An Interpretive Phenomenological Study of How White British Men on Low-incomes Understand, Experience and Create Positive Health and Well-being

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Reflexive introduction

This introduction forms part of a completed PhD. Achieving this point in an academic career as a part-time self-funded student is testament to a degree of intelligence and commitment. I have spent the majority of my working life with earnings in the lowest quintile of the population. More than a third of my life I have lived in areas of high derivation including three council housing estates. The following will detail how someone with the potential to complete a PhD slipped through the academic net at an early age and spent a life in relative poverty.

I was born and lived in South London and although not in poverty, we were a family of six living in a two bedroom flat with my older brother and me sleeping in bunk beds in the hall. For us, this was a normal way to live. My mum and dad both worked six days a week in catering and were hands off in their approach to parenting for the four children. I was bullied relentlessly at school, lacked confidence, was unmotivated and had no understanding of the benefits of achieving high grades in exams. I underperformed in my O-levels and A-levels and did not achieve the grades for the degree in Food Science at Kings College London for which I had a conditional offer. Instead, I studied for an HND in Hotel Management at Leeds Polytechnic. During my time studying in Leeds, my parents moved to a one bedroom house and it was clear I no longer had a home with my parents. I was homeless for a short time after a fire in the flat where I was living rendered it uninhabitable. After sleeping on the floor in friends' houses for a while, I found a room in a shared house. Looking back at that time in my life, it is not clear how close I came to becoming officially homeless but I can understand how easy it can be to end up living on the streets.

My career in catering lasted 3 years until I realised I did not want to live the way of life required for catering. Long shifts, split shifts and weekend working were taking its toll on my life and so I looked elsewhere for employment. I next worked in a cash and carry, filling shelves, working on the checkout and fork-lift truck driving. This was low paid work so I also took a part time job working in a pub, working long hours for low pay. After three years, I gained a job as a sales representative selling Pritt Sticks around northern England and Scotland but did not pass the probation and found myself out of work, claiming unemployment and housing benefit.

Within three months I had two part-time jobs. I was a part-time postman and part-time telemarketing operative at Kay's catalogue, again low paid jobs with long anti-social hours. I eventually went full-time as a postman and left my job at Kay's. Within a few years I became a manager at Royal Mail and bought a house in Harehills in Leeds. Harehills is an area of high deprivation and high non-white population. It is in the top ten (out of 108) Middle layer super output areas (MSOA) in Leeds for deprivation, unemployment, fewest GCSE passes and other measures. The life I led was simple and enjoyable despite the signs of poverty around me: the late night police helicopter hovering overhead;

the few cars on the street; the numbers of unemployed men gathered in groups on street corners and the nearest supermarket two miles away.

In 2005, at the age of 38, I realised that spending the rest of my life as a manager with Royal Mail was going to make me miserable. I decided to study for a degree and gain a more rewarding career. Having been involved in the Right to Read initiative where I listened to year 4 children read in primary schools, I realised that a lot of 8 years olds could not read well. To help children by becoming an educational psychologist, I needed a degree in psychology. The only option, beyond retaking A-levels was the Open University. To allow myself the mental space to do well, I became a postman again and studied part-time while working full-time. The most enjoyable module on the degree was the final year social psychology module which included a qualitative research project embedded within the module. I had previously lived with my wife prior to our divorce and knew that my health and wellbeing was not as good as a single man living alone as it had been as a married man. My research project was a discursive investigation of food, health and embodiment for people who live alone. One of my concerns during the literature review was that there was no data on low-income groups when it came to food, nutrition and health. My participants were high earners and found it easy to source food. My recommendation in the dissertation was to investigate low-income groups with their lower nutrition and lower food security.

Further research into literature on health and low-income groups led me to understand the disparity in research between low-income groups and the rest of the population. There was much less health research involving low-income groups despite low-income groups having the worst health outcomes in the population. When I delved further, I discovered that research into low-income groups predominately featured women. Men were in the minority in mixed gender groups and sometimes absent from the findings when the researcher claimed to be investigating low-income groups.
In my dissertation, I stated in the introduction that: ”women are seen as more comfortable accessing health care and push male partners to make appointments. Men were positioned as passive, helpless and incompetent and needing women to access healthcare. This helplessness was tolerated and welcomed partly by the use of humour by male doctors as part of the masculine hegemony.” I investigated hegemonic masculinity further and read about men being to blame for their own poorer health, particularly men on low-income. This was not my experience of men or men on low income. I had been working with, living with, playing football with and socialising with men on low-income for more than 20 years and I did not see in my lived experience what was being presented to me in the media and the academic literature. The men I knew and had known were in the main: hard working, caring; loving of the family; full of humour and expended a lot of physical and mental energy in their struggle just to live. By this I mean to feed and house themselves and their families and to try and be a part of society by wearing clothes that others wore and providing their children with things that other

children had. They were proud men who did not want to be seen as unable to provide. They deserved to have their story told as a counterpoint to the prevailing narrative of helpless men who were to blame for their poor health. I was motivated to undertake a PhD for my own career aspirations. However, I was motivated to choose this topic because the men I knew were not being represented accurately in academic literature, they were being demeaned and blamed for their problems. I knew that researching the reality I saw could be used to make a difference.

I applied for PhD studentships in 2011 but was unsuccessful. During the application process, I was medically retired as a postman and became a father for the first time. The need to find work to support my family took precedence over the need to commence a PhD. I found a zero hours minimum wage job as a carer for those who needed care in their own homes. I re-contacted my eventual lead supervisor and we agreed I would self-fund a part-time PhD commencing in 2012. To commit the time to complete the PhD and further my career, I found part-time work as a teaching assistant at a university in Leeds but this meant I would remain in the lowest earning quintile of the population for the duration of the research.

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Secondly, (and only marginally) thank you to my wife Jo and my son George for your unrelenting love, hugs, belief and cups of coffee. Jo, thank you for your kind words, support and the occasional kick up the backside when I needed it.

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Abstract

Introduction: Little is known about the positive health and well-being practices of men on the lowest incomes. The majority of health and well-being research with this group is conducted using masculinity as a framework thus ignoring individual, situated behaviours.

Aims: To situate the study of men's health within a historical and political context; review the positive health and well-being behaviours in the literature for men on low-income; capture and examine how White British men on low-incomes understand, experience and create health and well-being for themselves and then to critically assess the position of hegemonic and alternative masculinities in relation to men's positive health and well-being.

Methods: Three literature reviews were undertaken between 2013 and 2020 to explore current research on men's positive health and well-being. Participant data collection was facilitated by photo-elicitation. 21 men on low-income, aged 22-71 years were asked to photograph anything that affected their health and well-being. Photograph-led, exploratory interviews captured the meaning of each photograph for the participant. Transcripts were analysed using Content Analysis and Interpretative Phenomenological Analysis.

Findings: The Content Analysis produced four clusters of data: beneficial activities; awareness of the everyday; states of mind and moving away from risk. Seven themes were generated via IPA: Journey; Balance; Space; Time; Resilience; External Resources and Awareness. The analysis showed the men on low-income experienced multiple threats to their health and well-being through living in poverty. The phenomenological approach to understanding the men's lifeworld and lived experience of health and well-being in poverty unearthed many creative ways in which these men strived to counter these threats and many were flourishing despite their deprivation. A model of health and well-being based on the legend of Sisyphus was created to demonstrate how the themes intertwine and highlights the men's motivation towards personal growth, and their resilience in challenging setbacks to this growth.

Conclusion: For the first time, this model provides the situated positive exemplars of men's health and well-being that will complement the reductionist, negative concept of masculinity to show men on low-income a way to counter adversity and create positive health and well-being in their lives.

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1.1 Introduction

Men on the lowest incomes have the poorest health and the lowest life expectancy in the UK today. Very little is known about how men on the lowest incomes understand health and well-being or how they manage their health and well-being in the face of poverty, stigma and factors that induce the poorest health. This opening chapter aims to make the case about the importance of understanding health in the context of poverty and gender. The chapter will begin by examining the current effects of gender on health before moving on to the current effects of poverty on health. It aims to show how financial poverty has become entrenched within society in the UK and the subsequent effects on health of the poorest in the population. The chapter takes a historical perspective on financial poverty and view how government and other institutions have tried to ameliorate the worst effects of poverty on health. This will start with the first Poor Laws, through to the creation of the Welfare State and finally the situation in 2020 (the point of conclusion of this thesis). Much of the historical data is not gender specific, therefore the effects on men's health will only be discussed when it is clear that gender can be discerned from the data. The aim of this chapter is to detail the importance of situating the study of men's health within a historical and political context.

1.1.1 Health determinants and outcomes

Two of the strongest determinants of health in the world today are gender and income (WHO, 2019). Considering gender first, the most recent UK life expectancy figures from the Office for National Statistics (ONS, 2019) show that life expectancy for a woman is 82.9 years compared with 79.3 years for a man. Many reasons may explain this difference; compared to women: more men die across a wide range of diseases; men are twice as likely as women to die of the ten most common shared cancers (Public Health England, 2017a); men are 32% less likely to consult their doctor with health concerns and this figure is higher in deprived areas (Wang et al., 2013); 40% of men are overweight compared to 31% of women, with the highest rates in the Yorkshire and Humber region (NHS Digital, 2019); are less likely to eat five a day; and are more likely to smoke and drink more than the recommended amounts (NHS. 2013).

Although the gender health difference in favour of women is consistent across time, gender differences in life expectancy has narrowed from 6 years in 1980-82 to 3.6 years in 2016-18 (ONS, 2019). The narrowing in life expectancy between men and women is the sum of many positive and negative effects. There have been reductions in men's deaths from external causes due to improved health and safety legislation at work. Men gave up smoking in greater numbers than women twenty to thirty years ago, increasing their life expectancy at a more significant level than among women. Finally, although men have always had higher rates of hazardous drinking, with resultant long-term

risks for cardiovascular disease and cancer, this risk is increasingly prevalent in women whose associated life expectancy is reducing as a result (White et al., 2014). Despite these improvements in the comparisons between the death rates of men and women, large differences still exist. In some cases, they are much worse. Suicide rates for men are more than three times that of women with 4,903 men and 1,604 women dying from suicide in the UK in 2018 (Samaritans, 2019). It is argued that suicides tend to be higher than official figures as coroners must have no doubt that an unexplained death is suicide and if there is doubt, these deaths are recorded as undetermined or accidental (Värnik et al., 2010). The implications for men's health from all the above data, despite the recent narrowing in life expectancies, are often referred to as the 'crisis' in men's health (Sloan et al., 2010).
Income or socioeconomic status (SES) is also a significant predictor of health (Graham, 2009). SES is measured by combining social and economic status and higher values tend to be associated with better health and life expectancy (Cockerham et al., 2014).

Those in higher SES classifications are more likely to be able to afford health promoting resources. Moreover, they are more likely to be socialised to have better health through their lifetimes and to have had healthier lives and a consistent income through ability to work (Cockerham et al., 2014). Compared to people with high SES, people in the lowest SES classifications are more likely to: have an alcohol related death; be classed as binge drinkers; smoke; do less exercise; eat less than five a day, and children in the lowest classification are more likely to have poor mental health (Graham, 2009). Life expectancy at birth for men in the highest SES classification has risen from 75.7 to 82.5 years between 1982 and 2011, while in the lowest classification, it rose from 70.8 to 76.6 (ONS, 2015b). There has been no further data on this released by the government since 2015. Marmot (Marmot et al., 2010) highlights life expectancy differences at the neighbourhood level with up to 7 years life expectancy difference and 17 years difference in disability free life expectancy between the richest and poorest neighbourhoods. This life expectancy difference rises to 17 years between two areas of London 2 miles apart, with a man in Tottenham Green expected on average to live for 71 years and a man in Westminster expected to live for 88 years on average (Marmot et al., 2010).
The improvement in health and social care in recent years has increased life expectancy across all social groups but the inequality in health has widened over this time. Graham (2009) asserts that it is generally accepted that gender and SES are the main predictors of health and health behaviours. This places low SES men at the bottom of the health outcomes table (Acheson, 1998). When Graham (2000) examined health in later life, the social class differences in self-reported health were mostly confined to men. Thus, indicating that low SES men are more at risk of poor health outcomes than women and also men with higher SES, across the course of their lives.
From the first part of this chapter, it can be seen that poverty and gender both have a deleterious effect on the health and well-being of men. They are both complex topics that need unpacking to understand

the nuanced effects they have. The next chapter will look at men and their health and well-being. The rest of this chapter will look at how poverty has affected health and well-being over time.

1.1.2 Defining poverty and its effects

Poverty is a complex and contested social and political issue. The United Nations Copenhagen Declaration states that:

> Poverty has various manifestations, including lack of income and productive resources sufficient to ensure sustainable livelihoods; hunger and malnutrition; ill health; limited or lack of access to education and other basic services; increased morbidity and mortality from illness; homelessness and inadequate housing; unsafe environments; and social discrimination and exclusion. (United Nations, 1995, p. 57)

This statement argues that poverty is not just a lack of money or assets but about experiences of health, education, housing and social exclusion. To highlight recent effects of poverty in the UK, NHS Health Scotland found that, compared to children who did not grow up in poverty, those who did had: higher infant mortality rates; poorer health and well-being; fewer friends; less access to social activities and attained lower levels of reading, writing and numeracy (NHS Health Scotland, 2019).

The UK government collects poverty data at the Office for National Statistics (ONS) and publishes an annual report on Households Below Average Incomes (Department of Work and Pensions, 2016). The figure used as a measure of poverty by the ONS is 60% of median earnings, a figure now used by the European Union. About 20% of UK households are below this mark each year. The 60% of median incomes figure also closely relates to the lowest band of the occupation quintiles (ONS, 2015a) used by the government for individual incomes, with the lowest 20% of individual incomes in the bottom bracket. Men below the 60% median individual incomes are the group on which this research is based. At the time of first recruitment, the 60% figure related to an income of £14,300.[1]

To identify how financial poverty has become entrenched within society in the UK and the subsequent effect on health, an historical perspective is required. This will help to show the different prevailing ideologies concerning the health and well-being of the poorest and the factors that caused this to evolve over time. This historical perspective will detail public health policy, global events and political ideology from 1800 and how these have affected the health of the poorest in society.

1.2 An historical perspective on poverty

1.2.1 The evolution of the welfare state

In 1801, only 20% of the population of Great Britain[2] lived in towns of larger than 5,000 inhabitants, i.e. approximately 2.1 million people. In 1851, the figure increased to 54% and by 1911 the figure

[1] To ease understanding throughout the rest of the thesis, income will be used as the sole determinant of poverty.
[2] Depending on the source and the time of data collection, some is for the United Kingdom, some for Great Britain and some for England.

rose to nearly 80%, equating to approximately 28.8 million people (Mitchell & Deane, 1971). Thus, between 1801 and 1901, the population of Greater London rose from 100,000 to 6.6 million and Glasgow from 77,000 to 904,000 (Wohl, 1984). The mass migration to the cities in the 19th century meant that some parishes could not provide support to those in need and reform came in the 1834 Poor Law Act. Malthus concluded that the poor worsen their condition by breeding irresponsibly and that poor relief encouraged this irresponsibility (Jones, 1994). Hence, in an attempt to alleviate the burden on rate payers, the new Poor Law established that conditions in workhouses should be worse than those outside to deter anyone but the most desperate to use them (Fraser, 2009). The concept of poor relief as worth less than a working wage to encourage those on poor relief to find a job has been in place ever since (Novak, 1988).

The 1832 Reform Act denied the poor the vote and the Chartist movement was formed to challenge the Act and give the poor more power to protest to parliament. The Chartist movement grew strength from anti-poor law feeling and this growth eventually supported later reforms to suffrage and economic support for the poorest outside the workhouse. The migration to the cities, the resulting squalor and lack of meaningful financial support for the poorest lowered life expectancy significantly for those with the least. Life expectancy was around 40 in 1800 (Szreter & Mooney, 1998). It dipped to 25 in Liverpool and Manchester in 1841. The existing infrastructure could not cope with the rapid rise in population and it was not until 1854 that John Snow showed how disease was spread through contaminated water (Encyclopaedia Britannica, 2018).

The 1872, the Public Health Act created sanitary authorities who were obliged to provide public health services (Ham, 2009). The British Medical Journal voted the provision of sanitation and clean water supplies the greatest medical milestone over the last 150 years (Baggott, 2011).
In 1841, 10% of the enlisted men were under five foot six tall. By 1900, that figure had risen to over 56%. From volunteer rejection statistics, Rowntree (1902) concluded that about 50% of the nation was unfit for military service Winston Churchill crossed the floor in the House of Commons in 1904 from the Conservatives to the Liberals when he realised the damage poverty was exerting on the population. He said that inconsistent employment and subsistence were the enemies of Britain and her power (Novak, 1988).

During the great depression in the 1920's and 1930's, unemployment peaked at 22.1% (Pearce & Stewart, 2002) and infant mortality was 77 deaths per 1,000 in the lowest class (Stephenson & Cook, 1998). In 1936 the threat of Hitler in Germany was taken seriously, and the country started to gear up for war and unemployment began to lift.

After the Second World War, Labour swept to power in 1945. Sir William Beveridge outlined five giants that needed to be tackled as part of reconstruction: Want, Disease, Ignorance, Squalor and Idleness. These were all tackled between 1944 and 1949. With this legislation the last remnants of the Poor Law were finally cleared from statute. Want was tackled by an extended National Insurance scheme; Idleness by nationalisation of heavy industries; Ignorance by extending the school leaving age to 15; Squalor by building new towns and creating national parks; Disease by creating the NHS in 1948, bringing together nearly all the health services in the country under one banner.

When the idea of the NHS was mooted, there was a strong incentive to make the service a preventative rather than a curative service to reduce costs. This would be done through health centres which would promote prevention and be the first point of contact for the health service. Opposition from GPs and the British Medical Association meant that this idea was not implemented and although the NHS was set up with prevention in mind, this has never been seen in practice to a great extent (Berridge, 1999: Ham, 2009).

1.2.2 Austerity

The economic crash of 2008 in part precipitated the end of Labour government and the election of the Conservative/Liberal coalition in 2010. The coalition switched tack on social policy and championed austerity as a driver for change. The then Prime Minister, David Cameron, introduced the idea of the Big Society with charitable, private and informal sectors addressing social problems and pushing progress, similar to that of Victorian conservative government with a small central state and increased non-governmental interventions. Hence, resonant with the context of the 1834 Poor Law Amendment Act, Jones (1994) argues that it could be viewed that the problems for the poorest of that generation are the same today: battles over centralisation, stigmatisation of poverty and the hope that voluntary services will pick up what the state will not provide.

The Healthy Lives, Healthy People White Paper (Department of Health, 2010) acknowledged health inequalities and the way in which wider social factors determine health and well-being. The Conservative government decided tackling these inequalities would be devolved to local authorities to improve public health in their areas (Department of Health, 2010). Local authorities would receive more funding from central government through a health premium if they met targets on improving health in areas with the worst outcomes.

Several regulatory and advisory bodies were amalgamated to create Public Health England in 2013 to protect the public from health threats, improve the health of the poorest in the population and improve well-being and life expectancy (Department of Health, 2010).

In 2015, the Conservative government mounted a 4 year benefit freeze on working age benefits and tax credits, holding payments at 2015 levels. By 2019 this meant a 6.5% real terms reduction in benefit payments. Barnard (2019a) claims that by 2020 this freeze will have taken another 400,000 people into poverty and affected 27 million people including 11 million children. The 2015 Conservative government also introduced Universal Credit, simplifying the benefit payments made to claimants. This was welcomed by the Joseph Rowntree Foundation, committed to solving UK poverty. However, Barnard (2019b) points out that although 300,000 working benefit claimants will be lifted from poverty, another 200,000 out of work claimants, those most in need, will descend into poverty. The five or six week wait for the first payment exhausted some claimants' financial reserves and forced many to be reliant on foodbanks. In the 2018-2019 financial year, the Trussell trust supplied 1.6 million emergency three day food parcels to those in need, 577.618 of these went to children (Trussell Trust, 2019). Of 270 foodbank users surveyed in 2017, the authors found the homeless and men in single households were more likely to be classified as foodbank user (Prayogo et al., 2017).

In 2017, 112,000 households approached their local councils for help as they were either homeless or at risk of becoming homeless. Sleeping rough in England has increased from 1,748 to 4,677 since 2010. 84.5% of these homeless were men. The risk to health from homelessness will be explored in the next chapter.

In 1899 the infant mortality rate stood at 16%. This has gradually lowered to a record low in 2014 of 3.6%. The most recent figures show an increase to 3.9% in 2017. However, when deprivation is taken into account, the least deprived areas recorded infant mortality rates at 2.2% and the most deprived areas at 5.2%.

These statistics indicate that government policy since 2010 has had a detrimental effect on the levels of poverty and child mortality rates in the UK. After visiting the UK, the United Nations ruled in 2016 that UK austerity measures and welfare reforms breached international human rights (UN, 2016).

1.2.3 The impact of austerity specifically for men's health and well-being

MacKay et al., (2013) Suggest the majority of the earliest job losses in austerity were experienced by men but that trend was subsequently reversed to more job losses for women. Bennett & Daly (2014) highlight the lack of data on men in poverty as gaps in their evidence. They do highlight figures from the Department of Work and Pensions in 2013 that show all those in poverty 40% were women, 37% were men and 23% were children. The bedroom tax meant men moved into smaller accommodation with some high rise flats in Leeds having 75-80% male residents and the majority of the homeless population in Leeds was male in 2016 (White et al., 2016).

1.2.4 The rise of neo-liberalism

Margaret Thatcher said she believed there should be a difference between the earnings of those in work and those out of work, (Novak, 1988) an echo of Malthus in 1834. Two 1980 Social Security Acts did two things. Firstly, increases in benefits rose in line with prices rather than wages. Prices traditionally grew at a lower rate. Secondly, unemployment and other short-term benefits were cut by 5% on the grounds that benefits should be taxable, and the cut was in lieu of taxation, the first cut in benefit since 1934.

In the 1980's under the Thatcher administration, unemployment was used to drive down inflation by lowering wage demands (Jones, 1994) and thus increasing the levels of poverty. The Phillips Curve (Phillips, 1958) shows the correlation between wage rates and unemployment between 1861 and 1957. When this equation is applied to unemployment and inflation, when unemployment was at its peak in 1985 and 1986, inflation was at its lowest. Inflation slowly rose as unemployment reduced quite significantly in the following five years (Dawson, 1992). The burden of this success, as in previous periods of growth, was borne unequally by the poorer sections of society. Unemployment rose during the 1980s, peaking at over 3 million in 1985 and the social security system cost 30% of all public expenditure. High unemployment coupled with a rise in wages meant conditions similar to the 1930s with a polarised population and in increase in inequalities. Using the poverty figure of 60% of median income used earlier, the percentage of households falling into the category of poverty rose from 8% in 1979 to more than 20% in 1992 (Alcock, 2006).

With the return of the 2010 Conservative government and its austerity policies, came a return to neo-liberalism. Many policies such as Spearhead areas (Department of Health, 2004), designed to alleviate the worst of the effects of the social determinants on health were immediately stopped. Not only the funding was stopped but also the measurement of changes to key indicators was curtailed. Other policies, such as Sure Start centres entered a period of slow decline as central government reduced funding to local authorities. In 2017, Oxfordshire closed 31 of its 44 Sure Start centres (Oxford Mail, 2017). Several evaluations of the efficacy of Sure Start centres have shown improvements for children and families (Department for Education, 2010; Department for Education, 2015). The most recent by the Institute for Fiscal Studies concluded that hospital admissions have reduced by 5,500 annually for 11 year olds in the poorest areas saving the NHS £65 million a year (Institute for Fiscal Studies, 2019). This last report indicates that improvements from Sure Start interventions go beyond immediate improvements in education or health and well-being for infants.

Although eschewing discussing social determinants as a cause of health inequalities, the government does have one page on its website on which it presents research and analysis on the social determinants of health (Public Health England, 2017). The three areas detailed are living standards, employment and child development/educational attainment.

1.2.4.1 Reflective box 1

Reflective Box 1 'Creating unemployment'

I was 16 in 1983 and 18 in 1985. Leaving school and sixth form at a time when unemployment was rising rapidly and then reaching new heights was a worrying time for me. My A-Level results were poor and my mum and dad did not want me to stay and re-take them so I left home to take up an HND in Hotel Management at Leeds Polytechnic. Within a year, mum and dad had moved away from where I grew up and I did not return home. The catering life was not for me and I took up a series of poorly paid jobs including 16 years as a postman. Without this background, it is likely I would have never thought to undertake research with men on low income and if I had, I suspect that I would have been less able to understand and empathise with them in the recruitment and interview process. Understanding the reality behind many of these men's lives also enabled me to interpret the data with, at least some claim to, insider knowledge thus facilitating the research process. Until reading about the Phillip's curve in 2016, I did not consider that unemployment could be manufactured. I had assumed that economic downturns were a natural part of how the world worked. Learning about the deliberate destruction of communities and livelihoods of millions of people in the name of lowering inflation left me speechless with anger. My friends at school suffered years of unemployment and enrolling on Youth Training Schemes. My indignation at this deliberate manipulation motivated me to complete this thesis. I have never been a fan of Conservatism but I now know I am completely antithetical to it. My position within the thesis changed at this point. I became less of a research tourist in the men's lives and felt like I could be an agent for change for them and others like them. This then brings its own issues where I must not influence my analysis and writing to produce arguments that are not grounded in data or reality. I was aware that some of my writing had become like this and the drafting process with my supervisors showed me where I need to be more cautious about my arguments. This process has continued beyond the viva and into corrections where further reading has pulled me back from out-and-out socialism. I am now in a position taken up by the last Labour government where citizens must take on responsibility for their actions but where the worst areas affected by social determinants of health should be targeted to help people overcome barriers to self-improvement.

