or imagine a colleague explaining the medical causes of her time off work. This sounds relatively simple, but this thesis argues that the ‘telling’ of personal health information is actually far from simple. This thesis proposes that it is an interaction which can be laden with power dynamics, competing priorities, obligations and attempts to strengthen or distance relationships with others. Thus the health concern seems to become secondary to the relational dynamics that it is embedded in.

How and why do people decide to tell or not to tell somebody else about their health? What influences that decision? What is taken into account? What are the circumstances, illnesses or types of people that encourage or discourage telling? What is it that people hope to achieve by telling somebody about their medical diagnosis or health condition?

In attempting to answer these questions, this thesis draws upon examples from a range of people who were interviewed, some of whom were keen to disclose information about a health problem, and a larger group who were not keen, as well as those for whom it seems that disclosure was thrust upon them.

Alongside the data from study participants, I also draw upon my own recent experiences of managing the ‘telling’ of personal health information after my diagnosis of breast cancer during the course of writing this thesis.

*Disclosure as a currency of closeness*

These ideas of disclosure will be framed around the concept of currency. The participants’ accounts indicate that the telling (or not) of health information is used as a form of currency to ‘buy’ closeness to or distance from others. Disclosure can be used as a ‘gift’ to reward or strengthen a friendship. Simon gives us his reflections on this:
Well I think in perhaps medical conversations there is a little intimacy, a little bit of almost sexiness about it … Because it is within your barrier isn't it. You know, in most of the public health and those sorts of matters are in your little private zone, I think to offer conversation is to invite somebody to be perhaps closer than talking about the weather.

Simon

Conversely, non-disclosure can be used or interpreted as a mechanism of social distancing. An example of this is Philip and his neighbour's wife. Philip engages heavily in health interactions. His neighbour's wife (Catherine) does not. Here Philip is describing a sense of being distanced by her refusal to share health information about her husband (John), who is in hospital:

…The frustration was just voiced between my wife and myself … just the fact that we didn't know that John was poorly, we didn't know what was happening to him, and he had a relapse, we didn't know he had a relapse, … it was one of these private things that Catherine kept … it would have just been rather nice to have known exactly how he was getting on and whether there was anything he wanted … It was dealt with in that closed way, that is the personality of her… Purely from a friendship point of view really, not wanting to push our way in. Yes.

Philip

There does also appear to be a 'trade' in health disclosure. If someone tells you about their health problem or diagnosis, you may feel compelled to repay by telling them about yours (or a similar non-health disclosure). If their disclosure was serious and yours trivial, you are

A similar example from my own experience is my friend Kim. I have known Kim since my school days, she is part of a group of about eight school friends with whom I stay in touch. When I was diagnosed with cancer, I did not tell Kim or the other school friends immediately. When I finally did tell Kim, she was very upset; not only at me having cancer, but that I had not told her. She even described being initially very cross. She clearly took my lack of early disclosure as an insult to our friendship. It was as if I was denying her a closeness. She then recovered her composure and later arranged to meet me, which involved her in a four hour drive (a bit like Trish, one of the study participants who drove hundreds of miles to see her friend recently diagnosed with leukaemia). Kim now rings, texts or e-mails me on a regular basis to check if I’m OK, maybe to prevent the same happening again. Recently, when I replied to one of her e-mails, I failed to respond explicitly to her question about whether I was alright. So she then replied with another message: ‘but are you OK?’
still in disclosure ‘debt’. If you are aware that someone has withheld information from you, then you may feel within your right to feel cheated, or you may decide to decline to tell them something about yourself. This is one of the ways we establish, maintain and deepen friendships, and it links with the ideas of Roseneil and Budgeon (2004), who argue that there is an ‘ethical practice’ within friendship which creates a sense of obligation. This thesis argues that health disclosure and health interactions more generally are mechanisms between people that develop and strengthen friendships. They provide a way through which we control which friendships become deeper and which become superficial or fizzle out.

Thus, by having an illness or diagnosis, ironically perhaps, one has a relational commodity. It has some purchasing power. This is suggested by Terry, who is disinclined to tell people about any health problems, not only because it would burden them, but also because this would give the other person some kind of power over him which he does not want to permit.

I can’t see the point in burdening other people with a problem that you can deal with in the family. And I also think that sometime in the future, those people for whatever reason may not be your friends in the future, but they have got something like a hold, not a hold but you know they have got something on you that you don’t want the rest of the world to know.

Terry
Deciding to tell
Deciding to disclose information about a health condition or diagnosis is not a straightforward matter. Rather than being dealt with lightly, people weave a lot of considerations into this decision, which often have more to do with the friendship than the illness.

People may tell others about their health problems because of an implicit awareness of a ‘currency’, ‘trade’ or ‘commodity’ of health disclosure as discussed above. However, while this may always be an undercurrent, there may also be more instrumental reasons for disclosure, such as to get either emotional or practical support.

Occasionally people disclose health information because they want to ask for advice. Where this happens it is typically with a friend who has particular expertise – who shares the same condition or has a clinical background. There are a number of examples of this in Chapter 7.

Having to tell
Often the decision to tell is not actively made. The illness may become obvious and disclosure becomes inescapable. Sometimes it is visibly or audibly noticeable, as in the cases of both Mike and Terry who were observed limping and hobbling, Mary who kept falling over, Edward who was seen to be no longer driving, and the sound of Trish’s throat, which meant that there was ‘no need to tell’.
They can hear it as soon as I talk, what's the matter, as soon as I, what's the matter? Nothing, what's wrong, something wrong, I've got a sore throat.

Trish

When I found out I was having our Nicola I came out the doctor's and thought what am I going to do, how am I going to tell everyone, you know, and that was something I had to tell people because it wasn't something I could hide.

Diane

Lorraine, who had told practically no one about her painful arthritis, described the bad skin condition that her neighbour had and how, if that had been her, she would have mentioned it explicitly when she met people:

Julia: … if you had a bad skin outbreak, you would say that, but you wouldn't say it about the arthritis?
Lorraine: No, because … you can't see it, can you?

Absence was another way in which an illness became obvious to others. This could be absence from work (and needing to tell colleagues or the line manager). Or it could be absence from social or leisure activities, such as Philip who was alerted by a friend’s nonappearance on the golf course, or from commitments such as Diane’s babysitting for her grandchildren:

Well if I was seriously wrong ..., people would have to know, wouldn't they? ... If it was serious enough like, to stop helping them all, you know, helping out with schools and problems and things like that, I probably would because I think I would tell them if I had to … But it would be a case like I've got no choice.

Diane
It was similar circumstances of absence, this time from the workplace, that compelled Mike to tell his colleagues about his health problems. Being very private about his health, he did not discuss any health problems either with his co-resident adult sons, or with his friends Ronnie and Tommy. However, as he describes here, he was forced to tell colleagues, even if he would not tell his friends or sons.

… see in work it’s different because they know I’ve been to the doctor because … I’ve had to have time off … To go to there and when I come back they say “What did they say?” and everything … whereas Ronnie and Tommy they wouldn’t know I’ve been to the doctor’s or anything … so I certainly wouldn’t be raising it.

Mike

Another circumstance in which people were not really in control of the disclosure of their health problems was when having to respond to questioning from others. This created a situation where they had to either lie or tell (or give limited information only, as Daniel did). Sometimes this came up through everyday interactions such as being asked ‘how are you?’, or bumping into people in or on the way to the doctor’s surgery. As illustrated in the three quotes below, in some cases this everyday type of health questioning seemed to be welcomed, since it provided an opening, a trigger or a permission to disclose. This view was expressed by Edward in the first quote below. He seems to accept this as a ‘natural’ conversational technique that provides the opportunity to talk about his health. Edward also hints, unlike Alison in the second quote, that he would be prepared to respond to ‘how are you’ with health information of a negative nature, such as ‘I am not as good as I have been’. However, as Alison suggests in the second quote, this is unusual, as for many people ‘how are you’ is taken to be nothing more than a ritual greeting and not generally interpreted as an opportunity to respond with full accounts of your health. Alison suggests that people are still in control of whether or not they disclose, as they can, and she implies they normally do, decide to say nothing more than ‘fine’. This sense of control of disclosure is echoed by Patrick in the third quote. Patrick was keen to talk to others about his health and says he feels better when he does so. But he will not tell people about his health problems straight away. He waits to be asked. This suggests another
layer of complexity, which is that, as well as control of disclosure, there may also be caution. Patrick is using a delay in disclosure to protect himself, his information or his relationships.

I suppose it’s a natural thing in a way because thinking about it, if I saw you in the street or anywhere, your first snippet of conversation is how are you … that’s a natural thing to say and that sparks the conversation doesn’t it, how am I, oh I am not as good as I have been, or better than I have been and all this sort of stuff.

Edward

I mean, I suppose really when you think about it, if you are going out or you meet somebody and they say how are you, and you say I am fine, whether you are or not, if you say I am not very well they don’t want to know really, they say oh good so you know, I think that happens quite a lot. Because people don’t want to get into conversation about you being ill do they? They want you to say I am fine thank you, how are you and that’s it.

Alison

… what’s the old saying, or the, a trouble shared is a trouble halved or something like that. I feel better when I talk to anyone … I won’t, I won’t tell them right away, but if they ask about it I talk about it.

Patrick

Not telling

The complexities of disclosure become more evident when we consider the people who do not tell others, or prefer to keep silent (Charmaz, 2002) about their health condition or diagnosis.

Non-disclosure can be used as an important, but hidden, way to assert power or position oneself in relationships. In the same way as disclosure can be used to strengthen and deepen relationships or as a reward, non-disclosure can be used for social distancing or some kind of punishment. Not telling something significant can undoubtedly have a negative effect on the friendship and it may require a great deal of ‘repair work’ if the damage is to be healed.
She [Christine – a ‘sister-like’ cousin] would never tell you anything, you know she's just and like in fact she had a lump in her breast, this is like quite a few years ago you know and she just went on her own ... and, you know, when she was talking about it, I said, why didn't you tell me, I'd have come with you, you know and she said because I didn't even know what I was going for myself, you know ... I just thought it was funny, I mean, I just, she must have known, you know what I mean? But she just made a joke of it.

Diane

Mike: If it were up to me I wouldn't tell anyone anything ... In fact they got a cob on when I went in to have my operation because I didn't tell them ... I just got up the next morning and left here as if I was going to work and all, because I expected to be out that day, because they said if you go down early enough you'd be out the same day ... my wife came and talked to me, I had to phone up and say to her, "I'm not going to come home, they won't let me home." So she came in and she said, "Why didn't you tell the lads because they didn't know anything?" I said, "I just didn't want to, didn't want to worry them."

Julia: Is it to do with worrying them?

Mike: That could be one thing yeah, but it's just me I just keep things to myself ...

However, whilst these facts may be analysed in terms of currency, people did not usually describe their non-disclosure in such ways. The reasons they gave can be seen as rooted in concerns about identity (an argument made by Scott and Lyman, 1968), stigma and presentation of self. Charmaz (2002) has described the potential for damage to one’s sense of moral standing or self in this context. Independence and self-reliance were very important for many people and have been important themes throughout this thesis. Health problems had the potential to threaten people’s identity and sense of self and replace it with an illness identity, which was unwelcome and often felt to be stigmatising. It was, in many cases, in order to prevent this that people tried to avoid telling others about their health problems. This was sometimes taken to the extreme. Mike, for example, did not tell his adult sons (who lived with him) that he was going into hospital.

I don’t really need, that’s terrible isn’t it, I don’t really need to discuss it. I make my own mind up what I am going to do and I get on with it ... I was diagnosed with breast cancer ... and I didn’t tell anyone, I didn’t even tell my mother, my sister, I didn’t tell anybody and I sort of went through the preliminary things bluffing my way with the family.

Margaret
My mother and I are a bit like oil and water ... so I didn’t tell her ... She didn’t need to know that I couldn’t cope because I am the lynch pinch, in my mind in my family I am the lynch pin and you know people just couldn’t know that I couldn’t, I wasn’t strong enough to help them, and I just knew that that time would pass and I would be able, I would be the same person again. And I would be able to help them.

Fiona

I guess I don’t necessarily want people to know that I am suffering from stress, I see it as a sign of weakness.

Richard

It has been described above how both ‘currency’ and identity are central to the decision not to tell others about a health problem. However, those were not the reasons people typically gave for non-disclosure. People most commonly tended to describe their reasons for not telling about a health problem as a response to the anticipated reaction of others. This could be based on the imagined needs of the recipient such as not wanting to worry them or thinking of their needs. However, this may be a presentation of self in itself, masking other reasons for non-disclosure, of the type described above.

When she [the friend] did know [about Margaret’s cancer] she cried more than I did. Which it’s a lovely, I know she worries about me, so I am more inclined not to tell her anything if you, does that make sense ... Because I don’t want her worried. I don’t want her fussing over me, I don’t like fuss. I don’t like fuss at all ...

Margaret

Other concerns about the anticipated reaction of others involved trying to protect oneself from an unwanted response from others, fear of an unwanted system (e.g. of support) that may kick in upon disclosure, or realisation that there will be extra work created in managing the responses of others to one’s illness.

I help out and ... they might not ask me to do things for them ... I particularly help me daughter in the school holidays. Her little girl ... I look after her on a Thursday and a Friday ... so she would be like, oh, are you alright to do it, she would be like that, you know, are you sure you can do it ... but deep down I think it's just vanity, really. I'm just making excuses.

Diane
... I didn’t tell any of my family that had happened to me, no ... if my mother knew that I was off work, she would be, every day she would be saying what are we doing today, you know. Shall we go and visit the garden centre, shall we go here, shall we go there, and my mother would have had all of my time mapped out every day, you know.

Fiona

The central argument that has been made in this section is that ‘telling’ is an act that is used as a form of currency. The act of telling (or not) another person about an illness or diagnosis is laden with complex relational dynamics and can affect the relationship between people, it can strengthen it or weaken it and examples of both have been shown here.

**Health interactions with whom? Reflections on health interaction practices with families and friends**

For many people, family members are the first point of call at times of crisis or health problems. This was indeed the case for several of the participants in this study. However, a closer look at who people involve in their health problems muddies the waters somewhat. Although for some participants family members were the first people they approached, it is not a clear-cut and simple rule that family come first in matters of health.