1.2.5 The Black Report and socio-economic determinants of health

In 1977, Sir Douglas Black, President of the Royal College of Physicians and others were asked to examine social differences in health (Townsend & Davidson, 1992). The group concluded that, since the Second World War, in absolute terms, there had been health improvements for the whole population. Despite this, social inequalities in health had persisted and socio-economic factors had played a major part in this.

Poorer health was experienced by the poorest at all stages of life and, if the mortality rates for the highest 20% were applied to the lowest 40% between the years 1970-1972 - 74,000 lives would not have been lost, including 10,000 children (DHSS, 1980). The group went on to say that much of the problem lay outside the scope of the NHS and lay in the way people live their lives, income, education, transport, lack of work and lived environment. All these areas favour the better off and all affect health. The point was also made in the report that the lifestyle factors (e.g. smoking, drinking, eating and exercise), are not wholly the cause of income related health inequalities. Lifting people out of poverty, improving living environments and the quality of food they eat, would also improve health. Their recommendations focused on the rebalancing of the NHS toward prevention and community health - an original aim when the NHS was created - and much more cash for those most in need, such as children and those with disabilities. Black was arguing that health inequalities were partly related to personal choice and partly related to poverty and the lack of physical and social support structures associated with poverty.

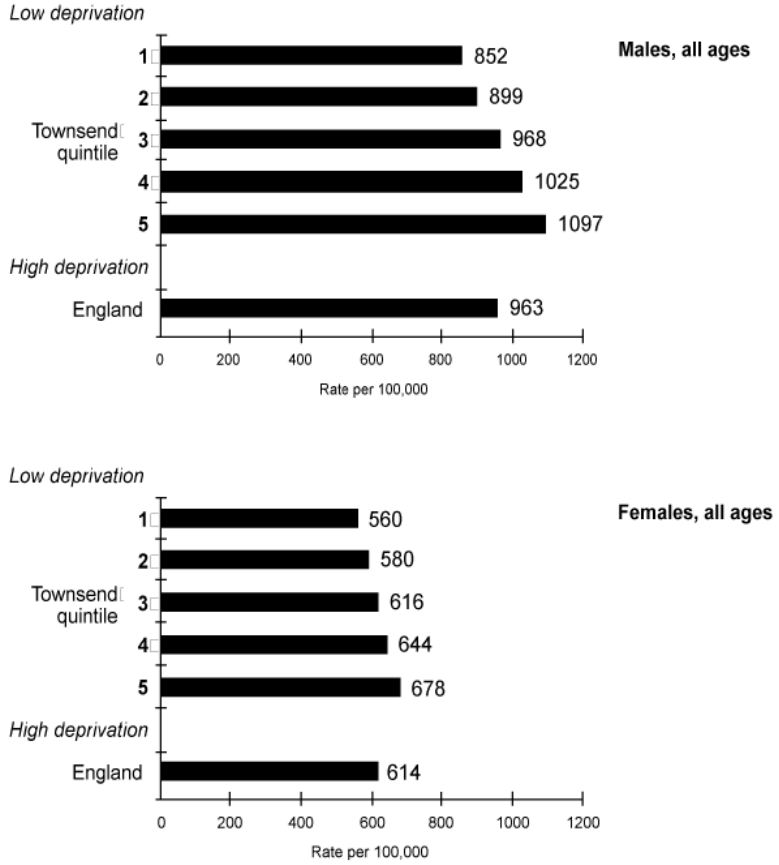
The report and proposals for improvements in inequalities commissioned by the previous administration was ignored by the Conservative government as it would cost more than £2 billion a year: an unrealistic figure for the economic climate at the time. The argument used by Patrick Jenkin was that increasing amounts has been spent on the NHS since its inception and it had made little difference in improving people health (Deitch, 1981). The argument made by the Black Report was that money needed to be spent differently on the NHS with more on prevention, not more spent overall. Black argued that housing is one of the prime requisites for health, meaning not just the physical building but, streets, shops and green spaces (Porter & Coles, 2011).

1.2.6 Mixing neo-liberalism and socio-economic determinants of health in policy

As soon as the Labour government of Tony Blair took office in 1997, they appointed Sir Donald Acheson to review and summarise inequalities in health in England. He was also asked to identify priority areas for the government to focus policy and interventions. Acheson found a similar situation to the Black Report where life expectancy was improving across all areas of the population but the inequalities between social groups had widened (Acheson, 1998). Acheson also found that there was a large difference between male and female mortality rates at all levels of deprivation. Figure 1.1 shows the difference between standardised mortality rates for males and females and by Townsend quintiles which measures, unemployment, car ownership, house ownership and overcrowding (Townsend et al., 1988). Males in every deprivation quintile had higher mortality rates than the highest mortality rate for females. The mortality rate increased with deprivation for males and more than 60% of males had mortality rates higher than the average, showing how much deprivation affects life expectancy.

Figure 1.1

Standardised Mortality rates in England by Townsend Quintile, Males and Females, 1993-1995 (Acheson, 1998)



The Blair government implemented many of Acheson's 39 recommendations, with policies aimed at improving education and housing, reducing poverty and social exclusion, and regenerating deprived areas. The most impactful recommendations implemented the public health campaigns of 5-a-day, the smoking ban in workplaces (Porter & Coles, 2011) and the introduction of a 10% income tax band (Gordon, 2000).

The Labour government elected in 1997 also used neo-liberalism and the concept of citizenship to stigmatise the poor (Morrison, 2003). The government's view was that all people are citizens and that good citizens are all pulling together to make the country a better place and that those that do not do this are bad citizens. This concept of citizenship was positioned as singular with no other concept of citizenship possible and the government would demand responsibilities of citizens and offer rights and opportunities in return. One of the conditions of citizenship was unemployment benefit which was conditional and could be withdrawn from a bad citizen. Bad citizens were shown in TV adverts working while claiming benefit and being subsequently caught (Morrison, 2003). This stigmatised those claiming benefits as there was no concept of a good unemployed citizen claiming benefits on offer, only a concept of a bad citizen.

1.2.7 Stigma

It has already been argued that problem families were the stigmatised group of the 1960s (Macnicol, 1999). In 1972, the chairman of the Social Science Research Council, Sir Keith Joseph promoted research which he claimed would show 'transmitted deprivation': the idea that, despite relative poverty, the same families were deprived generation after generation. Rutter and Madge (1976) conducted comprehensive research into family situations, economic status, crime and many other factors. Although they found continuities over time, these were not familial and therefore not generationally causal in the way suggested by the idea of transmitted deprivation. Continuities in poverty were influenced more by economic factors and regional context such as a persistently high unemployment rate. The answer that more needed to be invested in social services rather than to blame families was not what Sir Keith Joseph, as argued by Jones (2000), wanted and he promptly cut the budget of the council.

Monk and Kleinmann (1989) argue that the Conservatives saw local authority owned social housing as a symbol of the weakening of the moral fibre of the poorest. This could be seen as another attack on long term property tenure by the poorest in society. The language used to justify many of the changes in welfare provision under the Thatcher administration was similar to anti welfare reformers in Victorian times. The word underclass to describe those who are not only in poverty but are suffering social exclusion has been used for many years (Field, 1989). More recently, based on economic and social worth, (Valentine & Harris, 2014) underclass has been used as a form of political stigmatisation to describe those who are to blame for their problems and not deserving of public sympathy or help. Alcock (2006) argues that there is little evidence to show that the poorest are socially and economically excluded from society. Research on attitudes towards poverty, for example by Baumberg (2016), show that historical ideologies around deserving and undeserving poor remain. These reconstructions are often used by the media and politicians at times of austerity to stigmatise and blame those in poverty (Alcock, 2006). Stigmatisation leads to social exclusion as the experience is one of being separated from the rest of society (Miller, 1987). Stigmatisation may have increased with the recent prevalence of television shows such as Shameless (Abbott, 2013) and Benefits Street (Smith, 2015) depicting those in poverty in a poor light. Alcock's sources regarding social exclusion are not recent and attitudes may have changed since that time to create an underclass who are long term unemployed and socially and financially excluded from mainstream society.

Shildrick (2018) contends that recent misleading media depictions of the poor as feckless, unwilling to aspire or work can best be described as poverty propaganda. She argues that this propaganda stigmatises the poorest and hides the real reasons for their disadvantage. Punitive policies against the poorest become acceptable by the general public who then ignore the disparities between the richest

and poorest and also between the richest and themselves. The propaganda deflects attention from the richest to the poorest who face stigma and backlash from the rest of the population (Shildrick, 2018).

1.3 Neo-liberalism, the good citizen and healthcare

Perhaps in response to the rise in neo-liberal ethics of personal responsibility and reduction of direct state intervention, the World Health Organisation Research convened the 1986 Ottawa Conference on Health Promotion (WHO, 1986). Their conclusions were that the prerequisites for health were: food; shelter; education; income; social justice and equity, all seen as social determinants of health. However, most western governments ignored WHO advice and continued with their neo-liberal agenda. Lupton (1999) conceptualised neo-liberal government as neither forceful nor coercive but persuading autonomous individuals to act in ways that were in the best interests of the state and become health conscious citizens. To do this, messages from government must persuade citizens to change personal behaviours to improve their health (Markula & Pringle, 2006).

Ayo (2102) posits four neo-liberal principles of health promotion strategies, minimal government intervention, individual responsibility, market fundamentalism and the inevitable inequality as a consequence of choice. To enable minimal intervention, slews of information are made available to support citizens in their healthy life choices. Some from non-profit organisations offering advice about 5-a-day and the eat well plate and many from a flourishing health industry selling food, gym membership and personal training. Individual responsibility for health relieves a great burden from the state and converts social responsibility into personal responsibility (Ayo,2012). In this way, the burden of health inequalities is removed from the state as responsibilities become individual despite the oppressive structural and social forces that mediate the choices of the poorest in society. The inevitable inequality is a side effect of neoliberal government and a symbol of the healthy society in which some choose to be healthy and some choose not to be healthy. Thus, those who choose not to be healthy can be stigmatised and become the problem

underserving of government support.

Unemployment, poverty, lack of education, all major established social determinants of health, are rendered as poor personal choices made by freely choosing citizens rather than inevitable consequences of poverty.

In considering public health debates concerning social determinants of health on the one hand and neo-liberal injunctions of personal responsibility on the other, these are in some ways antithetical, approaches to encouraging better health (and well-being) in citizens, it appears an amalgamation of the two approaches would create the most benefit.

Darren McGarvey grew up in one of the more deprived area of Scotland His mother died of alcohol related issues at the age of 36 and he and his siblings have all been addicted to drugs or alcohol at some point in their lives. His book, Poverty Safari is his life journey through poverty, deprivation and politics. His argument centres on both political parties being hideously out of touch with the reality of lived poverty and the lack of choice in poverty. From this, he argues that too many people living in poverty have little connection with politics and see the state as the entity that will improve their lives rather than having the self-determination to make a difference for themselves. He concludes by saying that his most effective way of transforming his community is to first transform himself. Managing and maintaining oneself are the way to seize the means of production that can go on and help others do the same (McGarvey, 2017).

1.4 Health prevention in research

Health prevention is a contentious issue. Porter and Coles (2011) draw attention to the predominantly clinical aspect of health services in the UK and argue that a more preventative service would better serve public health. However, there are counter arguments about the cost of prevention services. Hey and Patel (1983) and Vandoros and Carman (2011) assessed the efficacy of preventative health care at two different times in the recent past. Hey and Patel (1983) did not come to any firm conclusion on the monopoly model provided by the NHS. However, in the more recent times of health economics, Vandoros and Carman (2011) conclude that usage of preventative health care in the entire population would be determined by the efficacy of the prevention and discount factor (how much people care about their future health). In other words, there are too many factors to conclude one way or another that providing a comprehensive prevention service is more effective than the current curative service. This is important when discussing preventative health care for men or low-income groups. Research points towards these groups having a lower discount factor (Emslie & Hunt, 2009; Jackson et al., 2002; McPherson & Turnbull, 2005; Stead et al., 2001) and would therefore not take up preventative health care to a great extent. Therefore, the cost of providing healthcare to the population would go up, without there being the associated benefit of reducing health inequalities. Perhaps in response to

this, independent of the National Health Service, Public Health England was set-up in 2013 to protect and improve the nation's health and well-being and reduce health inequalities (Public Health England, 2017).

The research on preventative health care efficacy is inconclusive. However, Barker and Chalmers (2000) contend that community health would take power away from the professionals and give agency to low income groups who are likely not to have the education to assume control over the health of themselves and their families. Without community health, these groups are then disadvantaged by travelling at a larger proportionate cost than those with more money, to a clinic where they are again disadvantaged by not having the skills and confidence to gain the most from the clinical meeting, an argument supported in the Black Report (DHSS, 1980). This has highlighted a specific gap in provision for men and low-income groups who would benefit from a less clinical, more preventative service supported by Kirby (2004).

1.5 Health interventions targeting low income groups

Robertson and Baker (2017) in a review of the previous ten years of health promotion for men highlight that is either non-existent for men on low-income or when it is implemented by the NHS at a national level, there is resistance to implementation. They highlight how the majority of Joint Strategic Needs Assessments, the key policy document in determining and subsequently implementing local health priorities and activities do not include men's health as a priority in any form. Neo-liberal ideologies about individual responsibility in health care mitigate against successful health promotion for men with the greatest health needs (Scott-Samuel et al., 2015; Williams et al., 2009).

The Public Health England strategy for reducing health inequalities (Baker et al., 2017) has no mention of men on low-income. Similarly, Public Health England (Connolly et al., 2017) do not discuss men on low-income when blogging about understanding health inequalities in England.

There are many non-statutory organisations supporting men's health and well-being both nationally and local to the research. As will be seen in the next chapter, there is minimal direct statutory health and well-being provision for men. Below is a selection of some of the services provided in and around Leeds and surrounding areas. Leeds was chosen as the research was conducted from the University of Leeds.

Homeless support. Men are six times more likely to be homeless on the streets than women. Homeless support for both genders.
St George's Crypt supporting the homeless in Leeds (St George's Crypt, 2020).

Simon on the Streets supporting the homeless in Leeds (Simon on the streets, 2020).
Carecent supporting the homeless in York (Carecent, 2020).

St George's Crypt offers support to the homeless, the vulnerable and those suffering from addictions. This ranges from food and temporary overnight accommodation to opticians, physiotherapy and signposting to council services. Simon on the Streets provide outreach support to those rough sleeping, including support on the street, accompanying rough sleepers to service appointments and finding permanent accommodation. Carecent in York provide breakfasts and sanitary facilities along with clothes, bags and signposting support.

Specific support for men
Men's sheds reduce loneliness and isolation in men of all ages and backgrounds (Men's Sheds, 2020). Leeds Dads is a voluntary group that organises events for dads in Leeds (Leeds Dads 2020). There are many other groups generically for men such as Walking football (Leeds City Council, 2020) and Health for all (Health for all, 2020).

Specific support for men includes a wide range of groups supporting men in different ways. There are over 600 Men's Sheds in the UK supporting isolated men through providing a space to connect, create and converse. They are open to any men and have benefited over 14,000 families through support for the men. Leeds Dads is a loose group of dads who meet for playgroups, support and advice. Health for all engages local men, including older men, men with learning disabilities and poor mental health or experiencing isolation, in healthy, energising activities.

Support for disadvantaged men
Orion Partnership in Leeds provides safe spaces for men, particularly those socially isolated, living with mental health challenges or long term unemployed, to come together learning new skills, making new friends and generally improving their wellbeing (Orion partnership, 2020).
There are another 37 men's groups offering a multitude of services and activities services both citywide and locally on the Mindwell website (Mindwell, 2020). Most of these operate from Community Centres and are Men's groups that provide peer support, support or activity groups that are for men only.

Of these Men's sheds, Leeds dads and the Orion Partnership were contacted and or accessed during the course of the research.

1.6 Conclusion

Alcock (2006) discusses poverty strategies and argues that the two main strategies used by government have both met with little success. The Strategy of Equality, where redistribution of

resources would lead to a more equal society through addressing socio-economic determinants of health, always had opponents and has never been implemented fully. The Beveridge reforms did much to equalise society but, with rising unemployment and a worsening economy, poverty was 'rediscovered' in the 1960s and worsened in the 1970s. The Strategy of Inequality or neo-liberalism was implemented by the Thatcher administration with the idea that providing incentives for the economy to grow would mean the benefits would trickle down to those in poverty. However, the opposite effect occurred with a widening of inequalities between 1977 and 1990 (Barclay, 1995). Neither strategy has met with success nor there does not appear to be any current coherent government plan to tackle poverty and inequalities in the UK.

The message from the British experience of politics and the Welfare State in all its forms is that political parties do not remain in power if they raise taxes. The public want to see fairness to all through a welfare system but are not prepared to pay for it. A major National Assistance Board study in the 1960s found that to expect people to live on National Assistance was to expect them to live as a class apart, leading to social exclusion. The study agreed that asking the public to finance this extra provision by taxation would not be accepted (Viet-Wilson, 1999) and charitable giving and the voluntary sector appear to be the only way to maintain services (Jones, 1994). The current Conservative policy of reducing involvement of the state in service provision and of commissioning the voluntary sector to undertake this role harks back to Victorian values of a small state and the voluntary sector as a buffer (Lewis, 1999). There appears to be no end to poverty in the UK under the current form of capitalist democracy.

The focus of this chapter has been the effect of poverty on health. It can be seen that over history, those with the lowest incomes have the poorest health and lowest life expectancy. The difference in life expectancy between men on the lowest incomes and the highest incomes widened from 1982 to 2011 (ONS, 2015b) by one year. This health inequality difference is likely to widen further with Conservative policies since that time and into the foreseeable future. In the absence of governmental support, there are many non-statutory organisations that provide support, advice and facilities for men on low-income to engage with to improve their health and well-being. Relating this to the focus of the thesis, men on low-income must therefore embrace the ideas of McGarvey (2017) and attempt to adopt behaviours to try to mitigate the effects of poverty which are likely to be a barrier to health (including mental health) and well-being.

Chapter 2 will examine the health and well-being of men and specifically men on low-incomes. The chapter then critiques current theory on understanding men's health and well-being. This will be followed the findings of a structured literature review in this area.

2 Chapter 2 Health and well-being of men on low-income and literature review

Chapter 1 provided an overview of financial poverty, specifically how it grew from the start of our wage economy, how it affected the health and life expectancy of those in poverty and how health inequalities have remained over time. The aims of Chapter 2 are to continue detailing the importance of situating the study of men's health within a historical and political context. This will be followed by: reviewing the positive health and well-being behaviours in the literature for men on low-income; to understand how positive health and well-being behaviours are framed in that literature; to reflect on missed opportunities from that literature with low income populations or men on low-income. The intention of Chapter 2 is to define and discuss health, then define and discuss mental health and well-being. This will be followed by examining gender, income and ethnicity and the effect on health and well-being. It will detail how mental health provision for men and men on low-income has not closed the life expectancy gap. The chapter will subsequently focus on a critique of health behaviour explanations from a gendered perspective. The chapter will then report a literature review which identified over 170,000 papers, none of which focused on the positive health and well-being of men on low-income. The review will firstly discuss the eleven papers in which there was some aspect of reporting positive health and well-being for this group. Secondly, six papers that used hegemonic masculinity as a lens to understand health are reviewed to understand how this influenced the presentation of men's health. Finally, in the literature review, a selection of papers that recruited a sample of men on low-income and missed the opportunity to research or report positive health behaviours. The chapter will conclude with the aims, objectives and research question for this thesis. The key point for this chapter is to show that despite a multitude of research to show that men on low-income have one of the poorest health and well-being outcomes of any group in the population, there is scant research to show the positive health and well-being behaviours they exhibit despite their poverty and deprivation.

2.1 Health

The definition of health is contested and dependent of the ontology, epistemology and political position of the definer. The first key principle that guides the NHS includes the sentence 'The service is designed to diagnose, treat and improve both physical and mental health.' (NHS Choices, 2017a). However, there is no definition of physical or mental health on the NHS website (NHS Choices, 2017b), Collins English Dictionary (Collins, 2006) defines health as the condition of a person's body and the extent it is free from or able to withstand illness. This definition focuses on lack of illness, a neutral position in which health is not noticed by the individual. If health, mental health and well-being are not noticed by an individual, this does not mean they cease to exist. The World Health Organisation (Grad, 2002) defined health in 1948 as a state of complete physical, mental, and social

well-being and not merely the absence of disease or infirmity. This broader definition involves the wider social aspect of health and includes well-being. Jadad and O'Grady (2008) explain that this definition was used to challenge governments around the world to improve their health care systems and to include social determinants within these systems for the first time. Furthermore, they propose that any attempt to define health is futile and cannot capture its complexity. It can only be defined within the limits of the resources available and common sense. IJsselmuiden and Matlin (2006) suggest that health research requires both qualitative and quantitative research that should focus on the nature and extent of underlying health problems and their root causes and this focus should include the wider determinants of health.

2.2 Mental health and well-being

The World Health Organisation's definition of health (Grad, 2002) refers to mental and social well-being. The World Health Organisation described mental health as more than a lack of mental disorders and includes a state of well-being where everyone realises their potential, can cope with life's stresses, work fruitfully and productively and contribute to their community (WHO, 2014). Conrad (2010) argued that many people who are simply unhappy, stressed, frustrated or anxious would not be diagnosed as having a mental disorder and do not have good well-being either. As was pointed out above, limited government resources may focus on physical health at the expense of the mentally unwell, who experience reduced capacity to enjoy a fulfilling life, but do not meet a classification in the DSM (Conrad, 2010).

From these arguments, well-being and mental health are not part of the same continuum and are separate entities with an as yet undefined neutral area of mental health where well-being and mental health are not apparent (Watson et al., 1988). Following work correlating aspects from the US wide Midus (2018) study, Keyes (2002) introduced the idea of a mental health continuum from flourishing to languishing. Flourishing is a state of positive psychological, emotional and social functioning with high levels of well-being. Languishing conversely is stagnation, emptiness and quiet despair with low levels of well-being. The area in between where adults are neither flourishing nor languishing, Keyes describes as moderately mentally healthy. He saw mental health on one continuum with mental illness and well-being correlating closely but being on separate continua. Huppert (2009), developing Keyes idea of languishing and flourishing, proposed a single continuum with mental illness at a lower point than languishing. Although there is debate about whether mental ill health and mental well-being are on the same or different continua, there is agreement that there is a state of neither well-being nor mental health disorder, termed 'languishing' that can be as detrimental to personal and social functioning as mental health disorder.

Languishing is reported by Sayers (2010) who describes men on low-income he meets in his clinical practice as ‘not feeling part of it all’ (p99) as they have little money and insecure job prospects in an increasingly materialistic and competitive world.

Mental health and well-being are sometimes incorporated and partially measured together through the absence of mental health disorders. Kahneman et al. (1999) pointed to a recognition that eliminating mental health disorders at an individual level did not automatically produce a positive state. Well-being is defined by the World Health Organisation (2005) as positive mental health, quality of life and productivity of families, citizens, nations and individuals. The UK Government Department of Health published a document entitled Well-being: Why it matters to health policy (Department of health, 2014). The document proposed that focusing on individual well-being would improve well-being for the population leading to improved health outcomes which would reduce the cost of the NHS. A range of behavioural improvements related to health outcomes were listed, leading to increased life expectancy and improved life expectancy from illness. These, it suggested would change the way health care is provided in the UK and how the NHS operates, ultimately leading to reduced costs. Well-being is about feeling good and functioning well and comprises an individual’s experience of their life; and a comparison of life circumstances with social norms of value.

Well-being: Why it matters to health policy (Department of health, 2014) also points out that there has been little change in well-being over the last 40 years despite the increase in GDP over that time and that GDP counts things associated with lower well-being. These two indicators of well-being have been known for many years (Burns, 2005; Kahneman et al., 1999). Recent research on a global scale has set the income satiation point for no more increase in life evaluation at $95,000 U.S. and emotional well-being at $75,000-$60,000. (Jebb et al., 2018). If well-being does not increase above these income values, research should focus on those earning below these levels to improve well-being levels for those on lower incomes.

There appear to be many definitions of well-being; possibly like health, the definitions depend on the political or economic ontology of the definer. The NHS website does not define well-being. However, there are five suggestions on the NHS website for improving well-being: Connect; be active; keep learning; give to others and be mindful (NHS choices, 2017c).
These suggestions were proposed in the last Labour government’s mental health and well-being project (Foresight Mental Capital and Well-being Project, 2008). The section on ways to mental well-being was designed to be the well-being equivalent of five pieces of fruit and vegetables a day for ease of public consumption. Based on extensive review of the evidence, the report states:

1. Connect… With the people around you. With family, friends, colleagues and neighbours. At home, work, school or in your local community. Think of these as the cornerstones of your life and invest time in developing them. Building these connections will support and enrich you every day.
2. Be active… Go for a walk or run. Step outside. Cycle. Play a game. Garden. Dance. Exercising makes you feel good. Most importantly, discover a physical activity you enjoy and that suits your level of mobility and fitness.
3. Take notice… Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Savour the moment, whether you are walking to work, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters to you.
4. Keep learning… Try something new. Rediscover an old interest. Sign up for that course. Take on a different responsibility at work. Fix a bike. Learn to play an instrument or how to cook your favourite food. Set a challenge you enjoy achieving. Learning new things will make you more confident as well as being fun.
5. Give… Do something nice for a friend, or a stranger. Thank someone. Smile. Volunteer your time. Join a community group. Look out, as well as in. Seeing yourself, and your happiness, as linked to the wider community can be incredibly rewarding and creates connections with the people around you. (Foresight Mental Capital and Well-being Project, 2008, pp. 23).

The section of the report is here reproduced in full. The 5 steps outlined above evolved into the 5 steps to well-being on the NHS website and try to create an outlook that is outward facing. These steps map onto the concepts supporting eudaemonic well-being outlined later in the chapter.

The Department of Health's defines well-being as feeling good, functioning well, subjective life experience and objective life circumstances (Department of Health, 2014). Subjective life experience maps onto hedonic well-being and objective life circumstances map onto eudaemonic well-being and these will be looked at in turn.

2.2.1 Hedonic Well-being

The Greek philosopher Aristippus in the fourth century B.C. taught his followers that the goal of life was to experience the most possible pleasure and that happiness was the sum of hedonic moments in one's life (Ryan & Deci, 2001). Hedonic psychology focuses on the subjective pleasures and preferences of the body and the mind. Hedonic well-being moves beyond physical pleasure to include happiness from goal attainments and hobbies. Diener and Lucas (1999) proposed that hedonic well-being could be assessed through the measurement of subjective well-being. Subjective well-being (SWB) consists of life satisfaction, presence of positive mood and absence of negative mood.

SWB researchers claim that important phenomena in people's lives should come from their own evaluations of what constitutes a good life (Diener et al., 2018). These evaluations are most often taken from questionnaire results. Despite the known benefits of questionnaires, there are major issues when collecting data on the subjectivity of a phenomena. Participants may struggle to apply their subjective experience of the phenomena to the objective questions posed (SurveyAnyPlace. 2019). Questionnaires produce scores that can be correlated but rarely examples of what subjective well-being looks like or feels like, nor how it comes to be. Csikszentmihalyi and Csikszentmihalyi (2006) point out that it is impossible to comprehend the feelings and thoughts of people without knowing what they value about their own existence. This cannot be captured from a questionnaire. We can learn different things (perhaps as yet unaddressed or unknown things) via different methods. This point is picked up again in the next chapter in the section on photo-elicitation.

2.2.2 Eudaemonic Well-being

Aristotle wrote about eudaemonia in around 350BC, attempting to answer the question how should we live (Ryff, 2018). Ryff argues that Aristotle got to the heart of eudaemonia by understanding it as humans achieving their potential and being the best that they can be. In terms of living a life that encompasses these aims, Ryan et al. (2013) propose three facets of eudaemonic living: shunning extrinsic goals such as appearance and wealth and embracing goals such as community intimacy and growth; being autonomous in outlook rather than being controlled by others; and acting with a sense of awareness and being mindful. These three examples of eudaemonic well-being are some of more than one hundred different measures of eudaemonia (Vitterso, 2016) but reflect the main domains seen across the measures.

Ryan and Deci (2001) see hedonic well-being as subjective well-being (SWB) and eudaemonic well-being as psychological well-being (PWB). They point to psychological well-being as summed up best by the model proposed by Ryff below. The version below is the most updated of this model.
Ryff (2018) proposes a model of eudaemonic well-being that includes many psychological theories of developmental, humanistic and existential psychology. There are six components of this model: Autonomy; Environmental Mastery; Personal Growth; Positive Relationships with Others; Purpose in Life and Self-acceptance.

> Autonomy relates to being self-determining, self-regulating and independent. These qualities are drawn from Maslow's (1998) ideas of autonomy, Rogers' (2004) focus on standards of self-evaluation and Jung's (2001) thoughts on individuation and being non-conventional.
>
> Choosing, creating and participating in environments conducive to one's psychic needs is an indicator of positive mental health (Jahoda, 1958) and key to Environmental Mastery.

Eudaemonic well-being through Personal Growth focuses on achieving human potential and self-realisation. Rogers' (2004) concept of self-becoming and ideas on human potential and self-determination (Ryan & Deci, 2000; Ryan & Deci, 2001) are central to this idea.

The ability to love, have empathy and affection for others is key to having Positive Relationships with Others. Again, Maslow's ideas are central to this concept who also saw deep friendship and close identification with others as part of self-actualisation. Ryan and Deci (2001) further this point by arguing that strong satisfying relationships build personal resilience.
Jahoda (1958) saw beliefs that gave one meaning and Purpose in Life as part of positive mental health. Frankl's (1984) focus on finding and creating meaning in life during times of adversity was understood by Ryff (2018) as part of the same entity. Goal pursuit (Ryan and Deci, 2001) was identified as giving purpose in life. However, these goals must be challenging but achievable (Csikszentmihalyi & Csikszentmihalyi, 2006)

Positive self-regard (Rogers, 2004) and Jung's (2001) notion of coming to terms with the dark side of one's personality form the central idea in Self-acceptance. It is important to note the acceptance of one's strengths and weaknesses.

2.2.3 Relating well-being to wealth and poverty

Ryan and Deci (2001) argue that social class and wealth are predictors of well-being by stating that increased relative wealth after basic needs are satisfied does not benefit well-being, often the opposite is true. For those in poverty and of lower social class, lack of access to material support and resources can be detrimental to happiness and self-realisation.

Frank (1999) argues that higher levels of well-being in a society are correlated with a more equitable income distribution. Higher taxes on luxuries and higher incomes reduce well-being for those affected by only very small amounts. Furthermore, Kasser (2006) posits that there is cognitive dissonance between the ideal life portrayed in the media and those on lower incomes. This suggests that if higher taxes and wealth redistribution reduces wealth disparities between rich and poor, this will lower that cognitive dissonance.

Kasser (2006) also argues that those implementing health and well-being targets do not understand the lives of those on the lowest incomes. Curtis (2010) claimed there is commitment from public health specialists to act on the social, economic and materialistic determinants of health but the evidence they need often does not exist. These views indicate that for policy makers to implement changes there needs to be greater levels of research into the lives of the poorest.

2.2.4 Summary

Mental health and well-being appear to be on a continuum from flourishing to languishing. The UK government attempt to raise well-being in the population was to introduce the five steps to well-being which maps directly onto the concept of eudemonic well-being. Men on low-income are reported to be at the languishing end of the continuum. Theory states that beyond an upper limit, income does not raise well-being. Income below a level that precludes material support and resources lowers well-being. Policy makers report they do not have the data necessary to implement changes to raise the well-being of the poorest in the population. The next section will look at the areas of concern for this thesis, the health and well-being of men on low-income.

2.3 Health inequalities

Sir Liam Donaldson (Donaldson, 2004) highlights that health inequalities are researched in two ways, contrasting gendered health and also by examining gender population subgroups. These will be examined in turn.

2.3.1 Men's Health

As described at the start of chapter one, the life expectancy of men is lower than women but this difference has narrowed aver the last 35 years (ONS, 2019). A gendered life expectancy difference in favour of women has existed since records were first kept in the UK in 1837 and has remained consistent over time (Wohl, 1984). The most recent international comparison shows that in 2015 there was no country in the world where male life expectancy was greater than for females. Only Mali had an equal life expectancy at 53 years (Population Reference Bureau, 2015). Despite this acknowledged gender based disparity in life expectancy and health, there has been little attention from policy makers and health-care providers to men's health worldwide (Baker et al., 2014). Moreover, only Australia, Brazil and Ireland have adopted national male-centred strategies to counter the burden of men's ill health. Only recently has men's health been seen as separate from the rest of the population. In contrast, women's health has been seen separate for over 400 years, the first text on midwifery was written in France in 1604 (Dunn, 2004).

A watershed for men's health in the UK came in 1992 with the annual report of The Chief Officer of Health (Calman, 1993). The report's Special Topic highlighted to the government several areas of concern for the health of men separate to the general population, and in particular, the higher death rates from circulatory diseases, suicide and external causes such as accidents. The death rates for all three of these causes were more than double that for women. Based on data from the 1970s, the report explained that women were more than twice as likely to report symptoms of depression and anxiety, and more than twice as likely as men to self-harm. Men, however, were more than twice as likely to die from suicide. Men were more than ten times as likely to be homeless, 75% of opioid addicts were men, 88% of drug offenders were men and men were three times more likely than women to be heavy

drinkers. Although these statistics had been published by the government in various reports, Calman brought them together to highlight the differences in the physical and mental health of men and women.

The studies Calman used were from 1977 and 1978 highlighting how little research had been done in this area in the 1980s. He highlighted that women were more aware of their bodies than men and paid more attention to health messages. This point was made again in 2014 by the World Health Organisation (Baker et al., 2014). Moreover, women were more frequent attenders at GP surgeries, and were thus more likely to receive opportunist counselling or health screening. Women's bodies undergo physiological changes through pregnancy and their monthly hormonal cycles. Therefore, women are much more likely to access not only health care but preventative health care related to this (White & Banks, 2004). Men without a drive for preventative health encounters are unlikely to visit a GP. Calman advocated a greater number of Well Man clinics and better ways of promoting men's health as there were many poor health outcomes for men that were preventable. Calman's report was positioned as the first time men's health had been seen as different to that of women (Lloyd, 2001) rather than vice-versa. This point of difference was taken further by the American writer Thomas Page McBee, who changed gender to become a man, and who argued that men do not think about gender, they are just men. (McBee, 2014). Just as Calman (1993) pointed out that women are more aware of their bodies, women are more aware of their gender, with the converse for men also true. This lack of reflexivity about being a man and lack of awareness of their bodies is argued to be a problem for men's health.

Baker et al. (2014) report that men are less likely to visit a doctor and when they attend, less likely to report on symptoms of illness or disease. Jewell (2001) observes that general practice can be seen as a female domain with most visible practitioners female and the female health agenda the one with most routine appointments. Moreover, women are more likely to accompany their children to their appointments than men. This combination of factors therefore makes GP surgeries feel less welcoming for men partially explaining a 32% lower consultation rate for men than women (Wang et al., 2013). Jewell (2001) goes on to argue that primary care has little to offer men and an alternative approach is needed.

In the forward of Men's Health, Clare (2004) asserts that, prior to Calman's report (Calman, 1993), the medical profession was predominantly male and reinforced ideas of health and disease that were sexist through the idea that to be male was to be healthy, and show strength, power and authority. To be female was to be fragile, sensitive, vulnerable, abnormal and not healthy. To admit to having problems with one's health as a man was to admit to a weakness in one's maleness.

In a guide for promoting men's health published in 2001 to non-clinicians, Trefor Lloyd notes the lack of definition for men's health and argues that misunderstandings and narrow strategies will continue to follow (Lloyd, 2001). Little seems to have changed since this time. Although Lloyd's book offers a lot of data about the issues of income health inequalities, there are no resources or interventions offered to practitioners for men on low-income – keeping this part of the population invisible to policy makers and health practitioners. It is interesting to note that the book has not been updated since 2001, showing the lack of interest in non-clinical health promotion, a point highlighted by Calman in 1993. The version for clinicians, Men's Health, is on its third edition since 1999. This difference in interest highlights the current thinking about men's health being curative rather than preventative with the implication that men are positioned as ineffective in preventative healthcare. As was discussed in the previous chapter, there are too many factors to conclude that a preventative healthcare service would be efficient for men on low-income. This has not prevented some NHS trusts setting up preventative services for men. Services set up to attempt to address prevention are discussed next.

2.3.2 Services for men

Specific preventative services for men in the NHS are Well Man clinics but are not a compulsory provision across NHS regions. The NHS website stated: 'Well man clinics offer a range of health checks for men. Some NHS GP surgeries or hospitals offer well man clinics, but many are private. You will have to pay for tests at a private clinic, which can be expensive' (NHS choices, 2016). Private clinics would be out of the reach of men on low-income. The first Well Man clinic was set up in Glasgow in 1984 and another in London in 1985. The Lewisham and North Southwark NHS trust wanted to provide a similar service but had to wait ten years to do so due to lack of funds (Watson, 2001). Between 400 and 500 visits were recorded by men to the Lewisham and North Southwark service annually up to 2001 showing that there was an uptake of this services by men in this area. Unfortunately, more demographic information is not available to assess uptake by men on low-income. The trust was disbanded and Lewisham and Greenwich NHS Trust replaced it in 2013. The new Trusts' website has a link to women's health but not to men's health. A search of the Trust's website produced no results for a search with the term 'well man' (Lewisham and Greenwich NHS Trust, 2017) highlighting the lack of consistency within the NHS for this service and the lack of focus and funding from the government to provide a universal preventative service for men. The most recent search on the NHS website did not find any reference to Well Man clinics, nor did it find reference to NHS choices, disbanded in 2018 (NHS, 2021a).

White and Banks (2004) argue that the relative lack of success with these services is due to staff training and poor targeting. Michael Kirby, (2004) a GP at the time of writing, listed eleven benefits from setting up a Well Man Clinic. Only one, 'Healthier patients' was patient focused and third on his list, the other ten were all about income generation, team building and target achievement. He later

goes on to say that health promotion is cost effective in improving the health of patients despite giving health promotion for men as only one of the eleven benefits for Well Man clinics. This guide is written in the clinical publication Men's Health and the author, an editor of the work. This non-universal service of Well Man clinics is supported through his book but the benefit to the men targeted is not the reason for the service and is an excellent example of where the people the NHS serves are not the focus of provision of services (Fraser, 2009). This lack of focus on the health of men, despite the statistics showing that they need more preventative health care, shows that health care providers are putting savings efficiencies and income generation of GP surgeries above the health of men.

2.3.2.1 Updated searches of NHS services for men – January 2021

With the withdrawal of the Well Man clinics, a further search was made of NHS sites for specific services for men. A query 'Men's Health' on the NHS site returned common health questions. All but one concerned sexual health and the other swollen breasts in men and boys (NHS, 2021b). To discover if any screening applied to men's health, 'screening' was applied to the NHS website (NHS, 2021c). There are seven reasons to screen, two apply directly to women: cervix and breast cancer screening. Two more apply to the very young: in pregnancy and as babies. None of the other three apply specifically to men. Prostate cancer is not screened for by the NHS; the website explains that it has not been proven that the benefits outweigh the risks (NHS, 2021d).

To understand NHS services for men at a local level, three Clinical Commissioning Groups (CCGs) websites were visited. Firstly Southwark CCG (SouthwarkCCG, 2017) and its successor South East London CCG (SELondonCCG, 2021). These were chosen as they have a high level of deprivation and a high level of ethnicities and nationalities, so provide services for a wider range of needs. The South East London CCG serves 1.9 million people. The search terms 'man' and 'men' were entered onto both sites. The results for services specific for men were a post for World Suicide Day 2014 and a post for Movember 2015 on the Southwark CCG site. There were no other mentions of anything specific to 'men' or 'man' on either site. Secondly the Leeds CCG site (LeedsCCG, 2021) was visited. Since 2018, no posts specific to men's health were found using the search terms man or men apart from a post about World Suicide Day, 2018.

The last search was for GP services for men's health. The only ones available are from private GPs and private healthcare providers. Private health providers are not financially accessible for men on low-income.

2.3.3 Men's mental health and well-being

In a report to the government on men's health, White (2001) found four areas of concern for men's mental health: lack of awareness of their own needs; inability to express emotions; access to mental health services; and men's lack of social networks.

The first three areas of concern highlighted above are often explained by the essentially negative concept of hegemonic masculinity in which men are represented as powerful, stoic, unemotional and independent (Conrad & Warwick-Booth, 2010). There is a critique of hegemonic masculinity later in the chapter. The theory behind hegemonic masculinity is that it is a social concept which is performed with and in front of other men as an expectation of being a man. Other forms of 'being' with other men, the theory goes, are seen as weak and unacceptable; men will therefore not think of their own needs, will not express emotions in front of other men and will not access mental health services. Wong and Rochlen (2005) theorise that there are four areas where the ability to express emotion breaks down; some men repress their feelings, some cannot identify what they feel, others are uncomfortable with negative feelings and finally, lack of social spaces to express emotions.

The fourth area of concern for White (2001) and Wong and Rochlen (2005) highlighted above is that men lack social networks and social spaces. White et al. (2016) highlight that in Leeds nearly 20% of men live alone and the occupants of the cities high-rise flats are two thirds male, leading to higher levels of isolation in men on low-income. Mackenzie and Harpham (2006) report higher mortality rates in those with reduced social networks. Halpern (2005) found that those with poorer mental health self-reported fewer intimate relationships and smaller social networks but Halpern (2005) did not infer causality in either direction. However, not all relationships promote good mental health however; for example, Braunholtz et al. (2004) posit that relationship problems also lowered mental health.

It is argued that the way men negotiate the balance between their public and private lives is another reason why men have a lower life expectancy. With smaller and less intimate social support networks than women, men have reduced possibilities for activating the necessary support in times of stress. Men are argued to then internalise their problems and have higher rates of suicide, alcoholism and risk taking behaviour (Clare, 2004). White and Banks (2004) also highlight the growing number of men living alone as a result of the death of their partner or divorce where the mother keeps custody of the children and then men live alone, often known double divorce for dads. The implications for men's health from these negative data are often referred to as the 'crisis' in men's health (Sloan et al., 2010). Men's health and well-being takes many forms. This social aspect of men's health has great importance and is often missed.

Brownhill et al. (2005) see five behaviours which are used to cope with mental health problems. Compared to men, women are more at risk of developing internalising disorders, such as anxiety and depression, moreover, they are more likely to express their distress in the form of crying and help seeking. Compared to women, men exhibit more externalising disorders and show higher incidence of substance abuse, suicide, extra-marital affairs and anti-social behaviour (White, 2010). Sayers (2010) suggests that women release emotion early after an emotionally distressing event through crying and talking but men hold onto the emotions for longer and tend to find a more (self) destructive release. This release can be in the form of anger which often adds to the sense of insecurity and shame that triggered the anger, thus enclosing angry men in a vicious circle (Dominey & Dominey, 2010).

Countering the idea of inexpressive men unable to talk about their feelings and thus suffering the consequences is one where men have multiple potentials for being (Gergen, 1991) or multiplicities of the self (McConnell, 2011). Schwab et al. (2016) argue that within interactions, individuals position aspects of themselves in contradictory ways. They highlight many examples of research where the concept of hegemonic masculinity does not fit behaviours displayed by men and suggest a different way of looking at the way men talk, behave, and live.

In the absence of specific government or NHS support for men's mental health, several charities have filled the void. Some examples are: Campaign against living miserably (CALM, 2020), Movember (Movember, 2020) and Brothers in Arms (Brothers in Arms, 2017). These all offer advice, support, webchat and helplines. They also signpost men to related services.

A review of the content on well-being in the most popular recent books on men's health and well-being (Gough & Robertson, 2009; Robertson, 2007) did not contain any theoretical underpinning for well-being. Moreover, there was no significant content from research to inform well-being for those seeking to understand well-being for men. There will be more on the lack of positive health and well-being in literature in the systematic literature review later in this chapter.

2.3.4 Implications for the health of men

When comparative deaths rates are studied for 190,500,000 men and women across Europe in 17 countries, at different ages, there are striking results. The ratio of male to female deaths at age 1-24 is 2.8:1, from 25-74 is 1.8:1 and only at age 75+ is the ratio the other way with 0.7:1 male to female deaths. A greater proportion of men die younger under the age of 75 (Bhopal et al., 2002). The greatest differences in these studies were that four times as many men as women died from 'mental and behavioural disorders' in the under 25 age group. Death by external causes (suicide and accidents) was markedly higher in the under 75 age group for men. External causes included, road traffic deaths, work related deaths and suicide (White & Banks, 2004). Suicide rates for men are more than three times that of women with 4,903 men and 1,604 women dying from suicide in the UK in

2018 (Samaritans, 2019). Unemployed men are twice as likely to die from suicide as those in employment and single men are three times as likely to die from suicide as those in relationships (Griffiths, 2001). Men are more likely to use drugs, 11.8% of men and 5% of women aged 16-59 reported using drugs in the 2015/16 Crime Survey for England and Wales (Home Office, 2016). Men are also ten times as likely to be homeless than women (Griffiths, 2001).

2.3.5 Health behaviour explanations from a gendered perspective

How can sense be made of the relationship between gender and health?

There is clear evidence of biological markers and specific risk factors. Short et al. (2013) highlight three sex (genetic) patterns in a large set data from the US. Women have higher rates of acute illness and non-fatal illnesses but men have higher rates of fatal illnesses. Men die of these fatal illnesses at younger ages. Controlling for social factors revealed repeated male vulnerability to illness and death. Biological explanations for this tend to focus on the singular X chromosome in male genes conferring weakness as there are no compensatory alleles if any on the X are deleterious. Early in life, the choice of X chromosome in women is random but more biased towards one or the other as they age. (Austad, 2006).

In contrast, the general health of men benefits from their healthier body weight and higher levels of physical activity (Verbrugge, 1989). Women also suffer higher levels of stress from gender harassment, discrimination, constrained choices and higher levels of poverty (Reiker & Bird, 2005; Springer et al., 2012)

However, the broader view of men's health highlights the social and psychosocial factors such as reluctance to seek help, putting work before health and being more likely to follow risk taking behaviours (Donaldson, 2004). One of the early pioneers of the socially constructed view of gender was the feminist writer de Beauvoir who wrote that we are not born our gender but become our gender. She wrote further that we are therefore constrained to act in certain ways within these gender constructs (de Beauvoir, 2015). To understand recent thinking on male gender health constructs, hegemonic masculinity will be explored next.

2.3.6 Hegemonic masculinity

Men's behaviours have attempted to be explained using the framework of hegemonic masculinity (Connell, 1987) and this has been the main theory by which men's health has been explored for the last thirty years. It characterises men as encouraged to be tough, competitive, unemotional, desiring success and to be envied by other men (Lee & Owens, 2002). Health behaviours associated with hegemonic masculinity are avoidance to seek help for physical and mental health problems, risky or aggressive behaviour and reluctance to express emotions. Men's mortality disadvantage is often explained by this risky construction of masculinity (Courtenay, 2000).

Prior to the 1970's, attempts to rationalise 'maleness' were measured and described using male sex role theory. The concept refers to the development of certain inherent, culture free traits. Masculinity within this concept was a single construct in which a man was strong, active, community orientated and rational (Smiler, 2004). Masculinity was measured on a continuum and insufficiently high levels of these traits was seen as problematic. The literature review of Constantinople (1973) discussed evidence that pointed to multidimensionality on the masculine/feminine scale to separate masculine and feminine dimensions. The review opened the door for Bem's (1974) ideas on gender role theory and androgyny. The latter concept highlighted the psychological benefits of having high scores on both masculinity and femininity scales, eliminating the masculinity/femininity dichotomy.

The first to critique Bem's gender role theory was Connell in 1979 (Demetriou, 2001). Connell agreed with de Beauvoir's idea of socially constructed gender. He did not see within gender theory any reference to power relations within and between genders. The theory he introduced to explain these power relations was hegemonic masculinity (Connell, 1995). Gramsci and Hoare (1971) used hegemonic to describe a situation where one social group dominates and leads all others. Masculinity denotes that the dominating group has masculine characteristics. Thus, hegemonic masculinity was a theory that explained how a powerful group of Caucasians with masculine characteristics dominated all others in gender relations. This domination subordinated some groups such as gay men who did not exhibit masculine characteristics and marginalised other races and those on low incomes. All other masculine Caucasians were complicit in upholding the hegemony whether they were aware of it or not. Connell does not develop the idea of marginalised masculinities beyond their lack of impact on construction of hegemonic masculinity and marginalised groups exist in tension with the hegemonic group (Connell & Messerschmidt, 2005).

To help understand how masculinities are created though men's embodied actions, Connell (1995) asks "What actions of any man in the world would not be an instance of masculinity?" (p. 43) This statement asserts that all actions men take are gendered actions and are some form of masculinity. Different forms of action are described in different circumstances. All men are unique physiologically and psychologically and interact uniquely with the social world in its myriad forms. As all actions and behaviours are classified and categorised within the concept of hegemonic masculinity. Connell (2005) says that an unmasculine person "Would behave differently: being peaceable rather than violent, conciliatory rather than dominating, hardly able to kick a football, uninterested in sexual conquest, and so forth" (p. 67).

Connell does not use femininity to describe non masculine traits; men are either masculine or they are unmasculine. Caring, loving, vulnerable actions can only sit outside this framework. Therefore

positioning these actions as feminine and not suitable for a man to perform. He also says that individual acts are not examples of masculinities but are configurations of practice performed by larger units of groups and people.

Connell's original concept of masculinity was heavily challenged and revised. Connell expanded the concept with the understanding of multiple masculinities. Multiple masculinities are not a static typology, more that men adopt which masculinities are needed to interact socially at any given time. Meuser and Behnke (1998) posited that there are 1001 variations of masculinity. Connell maintained that hegemonic masculinity remains essentially helpful to understand men's behaviour (Connell, 2005; Connell & Messerschmidt, 2005). Nonetheless, in the absence of other theorizing about the 'crisis' in men's health, hegemonic masculinity and more recently multiple masculinities have been the dominant frame since the publication of Gender and Power (Connell, 1987). One criticism of a 'masculinities' framework is its tendency to produce a reductionist outlook and attention is drawn away from men's situated health practices (Gough, 2018). Moreover, fracturing masculinities in this way produces a jigsaw puzzle effect. All the pieces of the jigsaw are studied intently to try and create understanding without looking at the bigger picture of the health practice in question.