An examination of whom we choose to talk to about our health problems can illuminate some of the complexities surrounding not only how we manage our health, but also who we consider to be ‘close’ to. The definition of ‘family’, while seemingly obvious, is actually contestable. Weston (1997) and Weeks et al (2001) use the term ‘families of choice’ to suggest that, rather than being biologically pre-determined, we can choose who we treat as ‘family’, regardless of whether or not they are biologically or legally related. However, as Bottero (2004) has pointed out, because of homophily, the extent to which we are really ‘close’ to others is limited. Still, to some extent the concept of kin is one of self-definition, that is, kin is who you define as kin (Carsten, 2004). So, ‘elective affinities’ (Beck-Gernsheim, 1999) are being established which include mixtures
of blood relatives and people who are unrelated by blood but who feel, or act, ‘like family’.

Thus, it is no longer possible to make a stark division between family and friends. Spencer and Pahl (2006) suggest that a blending or ‘suffusion’ of the concepts of ‘family’ and ‘friend’ is emerging. Their study identified different patterns of both kin and non-kin in what they prefer to call ‘personal communities’. Spencer and Pahl identified ‘friend like’ and ‘family like’ patterns of friendship. Each included both family members and friends.

In this thesis a similar pattern emerged. It was not blood relationships per se which dictated who was involved in matters of health, but other characteristics of the relationship and the practices which were engaged in. They could be family members, or they could be friends, or even neighbours or colleagues. What mattered for many people was not the formal definition of the relationship, but the shape it took. As will be seen in the quotations below, it was the closeness between people that led to engagement with health interactions, and which could also consolidate closeness. Some may have equated that as ‘family like’ (Spencer and Pahl, 2006), but this was not always the case.

Of the 25 participants in the study, five conducted their health interactions mostly with family members, ten with people who were not family – mostly friends, and a further ten with both families and friends. What we can see from this is that people clearly did not conduct their health interactions solely with family members. Friends (and other non-family) played an important part and were often the chosen partner for health matters.

The thesis revealed a lot of what Spencer and Pahl (2006) would call ‘family like’ health activity among non-kin. Examples of this include Bev, whose friend was the first person to be told about her diagnosis of MS; Patrick’s neighbours, who regularly ‘checked up’ on him when he was ill; Mary, who engaged in personal care for her neighbour such as putting stockings on; Bev, who was asked to be present at the death bed of her friend’s ex-husband; and Trish, who rushed to see her friend who had had a cancer diagnosis. It was common for people to explicitly describe some non-kin as ‘family like’ or vice versa:
Janet is my best friend, she is like a sister to me ... I have a sister who lives next door but one ... we have never been close, we are not sisters as such if you know what I mean.
Margaret

... my cousin lives along the road, our Christine, ... years ago amongst the slums and things we all lived together so she's like a sister to me and ..., I'll talk to her about it.
Diane

I will go so far as to say I am closer to Jane [friend] than I am to any of my other [sisters], I have got four sisters and I am certainly closer to Jane than I am to any of my sisters ... we have been through so much, our lives have been so similar ... Jane often says to me you know 'we don't know how we [would have] managed without you ... That is just what you would do for any of your family isn't it, that's not that unusual I don't think. I think families do things like that, support each other.
Fiona

These descriptions reveal the fluidity with which people define and redefine their family and siblings. In the last quote from Fiona, at the end she slips into referring to her friend Jane as family, not merely 'like family'. There were many examples of people taking it upon themselves to push the formal boundaries of 'family' and reclassify individuals. What was most interesting was when this came from people who had been, at other points in the interview, adamant that they only engaged in health interactions with immediate family. Daniel (below) is an example. He was among the most emphatic and explicit study participants in terms of his strong preference to limit his health interactions to within the family – in fact primarily to his wife.

I tend to talk more with my wife than with my extended family.
Daniel

However, later in the interview he made two statements which challenge the notion of family as his closest point, and show us how blurred and loose the concept of family was for him and how other factors, other than blood, influence the willingness to engage in health interactions.
… I wouldn't discuss with people outside of the family … because I've known them all for so long, I mean, even to a point I think where I would discuss more with my ex-family than I would with my wife's family now … Even though I've known them for a long, long time … 'cos my, my present wife I knew when we were sixteen and seventeen and we split up and didn't meet each other again for thirty years … so as I say I knew their family from a long time ago, in fact before I knew my ex-wife's family, but because I knew them [the ex-wife's family] for so long, I think there's certain things I would talk to them about that I wouldn't with my present family, just because I've known them longer.

Daniel

Daniel (who had stressed early in the interview that he felt that people talking about their health could feel like a burden), had a friend from his school days who now lives in Switzerland. They are occasionally in touch on the phone and sometimes these conversations will move to health or personal problems.

Julia: ‘And so when he phoned up about the problem with his legs, did that feel like a burden to you?
Daniel: No, because, once again, it's a close, within, it's what I would call within the family.
Julia: But he's not actually.
Daniel: He's not actually, no, he's not actually a part of my family as such, but he's a part of the family … He's not actually a relation.

An interesting distinction that Daniel makes here is between ‘family’ and ‘relation’. It suggests that he is using ‘family’ to refer to a feeling of closeness and ‘relation’ to refer to formal blood or legal ties.

There were also challenges to the conceptualisation of the family as ‘permanent’. The commonsense understanding of family members is that they are permanent fixtures, as opposed to friends, who have the potential to be more temporary, and can phase in and out of our lives in a way that family members cannot, however we may feel about them. But this notion was challenged by Trish, who felt that it was her friends who were the permanent fixture in her life:

Julia: ... and what do you think it does all that talking you know, what's the benefit of it?
Trish: Um, it just keeps us all informed about each other, keeps us all in the picture with each other's lives and up to date basis, so to speak. And although these two haven't met, when they do meet they'll feel like they
have and they’ll just swing right into it … Just keeping harmony flowing I suppose to the friendship. ‘Cos it’s important. These are going to be in the rest of my life so they’ve all got to know each other.
Julia: Why do you say it’s important?
Trish: ‘Cos they’re gonna be part of my life till I die they’ve all got to keep in the loop.

What is being described here by many is not necessarily a preference for health interactions with either family or friends. It is the characteristics that those people and relationships have, and the practices that are engaged in, that matter. For Daniel and Terry it was length of knowing that mattered more than whether somebody was a blood tie or not, for Diane and Fiona it was shared experience, for Jack and Lorraine it was physical proximity or the frequency and regularity of meeting, for a number of people (Ray, Jessie, Terry, Lorraine) it was familiarity and being understood that mattered, for Fiona and Terry it was the feeling of closeness – as Terry put it, we ‘just happen to be related’. People made judgements about their desire to interact about health, based on a number of characteristics which mirrored the characteristics that one might attribute to an idealised notion of ‘family’. These included trust, being long-standing, understanding, and having an in-depth knowledge of the person or their context, circumstances or condition.

It is now necessary to turn to what is seen here as a huge tension in the story that has been unfolding here. On one hand, people were basing their health interactions on individual characteristics, practices and histories of the relationship, not blood ties. However, on the other hand what was evident was a sense in which responsibility and obligation are seen to lie with the family.

Family responsibility

Strong and unequivocal views were expressed that it was the responsibility of the family to deal with the ill health of a family member. This was the case even where relationships were not close, such as the case of Trish and her mother described above. Trish still felt that she had an obligation to be involved in her mother’s health: ‘I have to, she’s my mother’.
Some people depicted a kind of hierarchy, where the responsibility fell to the most immediate family, not adult siblings or more distant relatives. Daniel for example described how, when his brother had a nervous breakdown, Daniel felt he did not really need to do anything, as his brother had a wife and daughter upon whom the responsibility fell.

It was particularly at times of a medical crisis or dire need that it was most clear that family members should take responsibility. Lorraine, for example, who never talked to her family about her health, and found it easier to tell people outside the family about her health problems, admitted that, if she had a crisis, it would be her immediate family that she would expect to play a role. Likewise, Margaret, one of the most self-reliant people in the study, had to admit that if she were in dire need it would be to her daughter that she would turn.

The clear expectations of the role of close relatives at times of illness or medical emergency meant that friends or other non-kin tended to step back or defer in order to allow the relatives to play their role. So, an example described earlier was when Jack had a heart attack, the neighbours rang Jack’s son and helped him find the hospital. This is despite the fact that Jack’s son had really been very minimally involved in Jack’s life or health problems, and was not there in the way Jack’s neighbours were to give daily support and monitoring or emergency support at the time of the heart attack. Similarly, both Terry and Philip described a kind of ‘holding back’ of support, while checking whether there was a competent relative who could provide support:

… her husband is just early 70s so he is able to cope with the driving and she has a daughter in the village who was a trained nurse … so she has got family who are competent medically to advise and make sure the right things are done.

Philip

There seemed to be some sense of pride when family members had fulfilled their health care responsibility. Edward for example seemed proud of the speed with which his sons reacted to his stroke:

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… you know they were all into hospital straight away to see how I was and what was going on. So yes, they are quite concerned about me ...

Edward

Conversely, people hinted at shame or disappointment when family members were inaccessible or otherwise unable to play their role. Mary excused her family as being busy with their jobs, and Geoffrey explained that both his sons lived abroad.

Sometimes the relative did not play the role they were seen to be obliged to play. Where this happened, observers were frustrated with them for not meeting their responsibilities. Alison, for example, was highly critical of her neighbour’s son, who she felt took insufficient care of his mother with the effect that it fell to the neighbours to take care of her:

… she [the neighbour] had one son who I don’t, I won’t say she didn’t get on with but they never saw each other very often at all, and once when he was a manager at a garage and we went over with our car to have something done with the car and I said to him, how is your mum, and he said oh she is fine, she is fine. And she wasn’t at all, but I don’t think he realised, I don’t think he thought as much about it you know … And, she [the neighbour] used to say to Angela [another neighbour] will you go up into my loft and get my suitcase down because I can’t and she wanted it to pack to go abroad. And I said to Angela you shouldn’t be doing that, she has a son who is, he was about 50 years old, I said he should be coming every week to see her now because anyone can see she is not well you know. But she didn’t particularly like her son … But she [Angela] was getting to the stage where she said, I can’t do it anymore, she is relying on me for everything when her son and his wife should be really taking some responsibility for her.

Alison

What seems to be happening is that there is a tension between theory and practice. In theory people felt that health and illness are clearly areas of family responsibility. But in practice they made day to day decisions about whom to interact about health with, based not on rules of family obligation, but on characteristics such as the feeling of closeness and shared experience. A similar thing has been argued by Gillis (1997), who uses the phrases ‘families we live by’ to describe the shared family ideals and ideologies, and ‘families we live with’ to describe the real life and often problematic family relationships that people have.
The power of strangers

It may be natural to imagine that the health interactions that have been examined in this thesis are conducted mainly between people who know each other well – partners, relatives, close friends. And that is most often the case. Yet there was evidence suggesting that health interactions also take place between people who do not know each other well at all – acquaintances, friends of friends, strangers. This is backed up by the work of David Morgan on acquaintances (Morgan, 2009, 2007; Hiscock, 2007). Why does this happen? What does it mean, if anything, for the connection between those two people? What does it tell us about connectedness?

An example from Diane (mentioned before in connection to surveillance) will be used to illustrate this. Diane had described previously in the interview her unsuccessful attempts to give up smoking, and the equally unsuccessful encouragement to do so she had received from family and friends.

I had this cough and then this lady lives over the other side of the estate, but I was talking to her and I coughed and she said, she said to me you've got to rear that child. And it must have been something that just stuck in my mind about it you know, because she had, she had a little boy at forty-five, she had like a family then she had and ... her mother said that to her, you've got him to raise, so you better give up them cigarettes, so she said that to me; I must have had the cough and she said that and I don't know, I didn't give them up there and then, but it must have been just something that played on my mind.

Diane

This conversation with the woman who lives on the other side of the estate played a role in Diane giving up smoking. In this passage we can also see the importance of shared experience, possibly a sense of some kind of sisterhood. But the particular point to pick up on here from Diane’s quote is the power that strangers, or acquaintances (Morgan, 2009), can have.

It was the interaction with that woman that made Diane give up smoking, not her friends or family. What makes strangers so powerful? It may be that it is easier for strangers to be bolder. Diane would not have expected a woman with whom she was having a casual conversation to plunge to the point and offer
such very pertinent advice, in fact more than advice it was almost a command. The very fact that strangers do not know us may give their words some power. We may wonder why they should care about us, why they should get involved. Because strangers have no history with us, no future relationship with us, they do not need to invest in helping us, which in turn does not have to be reciprocated by us helping them. In fact, unlike family and friends, strangers bring no baggage or agenda (at least that we know of). Possibly another important reason why strangers bring with them such power is that they are different. They bring different experiences, different ways of seeing and different ideas and knowledge. Here a link can be made with Granovetter’s (1973) theory of the strength of weak ties, which argues that it is the people on the outer reaches of our social networks that can be of most use to us. Granovetter based this on his study of job search, but it could be applied to health interactions, with the people we know less well, acquaintances for example, being more useful for health information or advice than those we know well.

On the other hand, the old adage that familiarity breeds contempt may have some truth. Neither Diane nor Alison took any notice of the efforts by their family members to encourage them to stop smoking. It can also be the case that it may be more difficult for friends, and maybe family too, to be honest and forthright where there could be fears of damaging the relationship.

Of particular interest about the power of these interactions with strangers is that it is counterintuitive. One would expect that the greater the closeness of the relationship, the greater the impact that person has. And that may well be the case on occasions. But clearly there are exceptions. If we could elevate ourselves above the social world, and take a bird’s eye view of social connections, we would expect to see what we could call ‘clusters of closeness’, similar to Spencer and Pahl’s ‘personal communities’ – people grouped into connected units with the people who are closest to them – families, partners, friends’ groups. But maybe we would also see other patterns of connection in operation - important connections with people who are not close. Connections based on fleeting interactions, a shared moment or experience or a comment. Each of these could be trivial, but they could also be very powerful, even life
changing. So, it is important to stress, as argued by Morgan (2009), that it is not only the people close to us, the people in the inner rings of our concentric circles that can have a profound influence on us, but also people more distant from us, even strangers.

There is also a gender dimension here. All of the people who talked about having been strongly influenced by the advice of strangers were women. They were all working class and they all lived in Liverpool. Some of them were the same people who were very self-reliant about their health (see below) and this may fit with the point made above that strangers bring no interpersonal baggage. The strangers were also all women. This could be interpreted as gendered practices of Liverpool working-class women, with their way of doing things or ‘doing gender’ (West and Zimmerman, 1987) being specific to them and influenced by their structural position and circumstances. These ‘gendered modes of behaviour’ (Hagemann-White, 1987) did not allow these women to take health advice from those close to them, but instead from strangers or acquaintances.

*But it took somebody, a stranger to say that to me, you know. Although I thought I was actually preventing things, and intervening and helping, I wasn’t really doing any of that.*

Fiona

**Not wanting to interact about health: the ‘self-reliant nine’**

This thesis is based on the notion that people interact with each other over matters of health. Health interactions were discussed in the preceding pages as if they are commonly accepted as desirable. Yet in nine of the 25 people interviewed there was no desire to engage with others about their health, in fact some of them were doggedly self-reliant. These nine people became analytically significant for the study and, borrowing principles from ‘analytic induction’ (Denzin, 1989), were important as contradictory or ‘negative’ cases which challenged the early ideas of the thesis.
The people who presented themselves as self-reliant reacted in ways that were not expected when the thesis was conceived. They challenged the researcher’s preconceptions and as such provided an important analytic device, in the way that analytical induction explores negative cases. So it makes sense to explore here how far this can be seen as a confirmation of the individualization thesis, or of other social forces, and also how it relates to the ideas of ‘currency’ which were discussed at the beginning of this chapter. The aim here is to understand what are the overarching dynamics and forces influencing the actions of people like the ‘self-reliant’ interviewees, and how this advantages or disadvantages them in their daily lives.

The individualization thesis

A determination to deal with one’s health problems on one’s own could be seen as an individualized response. The individualization thesis may therefore provide us with a place to start to see what we can learn about relational dynamics from the people who were doggedly self-reliant about their health. The individualization thesis presents connectedness in the social world as in decline (Giddens, 1991; Beck, 1992), with people becoming more isolated and atomised. Beck (1992) in particular views people becoming more and more individual units, disconnected from bonds with other people. So, this would be one way to understand the nine people in the thesis who did not want to engage with others about their health, at all.

The participants who have been categorised as ‘self-reliant’ described their lives in terms of what seemed to be the epitome of the society envisaged by the individualization thesis. Daniel, for example, talked about ‘keeping it within’, of a preference for a classic atomised way of life: ‘I don’t really want to be bothered too much with other people … I’d rather stick to myself’, and of his pride at not being given advice:

A lot of people know I’m a pretty sensible person, so they know that I would more than likely think of what they’re going to suggest to me, before they’ve suggested it.

Daniel
Lorraine depicted an atomised model of single isolated units, each one dealing with their own problems: ‘They’ve got their own problems, don’t want to be listening to mine.’ Differently from Daniel (above) and Margaret (see quote overleaf), Lorraine may be suggesting not that self-reliance is her choice of lifestyle, but that she is self-reliant because she has to be: ‘… half the time people don’t want to listen anyway do they? … I don’t think people want to know.’

Geoffrey reflected on this, and whilst presenting what he described as a ‘natural reluctance to impose upon people’, he also felt that maybe something was missing about this way of life:

Maybe we are a bit too independent … Maybe everybody is a bit too, maybe people could be a bit more dependent on each other.
Geoffrey

Margaret is a good illustration of someone who is self-reliant and self-sufficient about her health. In keeping with her determined self-sufficiency, Margaret really preferred to have little or no interactions about health, either for herself from other people or herself giving or listening to other people. So, it was not that she was a person that likes to give and not receive, it was more that she actually would rather get on with looking after her own health and other people get on with looking after theirs. A possible interpretation could be that this is Margaret’s reaction to her previous experiences of family members (particularly her ex-husband) failing to provide her with support. However, a sociological perspective on this could be to view Margaret’s position as part of a larger social trend of one-person households and self-reliance, which has been equated with the individualization thesis. Margaret also expressed another dimension of the individualization thesis, that of being the author of her own life, the creator of her destiny. At 73, Margaret has developed a newly found ‘life project’, taking A levels. For her, life is about coping and achieving. She directly challenged both the connectedness thesis (Smart, 2005) and the researcher’s own ontological position, by asserting that life is not about connections. Margaret felt that connections with others can be unhelpful.
I mean I could more or less say when I had the cancer I was on my own, because I didn’t have support from him at all … but that feeling of ..., horrible feeling of being on your own but you are not. I knew that he [husband, now ex] was there, I knew my kids were there and they were coming to see me and that, but I think I wanted more of a reaction from him, and it wasn’t there … When I moved in this flat, I made my mind up, and I have done it. And I am not going anywhere yet, I have still got things to do. Don’t know what they are yet, but … I am on the internet … I am doing things that I never thought I would do, but I am doing it. So that’s the only thing I can explain, that is why I won’t, I don’t want to involve other people in me … Let’s put it, it’s selfish I don’t want to get involved I am too set on what I am doing now.
Margaret

Gender, class and habitus

People’s self-reliance over their health could be taken as a confirmation of the individualization thesis. Now this thesis will take that one step further and argue instead that these people’s self-contained responses have more to do with class and gender, and especially with habitus (Bourdieu, 1977), than they do with the individualization thesis.

Although the actions of the ‘self-reliant nine’ seemed individualized, even atomised, this thesis will argue that this was actually borne out of necessity, as implied in the quote from Margaret, above. The ‘self-reliant’ nine had low expectations of the support that they could hope to receive from others. There were depictions of life as a struggle that one had to cope with alone.

Of the nine people who depicted themselves as self-reliant, five were women – Lorraine, Diane, Jessie, Mary and Margaret. These women described a kind of fatalistic acceptance of pain and ill health as part of their lives and fortitude in dealing with them:

If I’ve got a pain it’s got to be really painful for me to take something … if you can’t do anything about it, why worry over it.
Diane

Similarly:
If there is something wrong then you just get and fight through it. I am not a person that ‘oh I am ill’ and ‘oh I am not very well’ … you just have to go through it.

Jessie

And:

It’s like everything else, you have to struggle on … I just think ‘well that’s my problem’ … That’s my problem, you’ve just got to grin and bear it. If it’s arthritis, it’s not really anything you can do about it, is there … no good moaning, no one will take no notice, will they?

Lorraine

The four men (Daniel, Mike, Joe and Pete) were different from the women in the way they presented their self-reliance. Their descriptions of the importance of being self-reliant were more muted, presented as a preference, not a necessity - ‘that’s just me’ (Mike) and tended to be associated with their male identity.

Whereas the women were either single (Jessie, Mary and Margaret) or received little or no support from their husbands (Lorraine and Diane), all four of the men had wives and talked very explicitly about their wives being their main source of support.

The point to make here is that the women were self-reliant, because they felt compelled to be so, in order to cope in what they saw as a tough and challenging world. Where self-reliance may be an identity-related luxury for the men, it was seen as a necessity by these women.

All nine of the people identified as self-reliant were living in circumstances of structural disadvantage compared to more affluent members of the sample. So, can this lead us to consider whether self-reliance is somehow related to class or structural disadvantage? Why the more affluent people in the study did not feel the need to be self-reliant in the same way?

In a way this is counterintuitive. One may think that it would be easier to be self-reliant with more financial and other forms of resources to draw upon. Yet it is from the poorer people within the sample that the ‘self-reliant nine’ come.
The people who we may think would not be self-reliant, precisely as they have fewer resources to draw upon for their self-reliance.

It is possible that some of the gendered self-reliance described above, illustrated in the quotes from Diane, Jessie and Lorraine, may have a lot to do with class as well as with gender. Self-reliance as a response to having to cope in a tough world is likely to be experienced more by people with material constraints.

It is also possible that, by responding to challenges such as ill health in a self-contained way rather than asking for help, people may be perpetuating health and structural disadvantage. Likewise, those more materially advantaged people who also fill their world with additional resources in the form of connections of support, such as Philip described overleaf, in doing so may be perpetuating their advantage.

This suggests a type of habitus (Bourdieu, 1977). In the cyclical nature of habitus, people are constrained by their structural position and material conditions, which influence their practices, in this case the way they do or do not engage in health interactions (their agency) and how, and this in turn influences, or maintains, their structural position. Bourdieu uses the concept of habitus to explain why people engage in the type of practices they do, and why some people’s practices are different from others’, and how this is both a result of and replicates their structural position. The concept of habitus is also valuable in this thesis, as it is important to stop readers from mistakenly interpreting this thesis as having an undue focus on agency and a neglect of the structural circumstances within which people operate.

The self-reliance of the individuals discussed here could be analysed as a product of their structural position (as women and/or working class) creating low expectations of what they can expect from others (and maybe also of what they deserve), in terms of support for health (or any other) problems. This has been referred to as ‘necessity made into a virtue’ (Swartz, 1997) and in turn informs their agency, by bounding or adjusting to it within the possible. A contrasting example which has been referred to in previous chapters is that of Philip, who
lives in a ‘self-help cul-de-sac’ and is from a middle class community. This demonstrates what Bourdieu refers to as ‘symbolic power’ (Bourdieu, 1977), including the assumption that support will be provided for community members who need it by others, and that giving this support will be appreciated.

It would be very wrong to give the impression that this thesis is going to develop a theory of working class avoidance of health interactions and middle class engagement and generosity in health interactions. As seen in previous chapters, there were examples of very many health interaction practices from among the less wealthy participants. But the point that is being made here is that habitus may be used to identify important ways in which practices of interacting about health are different between richer and poorer communities. This is, according to habitus, the internalised master disposition, or what Bourdieu has referred to as the ‘cultural unconscious’ or ‘habit forming force’ (Schwartz, 1997) that leads to certain types of practices as opposed to others (for example, at periods of others’ hospitalisation, some people provide health interactions through housework, whereas others provide lifts).

Seven out of the ‘self-reliant nine’ were from Liverpool. There may be a Liverpool specific habitus relating to lifestyles and practices from the particular deprived neighbourhood of Liverpool from where the sample was drawn.

‘Currency’ exchange
The gendered and classed self-reliance which is described above is reflected in an unwillingness or disinterest in engaging in health interactions, or in what has been referred to at the beginning of this chapter as currency exchange. Where people engage in health interactions, this becomes some kind of exchange, the health interaction becomes some kind of currency. This could be reflected on in the light of Homan’s (1958) ideas of social exchange theory, which see all social interactions as exchanges. People who prefer to keep themselves self-contained are refusing to engage in any exchange of this ‘health interaction currency’. An example from Geoffrey may help to show what is meant here by currency exchange:
... you don’t feel as if you ought to ask, you ought to build up if you like a store of goodwill that you can call upon people if you are sort of in dire need or great need.

Geoffrey

The self-reliant people do not wish to engage in this currency exchange. Their refusal to do so can be seen as a refusal to become ‘indebted’, which in turn puts them in a powerful position, or at least prevents them from being in a weak position, relationally speaking. The following examples all indicate the need to remain in a position of strength:

_I would sooner just get on with it if you like that’s the best way ... I didn’t have any help. I didn’t want it, I am sure if I had ..., they did ask me did I want meals on wheels, but I bought myself in the meantime before that, I had bought a stool thing so if I was a little bit off, I can sit on my stool and prepare a meal. I don’t use it that often, it was very dusty last time I got it out so I put it back again._

Margaret

Geoffrey: People don’t ask for help a lot, we don’t ask for help a lot, we have been fortunate in being able to manage without asking, but it’s comforting to know ... if you did need some help then they would be very willing, one hesitates to overdo it if you like, and ask for help, you know if you need it then it is there.

_Julia: Why do you say one hesitates?  
Geoffrey: I suppose that natural reluctance to impose upon people. So you wouldn’t impose upon people ... but we sort of, I wouldn’t say ration it, but for a very good reason ..._

For all of these people, to become indebted in this way was something to be avoided. They would prefer to remain isolated as self-contained units, managing their health independently, than having to feel indebted to others.

Throughout the thesis, a recurring theme is that people have wanted to present themselves as giving more than they receive. As Margaret says below, it is possible to feel more powerful when relying only on oneself.

_So when I had the heart attack, there was just me and I was in charge if you like so I got on with it and I have never looked back, I am fine. That is the only way I can explain it, I know I am a funny twisted thing like but ... I know deep down if it was something really serious I could talk to her [daughter] if I wanted to. It’s me, it’s not them, it’s me. I don’t want to and it’s not as though I am trying to hide anything, I am not, I have got_
Margaret

this feeling while I am in control, while I can make my own decisions without help from anywhere else, I am in control of myself and my life and that’s what I want. Badly.

Having analysed the importance of the nine people in the study who did not want to engage in health interactions, the chapter will now move on to look at a related theme, the way that people did not want to accept the notion of reciprocity in relation to health interactions.

Reciprocity, balance and payback of health interactions and support

Participants were strongly averse to an explicit sense of ‘payback’ or ‘balance sheet’ within friendships. They were expressing a powerful view that another system operated in relation to health support among friends. Ideas of ‘payback’ were considered simply not appropriate for that context. Not only did they disagree that systems of reciprocity existed, they seemed to be quite affronted at the idea that friendships could operate in that way. This fits with other research which has suggested that people find it inappropriate to appear to be calculating or instrumental (see for example Finch and Mason, 1993, 2000).

Participants’ accounts described how support, care and favours for friends at times of ill health were done because of feelings of affection and care, not as obligation or repayment (this links to Chapter 9 on moral narratives of friendship). Participants were suggesting that there is something else in operation.

It just doesn’t happen that way. You don’t think, oh I did them a favour I expect them to do me a favour and what have you. You don’t draw up a balance sheet. You have people who help you and you help them, because you like them, and it’s as far as that goes.

Geoffrey

In Geoffrey’s statement that ‘it just doesn’t happen that way…’, it is almost possible to hear him being affronted. In the latter part of this quote, it is possible to see the sense with which he describes his support as being down to feelings of affection and care, as in ‘…people who help you and you help them,
because you like them…” It is noteworthy that Geoffrey is of course actually talking about reciprocity here (‘… people who help you and you help them …’), at the same time as strongly denying that that is what it is. The resistance that people showed to portraying themselves as beholden to others may suggest that they do actually think that there is a form of social reckoning taking place. This is also an example of the moral identity work which has been demonstrated throughout this thesis – people may be seeking to make themselves look more moral by arguing that they do not want to be reciprocated. This is also demonstrated by Trish:

*It doesn't work like that … don't do things like that. Do in business, but not with friends … you don't tally bits up. Because it's not a chore, it's not an effort to do. It's just something that comes along and you do it. You don't keep it up here what you've done.*

Trish

There are a number of interesting things in what Trish is saying. Firstly, similarly to Geoffrey above, we can also hear Trish being affronted (‘It doesn't work like that …’). Also, in that same expression she is suggesting again that there is something else in operation.