Hegemonic masculinity, when applied to understand men's health behaviour, is often used a negative framework, positioning men as too weak to free themselves from the dominant scripts for masculinity and lacking the agency to be healthy on their own terms. Much of the health-related research since 1987 has viewed men's health behaviour in a negative way. Often highlighting negative behaviours that fit the construct and therefore blaming men for being unhealthy. Alternatively, using hegemonic masculinity to frame research questions and finding negative behaviours. An example of this kind of research is a Health Development Agency report for the UK government that concluded that the constraints of playing out hegemonic masculinity meant that men did not get involved in health enhancing social networks (Swann & Morgan, 2002). Hegemonic masculinity can be unhelpful as it ignores all the positive health behaviours men exhibit, or even treat them as an anomaly (Burgoine et al., 2016).

More recently, the idea of multiple masculinities has been applied to health research. This can open up the acceptability of positive behaviours through responsibility for one's health (Crawford, 2006).

'Caring masculinities' can be a gender equality intervention (Hanlon, 2012) and help men adopt values of interdependence and care and reject values of domination and aggression (Elliot, 2016). Elliot (2016) further suggests that these values of care and interdependence can be integrated into masculine identities. Hanlon (2012) theorised that masculinities are understood by appreciating relations of power and dominance, but power and dominance can only be understood by appreciating

men's emotional lives, forging a direct link between masculinities and the emotional lives of men. Hanlon (2012) also discusses the intersectionality of men's complex multiple identities at different levels of Connell's (2005) global, regional and local masculinities. On a local level, Hanlon (2012) described engaging in caring masculinities as very rewarding for men with the men in his research describing caring as making them feel responsible, proud and wanted.

'Inclusive masculinities' counters one of the main issues with hegemonic masculinity theory, that it subordinates gay men and other minorities. For example, Anderson (2010) reveals how the sporting arena has change from a theatre of homophobia to one of inclusivity and tolerance through men's use of inclusive masculinities. This idea has been critiqued by O'Neill (2015) in being lacking in political theorising about gender issues and focusing almost solely in prompting a positive future for masculinities and social change.

Using men's existing strengths to promote their roles within families and society was seen was part of the vision of the Australian Government in their 2010 health policy and theorised by MacDonald (2011) as utilising 'salutogenic masculinities'. Thus, creating and promoting good health amongst men by appealing to their positives rather than criticising their negatives. Salutogenic masculinities appear to turn masculinity theory on its head where, instead of positioning men as their (and societies) worst enemy in terms of health, the positives men can provide for themselves and others are championed (Roy et al., 2017).

Tim Lomas (2013) views masculinity through a critically positive lens, finding that some men are able to negotiate hegemonic norms, resisting or reinterpreting them in a positive way. He concludes that we can and we should expect more from men than the very low baseline of hegemonic masculinity.

On a different tack to the recent examples above, de Visser and MacDonnell (2013) discuss 'man points' in relation to masculine capital. From their mixed methods approach with undergraduate students, they posit that personal masculinity levels are socially increased by traditional masculine displays such as sporting prowess or excessive alcohol consumption. Health and well-being levels can be increased, they suggest, by channelling these displays into healthier pursuits such as sports rather than unhealthy pursuits such as excessive drinking.

To widen the lens through which men's health behaviours are researched, concepts and theories other than masculinity could be used. The resultant broader spectrum of research, including reporting positive health behaviours in research might then promote men's health in a positive way. This positivity would then give practitioners a wider range of tools to promote men's health.

This section has explained how the concept of hegemonic masculinity has been the dominant lens by which to research and interpret men's health behaviours. However, this is now increasingly contested and there is greater agreement that there are multiple masculinities which allows for greater flexibility in research possibilities. Masculinity theories have not yet positioned men on low income as other than as being marginalised. They are neither hegemonic nor complicit in the hegemony. However, in reality, they may position themselves in many different ways included as hegemonic or non-marginalised. Thus, masculinity theories cannot be applied to men on low income and other approaches need to be applied to understand their lives. There is a significant need for research which broadens how we research and understand men's health behaviours beyond the limited viewpoint afforded by masculinity theory. This thesis will aim to provide 'grounded knowledge' of how men perform, understand and experience health and well-being un-reachable by masculinity theory.

2.3.6.1 Reflective box 2

Reflective Box 2 'Hegemonic masculinity'

I encountered hegemonic masculinity in one of my undergraduate dissertations in 2009 and did not understand how it applied to health research. That was ok for an undergraduate dissertation. For this thesis I knew I had to really understand hegemonic masculinity from the horse's mouth and not others interpretation, so have read both editions of Masculinities (Connell, 1995; Connell, 2005) cover to cover. Maybe I do not completely understand all the nuances of the concept but I do know I have not read one piece of research framed with hegemonic masculinity that promotes positive health and well-being. If this concept is applied to health research with men on low-income with little power or agency to facilitate change themselves and researchers only report negative health and well-being behaviours, then nothing will change and they will remain trapped in a downward circle of declining health and well-being. I acknowledge that there is scope for positive behaviours within masculinities but they are rarely seen in published papers. Moreover, the abstract conceptualisations within masculinity theory draws attention away from health and well-being practices, particularly positive ones. My position within the thesis changed as I became more focused on showing that there is another way to research positive health and well-being behaviours that does not include masculinities. This focus has occasionally become belligerence and I have been tactfully reminded to be more circumspect in my arguments. At supervision, my supervisors informed me that I could not extensively criticise an existing theory unless I was prepared to create something to replace it. I have since realised that using masculinities does create understanding of men's health behaviours. There needs to be other approaches that complement masculinities to highlight blind spots in research and provide examples of positive health behaviours.

2.4 Low income and links to poor health

The previous section explored gender as a mediator of health outcomes for men. This section examines how low-income, and its links to class, may also be driving health inequalities for men. Young (2010) argues that there are many challenges connecting and engaging with men on low-income, and that this is in effect a silenced community, unidentified and largely invisible. The data support this to some extent, although the links between income and health behaviour and outcomes is complex.

Table 1.2 in chapter one highlights the differences in life expectancy by professional male groups in 1843, showing that in all parts of the country the gentry had a life expectancy more than double those of labourers. These income related life expectancy differences reduced dramatically since those times. However, recently differences in life expectancy at birth related to income differences have widened again from 4.9 years in 1982 to 5.9 years in 2011 (ONS, 2015b). There is another classification used

by the government for those who do not have a profession. The life expectancy for this group was 11 years less than the highest group in 1982 and reduced to 8.5 years in 2011. The non-profession group, however, includes those in full time education and there are considerably more full time students in this group in 2011 compared to 1982 clouding the direct comparison of these figures. Whether it be 5.9 years or 8.5 years, the difference in life expectancy due to income is striking. Politically, the Conservative governments of the 1980s and 1990s would not, despite the exhortations of the Black Report (Townsend & Davidson, 1992), use the term health inequalities, preferring to use health variations and subsequently not focusing their attentions in this area. This lack of focus may account for part of the increase in life expectancy differential at this time.

People in the lowest SES classification are more likely to: have an alcohol related death; be classed as binge drinkers; smoke; do less exercise; less likely to eat five a day, and children in the lowest classification are more likely to have poor mental health (Graham, 2009). There is a strong geographical gradient for this group with higher mortality rate in the north than the south reinforcing the hypothesis that better access to employment, education and environment contribute to better health (Donaldson, 2004).

Research into provision and usage of the NHS by different social classes is contested and not completely clear. The ‘inverse care law ‘proposed by Tudor Hart (1971) argues that good medical care varies in an inverse proportion to the needs of the population, an argument supported by LeGrand (1978) suggesting that the NHS was pro rich (Ham, 2009). More recent evidence is much less clear cut. Acheson (1998) did not find any inequalities in access but Dixon et al. (2003) in a major micro and macro review found that the two lowest social groups had 10% fewer preventative consultations with GPs than the highest two social groups. They also found that overall, the health service was used less by more deprived individuals and families than they should at their levels of need. This argument is not supported by White & Banks (2004) who found that the most disadvantaged men accessed a GP more than any other group of men. However, they were also the group least likely to access NHS preventative healthcare with Griffiths (2001) arguing that the men who respond to public health messages are unlikely to be those at greatest risk.

2.4.1 Theory

Many explanations have been proposed to explain the health inequalities related to income and social class, including lifestyle choices. However, arguing that higher smoking and obesity levels among men on low-income in particular are due to social class lifestyles has been labelled as victim blaming as it does not account for wider socioeconomic factors (Backett & Davison, 1995). Taking a wider view of political, social and economic factors shows that income (Benzeval et al., 2001), car ownership, housing tenure (Macintyre et al., 2001), and education (Marmot, 2004) are all factors that contribute to possible health inequalities.

There is increasing understanding of the complexity of factors which impact on health outcomes. For example, Scambler and Scambler (2007) put forward six assets that affect health: social status at birth; psychological; social networks and support; education; location of domicile; and income. Singh-Manoux and Marmot (2005) include capability of future goal planning as another potential example.

The effects causing the above data are not entirely income related. Raphael (2006) argues that there is more to health than individual choice and that the choices available are shaped by economic and social context. Depriving individuals of material resources and reduced social structures give fewer opportunities to enjoy good health and create greater exposure to higher risks of disease, illness and injury (Baggott, 2011). Black highlighted these points in 1980 when he argued that differences in the material conditions of life were mainly responsible for health inequalities and that the causes were complex and multiple (Black, 1980). Little seems to have changed since this time. Income also determines place of residence which determines school, GPs, dentist, availability of shops and amount of green space. The more affluent have more choice and more power of choice (Holman, 1997). Giving those in poverty more money will not solve the problems of poverty. The structures of choice would also have to change and money alone will not alter these structures. Baggott (2011) argues that the health of those in poverty would be improved by removing the barriers of social exclusion, enabling those in poverty to participate in social and economic activities and become citizens in society.

Attempting to identify the links between low income and health inequalities in men is complicated and contested. This diversity of causes makes it even harder to provide simple solutions to the issue of health inequalities and highlights the limited understanding and piecemeal approach to research that is of limited help to those in need.

Having looked at the multiple and complex causes for the higher rates of poorer health in men on low-income, the next section will look at the impacts of poverty on the mental health of this group.

2.4.2 Mental health of men on low-income

The link between poverty and mental health is indisputable (Lund et al., 2010). Poverty increases the risk of mental health problems, and can be both a causal factor and a consequence of mental ill health (Fell & Hewstone, 2015). People with long-term conditions and co-morbid mental health problems disproportionately live in deprived areas and have access to fewer resources of all kinds. The interaction between co-morbidities and deprivation makes a significant contribution to generating and maintaining inequalities. The cost of mental health is high with between £8 billion and £13 billion (8-12% of total expenditure) spent on long-term mental health conditions in England each year (Naylor et al., 2012).

Twenty three percent of men are at high risk of mental health problems in the lowest socioeconomic class. (MacInnes et al., 2015). Young (2010) suggests that the pressures faced by poor men are particularly intense given their poorer living conditions, unreliable employment and income shortfalls. Compared with areas with higher socio-economic status there are higher levels of violence, under-education and cultural marginalisation, all factors lowering mental health. Homeless men have more of these pressures than any other group of men on low-income and have higher rates of mental health problems; they are eight times more likely than the general population to have a mental health problem if living in temporary accommodation and this goes up to eleven times if they are sleeping rough (Wright, 2002).

Young (2010), Kotila and Dush (2013) and The Joseph Rowntree Foundation (Fell & Hewstone, 2015) report there is minimal research on the mental health of men on low-income. In 2015, The Joseph Rowntree Foundation undertook a wide ranging review of poverty and mental health in the UK. There was very little gender related data and the author commented on how hard it was to understand the situation in the UK due to inadequate research and data. The review also highlighted the lack of clarity in quality of services for mental health in England. Further problems with research into mental health and poverty are that these are often defined differently or imprecisely (Cooper et al., 2012). Burns (2005) positions some of the problems and potential solutions in this area but there would need to be global political consensus for these solutions to become reality.

This lack of clarity for definition of mental health and inadequacy of data for this highly at risk group of men indicates that there is little focus in policy and unknown funding levels for mental health or well-being support for men on low-income.

2.5 Ethnicity, gender, poverty and health

There are many causes and correlates between ethnicity and men's health and well-being. A recent literature review by Public Health England (2018) highlighted differences in health and well-being behaviours and outcomes between ethnic minorities and the White British population. The report writers found research that did not cover every ethnic group or only covered specific behaviours or outcomes. Therefore, not every behaviour, outcome or ethnic group is covered below.

Pakistani and Bangladeshi men have the highest levels of smoking of any ethnic group. White British and Irish groups drink more alcohol more frequently than any other ethnic group. Black Caribbean men had the highest levels of adherence to the recommended physical activity levels. In 2004, amongst men, the White British groups had the lowest levels of adherence to the recommended fruit and vegetable intake of 5 a day. In 2014, the trend was reversed with no ethnic minority eating more than the recommended amount, the White British group reported 49% adherence. In three inner city

London boroughs, White British men were the least likely to attend health checks than any other group.

White British men reported higher more mental health disorder than any other ethnic group but Black men reported the highest levels of psychotic disorder. Overall levels of well-being were higher in the White population than most other ethnic groups with people in the Black ethnic group twice as likely to report lower life satisfaction as people in the Asian ethnic group.

The report authors highlight that it is the economic and social inequalities associated with ethnicity that drive the differences in health status detailed above. Thirty percent of those of non-White ethnic or Indian origin groups were classes as living in poverty. White British poverty rates have remained static at 19% for many years. Higher unemployment, lower pay and lower return on qualifications were the main reasons for the higher poverty rates among ethnic groups (Weekes-Bernard, 2017). There exists great diversity in cultural differences in health practices within and between ethnic groups, occurring over time and space. Public Health England (2018) report that culturally formed beliefs, and behaviours contribute to health inequalities between ethnic groups.

However, although ethnicity is an under-studied variable in terms of men's health inequalities, the present researcher's lack of detailed cultural understanding of the situatedness of cultural practices was felt to be a barrier to researching men from ethnic groups. To retain some homogeneity in the sample and benefit from the insider view of the researcher (who has spent many years as a man on low income), a White British low income sample was chosen.

2.5.1 Summary

This chapter has so far focused on defining health, mental health and well-being. Then it looked at the health, mental health of men then specifically the men on the lowest income. Men have lower life expectancy than women and less engagement with health services. Where specific health services are provided there is low uptake from men. Hegemonic masculinity, the main theory through which men's health has been explored in the last 30 years is essentially a negative concept. It positions men as too weak to free themselves from dominant scripts about how to be a man and this leads to poorer health outcomes. The majority of research into the health, mental health and well-being of men on low-income produces negative data.

To effect improvements in health, mental health and well-being for men on low-income there must be positive exemplars to position as ideals for these men to aspire to. Positive exemplars in terms of behaviours or multiple outcomes that show men on low-income are flourishing in their lives despite the deprivations caused by poverty. To understand the positive behaviours or outcomes for health and well-being for men on low-income, a literature review was undertaken.

2.6 The positive health and well-being of men on low-income: Literature review

This is a review of the qualitative literature on the positive behaviours and outcomes of men on low-income. In this body of work, poverty is defined by the study authors, as income data is often missing from their research. The review focuses on men in poverty, positive behaviours and qualitative methods to look beyond the numerical data to try to understand the lived experience of positive health and well-being for men in poverty in the UK. The review was carried out in 2013 and updated in 2016 and 2020.

The review had three aims: (i) to review the positive health and well-being behaviours in the literature for men on low-income; (ii) to understand how positive health and well-being behaviours are framed using hegemonic masculinity; and (iii) to reflect on missed opportunities from research with low income populations or men on low-income.

2.6.1 Methods

The following databases were searched electronically, Psychinfo, Medline, Embase, Cabextracts, Web of Science, ASSIA and Sociological Extracts. The search strategy involved keywords taken from the available men's health research literature and positive terms from the initial research question. Table 2.1 shows the terms used in the literature review search.

Table 2.1

Terms used in the Literature Review Search

Group	Terms
1	Man or men or male or masculin*
2	Low socioeconomic status or low income or poverty or deprivation or disadvantage or adversity
3	Positive or good or resilience or hardiness or lifestyle or attitudes or belief or risk taking or hegemon*
4	Qualitative or ethnographic or discourse or content or thematic or interpretative or interview or narrative or grounded theory or phenomenolog*

Group 1 represented all possible terms relating to male and was chosen as this was the gender under research. Group 2 represented all terms found in the literature that related to the income group under research. Group 3 related to the positive part of the research question but added terms that would collect the literature pertaining to hegemonic masculinity which had dominated men's health research

for decades. Group 4 related to different types of qualitative methods. Truncated keywords were used to maximise inclusion.

2.6.2 Inclusion criteria

Studies were included if they were qualitative studies on men's positive practices, were published in English and in journal articles in or after the year 2000. Health and well-being theories and practices change over time. Fourteen years of research were chosen to try and include current thinking and exclude out of date practices. Studies could be included from the UK and culturally comparable countries/ regions including western and central Europe, Canada, the USA, Australia and New Zealand.

2.6.3 Exclusion criteria

Studies were excluded if they included research on animals or exclusively on women. Studies that involved pre-existing medical conditions were excluded as the participants would think about health differently (Herzlich, 1973) and adapt their health and well-being practices in light of their medical condition, this was not part of the group under study. All studies purely on medical topics without qualitative work were also excluded.

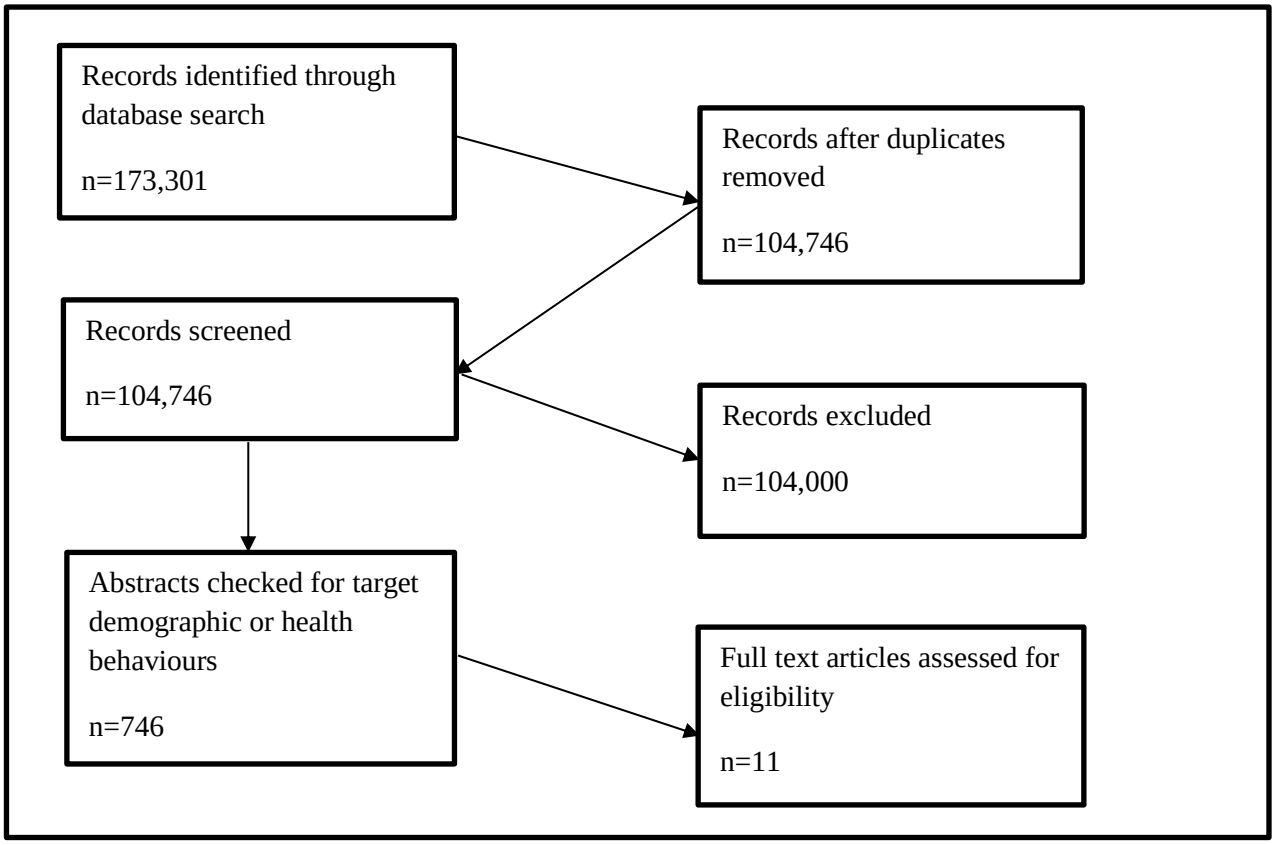
2.6.4 Results

The first search in 2013 used all 4 groups of search terms and produced 3,988 articles with none of interest to the research question. The second search used groups 1, 2 and 4 and produced 30,971 articles with only one of interest to the research question. The final search used groups 1, 2 and 3 (research without a specifically defined qualitative element) and produced 140,832 articles and produced 8 of interest to the research question. Subsequent searches in 2016 and 2020 found 2 more articles to make the total 11.

Figure 2.1 presents the flow chart for the selection of the included studies. Due to the general nature of the search terms, the search returned a very large number of articles.

Figure 2.1

Literature Search Flowchart



The literature search produced 173,301 articles, including duplicates. Psychinfo/Medline/Embase/Cabextracts -166,916, Web of Science – 3,916, ASSIA/Sociological Extracts – 2,469). After duplicates were removed, this total dropped to 104,746 articles. The search facility within the database was used to separate and remove articles which did not meet the inclusion criteria or met the exclusion criteria. Once this could be taken no further, article titles were visually scanned and manually removed from the database. This number was reduced to 746 after screening titles using the inclusion and exclusion criteria. The abstracts for these 746 articles were read and excluded if not containing the target demographic or health behaviours. 128 full articles were accessed, and the full papers reviewed.

For the first aim of the literature review (ie. review the positive health and well-being behaviours in the literature for men on low-income) 11 papers remained at this stage, the details of these are shown in Table 2.2. These papers were independently reviewed by one of the thesis supervisors and all met the inclusion criteria.

2.6.5 Coding of Studies

The 11 studies reporting positive and well-being practices were coded using 10 criteria similar to Gulliver et al. (2010): Authors name; year of publication; country or countries of study; population description; participant age; sample size; SES or income level, research question; methodology and key findings in relation to positive health and well-being behaviours.

2.6.6 Results

All papers were within the dates and countries specified in the inclusion criteria. The participants were all specifically men apart from one study (Martilla et al., 2013) which included women. The participants were all adults and two samples were from a low income group (Simpson & Richards, 2019; Vuori & Åstedt-Kurki, 2013) although two others (Fildes et al., 2010; Robertson et al., 2018) were from an area of relative social disadvantage.

2.6.7 Methodology of included studies

All used interviews to elicit data from participants except Robertson et al. (2018) who used focus groups but there were a range of analyses. Vuori and Åstedt-Kurki (2013) and Hollnagel et al. (2000) used a type of phenomenological analysis, two used a type of discursive analysis (Sloan et al., 2010; Wandel & Roos, 2006), one used content analysis (Nobis & Sanden, 2008), one narrative analysis (Gorman et al., 2007) and three thematic analysis (Martilla et al., 2013; Robertson et al., 2018; Simpson & Richards, 2019). The other two used un-named analyses (Branney et al., 2012; Fildes et al., 2010). All studies reported a perspective or theory driving their work.

Table 2.2

Studies Included in the Review

Author	Year	Country	Population description	Participant age	Sample size	SES or income level	Research question	Methodology	Key findings in relation to positive health and well-being behaviours
Hollnagel et al.	2000	Denmark and Norway	Men in GP consultation	19-84	39	Diverse	Self-assessed health resources in men?	Interview/ Giorgi's phenomenological approach	Personal health resources framed the analysis. The four themes were, taking pleasure from life and personal strength, happy at work, unwind with friends and energy from hobbies, exercise and a healthy life.
Wandel et al.	2006	Norway	Employed men	35-57, median 45	46	Engineers/ Carpenters /drivers	How different SES groups and work experience talk about aging and physical activity	Interview/ Unknown analysis based on discursive	Men not all low income. Exercise for health. Age giving experience so life can be managed better. Friends and family important for support and well-being.
Gorman et al	2007	Australia	Rural men	18 and over	10	Not collected	What are stressors to rural living and factors that enhance their resilience to mental illness?	Interview/ comparative narrative analysis	Self-awareness of health and especially mental health. Taking control and focusing outward. Seeking meaning in religion. Seeking professional help when needed. Talking with others about their problems. Support of family and friends. Making conscious changes to improve one's life. A change of focus in life to get away from the drudgery, Lions Club, fishing, photography.
Nobis et al.	2008	Sweden	Men	19-34	11	Not reported	How young men relate to health, ill health, masculinity and their bodies	Interview/ content analysis	Confirmation of hegemonic masculinity. 8 men described friends as being important and friends company helped them to be themselves, to feel relaxed, to feel good.
Fildes et al.	2010	Australia	Retired/ unemployed men	41 to 62, mean 54	15	Area of relative social dis advantage	Outcomes for men's health and well-being from participating in a Men's Shed?	Quantitative/ Qualitative/ un-named analysis	Men visiting Men's Sheds felt less closed up, now more comfortable and relaxed. 5/7 partners said men were happier and improved relationships. All men liked working in group and some socialised away from group. 6 had better health, 3 had better mental health.
Sloan et al.	2010	UK	Men	22-57	10	Not reported	How apparently healthy men account	Interview/ grounded theory/	Men not low income. Much confirmation of hegemonic masculinity in discussion and all

							for their health promoting practices and the role of masculinities in this?	discursive analysis	the men's healthy behaviour framed this way. Eating healthily, giving up smoking and controlling alcohol consumption discussed as autonomy.
Branney et al.	2012	UK	Men	Not reported	34	Not reported	How male frequent attenders construct decisions to use or not to use health care services?	Interviews/ unknown and un-named analysis	Good diet, physical activity, psychological well-being (unwinding after work, spirituality at church, job keeps one mentally alert). No mention of low income
Martilla et al.	2013	Sweden	Men and women	18 and over	5 men 8 women	Diverse	The way long-term social assistance recipients manage adversity and act as active agents in their lives.	Interview/ thematic analysis	Resilience in long term welfare recipients was the frame. The findings were given a hierarchy with managing and surviving as the lower stages, social belonging, mastery of situations, jobs and education as the higher stages. The focus was on the use of personal, social and situational resources to improve lives.
Vuori et al.	2013	Finland	Fathers	29-49, mean 43	7	Low Income fathers	Health and well-being experiences of low income fathers	Interview/ a phenomenological method	Focus on well-being with the men gaining pleasure from good food and spending time with their children.
Robertson et al.	2018	UK	Fathers	Not reported	6	Fathers from low income area	If we improve the well-being of fathers by sharing the behaviours of successful fathers, will this improve their children's well-being too?	Interview/ thematic analysis	Many men changed their way of thinking and started dealing positively with life's problems. Positive space with positive people engendered positive behaviour. Creating a space which avoids hegemonic masculinity allows men to engage in practices more conducive to positive well-being.
Simpson et al	2019	UK	Working class men	18 and over	21	Some earning less than £13,000	The ways in which working-class men involved in self-help groups can develop emotional reflexivity in relation to health/well-being collectively and from a position of struggle/hardship.	Focus group/ Thematic analysis	Accounts of men sharing emotional and material support in a group setting. Emotional reflexivity with family, friends and support groups. Reflexivity described as a commodity traditionally denied to working class men.