It is also interesting that Trish is saying that the reason people do not tally things up when it is a friend is that ‘… it's not a chore …’ This leads us to ask whether when people offer support or care to someone else they are really doing it for themselves. By saying that it is not a chore, Trish is implying that it is enjoyable. This may be important for understanding why she does not feel that her support needs to be reciprocated. But she may also feel that this is not a chore as it helps her to build a moral identity.

For other people, however, giving health support might be a chore (although evidence here suggests that they would be loathe to admit to that). Other people might have different motivations – for example, moral duty:

*I think at the end of the day, if it's got to be done, you’ve got to do it. There's no ifs, buts or what they've done for you or what they haven't done for you … if it's got to be done, it's just natural instinct, you will do it.*

Pete
Pete is reinforcing the perspective expressed by the two previous quotes, that there is a system totally different from reciprocity that is in operation (‘… There’s no ifs, buts or what they’ve done for you or what they haven’t done for you …’). But Pete is also saying something else. He is suggesting that there is no choice in the matter. With his ‘… no ifs, buts …’ he is expressing a sort of needs must attitude, which, interestingly, he calls a ‘natural instinct’.

*People here don’t think like that. They just do it.*  
Jack

This quote from Jack is expressing the same viewpoint, that support for others is just done, and never conceived of in terms of reciprocity. However, in addition, an important word in Jack’s quote is ‘here’. It does suggest a contradiction, because if everyone around ‘here’ where he lives do indeed do things for each other, then it cannot be one-sided. It inevitably must be reciprocal.

Jack’s quote is also interesting in terms of reflexivity and the researcher’s own presence in the interview. Jack is possibly making a reference to the interviewer, who is a southerner and may see things differently, but that around ‘here’, where he lives, people are different, the way of operating, or habitus, is different.

These observations are important because, on the surface, they challenge a number of foregone conclusions about reciprocity. They challenge the ‘golden rule’ of reciprocity - treat others as you would like to be treated. They challenge Homan’s ideas of social exchange - that in giving something to someone, we want to get something in return and in receiving something from another, we are then under pressure to give back. In one way they can be seen as challenging Mauss’ ideas of the gift relationship - that gifts are never free (Mauss, 1922), but always bring obligations to repay and the gift must always be returned. In another way though, they can be seen as confirming Mauss’ gift relationship, as they show why people do not want to say that they have ‘received’, but are happy to say that they have ‘given’. This has been an ongoing theme throughout the thesis, where people have preferred to present themselves as
net givers, rather than net receivers. It is argued here that what is going on is that we are dealing with moral narratives. This is discussed further in the next chapter.

**When health interactions are experienced as negative social connections**

When we think about people who get involved in the health problems of their friends or relatives, we may well assume that their involvement is helpful. We may imagine that the involvement helps with the management of the health problem and we may also think that it could additionally strengthen the relationship between the two people. It is these assumptions that the extensive body of literature on social support is based upon. But are these assumptions realistic? Or are they always realistic?

There were examples in this thesis of health interactions which may not have been good for people's health, or detracted from their management of their health (some of these examples have been used elsewhere in the thesis but are used again as they also have relevance here). Some health interactions appeared to be targeted at making others' health worse rather than better, which was often linked to prioritising the meeting of their own goals, such as sociability. There were cases of friends encouraging people to drink when they had given up alcohol, as in the cases of Pete and Ray (who was an alcoholic):

... they insist a lot of them you know, "Oh go on have one," and I'll say, "No, I don't want one, you know, "leave it," and they actually think you're not happy, you know, but you are, you are enjoying yourself just as much as them ... I just take no notice in the end; I just say "No, I'm quite happy ... people would say, "Oh you must have a drink." you know, "You're not enjoying yourself there," and you was.

Pete

Henry, my mate, like he is a big lad and he will go like that, look, just have another one, I don't want another one. [Julia: Another beer?] Yes, I don't want no more. Well look you have only had one, that's all right. And I will go, look I don't fucking want one, then they know you see. Not like, I mean you can turn round and go like that, fuck off, but when you go I don't want fucking one, they know the difference in the voice...

Ray
There were similar examples of unhelpful interventions towards people who were trying to give up smoking:

Saturday night I said to Anne [his wife] I am going to have a go at stopping smoking, it’s the 10th of the 10th I thought that’s something I will always remember, and I got up and I went downstairs and sat in the corner, on Sunday morning, got a cup of tea and I thought right keep going, because I never ate breakfast or weetabix or oat anyway then, I used to have 3 or 4 fags and that was it, and I thought right I will keep moving I will go over the shops Sunday morning get papers and that, and Anne walked over lit a fag, blew smoke straight in my face and said here is a tenner will you get us 40 fags when you go to the shop.

Steve

Alison gave an example of her neighbour who acted as her ‘enabler’ for her smoking:

I didn’t smoke at home, except sometimes I would go and have a cigarette in the bathroom, open the bathroom door because obviously I didn’t want Phil [her husband] to know that I was smoking and so I used to go across to Jane’s and she used to smoke but she had stopped years ago, and she said I know how you feel, she said if you feel really bad I will get a packet of cigarettes and keep them here and when you come across you can have one. So I used to do that.

Alison

Some interventions were perceived as undoing a recovery. Richard blamed his mother-in-law for taking his daughter from a special unit for her anorexia and treating her in a way that was contrary to the approach that Richard and his wife had been working at:

I think she [his mother-in-law] did it for herself, I think it was a selfish thing to do, as I say I have never, she won’t know this, but I have never forgiven her for that. It was an awful thing to do, and she should never have done it. And it did backfire, unfortunately, for a short while.

Richard
The impact of health interactions on friendship and connectedness

What do these health interactions do for our relationships with friends, family and others? Do they strengthen or weaken bonds?

There were three ways in which interactions about health strengthened. The first was mentioned by a number of people and related to the ‘warm feeling’ of being cared for and shown, through people’s reactions at times of illness, that others do care.

Well, it’s offering support, isn’t it and showing concern for people, not just as a work colleague but as a friend ... It’s nice, it’s nice to know that people are concerned about, about you and I think that would happen in any walk of life, you know even though I am a quiet and private person, it’s still nice to know that people are concerned, show that much concern about you.

Mike

Secondly, interactions over health can lead to a closer relationship:

… we became better friends, better business colleagues I guess in whatever way you want to describe it, as a result of that.

Richard

Health interactions can also strengthen bonds by confirming the importance of friendships. For example, when Trish’s father died, she felt that the fact that her friends showed support had strengthened their friendship and the meaning it had for her:

Just gives you moral support, you know, someone’s behind you when you’re gonna fall over, it’s great.

Trish

Health interactions may also strengthen bonds that people may have previously experienced as negative, but this earlier perception is challenged by the health interaction. An example was given before, where Trish described how she became involved in her mother’s health, because she had to. Whilst Trish experienced this as negative, it may nonetheless be strengthening ties between
them. Tying people into feeling beholden to others might also be interpreted as strengthening bonds, although it may not improve the quality of the relationship.

Health interactions weakening bonds

There were three main ways in which conversations about health were felt to weaken bonds between people. The first, as described here by Daniel and Alison, is the way that health talk can ‘bring you down’:

\[ I \text{ think if you start talking about your illnesses you can, it can go the opposite way than being helping people, it can become a downer on other people … it can kill a conversation stone dead.} \]

Daniel

\[ \ldots \text{we tried to lighten the evening and get you know, we had quizzes and all sorts of things you know and laughed and joked about things, and then if somebody started saying, well, when I had this or you know, it would deteriorate somehow.} \]

Alison

In a different vein, some people described the way in which trying to help somebody with (usually mental) health problems could have negative repercussions on the relationship. Diane, for example, mentioned how her colleague had made a big effort to support another colleague, but when she received no response she became angry and felt less friendly towards the colleague than if she had not tried. A similar example was given by Barry, who had tried to support an ex-colleague who had had a breakdown and who treated Barry very badly, which again led to a deterioration of their relationship. Richard had been on the other end of offers of help, and was aware that relationships could be damaged if people’s attempts to offer support were not shown to be appreciated:

\[ \text{Yes because you worry, I guess you worry that you hurt their feelings, you worry that they mightn’t offer support again if you turn them down once, but of course that’s not the case.} \]

Richard
Fiona’s effort to provide support to her sister-in-law to cope with alcoholism in her family found that her involvement became too much and had negative impacts, not only on Fiona’ health, but also on their relationship:

_Well, we had to end that actually and it was awful, because I was getting so down, I think that contributed in a big way to how I felt, because we were getting phone calls morning, noon and night … from my sister-in-law, what are you doing, 2 o’clock in the morning you are in bed sleeping, what are you doing, you know and I became so sarcastic I would say well Liz what do you think I am doing, I am up at 6 in the morning for work, I am in bed, oh right._

Fiona

The fear of being a burden or a ‘health bore’ has been mentioned elsewhere in this thesis and may be another reason that may make people less inclined to become involved in health interactions.

**Conclusion**

This chapter has added one last element to complete the conceptualisation and mapping of the notion of health interactions as used in this thesis. Previous chapters have illustrated how health interactions include not only ‘doing’ (as in Chapter 5), emotion work (as in Chapter 6), or advice giving (Chapter 7). This chapter has added a further element which is the relational dynamics which are embedded in health interactions. Health interactions are viewed in this thesis as _interactions_, and so this chapter has analysed health interactions as _relational_ practices and has explored the ways that they affect not only health and management of health, but also the way that they can have an influence on relationships and create a connectedness (or distance). Many examples of the way this happens have been outlined in this thesis and particularly in this chapter. It is argued that health interactions are not merely an informal route to improved health management, but are underpinned with relational dynamics which affect the ways personal life is experienced.

The complexity of health interactions has been gradually demonstrated as the thesis has progressed. Themes of gendered health interaction practices and
moral identity building have continued to be important in this chapter, as they have throughout the thesis. These will be picked up and developed further in the next chapter, which theorises some of the insights from the data chapters in Part Two.
PART THREE

MAKING SENSE OF HEALTH INTERACTIONS
Introduction to Part Three

It has been suggested earlier in this thesis that one of the important aspects of health interactions is that they are not only about health and management of health, but that they also are ways in which people make, strengthen or weaken connections with others. Part Three of the thesis will engage with the complexity of some of the ways in which this happens.

In Part Two the range in form and meaning of health interactions was illustrated. The examples given emphasised the ways this thesis conceptualises health interactions, not only as support or help, but as *interactions*. Part Two began to develop an outline of the meaning that health interactions have for people.

Part Three builds on that analysis, and develops more deeply an understanding of the ways people are connected through health interactions and how this is nuanced by gender, surveillance and moral agency. In Chapter 9 the contribution of this thesis to theory is presented and discussed. This is structured around the three perspectives outlined in Chapter 3 and is followed by reflections on the contribution that this thesis makes to first policy and then to clinical practice. Chapter 10 concludes the thesis.
Chapter 9: Discussion: theorising health interactions

One of the main contributions to theory that this thesis makes is to introduce the argument that health interactions should be conceptualised as *interactions*, and not as ‘support’. As interactions, they are viewed from the perspective of the layers of multiple experience and meaning that are part of an interaction. So, understanding a health interaction requires understanding the relational dynamics of that interaction, the moral agency and identity work that are embedded in that interaction, as well as the impact, positive or negative, that the interaction may or may not have on health and the management of health.

As well as illustrations of health interactions that operate at the level of practical actions (Chapter 5), that could be equated with ‘functional support’ (as described by Uchino, 2004), we also saw in the emotion work chapter (Chapter 6) examples of the way that health interactions do not just involve ‘doing’ things, but also include other types of links and more emotional connections such as understanding, being there, concern and ‘talking it over’. These are important since, as described by Bendelow (2010), emotional difficulties are often medicalised in the formal health service as mental illness, so informal health interactions offer something not medicalised. In many ways the health interactions examined here involve one person helping another and are similar to social support as discussed in the literature. However, in this thesis the argument is made that to see connections between people solely as a one-way, simple act of assistance is to ignore the interpersonal and relational dynamics that operate within health interactions (as discussed in Chapter 8). Health interactions can operate at a deeper level of connection than in some of the more practical interactions and they may be making connections with more inner and private parts of people’s worlds. Health interactions may be at least partly about shifting what is personal or private, to something more shared or public, or *interactive*. This means making a connection at a more profound level and a greater degree of closeness.

It was argued in the advice giving chapter (Chapter 7) that health interactions are more complex than ‘helping’ activities and that, for a health interaction to have relational meaning, it does not have to ‘help’ or ‘assist’ in either a practical
or emotional way, whether with health or anything else. Unhelpful forms of social support have been described before (Rook, 1992; Thoits, 1995). However, in the conceptualisation of health interactions used in this thesis, differently from social support, an ‘unhelpful’ health interaction would be considered to still have importance, as it still has an impact on the relational dynamics between those involved. Forms of health interactions like advice giving illuminate how health interactions can be unhelpful as well as helpful, and how they can also be more for the benefit of the giver, rather than the receiver.

In the chapter on relational dynamics (Chapter 8), the argument was made that health interactions are part of the way we develop our relationships with others and how we experience our social world. Health interactions are viewed here as connections between people, confirming the ideas of Smart’s (2007) connectedness thesis and contributing to the growing body of literature which challenges the individualization thesis (Beck, 1992). This thesis complements well Smart’s work in her connectedness thesis, particularly in the ways that Smart highlights possibly unseen avenues along which connections happen, such as through the imaginary or memory, as the connections that are made through health interactions may be similarly unnoticed, and the data show health interactions to be an important aspect of social life and of people’s experience. On the other hand, Beck’s (1992) portrayal of his particularly gloomy, disconnected version of the individualization thesis presents relationships between people as dislocated and disembedded, and although some people in this thesis wanted to be self-reliant and not engage with others about health (for example Margaret), there were also many examples in the data of connections, small and large, about health, and also examples of people who were very interconnected and inter-reliant. An example of this is Philip, mentioned in Chapter 7, who described himself as living in a ‘self-help cul-de-sac’. As Smart (2007) also noted, these links and interactions were not always positive, but even when negative, they represented connections. The thesis showed the inter-relationship of health interactions through the way that very often the people who had sometimes quite serious health conditions themselves, were also the people offering often quite extensive health interactions to others. Richardson et al. (2007) reminded us of a similar thing - that practical support can flow not only to a person with poor health, but also
from them. The difference is in the way this is viewed in this thesis, where these connections are seen not as one-way support, but as interactions.

There were a number of instances in the thesis of illness causing what could be described as biographical disruption (Bury, 1982), a good example being Simon, whose previously estranged sister had a car accident and Simon spent a lot of time with her, helping her come to terms with her new disability. We can see here a number of events and developments: firstly an example of biographical disruption, secondly that other people become involved in biographical disruption, so it is by no means a private process but very much a shared one (in this particular case, but not in all cases), and thirdly and most importantly for this thesis, the multiple layers of relationality that can be present in a health interaction. Simon’s involvement with his sister after her car accident repaired their previously estranged relationship and his input allowed him to do his own identity work and to build a moral self.

This thesis began with certain concepts in mind, which were developed in the sensitising concepts chapter (Chapter 3) and were then used to explore the themes emerging from the data. In addition, what was found in the data led to the engagement with other, unanticipated concepts. This chapter pulls together these threads to emphasise the contribution to theory that this thesis makes. It seeks to combine both anticipated and unanticipated theoretical perspectives with the sensitising concepts from earlier in the thesis and the data that were generated in the study, to outline the theoretical contribution of this thesis.

**Who is connected? Health interactions as gendered practices of moral identity work**

It has been argued so far in this chapter that health interactions are a way in which people are connected. However, it is necessary to take this further and ask who is it that is connected? Are all people connected in the same way? This will now be explored in relation to the gendered nature of health interactions. Earlier chapters described how, for many forms of health interactions, it was women who engaged in them more than men. This was
especially the case for practical health interactions and particularly those that involved work done within the domestic arena.

However, men were also active in health interactions, albeit less so overall than women, and the ways men were involved may be important in understanding what is behind the gendered differences in health interactions. Although men played a smaller part in most types of health interactions, they played a larger part than women in the giving of health advice. It is relevant to stress that this was only in the giving of advice and not the receiving. There were also areas of health interactions in which both men and women became involved to a similar extent, but the way men enacted those health interactions tended to be very different from the way women did, an example of this being the emotion work described in Chapter 6. The cases of study participants who did not engage in health interactions, preferring to take a self-reliant approach to their health, were also more or less equal in numbers between men and women. However, women tended to talk about being compelled by their circumstances to be self-reliant, whereas men seemed to present their self-reliance almost as a luxury, which they used as part of their identity work.

These gendered differences in health interactions are not viewed here as gendered ‘roles’ in the sense of the functionalist socio-sexual division of labour, where assumed ‘natural’ caring roles are associated with women, but are understood rather as ‘practices’, gendered practices which can explain the gendered patterning of involvement in health interactions.

There were numerous examples in the data of practices of gendered identity building. These are discussed below in relation to the moral agency of health interactions, but they also have relevance for the discussion of gender, as much of the work of identity construction was gendered as well as moral work.

The way women used health interactions to construct identity emphasised a range of notions of gendered identities. Women in the study used health interactions and their narratives of them in the interview, to construct identities as, for example, strong (Margaret, Lorraine), supportive (Fiona, Bev) or emotionally open (Trish, Bridget). Similarly to what Ungerson (1987) shows,
there were also examples of women’s presentations of their health interaction practices as ‘duty’, as Trish who, when asked about health interactions with her mother, to whom she was not close, said ‘I have to, she’s my mother.’

The men in the thesis made more obvious use of health interactions and the interview narratives about them to construct an identity. This was invariably a gendered identity and was often (though not always) based on ideas of masculinity which involved being tough (Mike) or not talking about health (Edward, Daniel). Other men presented different types of gendered identities such as being caring (Steve, Simon). All this leads on to the point that these gendered identities are fluid and not static or necessarily matched to biological sex. Although often people were, through their gendered practices of health interaction, following scripts of femininity or masculinity, there were enough examples which challenged this, to be able to appreciate that these were gendered identity work and not ascribed biological roles.

One of the themes to emerge from the present thesis which confirms earlier work (Mason et al., 2007) was that men, although less active in many forms of health interactions, were much more active in the giving (but not the receiving) of advice. This is another way in which we can see the role of health interactions as gendered identity work, since to give advice is to present oneself as an ‘expert’, and to admit to receiving (or needing) advice is akin to admitting to being weak and needy.

Are health connections always good? Health interactions as monitoring and surveillance

The argument that has been made in this chapter is that health interactions are a way in which people are connected. We also asked above whether people are all connected by health interactions in the same way, and we saw that one of the characteristics of health interactions is that they are gendered. But it has been important throughout this thesis not to make the assumption that health interactions are necessarily a good thing, or that they are always kindly or benign. This has been emphasised by Smart (2007), who talks about how connectedness can include ‘everyday unhappiness’ created through the way
people relate to each other. There have been a number of examples in each of the data chapters where this has been a theme and the respective health interactions could be conceptualised as monitoring and surveillance. It can be seen most vividly in Chapter 5, where people gave examples of literally ‘checking-up’ on others who had health problems.

Through the advice giving seen in Chapter 7, the practical support in Chapter 5, as well as examples throughout the thesis of people trying to motivate or encourage others towards what they saw as healthier lifestyles, it is possible to see a slightly different type of control of others which has been linked to Foucault’s theory of governmentality (Foucault, 1979; Rose, 1989). The concept of governmentality is that, rather than being directly controlled by the state, people tend to control or govern themselves, and have created systems by and for themselves which force them to adopt, for example, healthy lifestyles, an activity which is directly or indirectly supportive to the state. The argument that is being made in this thesis is that through health interactions, people come to govern not only themselves, but also others.

These notions of monitoring, surveillance and governing of the other show how health interactions are imbued with power and control, and that the interactions cannot be taken at face value, as simple acts or inputs of help or support, since there are other layers of relational complexity which are operating within health interactions.

A further complexity is the tension, described in Chapter 5, between surveillance and care. It would be possible to take, or read, a number of the examples of health interactions in this thesis as simple acts of kindness or care. However, the ideas discussed above suggest that, beneath the health interaction, there could also be power and control at work through surveillance or governing of the other. This presents a tension and in doing so it points to other dynamics going on within health interactions which will now be discussed in the next section.
**The moral meaning of health interactions**

This thesis has sought to explore whether there is a moral dimension to health interactions and whether it is forms of moral agency which underpin people’s involvement in health interactions.

It was proposed in Chapter 3 that moral understandings may influence participation in health interactions through a functionalist perspective that views health interactions as following social norms, such as ‘help the sick’. At first sight, moral norms could be seen to have been followed in some of the health interactions studied in this thesis, as in Trish saying that, despite not being close to her mother, she would have to help her with any health problems because ‘I have to, she’s my mother’. There were also Patrick’s neighbours, who seemed to assume that as Patrick, an elderly widower, was recuperating after a by-pass operation, they would need to come and clean and help Patrick on a daily basis. These examples could be seen as the following of social norms, but in this thesis they are viewed as *practices* and not as norms. This is because the people interviewed were more agentic than this functionalist theory of social norms permits. As Sayer (2011) has noted, norms are not universal and there were sufficient examples in this thesis of people (e.g. Margaret, Daniel or Mike) who were able to opt for not engaging in health interactions.

So, because of this we can assume that a functionalist explanation, arguing that people are operating within an overall social system which compels adherence to social norms, does not apply here. Bauman (1995) has proposed that contemporary society now rejects the control or enforcement of moral behaviour such as health interactions through the pressure of social norms, and this seems to be confirmed by the present thesis, as there were people in it who were well able to resist the pressure of social norms. On the other hand, the chapter on advice giving (Chapter 7) has shown that some people do, through the kind of Foucauldian surveillance or governmentality described above, try to exert moral pressure on others by giving advice or encouragement to conform to certain health promoting activities, which could be seen as ‘norms’.

However, this too is viewed in this thesis as practices, or normative practices, rather than norms because, although advice was given, there were many instances in the data where the advice was not adhered to. Some examples are Bridget’s colleague who tried to get Bridget to take up exercise, or Alison
whose family members exerted pressure on her to give up smoking, but neither of these worked, suggesting that other factors are in operation in addition to, or instead of the compulsion to adhere to social norms.

Having decided that moral norms are not a force that explains all, or most, health interaction practices, a further possible explanation is now considered, which is to see health interactions as a moral project of the self. The thesis has sought to explore whether, for some of the participants, health interactions offered a way to construct an identity as a moral actor, a good person, or a good relative, friend or neighbour. This has been a strong theme which emerged through the data and appeared in most of the previous chapters, suggesting that many of the study participants were engaged in moral agency through the health interactions, or the describing of them in the interview, which it is argued here is part of their construction of a moral self.

There were numerous examples of a wide range of different types of health interaction that appeared to be part of the identity work that people were doing in order to build a sense of self as a moral actor.

An aspect of the moral project of the self which, it is argued here, underpins many people’s involvement in health interactions is the performativity of health interactions. For Goffman (1959, 1971) this is a presentation of self as a moral actor, which he argues is crucial for participation in social groups.

Something particularly interesting about identity work as seen here is that it is about building a positive moral identity, not about trying to reverse a ‘spoiled identity’ (Goffman, 1963), the latter was observed in examples in Chapter 3 where women used moral identity work to try to overcome their identities as poor mothers (Radcliffe, 2011; May, 2008).

It has been discussed above and in the preceding chapters that this identity work is both gendered and socially patterned. There are examples of gendered identity work above and, in terms of social patterning, it was noted that the most powerful and prolific examples of identity work come from the more affluent people in the sample, suggesting that the work of building a moral identity can
be something of a luxury, and often very important to those whose more basic needs of survival are already satisfied. An example of this is Philip, quoted several times, as his presentation of how he helps people with their health related problems at the golf club and in his ‘self-help cul-de-sac' were vociferous and clearly formed the main agenda for Philip in the interview.

Not everybody in the sample presented their health interaction involvement as a moral narrative of themselves, but many did (Steve, Philip), and this again was gendered and socially patterned. But there were also people who did not present a moral narrative (Margaret, Edward, Mike, Pete). In fact Margaret could be described as presenting an ‘amoral' narrative, stating that she is selfish and does not wish to become involved in others’ health matters. Margaret's reason for not getting involved in others’ health was that she was totally absorbed in her own ‘project of the self', which was doing A’ levels at the age of 73.

Having discussed the way some people engage in health interactions in order to present a moral narrative, or construct a sense of self as moral, there is a third possible explanation, based on the ideas of Sayer (2011), of what could be going on when people engage in health interactions. They would do so because it matters to them, because they are motivated by human concern about others and by what has been called ‘moral emotion' (Sayer, 2011; Bauman, 1993, 1995; Pritchard, 1991). There have been a number of examples in this thesis that support this viewpoint. In many cases it would be hard to interpret some of the examples of health interactions as following moral norms or identity building. Sometimes people seemed to be engaging in health interactions because they cared, because it mattered to them to do so, and because of a sense of emotional connection, which could be called moral emotion. An example of this is Mary, who recounted various tales of health interactions which cannot be explained as the following of moral norms, or a moral project of the self. It is also important to note that moral concern or moral emotion as an explanation for health interaction practices may be combined with moral identity construction or the presentation of self as moral, as both aspects of moral agency may be important to some people. Indeed, both Bauman (1993, 1995) and Hekman (1995) have pointed out that people have a
choice whether to respond to a sense of moral emotion and whether or not to turn these emotions into moral practices. It has been demonstrated in this thesis that for many people it is important to translate their moral emotion into moral practices, but there are also people among the participants who do not choose to do this.

Three perspectives on moral agency have been presented in this thesis as a way of explaining what is underpinning people’s health interaction practices: social or moral norms, the construction of a moral identity, and moral emotion. The data did not entirely support the notion of moral norms, as the notion of norms applies universally as part of an overall system, which requires everybody to subscribe to the norms or be stigmatised. By contrast, there were a number of people who were able to reject what could have been described as the norm of ‘helping the sick’. However, the explanations that engaging in health interactions is a way of constructing and presenting a moral self, and that people possess a sense of moral emotion and concern which encourages them to engage in health interactions, may be seen as relevant explanations for the ways people described their health interactions in this thesis.

**Contribution to theory**

This chapter has outlined a number of ways in which this thesis contributes to theory. One of the theoretical contributions is a novel conceptualisation of health interactions as *interactions* rather than as helping, caring or support. So, as well as larger scale help, the thesis also included a wide range of types of health interactions such as conversations about health and small-scale, fleeting or incidental interactions about health. This is because it is argued that, only by combining all of these types of interactions and understanding the interpersonal and relational dynamics embedded within them, it is possible to begin to understand broader issues of sociological importance about the ways in which people relate to one another and how a seemingly personal task such as managing and maintaining one’s health becomes enmeshed with the input from and connections with other people.
The thesis identified many connections about health and many people (though not all) for whom practices of health interactions form an important part of their personal life. This study therefore challenges the individualization thesis (Beck, 1992) and aligns itself more closely with the ‘connectedness thesis’ as outlined by Smart (2007). However, this is not a neat conclusion, since there were people who did not engage in health interactions, some of whom could be seen as more ‘atomised’ than ‘connected’ in their interactions about health, or lack of. It is also important to consider who is connected through health interactions and how, there was a social patterning of health interactions and gendered differences were particularly stark. It is also important to remember that, just as other social interactions, health interactions are not universally kind and benign. Some health interactions could be seen as forms of control of others through monitoring, surveillance or governmentality (Foucault 1977). Morality is an important theme in this thesis and the moral meaning that health interactions held for people included the role of health interactions in moral identity construction. However, there were also people (sometimes the same people) who were motivated to engage in health interactions simply by a sense of concern or moral emotion.

**Contribution to policy**

As the UK Government continues to promote an individualized model of the self-activated patient, this thesis makes an important contribution to policy by depicting the reality of the web of social interactions that surround that patient and their attempts to manage their health. It has become clear through this thesis that, despite the official line that health policy documents promote, relatives, friends, neighbours, colleagues and others will inevitably become involved in the health and self-care of the people they know. Therefore, it could be advantageous if health policy and its implementation could be cognisant of this and actively take the opportunity to incorporate the involvement of others in self-care, through policies which recognise, support, encourage and maximise the involvement of others. Therefore, one of the contributions to policy which this thesis makes is to urge policy makers to incorporate the fact that health is rarely managed in isolation and that self-care is rarely done by the self alone.
Another way in which this thesis contributes to policy is in highlighting that health policies directed at individual patients will inevitably have an impact which extends beyond the patient. This thesis has shown that for many people it is inevitable that they will become involved in each other’s health. Health policy which is introduced to benefit patients will also have an impact on others in those patients’ social networks.