2.6.8 Findings

The earliest nine papers listed above did not have the paradigm of the positive health and well-being behaviours of men on low-income, but some was presented and discussed. The two most recent papers that did have the positive health and well-being behaviours of men on low-income as their paradigm will be discussed at the end of this section. Two of the early papers involved men on low-income as their participants (Fildes et al., 2010; Vuori & Åstedt-Kurki, 2013) and one mentioned a specific health behaviour from the men on low-income in their broader sample (Wandel & Roos, 2006). The data from the men on low-income will be highlighted as such in the findings. When the positive health behaviours described were compared, the data clustered around six broad themes. These were; family and friends, self-awareness, control and risk, hobbies, in the moment, and exercise/energy. How these six clusters of positive behaviours were reported will be discussed below.

2.6.8.1 Family and friends

The low income groups saw family and friends as providing acceptance and support in adversity (Martilla et al., 2013; Vuori & Åstedt-Kurki, 2013). This was supplemented with gifts of clothes, money, haircuts or just being there when needed. The data in the rest of this section relates to groups that were not low income. Friends and family did not provide support in such concrete ways. Family were there just to talk to (Branney et al., 2012; Gorman et al., 2007) to provide structure (Hollnagel et al., 2000) or support (Gorman et al., 2007). Hollnagel et al., (2000) also reported that participants had a beer with friends and escaped from the troubles of everyday life. Nobis and Sanden (2008) found that their participants felt the company of friends enabled them to be themselves and they relaxed and felt good. This drive to have a social life meant that men on low-income would save money on food to afford a beer (Martilla et al., 2013).

2.6.8.2 Taking action

Only research on higher income men reported self-awareness as a positive health and well-being behaviour. Branney et al. (2012) and Gorman et al. (2007) both reported their participants' descriptions of taking breaks from work or the farm during drought as a way of relieving stress. Branney et al. (2012) also reported a man who stepped down from a management position so he could enjoy his work while Hollnagel et al. (2000) described several strategies men use to reduce stress at work. Finally, Nobis and Sanden (2008) reported that more than half of their sample of young men had sought information or undergone tests for sexual transmitted diseases.

2.6.8.3 Control and Risk

There was research on higher and low income participants who described control and risk. Higher income participants described control when it came to changing health behaviours. The changed behaviours would improve their health and well-being but only incrementally. Sloan et al. (2010) found participants who described limiting diet, smoking and drinking. This finding was supported by Branney et al. (2012). Low income participants described major risks to their health and well-being when changing health behaviours. The participants of Martilla et al. (2013) were trying to cut down

on drugs and alcohol to reorient their lives and stay away from criminality. This difference between control of behaviours seen as unhealthy to higher income men and the movement away from major risks for men on low-income was quite marked.

2.6.8.4 Hobbies

Hobbies were important to low and higher income men with differences reported between the content of the hobbies. The higher income men's hobbies were of a higher status such as a Lions meeting and visiting a car rally within Gorman et al. (2007) or sailing (Hollnagel et al., 2000). Both studies reported hobbies to take a break from the stress at work. The men on low-income talked about reading books, watching TV and outdoor exercise as a means of diversion or recreation (Vuori & Åstedt-Kurki, 2013). The distinction between income groups was that the higher income men were taking breaks from the stress at work and the men on low-income needed a diversion, perhaps from no work or loneliness.

2.6.8.5 In the moment

Two participants were aware of being in the moment, one from higher income and one from low income. The higher income participant talked about looking at the beauty of life around you (Gorman et al., 2007), while the low income participant said that food meant more than nutrition (Vuori & Åstedt-Kurki, 2013).

2.6.8.6 Exercise/energy

Exercise had multiple health outcomes for the participants in this review. Hollnagel et al. (2000) reported that men gave a variety of positive outcomes; staying healthy, made them feel more energetic and gave a sense of well-being and feeling very well. One participant said that exercise gave him resilience as he went out drinking and smoking occasionally and gave him a reasonable balance. Wandel and Roos (2006) focused on older men and found that across the three occupations they interviewed, men from each group increased their physical activity as they got older. This was also a social activity as they enjoyed participating with family and friends. Men in all income groups reported positive feelings from exercise, energy, well-being and a social experience.

The most recent two papers however, investigated behaviours that improved the health and well-being of men on low-income (Robertson et al., 2018; Simpson & Richards, 2019). One involved a group setting that positively encouraged the men to talk about their feelings, the other used focus groups with men from deprived areas. Both reported the power of communal support groups to foster emotional expression and positive behaviours from men on low-income. The advantages of 'safe spaces' were positioned by both papers as facilitating role modelling for men to adjust their outlook and create positive health and well-being for themselves and others. Improved health well-being and positive behaviours improved the lives of their loved ones too. A wife of one of the men (Robertson et al., 2018) described the support group as a positive space with positive people as opposed to the pub with damaging friendships and wasted money.

The two recent papers take a different tack from previous research where the positive health and well-being of men on low-income was not centre stage. Here, it is accepted that it is possible for low men on low-income to exhibit positive behaviours. This recent change may reflect a growing disillusionment with hegemonic masculinity to frame health behaviours with men on low-income. Moreover, it appears there may be a move towards promoting positive health and well-being behaviours with this group. It must be noted that these papers are researching interventions for health and well-being and not reporting men's voluntary positive behaviours.

The next section of this literature review will now look at research using hegemonic masculinity to frame health and well-being.

2.6.9 Positive health and well-being behaviours framed using hegemonic masculinity

For the second aim of the literature review (to understand how positive health and well-being behaviours are framed using hegemonic masculinity) papers were reviewed which contained positive health behaviours within a framework of hegemonic masculinity. In addition to Nobis and Sanden (2008), there were 6 more papers framed that fitted the criteria.

Table 2.3 *Details of Articles with Positive Health and Well-being Behaviours Frames Using Hegemonic Masculinity*

Author	Year	Country	Population description	Participant age	Sample size	SES or income level	Research question	Methodology	Positive health and well-being behaviours framed using hegemonic masculinity
O'Brien et al.	2005	UK	Diverse population of men	15-72	55	Diverse	To what extent and what ways help-seeking behaviours are related to constructions of masculinity.	Focus group/ unknown analysis	Discussing health in focus groups reinforces socially constructed hegemonic masculine views on health. Positive health behaviours expressed were not explored or discussed.
De Visser et al.	2006	UK	Undergraduate student	19	1	Not reported	Exploration of young men's experience of masculinity and health related social behaviour.	Interview/ IPA	Questions asked about poor health behaviours, answers even when exhibiting positive health behaviour, framed as hegemonic masculinity. Positive health behaviours described by participants not explored.
Emslie et al.	2006	UK	Men with depression	18 and over	16	diverse	Exploration of accounts of depression and connections with hegemonic masculinity.	Interview/ secondary analysis	All analysis was framed by Connell's multiple masculinities. Positive expressions of difference and resilience were not explored outside the framework.
McVittie et al.	2006	UK	Older Scottish men	65 and over	12	Not reported	Men's understandings of health and ill health and whether hegemonic or other masculinities were implicated.	Interviews/ discourse analysis	Positive health behaviours quoted in text but not acknowledged. Discussion heavy on discourse and hegemonic masculinity and no mention of positive health behaviours.
O'Brien et al.	2009	UK	Diverse population of men	15-72	59	Diverse	To what extent and in what ways health related beliefs.	Focus group/ thematic analysis	Framework of positioning West of Scotland man using masculinity. As above focus groups reinforces socially constructed hegemonic masculine views on health. Brief mention of health behaviour change, all around diet or exercise with no exploration of positive behaviours.
Farrimond	2011	UK	Middle class professional men	20-60	14	High SES	The socially situated health practices of help seeking in men.	Interview/ thematic analysis	Analysis framed by hegemonic masculinity, positive health support networks framed as taboo. Help seeking not seen as positive but functional and efficient.

2.6.10 Findings in relation to the second aim of literature review

The positive health behaviours reported in the articles in Table 2.3 can be split into two distinct areas, behaviours reported and not explored, and behaviours reported and discussed in terms of masculinity or hegemonic masculinity.

Emslie et al. (2006) explored accounts of men with depression who spoke freely and openly about feelings and experiences of living with depression. The sample included six men who had survived a suicide attempt and established a successful recovery. These positive behaviours of surviving suicide and recovery and open expressions of feelings were seen as part of Connell and Messeschmidt's (2005) framework of multiple masculinities and not distinct behaviours outwith the multiple masculinity framework. O'Brien et al. (2009) started their analysis on competitive drinking and described men who found it easy to move away from this culture as exceptional. They also reported that those who focused on health and fitness as typically a minority, depicting men as having poor health and an inability to resist a drinking culture. The use of focus groups means that men are conscious of other men defining and policing their masculinity so discussion about positive health is less honest and revealing (Conrad & Warwick-Booth, 2010).

Secondly, the framework of hegemonic masculinity was applied to the majority of the examples in this section. De Visser and Smith (2006) reported participants describing authentic interpersonal relationships with females. These were labelled as rejecting the expectations of hegemonic masculinity and not explored as positive behaviours that are expressions of openness and rarely reported in the body of literature on men's health and well-being.

Farrimond (2012) claims she was looking beyond traditional masculine behaviour to show men actively seek health care but quoted a man saying that going to the doctors means you have lost the battle and are some kind of poof. The use of negative language towards a positive health behaviour does not promote the paper as being one of carrying a positive health message. Positive examples of seeking healthcare are not explored in any depth to support her claim. Help seeking was also explored by O'Brien et al. (2005) who concluded that men only actively seek help if diagnosed, otherwise hegemonic masculinity prevents them from doing so. Further examples of the concept of masculinity stifling reports of positive behaviours include McVittie and Willock (2006) describing older men's perceptions of health and aging. The only positive example in the paper is of a man who talks about eating well and doing exercise, however this is framed as power and control and not explored further.

2.6.11 Missed opportunities from research with low income populations or men on low-income

For the third aim of the literature review (to reflect on missed opportunities from research with low income populations or men on low-income) papers were reviewed that used a very narrow paradigm or recruited samples of hard to reach men and did not take full advantage of this opportunity. Nine of the many papers are presented below.

Table 2.4

Details of Articles with Missed Opportunities

Author	Year	Country	Population description	Participant age	Sample size	SES or income level	Research question	Methodology	Narrow frame for research or a missed opportunity to explore men's health behaviours
Wardle et al	2000	UK	Households in Office for National Statistics omnibus survey	Not reported	1,894	389 from lowest 2 (of 5) income brackets	Higher SES groups hypothesised to have lower ideal weight and monitor this, more likely to identify as overweight, more likely to try to lose weight and use more weight control strategies	Statistics about BMI, socioeconomic status, dieting and attitudes towards weight	The data clearly showed no association between socioeconomic status and obesity for men, and men on low-income had the lowest ideal BMI and actual BMI. These positive results for men and men on low-income were ignored and the discussion focused on higher income groups
Stead et al	2001	UK	Smokers and non-smokers in study on smoking and barriers to cessation	Not reported	18-44	Highest areas of deprivation in Glasgow	The ways in which smoking might be fostered in communities excluded economically, culturally and physically from mainstream society	Focus groups, topics around smoking and community, thematic analysis	Research into area effect of smoking and any discussion of smoking engendering community, identity, and resilience not developed but positioned with reference to areas that foster smoking and seen as a negative
Sixsmith et al	2002	UK	Deprived community in Bolton	Not reported	46	Low SES area	Reveal the complexities between social capital and health from a gendered perspective	Interviews and focus groups analysed thematically	No positive health discussed for men
Popay et al	2003	UK	Adults in Salford and Lancaster	Age range not reported	777 51	diverse	Exploration of lay theories about health inequalities and area effects	Questionnaire about neighbourhood Interview about health inequalities	Interview participants prompted by health inequality facts and newspaper headlines. Lay understandings of these, dichotomise answers between socioeconomic groups and reinforce stereotypes
McPherson et al	2005	UK	Low SES Scottish men	41.98 mean	80	Low SES	To identify the BMI and waist measurement more satisfying for the men	BMI compared with ideal body shape figure	Men with BMI of 27 wanted to be larger and above this figure, wanted to be smaller

Robertson	2006	UK	lay men	27-43	20	Not reported	Exploration of male gendered discourses on health including risk and responsibility	Focus groups and interviews about health	Interviews from a lay perspective as a contrast to biomedical model. Analysis focused on masculinities and risk and provided no positive framework. The model of men's health was a relationship between health and hegemonic masculinity
Canvin et al	2009	UK	Adults with experience of material adversity	Not reported	25	Living in a deprived area, on welfare benefits	What can be learnt about resilience in poor households in Britain by listening to people in hardship and understanding social context	Interviews about resilience analysed with Grounded Theory	Positive resilience was shown throughout the analysis but all the examples from women. There was no mention that this was a women only study. No examples of positive resilience from men
Pechey et al University of Cambridge	2014	UK	adults	18 or over	732	diverse	To investigate social patterning in motivation and perceived attributes of foods, social patterning for liking and food choices.	Questionnaire about food types	Participants were asked about consumption and liking of cheese, cake and fruit. Men and particularly lower SES men ate less fruit, no other patterns were reported as significant.
Livingstone	2014	Australia	Australians from the National Drug Strategy Household Survey	12 and over	20757	diverse	Socially disadvantaged people take greater risks when drinking, particularly vehicle accidents as a result of alcohol consumption	Data from Australian household survey	The data showed that socioeconomically advantaged households drank more alcohol and had more vehicle accidents as a result of alcohol. The researcher did not accept the data to be true and found three limitations of his research to negate what was found
Burgoine et al University of Cambridge	2016	UK	Adults in Fenland Study	29-62	5958	Not reported	How educational attainment modifies fast-food consumption and weight combined with fast-food outlet exposure	Questionnaire about fast-food	Greater fast-food consumption, BMI (Body Mass Index) and obesity were correlated with fast food exposure and lower educational level. The conclusion was to regulate fast food outlets

2.6.12 Findings in relation to the third aim of literature review

The papers reported here are a cross-section of a much larger body of literature that represents missed opportunities to explore or report positive health and well-being for men on low-income. At times I found this lack of positive data frustrating that so often opportunities to promote or explore positive health were missed or ignored by previous researchers. There appeared to be a reluctance to promote positive behaviour by low income groups.

The research in table 2.4 falls into four categories. The first is two pieces of research by the University of Cambridge which ask or report a very narrow question thereby missing an opportunity to investigate a broader view of health. Burgoine et al. (2016) collected data from an ongoing longitudinal study and used regression models on years of education, an estimate of grams per day of fast food consumption, BMI and odds of being obese and found that there was a higher consumption of fast food by those with less years of education. However, energy intake by the group with those with least years of education was less than 0.1% higher than the average across all groups and this was not discussed. The research also looked at the association between fast-food outlet and supermarket proximity to home and work addresses with educational attainment. This found that those with the least years of education had more than double the incidence of obesity of those with most years of education but only 2% more than the largest group of participants with the middle number of years of education.

The conclusion of this research is that there should be more fast-food outlet regulation to improve diets, reduce obesity and reduce socioeconomic inequalities in diet. However, this is based on marginal differences in data which does not show socioeconomic differences in energy intake or fast food outlet prevalence based on socioeconomic demographics. This is an example of narrow paradigm research that misrepresents data to present the poorest in society in a negative light. Regulating fast food outlets in low income areas would remove employment from those who need it most. The outlets are there to fulfil a need, so a better approach would be to remove the need by health education.

The second piece of research is from 2015. Pechey et al. (2015) researched via an online questionnaire frequency of consumption and implicit liking of three types of food, fruit, cake or cheese. They discovered men ate less fruit than women and lower socioeconomic groups ate less fruit than higher ones. This finding has been found before by the lead author (Pechey et al., 2013), the UK government (DEFRA, 2011) and many others. None of the recommendations of the previous reports have made any difference to levels of fruit consumption and this research does not take the understanding of these dietary differences any further.

The second category is research which finds that low income groups do not have the worst health behaviours and then explains this by presenting it as limitations in the research.

Wardle and Griffith (2000) took data from the monthly Omnibus Survey of the Office of National Statistics and looked at BMI, ideal BMI, weight control and dieting. The data showed that there was no association between obesity and socioeconomic status for men. The lowest BMI was in men on low-income and the lowest ideal BMI was also in men on low-income. This was not mentioned in the title, abstract or the key points table which said that obesity prevalence is higher in low income groups in Britain. The discussion mentions study limitations which could account for the data not being as predicted rather than exploring why the men on low-income in this research are not conforming to the norms and why this should be the case.

Livingstone (2014) assessed the relationship between socioeconomic status and risk taking while drinking alcohol, controlling for age, gender and alcohol consumption. The data showed that socioeconomically advantaged respondents drank more and showed more risky behaviours while drunk than socioeconomically disadvantaged respondents, refuting the hypothesis. More than 90% of the discussion concerned how the results differed from previous research and the limitations of the research to explain this rather than exploring the positives for low income groups. Both these papers report positive health behaviours in comparison to the rest of the population and ignores the positives and looks for reasons why this should be an anomaly.

The third category is research which misses the opportunity to undertake or present positive research on men on low-income when the opportunity arises with this hard to reach group.

Canvin et al. (2009) asked 25 adults in poverty about their achievements and positive transitions in their adverse circumstances. There were many examples of resilience in this sample but all seven of the examples given were from women. The research did not say that it was exclusively with women and did not report why men were not included in the results.

McPherson and Turnbull, (2005) recruited eighty men Scottish on low income for research and asked them about their BMI and ideal body shape. Their ideal BMI was 27 but here was an opportunity missed to ask this hard to recruit group so much more about weight, body image and health.

Forty men on low-income were recruited and interviewed by Sixsmith and Boneham (2002) about health and social capital. There was no reporting of any positive data amongst the results. It would have been very likely with 40 interviews and a positive topic that positive health and well-being

would have been mentioned by some of the participants. There was no report of positive behaviours in the research.

Finally, in this category, Stead, et al. (2001) researched the area effect of smoking, suggesting that it was independent of poverty and socioeconomic status. Eight focus groups in deprived areas of Glasgow discussed smoking, money and community. There were many positive examples of smoking fostering stronger community, personal identity and reliance, however, these were not explored as positives and positioned as negative factors engendering smoking behaviours.

The final category is clinical researchers exploring 'lay' perspectives on health. Popay et al. (2003) explored lay understanding of health inequalities and called their paper 'Beyond beer, fags, egg and chips'. This research interviewed 51 adults and began by asking what they thought about health inequalities between two areas, one advantaged, one disadvantaged. This leading question immediately dichotomised responses and all the research presented confirmed that poor people have poor health because they live in a poor area. There was no opportunity for the participants to answer an open question on this topic.

The other paper in this category (Robertson, 2006) is titled 'lay men understanding health and well-being' and asked 20 men in focus groups about health and well-being. The analysis focused on lay perspectives of health and well-being, risk, responsibility and masculinity. This closed perspective on men's health and well-being meant the analysis was very limited. Positive health behaviours were framed within existing frameworks as control and release, risky or reactions to responsibility and not as choices taken in wider contexts as responses to individual lifeworld's. Lay perspectives assume knowledge is held by the researcher and the participants are not active partners in the research. The knowledge they give during the research process is manipulated to fit the perspective of the researcher and not reported as a perspective from the lifeworld of the participant where it has coherent meaning.

2.6.12.1 Reflective box 3

Reflective Box 3 'Literature review'

My supervisors are acutely aware of my frustration at finding little research that highlighted positive health and well-being for men on low-income. To find papers with titles "like It's cavemen stuff, but that is to a certain extent how guys still operate': men's accounts of masculinity and help seeking" (O'Brien et al., 2005) and "The average Scottish man has a cigarette hanging out of his mouth, lying there with a portion of chips': prospects for change in Scottish man's constructions of masculinity and their health-related beliefs and behaviours." (O'Brien et al', 2009) did not improve my feelings of frustration. This frustration prompted me to write this literature review in the way that I have, highlighting the negatives and the way research can be skewed by researchers so as not to report positive health and well-being behaviours with this group. My friend, a GP who researches the health and mental health of the homeless said to me that if like him, I research the marginalized, I will become marginalised as a researcher. This advice will not stop me presenting the reality that I see to attempt to help men on low-income to live longer, healthier lives.

2.6.13 Summary

The literature review looked at search terms: 'Men' (with variations); 'low income' (with variations), 'qualitative methods' and 'positive' (with variations). In total, 173,301 papers were accessed via these search criteria. No study specifically examined the positive health or well-being of men on low income.

Aim 1: Only the two most recent papers had the positive health or well-being of men on low-income as part of the research question. They reported that it was possible for men on low income to exhibit positive behaviours and to enjoy positive health and well-being. Nine other papers analysed and discussed positive aspects of health and well-being presented by participants. These positive aspects can broadly be categorised into six areas: family and friends; taking action; control and risk; hobbies; in the moment and exercise/energy.

Aim 2: The six studies drew upon hegemonic masculinity or masculinities to understand health and well-being behaviours of the men. It is argued that this limited the opportunities to look beyond the negative health viewpoint and see the positive health and well-being behaviours of the low-income male participants. Any positive aspects of health and well-being in the extracts from the interviews were not explored in the analysis or were seen as deviant behaviours. Many years of research into men on low income using hegemonic masculinity has framed masculinity as being in crisis. Positive health and well-being has not been studied nor reported, and the overwhelming position from the

reviewed studies is that men are to blame for their own health, and cannot be helped. This position has not helped to improve the health and well-being of men on low income. Alternative way of researching this at risk group must be found to highlight positive behaviours.

Aim 3: There are missed opportunities in research with low income populations or men on low income. Two pieces of research with a narrow paradigm failed to consider the wider influences on men's health or the implications of their research. Two studies found that low income groups did not have the worst health in the population but this was explained as an anomaly and a limitation of the research. Four studies recruited a hard to reach group (men on low-income) but did not research positive health. Finally, two papers, researched lay perspectives on men's health. Entwistle et al. (1998) gives one reason for lay involvement and five reasons against and conclude that the appropriateness of lay perspectives must be considered in relation to the research question.

The literature review only highlighted two pieces of research where the positive health and or well-being of men on low-income was the focus. Men on low-income were also researched from within the framework of hegemonic masculinity and were found to exhibit negative health behaviours. Where positive behaviours were exhibited, they were belittled or treated as anomalous. Finally, there was a body of data which misrepresented positive health behaviours of low income groups or explained these away as limitations of the research.

2.7 Conclusion

The definition of health is a contested topic dependent on the political or economic ontology of the definer. A non-clinical definition sees health as a lack of illness, a neutral position in which health is not noticed by the individual. When health is noticed and interventions are required, IJsselmuiden and Matlin (2006) suggest that health research requires both qualitative and quantitative research. These should focus on the nature and extent of underlying health problems and their root causes and this focus should include the wider determinants of health that include poverty.

Men's health is different from women's health but neither NHS trusts nor GP surgeries are financially motivated to specifically target an improvement in men's health. Jewell (2001) argues that primary care has little to offer men and an alternative approach is needed. White (2001) found four areas of concern for men's mental health: lack of awareness of their own needs; inability to express emotions; access to mental health services; and men's lack of social networks. The implications for men's health from the negative data presented in these chapters are often referred to as the 'crisis' in men's health (Sloan, et al., 2010). Men's health and well-being takes many forms. This social aspect of men's health has great importance and is often missed.

Mental health and well-being are also not noticed by the majority unless there are events that raise or lower one's awareness of mental health or well-being. This neutral area in between is unlikely to be researched as there will not be a cost benefit to governments to improve well-being or mental health away from this neutral level. To effect health behaviour change, the focus must be on collecting and understanding the experience of health and well-being in the moment. Most well-being is experienced in the moment and only evaluated by research as remembered well-being thus removing the phenomenological aspects of that subjective well-being. To evaluate subjective well-being in a way that captures the phenomena in a subjective way, a different approach must be taken.

Kasser (2006) posits that there is cognitive dissonance between the ideal life portrayed in the media and those on lower incomes. He goes further by arguing that those implementing health and well-being targets do not understand the lives of those on the lowest incomes. Giving those in poverty more money will not solve the problems of poverty. The structures of choice would also have to change and money alone will not alter these structures. Young (2010) argues that there are many challenges connecting and engaging with men on low-income, and that this is in effect a silenced community, unidentified and largely invisible. Curtis (2010) claimed there is commitment from public health specialists to act on the social, economic and materialistic determinants of health but the evidence they need often does not exist.

The research found in the literature review highlighted only two pieces of recent research where the positive health and or well-being of men on low-income was the focus of the research. Men on low-income were also researched from within the framework of hegemonic masculinity and were found to exhibit negative health behaviours. Where positive behaviours were exhibited, they were belittled or treated as anomalous. Finally, there was a body of data which misrepresented positive health behaviours of low income groups or explained these away as limitations of the research. There were also nine papers that analysed and discussed aspects of positive aspects of health and well-being presented by participants but this was not the main focus of their research. These positive aspects can broadly be categorised into six areas: family and friends; self-awareness; control and risk; hobbies; in the moment and exercise/energy.

The key points from this chapter are that men's mental health is affected by their inability to understand or express themselves and their lack of social networks. Public health specialists do not have the data they need to act on social determinants of health. To effect behaviour change in men on low-income, an understanding must be gained of health and well-being 'in the moment'. Wider determinants of health must be studied using whatever methods suit the research question. Something to complement hegemonic masculinity or masculinities is needed as a framework with which to

understand men's health. Finally, current research does not include a focus on the positive health and well-being of men.

Chapter 1 showed that financial poverty has been with us since before the Black Death and there appears to be no end to poverty in the UK under the current form of capitalist democracy. The difference in life expectancy between men on the lowest incomes and the highest incomes widened from 1982 to 2011 (ONS, 2015b) by one year. This health inequality difference is likely to widen further with Conservative policies since that time and into the foreseeable future. In light of no foreseeable end to poverty and the current governments' policies, men on low-income must therefore attempt to adopt behaviours to mitigate the effects of poverty on their health and thus maintain or improve their health and well-being.

Thesis Aims

The historical and contemporary work on men's health behaviours reviewed across the first two chapters, shows the complexity of structural and often invisible forces on men's health practices, as well as the glaring gap in research about what low-income men are doing to stay well. This knowledge gap is problematic for a number of reasons. Men are less aware of their health and well-being than women and as a consequence less aware and less able to counteract the structural and other invisible forces acting on their health. The abject lack of knowledge of the positive health and well-being practices of men on low-income prevents policy makers from designing interventions that build on their current positive practices. Moreover, interventions designed with no data and no phenomenological understanding will be less likely to be understood and adopted by men on low-income. Therefore, a driving goal of the main empirical work of this thesis was to address this knowledge gap by generating novel data on how and why low-income men are looking after their health and well-being.

This thesis was structured to meet a number of aims:

The primary aim was to critically review the historical and contemporary positioning, evidence and experience of health and well-being among men on low-incomes.

The **secondary aims** were to:

(i) detail the importance of situating the study of men's health within a historical and political context: (Chapters 1 and 2).

(ii) to review the positive health and well-being behaviours in the literature for men on low-income; to understand how positive health and well-being behaviours are framed in that literature; to reflect on

missed opportunities from that literature with low income populations or men on low-income: (Chapter 2).

(iii) use visual methods to engage largely silenced, unidentified and often invisible community of men on low-income to given them a voice in research about them. The research question driving this chapter and chapters 4 & 5 was: How do White British men on low-incomes understand, experience and create positive health and well-being?

(iv) document and categorise the forms of health behaviours that White British men on low-incomes report: Chapters 4, 5 & 6).

(v) to critically consider findings in terms of White's four areas of concern for men's mental health: (Chapter 7).

(vi) to critically assess the position of hegemonic and alternative masculinities in relation to men's positive health and well-being: (Chapter 7).

3 Method

This chapter sets out the main empirical work of this thesis – an interview study with low-income men to understand how they experience and create positive health and well-being for themselves. The interviews utilised a photo-elicitation method, whereby participants bring photographs to the interview to scaffold their story and represent meaning. There were two meetings with each participant – the first to secure consent, explain the photo-elicitation task and provide them with a digital camera, and the second meeting was the main interview. This chapter reports the study methods for data collection and analysis which spanned a self-pilot, a pilot and main study.

3.1 Ethics

This study was conducted after obtaining ethical approval from the Faculty of Medicine and Health (School of Psychology) Research Ethics Committee at the University of Leeds (reference 13-0036, date: 20/02/13). There were seven key ethical issues: informed consent; physical safety of the researcher and participants; security of data; use of photographs; inclusion criteria, rewarding participation and power. All ethical considerations drew upon the British Psychological Society code of human research ethics (2010).

3.1.1 Informed consent

The British Psychological Society (2010) guidance is that participants should be able to consent freely based on adequate information.

3.1.2 Information booklet

Participants for this research were fully informed prior to the study via a comprehensive information booklet (appendix A). Radley (2011) suggests that being a participant in research is something most people understand. However, the target group of participants is an under researched group and hard to recruit (Bonevski et al., 2014 & Ellard-Gray et al., 2015). Therefore, it was important to offer a deep and clear explanation of what participation meant. The booklet was assessed by reading age software (The Writer, 2018) which calculated the reading age as thirteen, suitable for the target participants. This was to ensure participants in the lowest literacy level expected from some of the participant group would understand the booklet (The British Psychological Society, 2010). The information booklet explained that the aim of the study was to understand what men think and do about their own health and well-being, and what they think affects their health and well-being.

The booklet explained that if anything spoken about or photographed during the research process that led the researcher to think someone was at risk of harm, steps would be taken to break confidentiality. Another person would be informed of the researcher's concerns, but this would be discussed with the participant first (British Psychological Society, 2010). Booklets were not initially distributed directly to participants but via third parties or left in places likely to be frequented by the demographic required, such as working men's clubs, job clubs or sure start centres. This ensured sufficient time for

participants to make a decision about participating (The British Psychological Society, 2010). Potential participants were told they had as long as they wished to consider if participation was right for them. Similarly, once participants had consented to take part and were taking photographs, they were given as long as they liked before they brought the camera to the interview stage, but were given a guiding time period. Participants received one copy of the consent form and to contact the researcher when ready to be interviewed.

3.1.3 Competence to consent

The information booklet did not describe inclusion factors for competence to consent (The British Psychological Society, 2010). This was assessed at the initial meeting during the consent process. Assessment involved watching and listening to the participants as they spoke to identify any cognitive issues that might be considered as lack of competence. Erring on the side of caution was the default for this process but no participants showed any lack of competence at any stage.

3.1.4 Deception and debriefing

There was no deception. After the interview, participants were thanked for their time and given the supermarket voucher of their choice. This post interview time was also used to ask participants if they had any questions about the research and to bring them back to the present. The process of eliciting interview data takes participants back to past events and it is important for their safety that they are gently brought back to the present afterwards (Clarkson, 2009).

3.1.5 Physical safety of researcher and participant

The British Psychological Society (2010) gives clear guidance on maximising benefit and minimising harm to participants. However, there is no guidance for researcher safety. A risk assessment was completed and approved as part of the ethical approval. The researcher ensured his safety by arranging for the initial meeting (i.e. consenting and explaining the photo-elicitation task) to be in daylight hours. The choice of meeting place was decided upon by the participant and agreed by the researcher after considering his own safety. The pilot study was used to understand the potential risks for researcher and participant. Reflection on the interview and the process did not unearth any new safety issues. Three of the initial meetings in the main study were at the participant's place of work, fifteen in a public place, two in the participant's home and one at the researcher's place of work. The meetings in the participants' homes were with participants who were friends of a friend and therefore there was a degree of trust implicit in that arrangement. At these initial meetings the researcher decided if he would be safe meeting the participants in a more private location suitable for an audio recorded interview. In all cases, the decision was made to go ahead with the interview.

To help participants develop trust in the researcher prior to meeting, a photograph of the researcher was placed on the participant information booklet. This was supplemented with the lead supervisor's e-mail address and the researcher's mobile phone number. The initial meeting to hand over the camera and signing of the consent form also allowed both researcher and participant to decide

whether they were happy for this research dyad to continue. Interviews were held at a mutually agreed place. Eleven of the interviews were conducted in the participant's home, two at the researcher's place of work, one at the participant's place of work, four at the University of Leeds and three in a public place. All interviews were conducted in daylight hours. Another responsible person was kept informed of the location of the interviews and contacted pre and post interview as per risk assessment protocol.

There were several instances where traumatic events were reported within the interview including a suicide attempt and childhood sexual abuse. The emotional weight of these disclosures distracted the researcher during the interview for a time, but the interviews continued and there were no lasting effects. Post interview, the researcher reflected that his time as a volunteer supporting men who had been sexually abused in childhood enabled him to cope with that particular disclosure. The researcher ensured this was not a participant's first disclosure before continuing with the interview.

Creighton et al. (2018) report in their research, supervisory advice was to only complete one interview a day to prevent burnout. Similar advice was received for this research. When interviews were performed on consecutive days, the researcher reflected that his attention was not as focused towards the end of the second interview due to tiredness from intense concentration and this did not happen again.

3.1.6 Security of data

Data security followed British Psychological Society (2010) ethical guidelines. The data (audio recordings, transcripts, and photographs) were uploaded as soon as possible and kept secure in two locations: (1) a password protected personal drive on a university system; and (2) on a password protected laptop owned by the researcher which never left the researcher's house. Hard copies of anonymised transcripts were kept safely at the researcher's house during analysis. Participants were told that their data would only be viewed by the research team and that their names would not be used in conjunction with any data. Participants were informed that they could withdraw their data from the study at any point prior to publication or thesis submission. This was possible by coding the consent forms with the data name and number. However, it will be impossible to withdraw material if included in reports already made public, accepted for publication or submission for assessment.

The audio files were kept in separate password protected files from those which held the transcripts. Participants gave as much detail about their names, addresses, and phone numbers as they wished in order to facilitate the research process. This ranged from only knowing the name and email address of one participant who did not give a mobile phone number and was interviewed in a neutral location, to another participant who gave a mobile phone number and was interviewed at their home. The data was given a name and number at point of transcription and there was no link between the anonymised

stored data and the participant's personal details. The name given to the data was either the participant's first name if they wished that to happen or a pseudonym chosen by the researcher. The researcher will delete the data from the two storage locations ten years after the final publication from the data. The consent forms held at the University will be destroyed at this time. A protocol is in place for the researcher's supervisors to do this.

3.1.7 Use of Photographs

The British Psychological Society (2010) suggest additional informed consent procedures for data collection where individuals may be identifiable. Thus, participants were asked to obtain the verbal consent of adults prior to taking photographs of them and to refrain from taking photographs of children. Some participants agreed when asked that they had obtained verbal consent from friends and family members. Faces of adults and other details which might potentially identify the person in a photograph were obscured by the researcher. Banks & Zeitlyn (2015) argues this dehumanises participants and patronises them by overprotecting them in a research project where they are empowered to tell their story their way. However, all participants were informed that this was to be the case, and none questioned the rationale behind anonymising the photographs. During the interviews where a photograph needed to be anonymised, this was relayed to the participant and they all concurred. This was done using Microsoft Paint to insert white squares over parts of the photograph that might identify a person or their location.

There were several images of participant's children or grandchildren taken despite participants agreeing not to take them; these were redacted to exclude the child and the original photograph deleted by me entirely from the corpus. When the photographs of children were shown in the interviews, the participants were informed at this time that these photographs would not be used or the whole of the child would be obscured from the photograph in any reports.

Written consent was received from participants for the use of any of the photographs within reports, presentations, and publications on the understanding that potentially identifying features were removed prior to use. In data storage, each participant had an electronic folder which contained the transcript and the photographs, this was labelled with the chosen pseudonym. The audio files were stored in a separate electronic folder to the transcripts and photographs and labelled with the participant number. The only link between participant name and number was on the consent forms. No participants requested printed copies of the photographs, however, two requested and were sent digital copies of their photographs by email. Two participants said they had taken digital copies of the photographs prior to interview. No other participants were asked if they had done this.

3.1.8 Inclusion criteria

Participation was restricted to white British men aged 18 and over, who earned less than £14,000 and lived within an hour's drive of the researcher's home. The age restriction was in place to only include

participants who are legally considered adult and who, therefore, are awarded responsibility for the way they lived their lives. The income restriction of less than £14,000 a year was rounded down from the official government figure for the lowest 20% of earners in the population for ease of understanding. The research also would not include anyone with obvious mental health problems or obvious learning difficulties planned to be determined at the initial meeting as they would be too vulnerable for this kind of study, particularly in terms of known ability to give truly informed consent. In the event, this exclusion was not needed. Extending the population beyond white British men would have introduced many variations in cultural and gendered views on health and well-being. Three participants contacted the researcher via email who were not white British, the inclusion criteria were explained, and they were thanked for their interest in the study. The data was to be analysed using Interpretative Phenomenological Analysis, hence a specific perspective and thus specific demographic was required (Smith et al., 2009).

3.1.9 Rewarding participation

All participants were rewarded by keeping printed photographs taken in the research if they wished and received a £20 voucher from the supermarket of their choice. Payment was made to reimburse participants for their travel, time and inconvenience as it was quite a lengthy process (British Psychological Society, 2010).

3.1.10 Power

The British Psychological Society (2010) note that there will inevitably be a power difference between the participants and the researcher and researcher's need to be sensitive to this. This research was conducted with this in mind and efforts were made to minimise the power difference where possible. This included: having the initial meeting at the time and place of the participants choosing if this was considered safe; participants contacted the researcher when ready to be interviewed unless this time was more than three months from the initial meeting to ensure all was well with the participant and with the research; the interview was conducted at the time and place of the participants choosing; the researcher did not touch the camera during the interview, participants moved on to the next photograph when they wanted; participants could choose a pseudonym or their own name to be linked to the data. There was a sense of the participants undertaking their own research project and sharing their findings at the interview. Del Busso (2011) notes that qualitative methods using photographs affords the participant an active position in the research process. They can follow their own agenda in the interview regarding images shown and how they are discussed, further equalising the power differential in this research. Moreover, Creighton et al. (2018) argue that the participant driving data production flattens power dynamics in the research process.

3.2 Photo-elicitation

As discussed below, men on low-income are traditionally hard to recruit and reticent in traditional semi-structured interviews, therefore, photo-elicitation was used. Rose (2012) gives three reasons for using photo-elicitation with this group of men. First, different topics of discussion emerge compared

to talk only interviews. Second, photo-elicitation is particularly good for talking about every day, taken for granted things in people's lives such as health and well-being. Thirdly, participants are empowered to be the experts in the process which demands collaboration between researcher and participant, a point agreed by Pauwels (2015). It has also been noted that asking participants to take photographs is a boost to recruitment because taking photographs is fun and easy to do (Derbyshire, 2005; Wright et al., 2010). Furthermore, Creighton et al. (2018) posit that photo-elicitation encourages hard to reach participants to take part in research that they may not have been invited to otherwise either.

3.2.1 Photographs in research

Photographs have been put to many uses since the first photograph was taken in 1826 (Gernsheim, 1977). In the nineteenth century, photographs were used by Darwin in his research to understand facial expression in humans and animals (Reavey, 2011). The first recorded instance of photographs being used to elicit information in interviews is John Collier's ethnographic work with Acadian-French speakers in eastern Canada (Collier, 1959). He had taken photographs of the locality to encourage discussion with participants but with limited success. However, when he used photographs he had taken of the participants, the interviewees where more animated and spoke with more emotion about the scenes depicted. He surmised firstly that the photographs allowed less verbally fluent participants to articulate clearly about otherwise complex situations which may be difficult to express. Secondly, photographs worked to jog the memory of participants and release emotional statements about the content. Both these attributes are important to this thesis as men on low-income may be less articulate and potentially less willing to discuss feelings about their health.

3.2.2 Photographs as aide-memoire and participatory tool

In the context of this thesis, photo-elicitation asked research participants to take photographs which were later described and discussed in a recorded interview with the researcher (Rose, 2012). Viewing photographs can be seen as a moment in the past remembered in the present (Berger, 1992) thus facilitating recall in photo-elicitation interviews. For the purposes of photo-elicitation research, each photograph is a moment from the past, remembered in the present and analysed in the future. However, the memory of that moment is entirely subjective and is interpreted by the participant in the research (Wright, 2004). Although this image depicts the truth of the scene before the camera (Sontag, 1979), the image is always a representation of the truth for the participant in recalling the reasons for taking it (Wright, 2004). These representations act as metaphors which act as a layer of protection between the participants and any sensitive or difficult topics not normally talked about in talk only interviews (Creighton et al., 2018). Thus, further facilitating the traditionally reticent men in the research to talk about sensitive topics.

It is possible within photo-elicitation interviews to use pre-existing photographs provided by the researcher or the participants own (Del Busso, 2011). The decision was made to use photographs

participants took to capture participant's individual memories, thoughts and reflections of their health and well-being (Rose, 2012). Therefore, the photograph discussed or even photographs they would have liked to have taken (Hodgetts et al., 2007) cannot be seen as anything other than an aide-memoire and not an artefact to be interpreted. Knowles and Sweetman (2004) go further by saying that photographs are nothing more than a means to an end in the research process.

Pauwels (2015) posits that photography incentivises recruitment as visual material tends to be more interesting to participants, especially if it explores the immediate environment of the participant. Photographs release the potential for greater participation from participants, where participants are able to narrate their stories and shape the context of what is told in research interviews (Reavey, 2011). The use of photographs to release this potential is important for this research where recruitment for men on low-income is traditionally low (Bonevski et al., 2014 & Ellard-Gray et al., 2015). Radley (2009) sees researchers attempting to understand participants world-making through use of photographs in interviews. Each participant inhabits a world individual to them, and photographs forge a link between the researcher and the world of the participant (Radley, 2011). An attempt to understand this world using the photograph as an anchor is made though questions in the interview rather than just interpreting the narrative alone. Particularly in photo-elicitation research, photographs are used to represent ideas and concepts and not necessarily the truth of the image captured. These concepts and ideas are explored by the participant; therefore, the interpretation of the image is wholly theirs. Again, this suits this research as participants are aware they are depicting a subjective concept linked to their health and well-being in their photographs. These concepts are then explained and discussed in the interview for the researcher to understand the participant's subjective understanding of health and well-being in relation to their lifeworld. The researchers understanding is aided by a visual representation of the concept and the participant's recall is aided by the use of photographs as an aide-memoire.

3.3 Subjective Well-being

In the previous chapter, it was discussed that capturing subjective well-being via questionnaires meant participants would not remember everything about their subjective well-being. Questionnaires removed the opportunity to see examples of what subjective well-being looked like and the emotions and feelings attached to the phenomena. Photo-elicitation allows this as an inherent part of the method, participants are able to show the phenomena and describe the emotions attached to their feelings of subjective well-being. Well-being research using questionnaires captures the remembered self with limited research into the experiencing self. It is possible that photo-elicitation will capture both the remembered self and the experiencing self together. Each photograph will capture well-being as it is experienced by the participant and the experience will be remembered by the participant in the interview setting. This will be explored in the conclusion using participants' data.

3.4 Space

Sontag (1979) suggests that as well as a thin slice of time, a thin slice of space is included in photographs too. This space and its contents appears to be what is interpreted by the participants in recalling why they took the photograph. Time and space are frozen to be analysed at leisure by participant and researcher. This world inhabited by participants is full of meaningful spaces (Reavey, 2011). Photo-elicitation captures these spaces and brings them to be discussed in the interview, thus foregrounding the setting and introducing a layer of experience not available in traditional semi-structured interviews. Radley (2011) expands this idea by arguing that the material settings in which people live their lives are foregrounded. This method is therefore particularly suited for men on low-income to highlight the otherwise hidden spaces in which they live to explain the impact of these spaces on their health and well-being.

Radley (2009) cautions that photographs are as open to interpretation as any other modality. However, he continues by positing that photographs evoke emotions and memories of spaces and embodied states not apparent in the image to a casual observer. Radley (2011) furthers this point when talking about a cancer patient in an interview by suggesting that the story of her suffering may not have been told in the same way without the aid of her photographs. She did not suffer again in the reimagining of her cancer but was able to articulate the distress that remained once again by viewing the place and time of taking the photograph. Thus, furthering the potentiality of this method to encourage men on low-income to articulate their feelings about health and well-being spaces captured in their photographs.

The decision to use photo-elicitation in this research was further supported by Majumdar (2011) who draws from her research that photo-elicitation is particularly useful with groups who are less heard or visible. Marginalised groups are facilitated to participate and are empowered by photo-elicitation (Wang et al., 1997). Further evidence comes from Hodgetts et al. (2011) who suggest that in community-based participatory research, photo-elicitation should include those marginalised from decision making processes to promote inclusion and a wider understanding. A central tenet of this thesis is inclusion and understanding the marginalised.

Pre-rehearsed cultural narratives are not reproduced in photo-elicitation interviews (Reavey & Johnson, 2008). Creighton et al., (2017) go further by suggesting that semi-structured interviews can pressure men to bring self-understanding to their identities during the interviews. Creighton et al. (2017) later discuss narrative interviews moving into theoretical self-claims by participants, whereas the photo-elicitation interview remains in concrete experiences and the emotions that accompany them. Pauwels (2015) agrees this point by stating that visual methods are rarely found irritating or confrontational unlike other methods, this prevents the participant from occupying defensive positions

during interviews. These ideas support the idea not to use a semi-structured interview schedule as the main method of understanding health and well-being from this under researched group. Moving away from reproducing dominant cultural narratives around health, well-being and masculinity is the focus of this thesis. Opportunities and constraints on the lives (Hodgetts et al., 2011) of low-income men are not known and photo-elicitation will highlight these in relation to health and well-being. This in turn will aid policy makers in creating bespoke, more achievable interventions for this less well understood group of men.

3.5 Overcoming reticence

Bahn and Barratt-Pugh (2011) and others report that men, particularly young men can be reticent when expressing feelings in an interview setting (Bahn and Barratt-Pugh, 2011; Monaghan & Goodman, 2007; Simpson & Lewis, 2007). Bahn and Barratt-Pugh. (2011) initially used a traditional semi-structured interview method with 17-21 year old Australian apprentices in the construction industry. These men had low literacy levels and were likely to be on a low income. The interviews elicited little information from the participants until the researchers introduced photographs of construction sites. These stimuli resulted in rich, plentiful data collection from that point in the interview, mirroring the findings of Collier (1959) more than 50 years before.

Further support for this method with men on low-income comes from Packard (2008) and Radley et al. (2005) who used photo-elicitation using loaned cameras with the homeless in Nashville, USA and London respectively. Despite pitfalls associated with a group leading chaotic lives, both successfully obtained rich data from their mostly male participants.

Pauwels (2015) claims that photo-elicitation encourages longer interviews and generates novel data. Novel data is essential for this thesis with its exploratory design and longer interviews necessary due to the historical reticence of the participant group (Bahn and Barratt-Pugh, 2011).

3.6 Pilot Work

Two forms of piloting were conducted: (1) a self-pilot, followed by (2) a pilot with one participant who matched the inclusion criteria for the study. Prior to this, the pilot interview schedule will be described.

3.6.1 Pilot Interview Schedule

As the interview was going to be participant led using the photographs, the interview schedule was to supplement this only. Prior to the first interview, I memorised as much of the semi-structured interview schedule as possible and used the questions to supplement enquiry when a photograph was shown. The remaining questions were asked after the last photograph was shown. In the following three interviews, as I was more familiar with the semi-structured interview schedule, more questions were asked in the course of the interviews. The literature that informed the research question (How do White British men on low-incomes understand, experience and create positive health and well-being?) informed the selection of topics that have concerned health and well-being research in this area. The mainstream health psychology literature focused on five main areas: food, alcohol, exercise, smoking,

and health problems. As there was no literature to inform an interview schedule on positive health and well-being, it was decided that the interview would initially mirror the five topics from health psychology research and that positive perspectives on health would be pursued if raised by participants. A schedule was drawn up exploring the five main areas via open questions, as follows:

Food in the literature on men's health is presented as being inextricably linked to health. The developed interview questions reflected prominence in the literature around men's consumption of fast food vs. healthy home cooking.

So, what did you have for dinner last night?
What kind of food do you regularly eat at home?
Who cooks at home?
How much cooking do you do?
How do you/other person decide what to cook each night?
Who does the food shopping?
Where do 'they' shop?
Why do 'they' shop there?
What things influence what 'they' choose to buy?
How often do you get takeaways?
What takeaways do you get?
What is your favourite?
Why is it your favourite?
Where do you go when you eat out?
Why do you choose to go there?
What do you order when you eat out?
Why do you choose that?
What kind of food did you eat when you were growing up?
Do you enjoy that kind of food now?
Do you think about eating healthily when you are shopping or cooking?
What things do you cook that are healthy?
Why do you choose those?
What things do you buy that are healthy?
Why do you choose these?
Do you diet or watch your weight?
Why do you do this?
What do you think about healthy eating messages?
What ones do you agree with? And why?