There has been a tendency, where policy does anticipate that others may be involved in a patient’s care, to assume that that will be a partner, spouse or other close family member. A message which this thesis puts forward for policy makers is that it is not only family members who become involved in patients’ health, but also friends, neighbours, colleagues and at times more distant social ties. This could contribute to new ways of thinking about developing policy. Health policy makers could develop policy for the group of people, close and not so close, who may be surrounding the patient and engaging in their health condition or needs.

A contribution to a more explicit formulation of policy based on this thesis could be more difficult, due to the very nature of the study findings. It was demonstrated in the thesis that people engage in health interactions because they want to, not because they have been told that they have to. They engage with others about health out of moral concern, or as part of their own moral identity building. So, it would be difficult or counterproductive at policy level to structure any kind of compulsion (as opposed to encouragement), to support or interact about health, since compelling people would destroy precisely the dynamics that this thesis has shown make health interactions work.

**Contribution to clinical practice**

In some ways it is hard to see the contribution that this thesis makes to clinical practice, as the health interactions that are the subject of this study take place entirely outside of the health service. However, on closer analysis it is possible to see a number of ways in which the thesis could contribute to the understanding with which clinicians approach their patients.
An important contribution of this thesis to clinical practice is that it suggests new ways of intervening based on the assumption that the patient is part of a ‘team’ of lay others who have become or will become involved in the management of that patient’s health condition. This thesis also provides useful information for clinicians to illustrate that this ‘lay team’ is rarely limited to family members alone and usually also involves friends, colleagues, neighbours or others, who may play small or larger parts in the patient’s health. These people constitute a lay team which complements the clinical team helping the patient.

Another contribution that this thesis makes to clinical practice is to raise awareness for clinicians that friends and relatives, in addition to offering a lay version of the types of input provided by the formal health service (e.g. health advice), also offer types of health support and engagement that are not possible for health professionals to provide in the same way. An example of this is lay support for emotional difficulties. There were many examples in the thesis where friends and family offered non-medicalised support for emotional difficulties. This was done without defining the problem as a mental health problem, as may have happened in some cases if the problem was dealt with within the formal health services (Bendelow, 2010).

The thesis analysed the moral importance of engaging in health interactions. It may be useful for clinical teams to be aware that moral identity building through informal health interactions is a motivating force not only for the patient, but also for those who seek to help or support them. Informal interactions about health between friends, relatives and others have great importance not only for the patient and their health, but also for their friends and relatives. So a contribution that this thesis makes is to alert clinical teams to this, and to propose that interventions are designed with a wider ‘lay team’ in mind.
Chapter 10: Conclusion

This thesis set out to answer three research questions about the way people connect about health. This chapter first reflects on each of the research questions in turn.

Before moving on to the research questions, the definition used for health interactions is revisited. The term ‘health interaction’ has been used in this thesis for any form of interaction, contact, communication or exchange between two or more people, that is either loosely or directly related to health in its broadest definition. These informal health interactions are outside the formal NHS services and are lay health interactions, rather than interactions with health professionals of any sort.

Research question 1: In what ways do people interact over matters of health?
In Part Two three main ways in which people interact over health issues were discussed. It was argued that health interactions as used here are distinct from social support by their concern with the entirety of the range of relational and other dynamics that go on when two people interact about health, as opposed to acts of social support, which can be one-way and, more importantly, are viewed from the perspective of the act of assistance or support itself and not the wider and deeper implications of that interaction. Descriptions were offered of how people engage about health through practical health interactions, emotion work and the giving of advice. Health interactions were often ongoing, constant or regular, but there were also examples of ways in which health interactions were fleeting or seemingly trivial interactions, yet the thesis described how these still can have an important impact (positive or negative) on people’s lives, on their relationships or on the management of their health, which is why this study has focused on interactions and not on acts of support.

This thesis illuminated varying examples of social connectedness created though health interactions. We also saw how some people preferred individualized ways of managing their health. Thus, although there is complexity surrounding the extent to which health is managed in either
connected or individualized ways, the argument of this thesis is that many people manage health in a shared and connected manner, through large scale acts of assistance or smaller-scale, fleeting words or actions which nonetheless create a connection, both over the matter of that health issue and also for the relationship between those involved.

In general, health interactions were presented as positive and helpful, but importantly, this description tended to come from the ‘giver’ and so it is linked to moral identity work. This thesis also showed ways in which health interactions can be negative, or not appreciated or embraced. Health interactions can be analysed as monitoring and surveillance or control of others, through for example advice giving or encouragement to lifestyle change (Foucault, 1979; Rose, 1989).

Research question 2: Who becomes involved in health interactions, who does not, and how?
The case has been made that people do connect over matters of health. Twenty five people with either heart disease or mental health problems were interviewed, aged between 45-55 and 70-80, approximately equally balanced between men and women and from two contrasting areas of northern England. All of these 25 people had some form of health interaction to recount, most had many, both from them to others and from others to them. For many participants, interacting with others about health was a significant part of their social life and human interaction. However, complexity has been shown in that there were nine participants (a minority but still a large proportion of the total) who presented themselves as strongly self-reliant. It was important to them to manage their health in a private and independent way. Some people also tried to avoid telling others about any health problems or concerns they may have had. This lack of disclosure had an impact on their relationships with others and it also prevented people close to them from giving them support at times of illness, thus barring others from having health interactions they may have wanted. As seen in Chapter 8, telling or disclosure can also be difficult for relationships.
This thesis has questioned assumptions that engagement about health is solely the domain of the family and shown that there are a range of others – friends, neighbours, colleagues, acquaintances, even strangers – who become involved. The thesis highlighted an interplay between family, friends and others in interactions about health. There were many examples of a range of ways by which non-family become involved in health interactions and indications that friends and neighbours can feel responsible for each other (Roseneil and Budgeon, 2004), yet there was also an underlying sense of family responsibility. There was fluidity when people defined and redefined people in the way described by Spencer and Pahl (2006) as ‘family like’ or personal communities, and with that was fluidity about with whom people engaged in health interactions. On one hand, people were building their health interactions on individual characteristics and practices, not blood ties. On the other hand, some level of responsibility and obligation were seen to lie with the family. In theory, people felt that health and illnesses are clearly areas of family responsibility. But in practice, they made day to day decisions about with whom to interact about health, based not on rules of family obligation, but on characteristics such as the feeling of closeness and shared experience. This balance of theory and practice resonates with the work of Gillis (1997), who makes a distinction between the shared family ideals and ideologies which he describes as the ‘families we live by’, and real life and often problematic family relationships, ‘families we live with’.

This thesis has confirmed the strongly gendered nature of health interactions (which has been long highlighted in the caring and feminist literature, for example Stacey, 1988; James, 1992; Bracke et al., 2008). As expected, women did engage in many types of health interactions, and certain types of health interactions were conducted exclusively by women. Men were also active in engaging in health interactions and, in the giving of advice in particular men were especially dominant. This was interpreted in this thesis as gendered identity work, since being the giver of advice is to have some expertise and power. Indeed it is argued that, as men and women often are in different structural positions, the health interaction practices of both men and women are also the work of constructing a gendered, and often moral, identity.
While most participants engaged in a quite considerable volume of health interactions, the fact that some people tried to avoid engaging with others about health at all tells us that these are not normative roles in a functionalist sense, but that this is agentic work which can be understood as identity work. Similarly, the fact that women and men engaged differently in health interactions indicates a gendered identity construction.

*Research question 3: What is the meaning that interactions about health have for people?*

It was important to convey in this thesis that health interactions have an impact, not just on health, but also on relationships. The thesis demonstrated how bonds between people can be strengthened or weakened as a result of health interactions, and the argument being made here is that this is because a health interaction is operating at a number of different levels of connectedness. So, as well as the more simple act of assistance or participation in another’s health issue, there are also powerful relational dynamics in operation. This is important because most studies of social support look only at the implications for health and not at these wider implications. This thesis argues that the meaning that people derive from health interactions seems to be closely interwoven with a sense of moral virtue. It seemed important to people to present a moral self and to provide moral narratives (Lawler, 2008), both about being a ‘good friend’ and about doing ‘good deeds’ such as providing support at times of illness. In keeping with this, people tended to present themselves more in terms of giving than receiving support, and reciprocity was considered to be a somewhat offensive notion in this context (Finch and Mason, 1993, 2000). This links to other arguments made earlier in the thesis, that construction of a moral identity is an important element of the dynamics of health interactions. As well as moral identity construction, for a number of participants the meaning that health interactions had was related to moral emotion and moral concern – to engage with others about their health mattered to people (Sayer, 2011).
Having reflected on the way this thesis answered the research questions, we now turn to a discussion of the limitations and strengths of the methodological approach are addressed. The contribution of the thesis is then discussed in terms of areas of research that could be developed from it. The last part of the chapter deals with the conceptual contribution of the thesis, it is organised loosely following on the structure of the chapters in Part One, and it takes us back to the themes which have emerged throughout the thesis.

**Limitations**

The purposive, qualitative sample was carefully composed to make sure that the sampling prioritised characteristics that could be important to explore in answering the research questions. However, although that was successfully achieved, there are some limitations in the sample. Firstly, the sample does not include many people who are currently in employment (only 9 people out of the total sample of 25 were in paid employment). This means that the possibilities to explore health interactions among colleagues in the workplace were limited. Possibly related to this, there was plenty of opportunity to explore health interactions among neighbours, which may act as a substitute for colleagues for some people who are at home during the day due to retirement, unemployment or ill health. Some important observations about contemporary neighbouring were made as a result. A second limitation of the sample is that it does not include young people. The two age clusters (45-55 and 70-80) were deliberately chosen to ensure that there would be sufficient health problems (among the study participants and their peers) to talk about in interviews, which worked well and was proven to be a successful strategy. However, with a greater understanding of the topic that comes with hindsight, and after a discussion at a conference presentation, it became clear that young people do engage in health interactions, albeit on different health issues. Exploring health interactions among young people is proposed as a possible area for future research.

This was not a representative study, since it used a small, carefully selected purposive sample. Whereas it was possible to identify patterns, the sample is not representative in a statistical way. However, the thesis followed a
 qualitative analytical approach and its strength lies in being analytically strong and rigorous.

Possibilities for further research

A theme which has run through this thesis has been a Foucauldian perspective on health interactions, which involves seeing health interactions as acts of monitoring or surveillance which contain power dynamics. This is an area worth further in-depth study, focusing particularly on the way that while governmentality (Foucault, 1979; Rose, 1989) is typically used to describe the ways in which people govern themselves, here it is used to explore how people are governed by others.

Related to this is another area which has been identified in this thesis and would be interesting to pursue further, namely the tension between surveillance and care. These two things have been discussed alongside in this thesis, but merit further exploration to understand whether they are starkly different or two parts of the same thing.

The relational complexity of disclosing a health concern is an interesting subject and would merit a more in-depth study than has been possible here. Disclosure is an important subject in the sociology of health and illness, but the advantage of looking at the subject from the perspective of this thesis is that here the literature and perspectives of the sociology of personal life was included to add strength to the relationality embedded in the disclosure (or lack of it).

The boundary blurring and suffusion of concepts of ‘family’ and ‘friend’, as illustrated through practices of interaction about health, are an important area of study and would make a contribution to the literature, which has more studies of family support and caring than of the involvement of friends and non-family.

Linked to this, the thesis also makes a contribution to the study of contemporary neighbouring, and further research on this would be of sociological interest.
This thesis argued that underpinning much health interaction activity are issues of moral virtue and moral agency. People seemed to use health interactions as an opportunity to develop, express or present a moral identity. This is proposed as an area for future research, as there has been considerable research within the sociology of health and illness on moral virtue in illness, but this would take a totally different perspective and would be looking not at the morality of coping with an illness, but the morality of interacting with, or supporting, someone else who has a health condition. So this is proposed as an important area for future research, to explore the moral narratives, moral agency and the construction of a moral identity through engagement in others’ health.

This thesis will now draw to a close by revisiting the themes from Part One of the thesis, which were chosen to illustrate the importance of the thesis questions.

*Health interactions show the complexity inherent in interacting about health*

This thesis added ‘fine mesh’ detail to the way that people interact about health. It adds to the social support literature by showing the importance of fleeting health interactions. There has been a tendency in the social support and caring literature to discuss social support as solid, dependable, ongoing support (Uchino, 2004; Richardson et al., 2007). This thesis shows that there are many examples of interactions about health which are far more fleeting or seemingly trivial. There were numerous examples in the thesis of ways in which short term or temporary health interactions have major impacts on people’s health, their management of their health or on their sense of self.

Something else that was identified in this thesis is unequal access to the resources of health interactions, where those who need more get less and those who need less get more. In the social support literature, social support has tended to be written about as a valuable resource for those who need it.
Indeed Thoits (2005) and others are persuasive in outlining the health-protective value of social support. However, an important consideration is that access to social (or health) support is not equal. This thesis identified ways in which people who have less material resources, and therefore could benefit more from social support resources, may actually have access to fewer social support resources than more affluent people, who both have more material resources and are also able to access more social support (or health support) resources. This is counterintuitive – we tend to assume that people who are more structurally and materially disadvantaged will supplement their resources with social resources, resources from friends, neighbours and relatives which they can reciprocate. However, although this does indeed sometimes happen and there are examples of it in this thesis, there were many who eschewed offers of help in favour of self-reliance, or less valuable resources were offered as the provider of the support had fewer material resources (e.g. a car for a lift) to offer. This works through, or at least it is related to, the principle of homophily (McPherson et al., 2001; Bottero, 2005), which argues that social networks are socially homogenous. This means that, as seen in the findings of this thesis, people with few material resources can only offer and receive support from those with few material resources. Whereas people with substantially more material resources have a great deal to share and also need it less, and they give it to those similar to themselves (as Philip who gave lifts to his neighbours in the ‘self-help cul-de-sac’). This is a variation on the inverse care law (Tudor-Hart, 1971).

This thesis questions the notion of strong working class support. Over half a century ago, Young and Wilmott (1957) depicted a very influential and slightly cosy picture of strong and effective levels of social support within working class communities. This thesis challenges this somewhat. It was described above how access to social support resources is unequal. There are also descriptions in this thesis of how some of the people who may need health interactions most do not ask for them, or feel that they cannot or do not wish to ask for them.