What ones do you disagree with? And why?

Alcohol: The consumption of alcohol in levels above those recommended is a popular theme in men's health research and the following questions were designed to explore this.

Do you drink alcohol?
What do you like to drink?
Where do you normally go?
What makes you choose to go there?
How often do you go out?
Do you ever drink too much?
What is too much?
How do you feel when you have had too much?
Do you drink at home?
What do you drink?
Is it different to when you go out to drink?
What is different?
Has your drinking changed with age?
Has anything else changed your drinking habits?

Exercise: levels of exercise and fitness have a claimed impact on levels of heart disease and other potentially terminal and debilitating conditions. The following questions were designed to find out the participant's position on exercise and fitness.

How do you feel about your fitness levels?
What exercise do you do?
Why do you do that?
How often do you go?
How often do you want to go?
What influences how often you go?
What would be an ideal amount of exercise for you?
What sports centres or fitness places are there near here?
How easy is it to access them?
What green spaces are the near here? Parks and places like that?
What are they like?
How often do you go and what do you do there?
How do feel about the way you look physically?

Would you change the way you look?
How would you go about it?

Literature suggested that smoking levels are much higher among low income populations and the follow questions were created to explore this.

Do you smoke?
How many a day?
How do you feel about smoking?
How much does that cost?
Does it affect your health?
Do you want to stop or cut down?
What prevents you from doing so?

The last section looks at the wealth of literature into men's health that indicates men are reluctant to access health care when needed.

Can you tell me what your health is like in general?
When was the last time you were unwell?
(What did you do to help you feel better?)
When did you last visit the doctor?
Can you tell me about this visit?
What was the reason?
What did the doctor say?
Did you follow the doctor's recommendations?
How did your health improve?
How do you feel about visiting the doctor?
What health problems do you take to the doctor and what health problems do you decide not to take to the doctor?
What is the difference between them?
What kind of work have you done over your life?
How has this affected your health?
How often have you been off sick?
How do you feel when this happens?
Has your health changed as you have become older?
What differences have you noticed?
Do you do anything differently now because of your health?

If tattoos/piercings, gangs/violence/ mental health or sexual health were mentioned, they were to be followed up if introduced but not asked about otherwise. These were considered to be sensitive topics which, if introduced, might interrupt the rapport between the researcher and participant. These four topics were included as they are reported in the literature as having an impact on men's health and well-being. No specific questions were formulated for these topics as it was unclear if or how they would be introduced. The researcher felt capable of following the topic if introduced by the participant in a sensitive way. During the twenty-one interviews, mental health was introduced by all of the participants to varying degrees. Two participants talked about tattoos but there was no mention of sexual health or being involved in gangs. Violence was talked about by three participants as events in the past to counterpoint their current violence-free lives.

3.6.2 Self-Pilot

For this pilot, the researcher assumed the position of participant and the interviewer was a fellow PhD student of the School of Psychology at the University of Leeds. The interviewer was chosen as he had many years' experience of interviewing. He was white, working class, and his age was early to mid-fifties. The self-pilot therefore mirrored the anticipated dynamic of the research interviews with intended participants.

3.6.3 Interview Procedure

The self-pilot followed the entire procedure intended for the research participants, except for the consenting process due to time restraints. I used my mobile phone to take photographs rather than a digital camera as this was an option considered as an alternative to using a loaned digital camera. In my case, I took nine days to take all the photographs I felt represented what affected my feelings of health and well-being. The interview was undertaken at the interviewer's home at a mutually agreed time and lasted for 84 minutes. The format for the interview was for me to show the interviewer the photographs on the screen of my phone in turn and describe why the photograph was taken and the issues it represented in relation to my health and well-being. I decided I did not need to print the photographs and the use of camera screens could be an option that the participants chose so the pilot was an opportunity to test this. The interviewer asked relevant follow up questions for each photograph to gain more detail on points of interest, such as why the photograph was taken. What did the photograph mean to me? This is similar to the SHOWed questions format (Wang et al., 2004) but these were thought to be too formulaic and not flexible enough to deal with the complex range of issues that could be presented by the participants. After all the photographs were discussed, the interviewer used the interview schedule to ask any questions that did not occur naturally during the interview.

3.6.4 Reflective box 4

Reflective Box 4 'Self-pilot interview'

The self-pilot was arranged to understand the experiences and challenges facing the participants in this study and to test out the general workability of procedures and appropriateness of the interview schedule, as well as to understand further my positioning in relation to the research. The time between starting the photography process and the interview was enough to think about the ideas of health and well-being and prepare for the interview. However, the time between the start of the process and the interview was nine days rather than the seven considered as the minimum as this was the first opportunity after the start of the process and interview that both parties were available. Taking photographs that represented things that I considered affected health and well-being was more challenging than anticipated. The idea that something affected health and well-being had to be in the conscious awareness to be captured, and in a way that could be discussed. This meant sometimes finding a way to take a photograph that provided a metaphorical, symbolic, or part representation. Fortunately, the photographs for the self-pilot were captured on a mobile phone which was always available. After some reflection, I knew that there were about four photographs that I was going to take that represented things that I wanted to talk about. The rest were taken after ideas became apparent during the course of the process. In the interview, I had a strong feeling of leading the research and being in control of the process in contrast to my past experiences of research participation in which I had the feeling that the researcher was in control and I merely followed instructions without understanding why. In the self-pilot, that feeling of being directed and measured was absent and I could talk about what I wanted. Initially I was aware of the recording equipment, but this soon disappeared, and I was able to lose myself in the story telling around my health and well-being. It felt as though I had an extended narrative to tell, facilitated by the photographs I had taken. I did not have to search for meaning from the photographs because I had taken them deliberately to encapsulate something relevant and important to me. Revealing my life to a stranger did not feel awkward at all. I understood that I was part of a process of data collection and focused on that. This removed any self-consciousness. I was also aware that I was only going to reveal what I wanted to reveal. I had taken the photographs and drafted the interview schedule so there were going to be no surprises or awkward moments.

Being aware of being part of a process of data collection and drafting the questions in the interview would not be available to my participants. They also would probably have not taken part in the variety of psychological studies that I have done over the course of my psychology education. This meant that my participants would be likely to value more reassurance about the process.

They would also be likely to value being gently introduced into the interview with plenty of small talk and their well-being assessed during the interview. Any decisions made during the interview regarding their right to not answer a question or terminate the interview would be respected without question.

The pilot interviewer commented on how well the photographs facilitated discussion. Of particular use was the advice from the interviewer that, although the focus for the role of health and well-being in the interview was not to be on negative health events, if introduced into the interview, it could be a way of focusing on positive changes this influenced. Overall, the interview schedule appeared to work well and therefore was not changed. The extra time available to me to take pictures and compose my thoughts were not used as I was ready after seven days. This extra time was only available as it took time to arrange a mutually available time for the interview. This extra time was very likely to be available to all participants as it always takes time to agree a mutually agreeable time. The questions were about everyday events and I did not feel they pathologised me in any way.
The self-pilot did, however, influence the proposed style of the interview in two ways and these are discussed below.

3.6.5 Conducting the interview

Firstly, through the experience of being the interviewee: the interviewer had positioned the chairs to avoid them directly facing each other and this was experienced as enabling focus and comfort while thinking and talking; the interviewer did not interrupt and only asked questions when there was a natural pause, giving me a sense of control and of being the focus of the interview; and that the questioning style was very gentle and non-interrogative giving the feeling of a friendly chat rather than of an interview.

3.6.6 Listening and interviewing skills

Secondly, listening to the interview and critiquing the interviewer I was impressed by his: listening skills and demonstration of interest with ‘mmms’ and empathic silence to encourage a participant-centred and relaxed manner; appropriate non-intrusive interviewer self-disclosure; and the way in which the interviewer summed up with ‘is there anything left unsaid?’ which felt relaxed and encouraging. All this was considered and incorporated into the interview preparation and delivery.

3.7 Pilot Interview

3.7.1 Participant

The pilot participant was recruited using the detailed participant information booklet. These were given to interested friends, colleagues, and students at the researcher's workplace (an educational establishment). Participants were encouraged to contact the researcher if they were interested in taking part. The participant was a 24 year old man living in a low-income area of a large city who worked occasional shifts for an agency and confirmed that he earned the low income required for inclusion in the study. He lived with a female partner and his highest educational achievement was level 3.

3.7.2 Pilot Interview Schedule

This was the same as used in the self-pilot interview.

3.7.3 Interview Process

Low income participants were considered less likely to own a smart phone for taking photographs so loaned digital cameras were made available. Digital cameras were used for several reasons: participants were able to edit or delete what they showed prior to the interview (Clark-Ibanez, 2004); a need for a further meeting to collect cameras was not needed; it ensured the photographs were taken as the participants could see the result on the camera screen and it encouraged the participants to return the camera even if they did not wish to take part in the interview. The first pilot participant agreed to use his mobile phone to take the photographs and did not make contact to meet for the interview, so this option was dropped for subsequent participants. The participants were given a minimum of a week to take photographs of things that affected or represented their health and well-being. This was followed by an audio-recorded interview using the photographs with the interview schedule. The second pilot participant contacted the researcher via email to confirm he was willing to take part in the study. After confirming that the participant had read and understood the participant information booklet, the researcher and participant met in a public place. At the meeting, the participant completed the consent form (appendix B) before the research commenced to confirm that: they had read the information booklet; had been given the opportunity to ask questions and had received satisfactory answers to those questions; they understood they could choose not to answer a question in the interview; they understood that the interview was being audio-recorded; that they could leave the interview at any time; that they could withdraw their data at any point prior to publication or thesis submission; that they understood they could not photograph children; understood that they were to try and gain permission from any adults they photographed; that all identifying features would be blurred to preserve anonymity; and that they gave consent for anonymous photographs to be used in dissemination of the research. The participant was given an instruction sheet for taking the photographs (appendix C). This asked participants to take photographs of anything in their lives that that reflected their feelings of health and well-being in a positive or negative way and that they were not going to be guided as to the things that they might want to

photograph. The participant was then given an opportunity to ask any questions he had about the research prior to signing the consent form. The participant received the digital camera and the set of instructions for taking photographs. The key instruction was to photograph anything in their lives that affected their health and well-being. There was no definition given of health or well-being. This point is supported by Pauwels (2015) who argues that researchers must not inadvertently transfer cultural norms to the participant which in this came would irreparably influence the participants' topic choices. Participants were not therefore swayed by any other definition other than their own. There was an opportunity for the participant to ask any questions about the study.

The participant contacted the researcher eleven days after receiving the camera. It was a further three days between contact and interview. The date stamps and the code numbers on the photographs show that the participant had taken photographs regularly throughout the fourteen-day period and had deleted some of the photographs. He showed me twelve photographs, but the sequence ran from number one to number twenty six; fourteen photographs had been deleted. This suggests that he had taken the research seriously and considered carefully which photographs to show me. The participant was interviewed at a mutually agreed time and place: an interview room at the researcher's place of work. The participant declined the option of having the photographs printed and instead talked through the photographs he had taken by showing them on the small screen on the back of the camera. This process of talking through the photographs on the screen worked very well as all the detail needed to explain the photograph could be done quickly. The talk about the concept in the photograph did not then need the photograph again to facilitate it. In the interview, the participant showed each of the twelve photographs he had taken in turn and explained the reasons for taking the photograph and what it meant to him in relation to his health and well-being. The participant was asked for clarification when necessary and for more information when talking about positive health and well-being. Discussion of the photographs lasted 67 minutes and the remaining 24 minutes were taken up with the interview schedule which was followed where the topics had not already been discussed via the photographs. At 91 minutes, the interview ended. The participant did not mind what pseudonym was used to preserve anonymity so one was chosen for him.

3.7.4 Reflective box 5

Reflective Box 5 'Pilot interview'

The photo-elicitation process worked as well in the pilot interview as it had in the self-pilot. The participant appeared to have a point in mind when the photographs were taken and used the photographs as a reminder in the interview. There appeared to be a reason for every photograph and he spoke fluently about those reasons, even when questioned in detail about the photographs. He took the first photograph the day after receiving the camera and took photographs at regular spaces throughout the time between initial meeting and interview. The final photograph was taken on the morning of the interview, showing he was still engaging in the process of reflecting on his health and well-being after he thought he had finished and contacted me for the interview. The interview schedule, which was designed to have a neutral slant, did not generate much positive data on health and well-being but this may have been due to the particular participant or the questions so it was decided to continue with the schedule and review it after more interviews. It was possible to introduce some of the questions from the interview schedule during the interview as follow-up questions during the photo-elicitation. In future interviews, it was planned to introduce more during the photo-elicitation and not rely so much on a separate section after the photo-elicitation. This was to improve the flow of the interview by not relying on what felt like another task after the interview had finished. By including more in the photograph part of the interview, this extra task would be shortened. The listening skills and interviewing techniques learned in the self-pilot worked very well in the pilot with a participant as it allowed the participant to talk as much as he liked about each photograph without interruption and relevant follow up questions were then asked. The data from the pilot interview was retained for analysis in the research.

3.8 Main Study

3.8.1 Recruitment

Twenty eight participants were recruited for the research but only twenty one completed interviews that were included in the analysis. One participant's data was excluded after interview when it became apparent during the interview that he earned more than the £14,000 threshold for qualification. Two participants did not contact the researcher after taking the cameras and it was not possible to contact them either. Two took photographs but decided later that they did not wish to be interviewed. One completed the consent form and then on reflection declined to take the camera and take part in the research. Finally, one took the camera and then moved away from the area. Several attempts were made to arrange an interview and when this proved impossible, the participant mailed the camera to the researcher and was reimbursed for his expenses.

Of the participants whose data was included in the analysis, six were directly recruited by the researcher at a job club, food bank or men's group and fifteen were recruited by other means. Leaflets were given to friends and colleagues who knew someone who might be interested in taking part in the study and who met the inclusion criteria. As recruitment progressed and these avenues were exhausted, many other options were explored. These included the use of Twitter, visiting food banks, social clubs, a job club, online newsletters, a radio interview promoting men's health week, a local newspaper and a website promoting positive links in the community. Participants contacted the researcher by email in the first instance in all cases except at the job club, food bank and men's group where the researcher presented to potential recruits. Fourteen of the participants contacted the researcher by email in the first instance, one via twitter and six were directly recruited via a presentation. The most successful method of recruitment was meeting men face to face and discussing the research with them. This seemed to create a connection with the men that would be absent if they only had the recruitment leaflet. Gaining face to face access to groups of men who might be willing to take part in the research was difficult but the main issue with recruitment was halting recruitment to write the Ph.D. transfer report as the momentum of snowballing was lost. Three of the initial seven participants were recruited through snowballing. When recruitment recommenced, it took time to build momentum again and there was not one instance of snowballing in the second phase.

3.8.2 Participants

Twenty further participants were recruited in the ways outlined in the recruitment area of the Ethics section. They all lived in low-income areas, confirmed they earned less than the minimum income criteria and were white British males of at least 18 years of age. The age, employment, living circumstances and educational level of each participant was discerned from the interview if possible. Where this was missing, participants were asked directly after the interview. Pseudonyms were allocated to six of the first seven participants. Dave decided that he wanted me to use his name in the research. This follows guidance from the British Psychological Society (2010) who suggest that researchers respect the wishes of participants who want their identity linked to their voice where possible. After supervisory discussion, the remaining fourteen participants were offered the option of their own name or a pseudonym to be linked to their data. All fourteen requested that their own name be used in connection with their data. There is some repetition of names in the data with three men named Paul. The first is Paul, the other Paul C. and Paul F. The initials are the first letters of their surname. Although this does complicate reporting and reading the data, it means the research stays true to its ethical principles. Detailed information for each participant is shown in Table 3.1.

3.8.3 Reflective box 6

Reflective Box 6 'Participants'

My overwhelming reflection on my participants was one of being humbled by them. These men who had very little were willing to give me so much of their time and there were many instances where the men refused the voucher at the end of the research. I told them they could give it to someone they knew who might need it and left it with them. I was welcomed into their homes with warmth and generosity. I was allowed access to their lives for the research. Some of the men wanted to visit the University of Leeds for their interview as they had never been so an interview room was arranged for them. I loved that curiosity to explore somewhere new. Some men had so little furniture in their homes, we shared a two seat sofa and sat side by side with the camera as the focus. I did not at any time feel threatened or uncomfortable in the men's presence. Some men became angry at aspects of their lives during the interview but the anger was not directed at me and I did not feel concerned. It was an overwhelmingly positive experience.

Table 3.1

The Pseudonym, Age, Employment Circumstances, Number of Photographs, Length of Interview and Education Level for Each participant Listed in Order of Interview

Pseudonym	Age	Employment	Circumstances	No. of photographs	Length of Interview	Education level[a]	Days between first meeting and interview
Brian (pilot)	24	Agency	Living with female partner	12	91 mins	3	14
Dave	28	Unemployed	Living with mother	21	63 mins	3	19
Colin	50	3 part time jobs	Living alone	18	91 mins	3	22
Liam	38	Full Time	Living alone	11	65 mins	2	18
Alan	48	Full time	Living alone	18	76 mins	2	21
Simon	33	3 part time jobs	Living alone	23	95 mins	2	23
Tony	62	Unemployed	Living alone	18	69 mins	2	58
Mark	52	Unemployed	Living alone	8	92 mins	2	43
Paul	55	Unemployed	Living alone	9	36 mins	2	18
Andrew	54	Full time	Living alone	13	43 mins	4	31
George	23	Part-time	With parents	36	94 mins	3	155
James	22	Unemployed	With friends	19	47 mins	4	47
Stan	65	Retired	Living alone	55	15 mins	1	39
Peter	64	Full time	With partner	16	60 mins	1	63
Will	24	Unemployed	With friends	23	64 mins	4	78
Paul C	71	Retired	With wife	50	87 mins	2	12
Paul F	62	Unemployed	Living alone	50	58 mins	1	25
Geoff	60	Unemployed	Living alone	517	27 mins	1	28
Keith	52	Self-employed musician	With wife and two children	10	62 mins	3	126
David	66	Retired	Living alone	33	33 mins	1	40
Derek	54	Unemployed	Living alone	310	51 mins	2	144

[a] Education level 1 was less that GCSE, 2 was GCSE level or equivalent, level 3 was A level or equivalent, 4 was degree level.

3.8.4 Developing the Interview Schedule

The interview schedule used for the pilot studies was used where possible for the first four participants. It became apparent after four interviews that the questions in the semi-structured interview schedule were not generating sufficient description or exploration of positive health experiences, possibly because it had been created from examination of the current literature which had a negative health slant. A new schedule was adapted from preliminary analysis of the first four interviews and integrated themes introduced by the participants that are of particular interest in this research. The five themes most common to the first four participants were: messages about health; friends and relationships; living arrangements; environment and role models. Although there is some mention of these in the literature, the questions were left as open as possible for the participants to tell their own story. The revised interview schedule comprised thirteen items. It retained four questions that generated positive responses from the first interview schedule?: 'What's your health like in general?'; 'Has your health changed as you've got older?';' When would you visit the doctor?' and 'Smoking' as a general prompt to ask about this topic if not brought up by the participant. It also retained five areas that generated interesting data from the first four interviews: 'Messages - How much do you listen to those messages?'; 'Relationships/friends, explore if introduced'; 'Can you describe your living arrangements for me?'; 'Environment' and 'Role model?' 'Environment' was a prompt designed to explore the immediate surrounding for the participant - whether it was the building they occupied or the surrounding area - and 'role model' was a prompt to ask if there were important people in the participant's life who had some influence over the way they lived. The next two new items were designed to explore the feelings of the participants in relation to their well-being: 'I just want to understand what it is about the things you do that make you feel good' and 'What else in your life makes you feel good?'. These two items had been introduced by the researcher 'off the cuff' during the interviews and seemed to make sense to the participants and generate interesting data. After the last photograph was discussed, participants were asked there were any photographs they wished they had taken. This was an off the cuff prompt that appeared to work well in an early interview and served well in later interviews also. Frith (2011) and Hodgetts et al. (2005) discuss this in some depth. How this worked in relation to these interviews will be analysed in depth in the discussion chapter. Finally, after the interview was over, but still recorded, participants were asked about how the camera helped with preparing for the interview and during the interview. This was not part of the second interview schedule but asked to understand more about how the photo-elicitation process helped this group of men in the interview process.

3.8.5 Interview Process

The first four interviews were completed in the same way as the participant pilot. The next seventeen used the revised interview schedule. All interviews lasted between 15 and 95 minutes with the average being 63 minutes. The shortest time between consent and interview was twelve days and the longest one hundred and fifty five days (see table 3.1). All interview locations were all chosen by the

participants. There was no-one else present at the interviews. All participants engaged fully with the photo-elicitation process by taking photographs that covered a wide range of concepts around health and well-being. All the photographs taken by the participants were spoken about to different degrees. Some photographs produced a short discussion but this was usually because the topic had been covered earlier in the interview. For example, talking about food, the first participant took a photograph of some chocolate pancakes to indicate a snack, pans on a stove to indicate cooking at home. Further pictures showed a chocolate bar as his addiction, a plate of food on the table with a cup of tea to highlight mixed media messages about the amount of tea to drink and finally a supermarket voucher to remind him of what he shops for at the supermarket. As a counterpoint, the second participant took a picture of an empty cupboard to highlight his lack of money, some 'basics' foods to show what limited choices he has when he does shop and finally two photographs together. One depicting a range of vegetables which he could have bought and crisps, biscuits and alcohol which he bought instead. As with the pilot, participants were asked to choose their pseudonym if they so wished. Fifteen of the twenty one participants chose to have their own name used, the rest were chosen by the researcher.

3.9 Transcription

Transcription level was appropriate to the form of analysis to be performed. Hence, the interviews were transcribed verbatim and contained features that aided interpretation of the content (Hugh-Jones & Madill, 2009). Interpretative Phenomenological Analysis needs a greater depth of detail than Thematic Analysis (King & Horrocks, 2010) therefore the transcripts include pauses, rising intonation, emphasis, and non-verbal noise such as sighs, coughs or laughter. The other ten conventions outlined below are standard practice or work to preserve participant's anonymity. The researcher combined the transcription guidelines of DuBois et al. (1993) and Hugh-Jones and Madill (2009).

Space indicates a separate unit of speech, laughter, pause etc.
Speakers name or 'Int' followed by a colon denotes turn taking in interview.
Names of participants in transcripts are original or pseudonyms that retain a flavour of the original.
[ ] Denotes overlap of speaker's voices with primary speaker continuing on their named line.
? Denotes rising questioning intonation.
Non-verbal noises are represented within double brackets (( )).
. Indicates vocal but not grammatical stop.
, Pause of less than 2 seconds (pause) for longer pauses.
(inaudible) For undecipherable speech.
(name) To anonymize people and places.
_____ Underlined for emphasis.
– Indicates truncated sentence.

[…] Indicates a break in a quote
All transcription is in Standard English so that dialects and pronunciation can be easily understood.

The pilot interview, which was the first interview, was transcribed verbatim by the researcher. Interviews 2, 9, 10, 13, 15-21 were transcribed by an external transcription service. These transcripts were altered from grammatical punctuation to transcription punctuation by the researcher and checked by him against the audio-recording. All other interviews were transcribed by the researcher using Dragon Naturally Speaking software. Dragon software (Dragon Naturally Speaking Home 12.0) needs to be trained to recognise a voice. This takes a few hours of vocal exercises provided with the software. The interviews could not be played to the software as it would not recognise the accent variations. This was overcome by the researcher listening to the interview via headphones and speaking into the microphone the words in the interview. The software is not perfect, however, and two further edits were required of each transcript. 783 pages and 213,082 words of transcript were produced.

3.10 Analytic Procedures

The process of transcription or editing was the first level of analysis, helping the researcher to become familiar with the data. This process involved the first use of the hermeneutic circle (Smith et al., 2009) where words only became understood in the context of sentences and sentences understood in the context of the whole interview and the research question. An example of this is in the second interview where Dave talks of 'the lotus grows in the muddy pool' (line 628). Dave was talking about the pure spirit and pure mind in Buddhism represented by the lotus flower growing from a muddy pool. This sentence helped me understand the whole interview as Dave was using this to represent him trying to rid himself of alcoholism by freeing his pure spirit and mind and becoming the lotus flower growing from the muddy pool of alcoholism which he talks about throughout the interview. This is understood in the context of the research question as Dave sees freeing himself from alcohol as positive health and well-being.

The chosen methods of analysis for the data were Content Analysis and Interpretative Phenomenological Analysis (IPA). Both analyses were done by hand to have a sense of the whole data corpus and to spot interesting detail in the beachcombing process (Gabriel, 2018) or while diving for pearls (Smith, 2011a).

3.10.1 Content Analysis

Content Analysis was chosen alongside IPA as a way of conveying the data in a more accessible format as it does not impose preconceived categories or theoretical perspectives on the data (Hsieh & Shannon, 2005). Its flexibility lent itself well to the novel data collected during the interviews and allowed for the classification of large amounts of textual material into categories that represent similar meanings (Weber, 1990). Hsieh and Shannon (2005) highlight three approaches to Content Analysis:

a directed approach where an existing theory would benefit from more data, a summative approach which quantifies words or content and a conventional approach which aims to describe a phenomenon, most appropriate where data and theory is limited. Data should also be collected using open ended questions in interviews not influenced by pre-existing theory. The conventional approach was chosen for this data analysis as this perfectly fitted the data set.