There is some evidence in the social support literature of negative social support (Rok, 1992; Thoits, 1995), but it is much more common for this literature to describe social support as positive and protective (Reblin and
In this thesis there have been many examples of interactions about health which are positive and helpful to people’s health or their relationships. However, the thesis also identified examples of health interactions which are negative. In addition, some health interactions which are presented as positive (often by the giver) could be construed as less benign and kindly when viewed from a Foucauldian perspective as monitoring and surveillance. This thesis uses the concept of governmentality (Foucault, 1979; Rose, 1989) and argues that, while Foucauldian theory depicts people as engaged in governmentality or a ‘project of the self’ directed at their own self-improvement (in this case, at their own health-giving practices), this thesis has shown ways in which this is extended to include the governing of others. Examples were shown where advice giving or motivation to healthier lifestyles can be interpreted as surveillance and a form of power or control from the ‘giver’.

**Self-care policy is not done by the self alone**

This thesis set out to question the assumption in UK government policy on ‘self-care’ (Department of Health, 2005), that care is done by the self alone. Numerous examples were identified of ways friends, family, neighbours, colleagues – even acquaintances and strangers become involved in others’ health. This challenges the way health policy focuses on the individual patient, rather than on the health interactions and (often quite deeply and widely) shared activity that actually goes on to manage health. This thesis aimed to depict the reality of the web of social interactions that surrounds the patient and works with him or her in managing their health. The thesis argues that it is important for policy makers to incorporate the fact that health is rarely managed in isolation and that self-care is rarely done by the self alone. It is also important for policy makers to be aware of the findings of this thesis which show that it is not only family members who become involved in patients’ health, but also friends, neighbours, colleagues and others. This thesis also shows that people would not be able to manage their health totally alone.
Health interactions affect relationships

The individualization thesis (Beck, 1992; Giddens, 1991) presents modern life as lived in a very private, atomised way, with projects of the self, self-improvement, self-reliance, and self-care. This thesis adds to the body of literature (see for example Jamieson, 1998) which challenge the individualization thesis, arguing instead for something closer to what Smart (2007) refers to as the ‘connectedness thesis’.

The findings of this thesis reveal not only connectedness, but also some examples of individualized ways of life and individualized ways of managing health. Included in the previous chapters are examples of people managing their health in self-reliant ways, of refusals to disclose health problems, diagnoses or worries, and of expectations that others will want to live their lives in individualized ways and will not want to engage with their health problems. So we can see that there is complexity surrounding the extent to which the management of health is an individualized or shared activity.

This thesis adds a new dimension to previous research by looking not only at the effect of health interactions on health, but on the relationship. The thesis found a number of ways in which bonds are strengthened, or weakened, by interactions about health (or the lack of them).

Another contribution that this thesis makes is that it nuances the understanding of roles played by friends and family. There is a debate within the sociological literature on friendship and personal life about the fluidity between, or suffusion of concepts of ‘family’ and ‘friend’ (Spencer and Pahl, 2006; Weeks et al., 2001; Weston, 1997). This thesis contributes to that debate and adds an understanding of the interplay between friends, family, neighbours and others specifically about health. There is fluidity in terms of who engages in health interactions. In the preceding chapters we have seen examples of friends and neighbours taking on ‘family like’ roles, but also of family not playing ‘family like’ roles. Although family has been said to be permanent and compulsory, and friendships to be voluntary, in this thesis there have been examples of friends who are described as ‘for life’ and compulsory, and family members who have been dropped or replaced by friends, very much ‘kin is who you define as kin’
(Carsten, 2004). It seems that what matters is not whether they are friends, family, neighbours, colleagues or acquaintances, but rather the characteristics of the relationship, the history they share and what they bring to the health interaction.

The thesis identified moral narratives that people tell about themselves and about their role as a ‘good friend’ or in providing support in times of ill health (a ‘good deed’). This adds to previous work on moral narratives (May 2008) and extends it to the field of health. Participants were keen to offer a strong presentation of self (Goffman, 1959) as morally virtuous. This shows that health is an important arena in which to demonstrate moral virtue or a moral self, where, for example, supporting others is more important than receiving support and the notion of reciprocity in health interactions is frowned upon.

This thesis argued that there are broader issues of sociological significance in the practices of health interactions. It was shown that health interactions affect and are affected by the ways people relate to one another and make connections. The argument was made that the moral meaning of interactions about health is of great importance to people and underpins much of the practices studied in this thesis. The thesis illustrated how a task which, on the face of it, is a private one such as managing and maintaining one’s health, becomes public and so of sociological interest, as it becomes enveloped in the input from and connections with other people.
References


Popay, J., Rogers, A., and Williams, G. (1998) Rationale and standards for the systematic review of qualitative literature in health services research. *Qualitative Health Research*, 8, pp. 341-351.


Zola I.K (1973) Pathways to the doctor: from person to patient. *Social Science and Medicine, 7* (9), pp. 677-689.
Appendices

Appendix A
Web of Knowledge databases

The Web of Knowledge (‘All Databases’ search facility) was chosen to conduct the literature search as it incorporates all the databases relevant to the research questions. In particular it includes the Social Sciences Citation Index and Medline, which are the two most important databases for this study.

Strengths

- A citation-based structure
- Listing of references with option to view abstracts for some articles
- Identifies highly-cited papers (which help to indicate strength)
- Includes conferences and meetings
- Includes ‘KeyWords Plus’ which offers additional keywords in addition to those supplied by the author
- Good for interdisciplinary research (including the hard sciences and social sciences)
- International coverage
- Starts with broad coverage which is good to ensure a comprehensive search, and allows for progressively narrowing the search
- Allows for trail-following via cited references
- Links to abstract and to the full text of the paper
- Includes meeting and conference proceedings which aids the search and discovery process

The databases which are part of the Web of Knowledge include:

1. Web of Science

   The Web of Science databases includes:

   - Social Sciences Citation Index
   - Science Citation Index
   - Arts and Humanities Citation Index
   - Conference Proceedings Citation Index (both the Science and the Social Science and Humanities editions)

2. MEDLINE

   MEDLINE covers the subject areas within medicine and health sciences that may contain references of relevance to the study, including nursing, medicine, behavioral sciences and the health care system.
Appendix B

Literature Review Appraisal Form

Author:
Year:
Title:
Pages:
Journal / Publisher:
Language:
Type of source:
Date reviewed:

Summary of usefulness / importance to the study:

Summary of paper:

Relevance: assessment of relevance to study:
Fit with inclusion and exclusion criteria?
Quality: assessment of quality:
Methodology used:
 Appropriateness of study design:
Methodological strengths or weaknesses:
Data (quality of):
RCTS and quantitative studies - bias:
Qualitative studies - importance placed on subjective meaning:
Quality of analysis:
Observations on structure, style, other aspects of the form of the paper:
Use of theory:
Any other theory referred to:

Parallels that occur to me with other theories / bodies of literature:

References to follow up:
Appendix C
Opinion piece published in Medical Sociology Online (MSo)

Acquaintances, friends and strangers – do they matter to medical sociology?
A response to David Morgan

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David Morgan has thrown at us a concept rarely, if ever, considered within medical sociology - that of acquaintanceship. He is concerned that with late modernity's emphasis on intimacy (and I would add, on individualism) forms of connectedness such as acquaintanceship have been ignored.

Can Morgan’s piece broaden for us the boundaries of what medical sociology could, or should, consider? In an already broad and possibly disparate sub-discipline, some may believe that acquaintanceship falls outside of our concerns. I, however, would argue the opposite, that other people in our social worlds can have a profound influence on our health. Because of this I would maintain that within medical sociology we should be engaging with the dynamics of interpersonal connections and their effect on our health. This could include friends, neighbours or colleagues. It could also at times include strangers. And it could include acquaintances such as David Morgan’s Telegraph reader (why did he stop catching the train – a change of job, a weariness with that early start, or an illness? Did Morgan notice, as I do at my morning station, when the regulars have a bad cold, look stressed, pale or hung-over, or when they turn up with a new girlfriend?).
I am of the belief that our fleeting interactions with others, including acquaintances, can impact on our health in a number of ways. Firstly, through some kind of Foucauldian self-surveillance, we can reflect on our own lifestyle and health options, by observing those of others. What do we think about ourselves and our own health, when we observe joggers, gym bag carriers and apple eaters or, on the flip side, the smokers outside the office or the fast food diners? And do we control our own health behaviour as a result of those reflections?

Secondly, strangers (slightly different from acquaintances, as Morgan reminds us) enter our personal space and our health in uninvited and unexpected ways. This might be through the cold caught from a fellow traveller on the bus, or, after a car crash, through our dependence on the intervention of a total stranger in what could be the most urgent medical crisis of our life. In doing so that stranger momentarily becomes an intimate.

Thirdly, within the context of reflexive late modernity, we are supposedly free to create and recreate our self. Sometimes this is by choice. At other times, such as at the onset of illness, it is by necessity. Illness identity and the biographical disruption (Bury, 1982) it can create has been a longstanding theme in the sociology of health and illness. Friends, and possibly acquaintances, invariably play a role in identity formation and reformulation, and may also be involved in illness identity and the process of coping with or responding to biographical disruption and reconstruction.

Acquaintances could be conceptualised as ‘weak ties’. Granovetter (1973) proposes that weak ties, people in more distant parts of our social networks, can be more useful to us than strong, closer ties. We could apply this notion to health support, health information or health advice. It may be for example that one of our ‘weak ties’, our acquaintances, has the same condition we have, or had the same health related decision to make. This puts them in an ideal position to play an important role in helping us to manage our health.

Strangers and acquaintances also play a role in arenas more familiar to medical sociologists. Morgan refers to the people with whom we share our waiting rooms (and I am very enthusiastic about his suggestion of unpicking sociologically what goes on in the process of waiting). I could add to the people in the waiting room, those with whom we develop an important connection for a fleeting period of time in a shared hospital ward. How do these people, these
interactions, influence our health? Do they help us to better understand the human condition, or at least the condition that brought us there? Do we learn some tips? Or some motivation? Or receive or give some support? At the very least these kinds of interactions with people we meet fleetingly in medical contexts may offer us new reflections on illness. Here I am reminded of the debate on suffering in the Opinion Piece of the first issue of this journal (www.medicalsociologyonline.org). Gareth Williams, Arthur Frank and Iain Wilkinson (2006) discussed how it is that we, as medical sociologists, can actually engage with, or really appreciate the reality of suffering. Possibly one moment when we do begin to feel the meaning of others’ suffering is when they touch our lives through some kind of interaction, however distant or fleeting.

These subjects have not been totally ignored by medical sociologists. The literature on lay beliefs and lay epidemiology provides us with an, albeit oblique, reference point for these ideas. It helps us in thinking about how other people with whom we brush our way through life may offer us different, usually less medicalised, models to explain our health. Elliot Freidson’s (1970) concept of the lay consultant is possibly the closest medical sociology has yet come to the ideas in David Morgan's piece. Our friends, and possibly occasionally our acquaintances, become the people we consult about our health. This can happen in place of, or before, a visit to a medical professional is ‘sanctioned’ (Zola, 1973). I am reminded here of conversations I am sure we have all overheard on trains, buses and over the kettle at work.

The medical professionals we encounter are an interesting type of acquaintance. As Morgan notes, they ‘have a detailed, intimate and embodied knowledge of us although they, themselves, are not intimates’. As medical sociologists we are concerned about a dehumanised and disembodied treatment from (some) medical professionals where we feel disconnected not only from the entirety of the parts of our body, but also from the human being who is focusing on one part of us. Some models of health try to overcome this. Complementary and alternative medicine, community pharmacists, peer health buddies, some specialist nurses and so on try to integrate a holistic or relational approach to managing health. And despite the end of GPs’ personal lists, we apparently still treasure our special relationship with our GP, as one of the few health professionals with whom (in some cases at least) we have a relationship which is a tad more than a stranger, possibly more than an acquaintance.
Morgan’s piece introduces his interest in acquaintanceship. Yet the applicability of these ideas for medical sociology could be taken further to look at the health role of social relationships more broadly. The predictive and protective role of social networks for health has been well documented. Self-help groups and internet communications between people who share a condition have also been studied by medical sociologists (see Bernadette McCreight’s paper in this edition) and underscore the importance of Morgan’s overall theme of the central role of connectedness in social life, and I would add in health. David Morgan ends his piece with a call for us, as sociologists, to recognise the importance of this connectedness. I would endorse this, and I would add a call for us as medical sociologists to recognise the importance of connectedness for health.

References
Zola, I. K. (1973) Pathways to the doctor: from person to patient. Social Science and Medicine, 7: 677-89
Julia Hiscock is a Research Training Fellow in the University of Manchester, undertaking a study on social networks and self-care, based in NPCRDC (National Primary Care Research and Development Centre) and conducted jointly with the Department of Sociology. This research is funded by a NCCRDC Personal Fellowship Award, leading to a PhD. Julia is also an editor of Medical Sociology Online (MSo).

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Appendix D

Recruitment list given to practices to guide recruitment

Sampling criteria to be identified via practice READ code search:

*Type of condition:*  
1. Heart failure  
2. Hypertension  
3. Depression / taking anti-depressants  
4. Stress / anxiety

*Gender:*  
1. Male  
2. Female

*Age:*  
1. middle aged - 45-55  
2. older - 70-80

Sampling criteria to be identified via screening questionnaire, conducted over telephone once reply slip has been returned:

*Household composition:*  
1. Lives alone  
2. Lives with others

*Employment status:*  
1. In paid employment (full time or part-time)  
2. Not in paid employment (i.e. retired, unemployed, or on Incapacity Benefit)

*Sample size:*  
Target for total sample recruited = 24  
= target for total sample per practice (assuming 2 practices) = 12  
But doubling the numbers recruited via READ codes to allow for choice in screening questionnaire, so total number required from each practice = 24  
I am assuming a 10% response rate in general, and a 5% response rate from men* and people with mental health problems**. I would also like to recruit larger numbers in the 45-55 age group***, as I want to make sure I have sufficient numbers of people in paid employment, who will be largely absent in the 70-80 age group.
### Sampling criteria to be identified via practice READ code search:

#### Type of condition:

1. Heart failure 6 x10 60  
2. Hypertension 6 x10 60  
3. Depression / taking anti-depressants 6 x20** 120  
4. Stress / anxiety 6 x20** 120

#### Gender:

1. Male 12 x20* 240  
2. Female 12 x10 120

#### Age:

1. middle aged - 45-55 12 x20*** 240  
2. older - 70-80 12 x10 120
<table>
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<th>Total number needed to approach(^1)</th>
<th>Age / gender</th>
<th>Age / gender</th>
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</thead>
<tbody>
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<td>6</td>
<td>60</td>
<td>40 (of which 30 = men 10 = women)</td>
<td>20 (of which 15 = men 5 = women)</td>
</tr>
<tr>
<td>Hypertension</td>
<td>6</td>
<td>60</td>
<td>40 (of which 30 = men 10 = women)</td>
<td>20 (of which 15 = men 5 = women)</td>
</tr>
<tr>
<td>Depression</td>
<td>6</td>
<td>120</td>
<td>80 (of which 60 = men 20 = women)</td>
<td>40 (of which 30 = men 10 = women)</td>
</tr>
<tr>
<td>Stress/anxiety</td>
<td>6</td>
<td>120</td>
<td>80 (of which 60 = men 20 = women)</td>
<td>40 (of which 30 = men 10 = women)</td>
</tr>
</tbody>
</table>

\(^1\) At a response rate of 10% or 20%
Mental health

1. STRESS

Search terms: Patient consulted between 01/01/2006 – 19/05/2008 with EITHER/OR

1. 13HT home problems (including stress at home; unable to cope)
2. 13JM. Problems at work
3. 1b1 General nervous symptoms (includes anxious, irritable, tension, emotional, stress related etc)

***AND EXCLUDED IF CAME UP ON DEPRESSION SEARCH

<table>
<thead>
<tr>
<th>Category</th>
<th>Aiming for</th>
<th>No found</th>
<th>No. excluded (reason)</th>
<th>Final no invited</th>
</tr>
</thead>
<tbody>
<tr>
<td>MALE 45-55</td>
<td>60</td>
<td>63</td>
<td>34 (in depr gp)</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5 (other: 1 bereaved, 1 memory loss, 2 high risk to researcher – social circs, 1 alcoholic with suicide risk)</td>
<td></td>
</tr>
<tr>
<td>MALE 70-80</td>
<td>30</td>
<td>13</td>
<td>4 (in depr gp)</td>
<td>9</td>
</tr>
<tr>
<td>FEMALE 45-55</td>
<td>20</td>
<td>137</td>
<td>80 (in depr)</td>
<td>20 (1 in 3 of 57)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3 (other: suspected ca, social circs not safe, wrong code)</td>
<td></td>
</tr>
<tr>
<td>FEMALE 70-80</td>
<td>10</td>
<td>47</td>
<td>16 (in depr gp)</td>
<td>10 (1 in 3 of 31)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>6 others (5 dementia, 1 hearing loss++)</td>
<td></td>
</tr>
</tbody>
</table>
2. DEPRESSION
Search terms: Patient consulted between 01/01/2006 – 19/05/2008 with EITHER/OR
1. 388P HAD score done
2. E2003. anxiety with depression
3. Eu32... depressive episode
4. E112 single depressive episode
5. E113 recurrent major depressive episode
6. 1b17 depressed
7. 1bt depressed mood
8. e2b1 chronic depression

<table>
<thead>
<tr>
<th>Category</th>
<th>Aiming for</th>
<th>No. found</th>
<th>No. excluded (reason)</th>
<th>Final no invited</th>
</tr>
</thead>
<tbody>
<tr>
<td>MALE 45-55</td>
<td>60</td>
<td>62</td>
<td>20 (2x acute psychotic episodes; 1 x acute bereavement; 17 x opiate or alcohol issues and safety concerns for researcher)</td>
<td>42</td>
</tr>
<tr>
<td>MALE 70-80</td>
<td>30</td>
<td>15</td>
<td>7: (3 acutely unwell; 2 dementia; 1 new dx cancer; 1 wrong code)</td>
<td>8</td>
</tr>
<tr>
<td>FEMALE 45-55</td>
<td>20</td>
<td>170</td>
<td>5 removed (2 unsafe for researcher to visit; 3 acute crises)</td>
<td>20 (1 in 8 with removals)</td>
</tr>
<tr>
<td>FEMALE 70-80</td>
<td>10</td>
<td>33</td>
<td>1 (dementia)</td>
<td>10 (1 in 3)</td>
</tr>
</tbody>
</table>

Physical health

3. HYPERTENSION
Search terms: Patient on HYPERTENSION register
And EXCLUDED if on CHD list
<table>
<thead>
<tr>
<th>Category</th>
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<th>No. excluded (reason)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>MALE 45-55</td>
<td>30</td>
<td>71</td>
<td>10 (on CHD)</td>
<td>30 (1 in 2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3 (other: 2 risk to researcher; 1 left practice)</td>
<td></td>
</tr>
<tr>
<td>MALE 70-80</td>
<td>15</td>
<td>105</td>
<td>28 (on CHD)</td>
<td>15 (first 15 of 1 in 4)</td>
</tr>
<tr>
<td>FEMALE 45-55</td>
<td>10</td>
<td>72</td>
<td>9 (on CHD)</td>
<td>10 (first 10 of 1 in 6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(1 bereaved)</td>
<td></td>
</tr>
<tr>
<td>FEMALE 70-80</td>
<td>5</td>
<td>132</td>
<td>22 (on CHD)</td>
<td>5 (first of 1 in 20)</td>
</tr>
</tbody>
</table>

4. CORONARY HEART DISEASE (Ischaemic heart disease)

Search terms: Patient on CHD register

<table>
<thead>
<tr>
<th>Category</th>
<th>Aiming for</th>
<th>No. found</th>
<th>No. excluded (reason)</th>
<th>Final no invited</th>
</tr>
</thead>
<tbody>
<tr>
<td>MALE 45-55</td>
<td>30</td>
<td>19</td>
<td>5 (2 left; 1 alcohol; 1 acute bereavement; 1 on depr invite list)</td>
<td>14</td>
</tr>
<tr>
<td>MALE 70-80</td>
<td>15</td>
<td>46</td>
<td>None</td>
<td>15 (1 in 3)</td>
</tr>
<tr>
<td>FEMALE 45-55</td>
<td>10</td>
<td>20</td>
<td>3 (1 unwell; 1 alcohol; 1 vulnerable adult)</td>
<td>10 (1 in 2)</td>
</tr>
<tr>
<td>FEMALE 70-80</td>
<td>5</td>
<td>37</td>
<td>1 (dementia)</td>
<td>5 (1 in 6)</td>
</tr>
</tbody>
</table>

Total letters to go = 247
Sample wanted ~24 ie 1 in 10
Appendix E

Topic Guide

TOPIC GUIDE – starting with involvement in other people’s health

1. Explicit introduction and start.

2. Ask participant about a time when they have got involved in the health / health problems of a friend, or someone else they know
   
   Explore circumstances
   
   What type of ways did they get involved?
   
   o Talking about it / conversations
   
   o Support (type of support, e.g. practical, emotional)
   
   o Motivational
   
   o Advice, suggestions
   
   o Information, tips
   
   o Sharing (e.g. of medicines)
   
   o Negative health interactions
   
   o Non-health involvement
   
   o Views on, experiences of

3. Explore whether they’d get involved in the same way with the health of other people they know:
   
   Probe differences and reasons
   
   o Family
   
   o Non-family
     ▪ Friends
     ▪ Colleagues
     ▪ Neighbours
- Acquaintances / weak ties
- Others

- Differences between interactions with different types of people
  - Different types of friends
  - Different types of family
  - Different types of colleagues
  - Different types of neighbours

4. Explore the **circumstances** under which the health interactions occurred

- Different types of illnesses
- Different severity of illnesses
- Different stages of illnesses
- Health rather than illness
- Requests for help / support / advice
- Unsolicited offers of help / support / advice
- Accepting / refusing offers
- Offers based on observed need
- Offers based on own need to give / support
- Giving v receiving - personal preferences

5. Knowledge base used – what are people basing their information or advice on?

- Media
- Info from formal health service
- Other friends
- Common knowledge / folklore
- Own experience
- Internet
- Reading / research
Views on quality of info:

- How well informed / well founded
- Is there debate / disagreement about different viewpoints / health information
- Extent aware of where info comes from
- Extent aware of the ‘truth’ of the info

6. Reciprocity – ways that person has supported / helped / shown interest in their own health

- Reciprocity considered appropriate / necessary
- Immediate or delayed reciprocity
- Like for like reciprocity or ‘pay back’ in different (non-health) forms?
- Are mental balance sheets kept
- How are reciprocity requirements accounted for / recalled
- Are ‘pay backs’ requested / pointed out
- How do reciprocity arrangements affect the friendship
- Different reciprocity arrangements depending on:
  - family or not
  - different types of relationships
  - different types of illnesses
  - nature of the help / support / advice being reciprocated

7. Ask participant about a time when they had a health problem themselves

Explore who got involved:
- Family
- Non-family
  - Friends
  - Colleagues
  - Neighbours
  - Acquaintances / weak ties
- Others
  - Differences between interactions with different types of people
  - Views on, experience of

What type of ways did they get involved
  - Talking about it / conversations
  - Support
  - Motivational
  - Advice, suggestions
  - Information, tips
  - Sharing (e.g. of medicines)
  - Negative health interactions

6. End with demographic information which will be useful for analysis
   - age
   - who lives in the household
   - how far family members live
   - how far friends live
   - type of activity during the day (ie paid employment? F/T? P/T?)
   - list of different health problems
   - list of medicines taking

THANK YOU

FOR NON-INTERACTORS:

- observations of / views of health interactions going on between other people
  (i.e. not involving them at all)
Try to explore what’s behind the non-interacting:

Probe:
- Weakness / strength
- Gender

non-health interactions:
- work
- finances
- relationships
- external events – news, sport

Try to explore ways they interact with people
- Focused on one topic
- Humour
- Non-personal
Appendix F

Recruitment documentation

Letter from practice to potential participant

To be printed on practice headed notepaper

Dear [insert name of patient],

[Insert name of GP practice] is taking part in a research study which will help us learn more about what people do when they are not feeling well – who they talk to and where they get help from. We would like to invite you to take part in this research study.

More details about the study are in the leaflet we are sending you with this letter.

If you are interested in taking part in the study, or want to find out more about it, Julia, the researcher, would be very keen to hear from you. **The Practice has not given any of your personal details to the research team.** So if you want to take part, you will need to fill in the enclosed form and return it in the envelope provided so that Julia can get in touch with you. The envelope does not need a stamp.

With best wishes

[Name of the GP who practice thinks best to sign the letter]
Study about health interactions in social networks

I am interested in participating in this study.

Name  __________________________________________

Address  __________________________________________

________________________________________________________________________

Post code ________________

Telephone number     -     Home
________________________________________________________________________

- Mobile

________________________________________________________________________

E-mail address (if you use it)

________________________________________________________________________

Please fill in this form and post it in the envelope provided.

The envelope does not need a stamp.

The envelope is addressed to the researcher, Julia Hiscock, who will contact you.
CONSENT FORM
Study number: 08/H1005/5
Title of project: Health interactions in social networks
Name of researcher: Julia Hiscock

Please initial box

1. I confirm that I have read and understand the information sheet dated

13/03/08 for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. I agree to take part in the above study

_________________________     __________________________
Name of participant          Date                     Signature

_________________________     __________________________
Name of researcher           Date                     Signature
Information about the research

Study title: Health interactions in social networks

We would like to invite you to take part in a research study. Before you decide, you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish, and take time to decide whether or not you would like to take part. Ask us if there is anything that is not clear, or if you would like more information.

What is the purpose of the study?

The study aims to find out how the people we know get involved in our own management of our health. The study is looking at the ways other people may, or may not, offer support, but it is also looking at more general conversations and interactions about health.
Why have I been invited to take part?

People from your GP practice and other GP practices have been selected, to get a range of types of people for the study (e.g. people of different ages, a mixture of men and women and different health conditions).

Do I have to take part?

Taking part in research is entirely voluntary. It is up to you to decide whether you would like to participate or not. Whatever you decide, the care you receive from your GP or any other part of the health service will not be affected in any way. If you do decide to take part, you are free to change your mind at any time, without giving a reason.

What will happen to me if I take part?

The researcher (Julia Hiscock) will interview you about ways in which any of the people you know get involved in your health, either through support, conversations, or in other ways. Julia will come to your house to conduct the interview. If you would prefer to meet somewhere else, we can arrange another venue. The interview usually takes about one and a half hours, but it could be shorter if we cover everything.

The interview will be audio-recorded using a small digital tape recorder. After the interview everything on the tape will be typed up. This will not have your name on it, it will just have a code, to protect your anonymity.

At a later date, after the interview, it is possible that Julia may ask you if you would like to take part in any future parts of the same study, and will explain what that will involve. However, there is absolutely no obligation on you to do so, and it is entirely up to you to decide whether or not you would like to do this.
What are the possible disadvantages of taking part?

The main disadvantage to you of taking part is that you will be giving up about one and a half hours of your time. Also, although we do not expect this, there may be some people who find talking about their health or their social networks distressing.

What are the possible benefits of taking part?

There are no direct benefits to you personally of participating in the study. However sometimes some people may find talking about their health or their social networks therapeutic.

Will my taking part in the study be kept confidential?

Yes. All information about you will be kept strictly confidential. What you say in the interview will be recorded on a digital tape recorder, it will be typed up and a code will be allocated to it. Nobody else apart from Julia will be able to link the code to your identity. Once the interview has been typed up and checked, the computer file which holds the audio-taping of your interview will be deleted. The electronic and paper transcript of the interview will be kept for ten years, to comply with the Data Protection Act, and will then be destroyed. Nothing will be published or shown to anyone else in a form that you can be identified.

What will happen to the results of the research study?

The results of the research study will be written up as part of Julia’s PhD thesis. It is also likely to be published in research journals and presented at conferences. A summary of the research findings will be produced at the end of the study for the everyone who was interviewed in the study. So you will have a chance to read about what the study found.
Who is conducting and funding the research?

The study is being carried out by Julia Hiscock, a Research Training Fellow at the University of Manchester, for her PhD. The PhD has been funded by the Department of Health.

Who has reviewed this study?

All research in the NHS is looked at by a Research Ethics Committee, which is an independent group of people who review research studies to protect your safety, rights, wellbeing and dignity. This study has been reviewed by the Sefton Research Ethics Committee.

What if there is a problem?

Should you have a concern about any aspect of this study, you should speak to the researcher, Julia, on 0161-275-7601, who will do her best to answer your questions. If you remain unhappy, or wish to speak to somebody else outside of the research team, you can do this through the University of Manchester (see contact details below).

Further information and contact details:

Lead researcher, to contact for further information or any concerns:

Julia Hiscock
Research Training Fellow
NPCRDC (National Primary Care Research and Development Centre)
University of Manchester
Williamson Building
Person unrelated to the study, to contact with any concern you do not wish to take to the lead researcher:

The Research Governance and Practice Co-ordinator
Research Office
University of Manchester
Williamson Building
Oxford Road
Manchester
M13 9PL

Tel: 0161-275-7583