The data was read repeatedly to achieve immersion and as far as possible a sense of interconnections between the whole data set. Words, phrases and passages were then highlighted that appeared to convey similarities with other areas of the data and short summaries (codes) noted in the margins of the data set. These codes were typed with identifiers added to pinpoint where in the data set these were from. Once this process was complete, these codes were printed and cut out. These codes were then spread out onto a table and moved around until as many codes as possible had found similar content. Some codes did not link well with others and were discarded at this point. These groups of similar content were given names to identify their content area and became sub-categories. These sub-categories were then analysed and moved around until they had coalesced into larger groups that shared similar ideas, these groups became sixteen categories and were given names to indicate their general content. The sub-categories that did not fit these main categories were discarded at this point. The sixteen categories were then associated to find similar content and this process produced four clusters of categories. The cluster titles were: awareness of the everyday; beneficial activities; moving away from risk; and states of mind. Hsieh and Shannon (2005) warn that conventional content analysis can be confused with Grounded Theory or Phenomenology. Care was taken not to do this and report the content of the data using the metaphors in the photographs as anchors to the data wherever possible.

3.10.2 Interpretative Phenomenological Analysis

As seen in chapter 2, the data on men on low-income is mostly presented as a series of negative statistics on lower life expectancy. The meta data related to this covered higher rates of alcohol and cigarette consumption and lower rates of exercise and healthy eating. The literature review found little qualitative data on men's health that looked beyond framing their accounts with the concept of hegemonic masculinity or exploring the negative health aspects of men's lives. This research looked beyond those restricting negative narratives to find idiographic accounts of how health and well-being is understood and experienced by men who fall into the lowest income bracket. IPA was therefore used to create these accounts as it places the emphasis on experiential meaning making by participants (Smith, 2011b). IPA is also particularly relevant due to the openness of the research question (Larkin &Thompson, 2012).

Larkin et al. (2006) claim that any IPA study should have a phenomenological emphasis on the experiential claims and concerns of participants. To this end, IPA research should have two aims in

mind. It must try to understand the participant's world and describe it. The description should be a collaborative account constructed by both researcher and participant to produce a psychologically informed description. Secondly, and supported by Todorova (2011), it is an interpretative analysis that positions the account in a wider socio-political context, in this case poverty for men in the UK in the 2010s. The interpretative analysis should deal with what it means for participants to express feelings and concerns and make claims about them in their particular situation. Ultimately, the interpretative analysis of the participants account is an interpretation of the phenomena they experience, the double hermeneutic in IPA (Smith, 2011b).

Heidegger (1962) understood phenomenology through the concept of 'Dasein' translated as 'being there'. Participants in this thesis are 'being there' in their world therefore, their experience of existence in the world can only be understood from their immersed position with in it. Merleau-Ponty (1962) argued that embodied existence is understood as being-in-the-world. Ahmed (2006) further argues that embodiment is one's continuous progress through a world of objects, others and spaces. This concept incorporates living in time and space as a continuous process and the photographs taken by participants capture this as a thin slice of time and space (Sontag, 1979).
Rose (2012) makes it clear that photographs tap into this process by grounding phenomenological talk in remembered experiences of the time and place of the photograph being discussed. Although the photographs help the participants see their world from a distance (Rose, 2012) they are still a part of that world they capture and give meaning to via the images they produce and the stories they tell. The link between the use of personal photographs in interviews and phenomenological interpretation of the talk produced is very strong which is why this method of analysis was used. There will be a section in the discussion using the data from the interviews to highlight the particularly phenomenological nature of the data produced.

Larkin et al. (2006) argue that the explanation and understanding of the nature of lived experience for, in this case, health and well-being for men on low-income, is dependent on the structure of the encounter. The structure of the encounter in this case was to give participants the power to define health and well-being and explain it in the embodied reality of men living in poverty. Larkin et al. (2006) explain that approaches that are sensitive and responsive to their subject matter will yield the most profitable outcomes. This argument supported the decision to attempt to equalise the power relationship in this thesis and the use of cameras to capture phenomenological data.
It was interesting to note that Smith (2011b) in producing a guide for rating IPA papers chose only clinical health and illness research. There appeared to be no health research that looked at the lived experience of health and well-being in the much larger non-clinical population of the world. In response to Smith (2011b), Smith (2011c) hopes that IPA will extend into preventative healthcare but

missed the opportunity to open up IPA to everyday lived experience of health and well-being which encompasses a much wider population and whose findings could inform preventative healthcare.

I had not used IPA prior to this piece of research so initially used the step by step guide published in Smith et al. (2009). This was used in the first seven transcripts. However, when reviewing the analysis at this point the analysis did not feel sufficiently phenomenological. The work of Michael Larkin was reviewed following an inspiring training event when he foregrounded phenomenology in IPA. This led to some experimentation in analysis until a combination of analyses produced the most understandable and fruitful results. Smith et al. (2009) say that there is no right or wrong way of doing IPA analysis and they encourage IPA researchers to be innovative. The steps they describe in their book is for analysis which is 'good enough'. The two approaches do not diverge too much but are slightly different in procedure and concept. However, the phenomenological concepts that make the most sense for me and helped me understand what is going on for participants are from Michael Larkin. He uses the phrase 'cares and concerns in relation to participant's lifeworld' (Larkin et al., 2006). This brings into focus the lifeworld of the participant and makes sense of their own health and well-being in the lifeworld that they inhabit. This phenomenological concept was much less defined in Smith et al. (2009) where the process of understanding the participant's lifeworld appeared to me to be separate from the doing of the analysis.

The initial stage of this hybrid analysis was to read the script all the way through while listening to the interview again to bring the interview back into focus and get a sense of the participant's lifeworld. Moreover, to understand phrases and intonation and a sense of the rapport and relationship between researcher and participant. Notes were made about recollections of the interview and transcript separately after listening to the recording (Smith et al., 2009). Then the script was read again, and the data was free coded. Notes were made on ideas about themes, metaphors and imagery and any emotional reactions to the data or to the participant themselves. Larkin and Thompson (2012) say it is ok to be 'wrong, presumptive, wayward, biased, creative, self-absorbed and unsystematic'. This approach was really helpful and allowed me to ask questions of the data continuously. During this free coding stage, instances of emotional, evaluative and metaphorical language were highlighted to allow access to objects of concern, these are things with significance, concepts and ideas (Larkin, 2014). These objects of concern are experiential claims accessed through the language highlighted and it was easier to access this language while free coding. Smith et al. (2009) talk about process, events, values and principles and it was too complex to think about this while coding.
This was followed by line by line coding of the data while thinking about the cares and concerns of the participants in relation to their lifeworld. Smith et al. (2009) suggest using three types of coding (comments) on the data. Descriptive which is self-explanatory. Linguistic, for which an extended

version was used with Michael Larkin's use of language for experiential claims Conceptual, which was picked up during free coding was the last of the coding to be completed.
Having completed the Content Analysis and coded the data for IPA multiple times, the large data set had increased in size through the extra notation. This notation was Interpretative and Phenomenological and contained more of me than the original data set (Smith et al., (2009). At this point I reached an impasse in how to theme the complete data set where the themes were inclusive of all the data rather than just idiographic cases. This impasse was taken to supervision where I was asked using free association to say out loud what occurred to me regarding themes. In supervision, I created five themes: Journey; Balance; Space; Resilience and Awareness. These themes were then applied to the transcripts to discover if they fitted my interpretation of the data. This process confirmed that these themes were not enough to completely summarise the data and four more themes were created. When applied back to the data, only two of these themes fitted the data. These were External Resources and Time. The other two themes were rejected and discarded at this point. These 7 remaining themes were necessary and sufficient to capture the whole data set.

All the transcripts were re-read for examples of the themes and these were woven together for each participant to create an individual case study. Each participant's phenomenological story of their health and well-being was told using the seven themes highlighted above to show how all the men strive to improve their health and well-being despite living in poverty. The idiographic nature of the analysis does not lend itself easily to presenting 21 case studies interwoven together. After some supervisory deliberation on how this might be done, it was decided not to interweave them but present them complete to preserve the individual lifeworld's of this diverse participant group. Smith et al. (2009) suggest that similarities and differences between case studies can be examined and so this was done by presenting the 21 case studies in an order that enables similarities and differences between case studies to be analysed. Short paragraphs between case studies highlighted similarities and differences for ease of understanding.

The 21 case studies were grouped into five clusters despite the demographic and lifeworld differences between participants. Clustering the analysis in this way simplified the presentation and the ease of understanding for the reader. These clusters were: Unemployed men who live alone resisting loneliness (two case studies); Meaningful influence of partners to bring well-being (five case studies); Countering addiction to improve health and well-being (five case studies); Overcoming challenges to health and well-being from mental and physical impairments (six case studies); and Memory loss and its implications (two case studies).

3.11 Reflexivity

Reflexivity has been the most intellectually challenging aspect of the research process to understand and this process has been done in a necessarily reflexive way.

Finlay (2003) argues that the qualitative researcher is central to the research process, constructing the collection, selection and interpretation of the data. A reflexive study will assume meanings are negotiated and co-constituted between researcher and researched in a social context (Finlay, 2003; Shaw; 2010). Gough (2003) using a social constructivist approach sees reflexivity as a critical attitude to all aspects of the research process, including research design, data collection and analysis. Gough (2003) makes the distinction between personal and functional reflexivity. Personal refers to the researcher's interests, attitudes and motivations towards the research and its outcomes. Functional refers to the role of the researcher in the process and the different identities and power relations that may occur within the research paradigm. Parker (1992) sees inequalities in the research relationship with the researcher creating the research situation into which the participant enters. However, reflexivity can be taken too far with Weick (2002) cautioning that it should not become a navel gazing exercise.

3.11.1 Phenomenological Reflexivity

Heidegger (1962) explained that when encountering a new phenomenon, we each experience it in a different way. Our individual reflections on past experiences create a pre understanding of that particular phenomenon, allowing us to build a new pre understanding for our next encounter. The framework in which phenomenological reflexivity occurs when we are aware of challenging our current pre understandings in a transparent way (Shaw, 2010). Finlay (2003) takes this further by explaining that our perceptions of phenomena are structured by our interpretations and these interpretations are embedded in our past experiences, present expectations and cultural situated-ness. Gabriel (2018) argues we cannot be fully transparent in reflexivity but must enable ourselves to be less opaque to others. We need to reflect as far as we are able to gain self-awareness of these usually unexplored barriers to experiencing the phenomena as it is and not as we construct it through unreflective experience. Phenomenological research involves exploring chosen phenomena and reflexively challenging our pre understandings of those phenomena to create new interpretative pre understandings that become the data presented as research findings. An example of my reflexivity in the process of accessing participant's understandings of health and well-being is described in the paragraph below. Further examples of reflexivity are in reflective boxes throughout the thesis and are marked as such (Finlay, 2003). There were many examples of potential reflective boxes but after discussion in supervision, it was decided to only include those that I felt impelled to include as they created the strongest resonance.

In this thesis I did not want my pre understandings of the phenomena of health and well-being to influence my participants, hence the use of cameras and open instructions for their use. Participant understandings were foregrounded in the images they selected to present. The images helped me make

sense of the phenomena of health and well-being as it appeared to my participants and revise my pre understandings of that phenomena.

Reflexivity has been captured in several ways. A research diary was kept with notes made on aspects of decision making or parts of the research that felt out of the ordinary for the researcher. This was supplemented with collaborative discussions from supervision that opened up hitherto unexplored aspects of the research (Gough, 2003; Parker, 2005). After each interview, notes were made on aspects of the interview that challenged pre understandings such as unexpected relationships or discussions. These were supplemented by initial notes made in the first read through of the transcript, anything that jarred with the researcher was noted in pencil. Finally, at the end of each interview, participants were asked for their reflections on the process of using the camera and how the photographs helped them discuss their health and well-being in the interview. Reflective boxes have been inserted into the thesis at pertinent points. They include a short discussion of reflexivity and how it impacted on the research or changed my position with the research.

3.12 Summary

Chapter 3 has detailed the methods used, the thinking behind the decisions made and the processes involved in creating, analysing and presenting the data presented in the next chapters. Firstly, ethical considerations were presented followed by an analytical discussion of the processes and benefits of using photo-elicitation. Extensive pilot work through a self-pilot and reflective thoughts on how this would influence the research process were followed by the initial pilot study with what became the first participant. The demographic details of the 21 participants who took part in the research are detailed followed by reflections on the research interviews which changed the way the subsequent interviews were conducted. The next section detailed the transcription conventions followed by the theory and process of the two analyses, Content and Interpretative Phenomenological Analysis. Finally, a reflection on reflexivity with theoretical ideas and application in practice was offered. The next chapter reports the Content Analysis carried out on the data set.

4 Chapter 4 Content Analysis

This chapter presents the results of the content analysis performed across the data corpus speaking to the aim of this thesis (to critically review the historical and contemporary positioning, evidence and experience of health and well-being among men on low-incomes) and two of the secondary aims (use visual methods to engage largely silenced, unidentified and often invisible community of men on low-income to given them a voice in research about them, document and categorise the forms of health behaviours that white British men on low-incomes report). Content Analysis was used to capture in a straightforward, descriptive way the health practices mentioned spontaneously by participants within the interviews, without prompts by the researcher. Content Analysis allows for the classification of large amounts of textual material into categories that represent similar meanings (Weber, 1990). It is therefore a very useful method to capture the range of health practices alluded to by participants and to illuminate potential patterns - similarities and differences - between them. Hence, although deliberately descriptive, Content Analysis has the potential to provide knowledge by identifying how the men in this study engaged with positive health and well-being practices. Findings of this type have not yet been reported elsewhere. Chapter 4 is divided into four sections, each with its own discussion section corresponding to the four clusters of categories.

Content Analysis both contrasts and complements the Interpretative Phenomenological Analysis (IPA) utilised in chapter 5. Both analyses are inductive. The data drives the analysis rather than driven by previous knowledge. By providing a contextual overview, it complements IPA by making space for a more nuanced analysis. This is important because the full range of positive health and well-being practices of the men studied will not be reiterated in the IPA chapter. It contrasts IPA by providing a systematic list of the positive health and well-being practices of low-income men without applying a theoretical overlay. IPA concentrates on the phenomenological experiential meaning making of the men. IPA describes the world the men inhabit and positions this world in the socio-political context of men living in poverty in the UK. Content Analysis concentrates on reporting behaviours described by the men systematically and without context.

4.1 Analytical procedures

The aim of Content Analysis in this thesis was to document and categorise positive examples of health and well-being introduced by participants via the photographs they had taken. These examples were then clustered and analysed without interpretation and presented in a simple format.

The data was analysed using Content Analysis as described in chapter 3, grouping sections of transcripts into codes and giving them labels. These labels were then sorted into 27 collective sub-categories within and across transcripts. Some of these sub-categories were then grouped into sixteen

categories that shared similar ideas. Finally, associations between categories were found which created four clusters of categories: (1) beneficial activities; (2) awareness of the everyday; (3) states of mind and (4) moving away from risk. The cluster titles are more conceptual than is normal in Content Analysis due to the three levels of aggregation to create them. Moreover, the range of diverse activities within each cluster have similar associations in the photographic metaphors that introduced the ideas discussed. Beneficial activities are as the title says activities the men take part in that have positive benefits for their health and well-being. These include walking, singing, praying and playing football. Awareness of the everyday is potentially created by the participants 'reflection from a distance' discussed in the previous chapter but relates to reflective thoughts about taken for granted areas of their lives that bring them positive benefits. These include their friends, the healthy food that they eat or grow and the spaces they inhabit that bring them positive benefits. States of mind refers to behaviours or thoughts that improve others' lives or their own. Including self-improvement plans, volunteering or embracing the positives in mental health problems. Moving away from risk encapsulates the positive changes the men have made or are making to reduce or remove risks from their lives. Examples are moving away from or attempting to move away from smoking or other forms of addiction.

4.2 Novel narratives on health and well-being

It must be remembered that all the interviews were unstructured beyond the scaffolding by the photographs. The only guidance the men had was to photograph anything that reflected their feelings of health and well-being in a positive or negative way. The analysis detailed below was what the men wanted to bring to the interviews and spoken about in the terms that they wished to convey their feelings. They are therefore producing often novel data which does not cluster as well as data either produced about a specific health phenomenon or with a theoretical overlay. Most of the men were not undergoing or recovering from any medical treatment so medicalised reproductions of health were kept to a minimum. The narratives they told were more about an interweaving of life, love, family and well-being from a perspective of being men in poverty.

The participants were given the option of choosing their own names or pseudonyms to be used in the thesis. Fourteen chose to use their own names, this means there is a Dave and a David. There are also three men named Paul. There first participant is Paul, the second Paul is Paul F. and the third, Paul C. The initials are the first letters of their surname.

4.3 Analysis

The four clusters are presented in tables in which the categories and sub-categories are listed and the participants who mentioned each are indicated. Categories are not listed in any order and participants are listed in the order in which the interviews were conducted. Each table is followed by a more detailed exposition of the content of the cluster with illustrative quotes from participants.

Note that the term ‘health and well-being’ was defined by participants as anything they felt fitted the definition. It is necessarily a broad term encompassing many overlapping concepts about health and well-being. The rationale for this is laid out in chapter 3.

4.3.1 Beneficial activities

There are much publicised benefits in physical activity that contains exercise. The men were asked to photograph things that affected their health and well-being. They chose to photograph activities that included exercise in different forms but also other activities that endowed benefits. Two of the men gained benefit from art. Six men saw benefits in performance, whether they were viewing or taking part in. Sixteen of the twenty one men saw benefit from exercise, eleven from walking and seven from other forms. Four men gained well-being from external well-being support, two from religion and spirituality and two from alternative therapy.

The table below indicates which men introduced things that affected their health and well-being within each category and sub-category.

Table 4.1

Categories and Sub-categories for the Cluster ‘Beneficial Activities’, by Participant Contribution.

Category	Sub-category	Brian	Dave	Colin	Liam	Alan	Simon	Tony	Mark	Paul	Andrew	George	James	Stan	Peter	Will	PaulC	PaulF	Geoff	Keith	David	Derek
Benefit from art	/		✓																			✓
Benefit from performance	/			✓	✓		✓	✓									✓			✓		
Exercise	Walking	✓	✓	✓			✓	✓		✓	✓							✓	✓		✓	✓
	Other			✓	✓	✓	✓		✓			✓					✓					
External well-being support	Religion and spirituality		✓			✓																
	Alternative therapy							✓			✓											

As can be seen in Table 4.1, there were four categories of content data, ‘Exercise’ and ‘External well-being support’ had separate sub-categories where the data went beyond the broad headings for the category. Each of these will be described in turn below.

4.3.1.1 Benefit from art

Two men talked about art, Dave talked about art appreciation and both Dave and Derek talked about art production. Dave was an alcoholic with mental health difficulties and felt excluded from much of society. Dave regularly visited art galleries, he said he felt like he was treated with respect and felt like a citizen. This contrast existed for Dave due to his mental health problems and poverty, thus he was therefore excluded from much of society.

> …because it’s a public space where anyone can enter and I think it does help the self-esteem and mental health of anyone who is suffering from a mental health problem to be able to go into a building where you don’t have to pay to go in where you don’t have to be anyone of any particular class or any standing to go in […] they just need to be treated with respect and allowed to look at culture and feel like a citizen and then interact with art and society and I think that really does help and I think I’d feel a lot worse if I didn’t have those things […] if it was wasn’t there I just think there would be more despair, in the world.

When Dave produced portraits of friends, he found it therapeutic and a way of achieving self-understanding about his mental health conditions.

> …this was more of a kind of um exploring my psychology kind of thing and I found this very therapeutic I was sort of exploring kind of some of the darkness in me.

Derek talked about art projects facilitated by the weekly men’s group of which he was a part. A photography course inspired him to think about light and perspective and he took a couple of art photographs for the research. He also tried to create sculpture with the junk in the basement of the men’s group. Art made him very happy when it went to plan.

> We loved it because we could paint there was so much light coming through the windows and he’s got the easels up you’ve got all these acrylics they provided for you and sort of started painting it was fantastic […] I was in my photography course […] very similar stuff to what she took and made me very happy…

Art, either when viewed or created brought positive benefits for two of the men. Viewing art helped Dave feel like a citizen and that he was being treated with respect. For Derek, creating art produced positive feelings of well-being.

4.3.1.2 Benefit from performance

Tony, Paul C and Keith talked about performing. Colin, Liam and Simon all enjoyed going to see music live.

Colin had been to many gigs before but during the research data collection he went to two gigs, took lots of photographs and described how it felt. He said the first gig was the best he had been to that year and at the end of the night felt euphoric about the evening.

> …feel good factor it was definitely the best gig that I'd been to this year […] I chatted to quite a lot of different people […] I had quite a euphoric feeling at the end of the night […] jigging about dancing and talking to people […] I was having a good time.

Liam had always been a fan of the Happy Mondays, from the time of the rave scene where he became a heroin addict, through to the time of the research. He had beaten his addiction but still enjoyed the gigs as they made him laugh.

> I've seen them about fifty times […] every time I listen to the Happy Mondays or every time I see owt about them I don't know they always make me laugh […] I used I used to like take drugs and that and ended up with like a problem […] that's all all been addressed and that now and I still enjoy listening to Happy Mondays.

Simon lived for music, working in two record shops and at a music venue. He even took working holidays to European music festivals. He said he enjoyed the live element of the music scene and had seen his favourite band several times for free through his work.

> I've seen The Eels a couple of times they're my favourite band…

Tony, Paul C. and Keith spoke about different aspects of performing that provided benefits. Paul C. was 71 and had a natural talent for singing. He had sung all his life, mostly folk songs at gigs and festivals but also in Rome singing Gilbert and Sullivan. He had sung for money, for charity, for the social aspects of the music scene and more recently as a way of preserving his failing memory.

> I sung for one night at local pub and we had a raffle and I raised £120 […] people love it you know you're singing […] long may I be able to sing…

Tony was in his sixties and played guitar and sang most days since he learnt to play at age fourteen. He said that it has been important for his health because whenever he was pent up, pissed off or a bit sad, he sang a few songs and it cheered him up. Tony also wrote humourous songs and poetry about his mental health issues and performed them in public. He said these had been therapeutic for him to help him come to terms with difficult personal issues.

> …usually I can sing something or other everyday […] it's a great thing if you're if you're feeling pent up or you know pissed off […] sing a few songs and it cheers you up […] I've played in a band for about ten years […] a great place for meeting people […] some of the

> songs I've written are kind of humorous songs particularly about mental health issues […] that's really therapeutic.

Keith played the tenor saxophone. He had played for forty years and when he played with his band, he could say things with the music he would not be able to with just words. He said that his mental illness meant he always felt like he did not work properly. The saxophone showed him that he did work properly but in his own way.

> … the saxophone that's like that is one of the ways I fly […] it's absolutely central to my faith my existence and yet it's just a piece of brass […] the saxophone is a way of becoming courageous sort of like I couldn't stand in a pub and say those things with words very easily […] going into the pub and just standing there naked…

Performance, whether attending or performing was good for the positive well-being of the men who introduced it in the interview. It improved the mental health of two of the men who perform in front of others.

4.3.1.3 Exercise

Exercise is promoted for staying healthy or improving health (NHS, 2018). Sixteen of the twenty one men talked about exercise in some form. Eleven talked about walking and six about other exercise and physical health issues.

4.3.1.3.1 Walking

Brian, Simon and Colin introduced walking as incidental exercise. Brian and Simon walked as a means of getting to where they wanted to be and considered it good for them as exercise. Brian walked to and from bus stops for job interviews, work and social life

> I walk most places […] its healthy to walk […] I've had sales jobs which, which were like walking like ten miles a day…

Simon lived and worked in a city centre and walked everywhere he wanted to go.

> I walk everywhere […] I think that is doing me good

Colin walked and lifted as part of his job, he also walked his dog and saw both as forms of exercise. He said that he had discovered as he was getting older, (over 50) that he was getting out of breath if he did more than usual and he said he should not be getting out of breath this quick.

> …that my exercise is […] walking and lifting […] a lot of up and down stairs […] sometimes I walk the dog if I'm just literally going round the corner.

Several men described mobility issues during the interviews but also talked about walking despite those issues or as a way of improving their situation. Paul F. had arthritis and asthma and walked everywhere he could, including walking with a men's group. He said this was to help improve his

conditions including up a long hill to get home. He said he had to stop halfway up the hill to use his inhaler but knew exercise was doing him good.

> that great big hill that I have to walk up […] I suffer asthma and arthritis […] I have to use the inhaler when I get halfway up and then when I get to the top use it again […] you get your exercise.

David walked everywhere he could despite needing two sticks to walk. He said he was determined to keep going as long as he could.

> as long as these little things are walking underneath me, I've got to follow them and to me that's pretty good […] I really enjoy walking down there.

Derek had fibromyalgia which occasionally incapacitated him but participated in walks with a men's group. The example Derek gave was a walk to look at the Christmas lights with the group. Derek loved walking despite the pain.

> I enjoyed it but it was really tiring for me […] I like walking actually I love walking really […] the fibromyalgia won't let me do stuff

Dave was an alcoholic with mental health issues and had very little money. He made sure he walked somewhere every day and said he found walking in the country really helpful. Dave walked with friends or on his own. He said the endorphin rush lifted his mood and killed pain.

> I walk a lot […] when you push yourself you get that endorphins rush and it is like an antidepressant. It is it kills pain and it does lift your mood a lot and I think it does help.

The last three walkers did so for different reasons. Andrew walked in the local park saying that he enjoyed the fresh air and open space. Andrew also walked in the hills near his home but caught the bus so he could go to places that no one else went.

> …like just being able to get out and about and bit of fresh air a bit of exercise […] I always think sometimes that your mind expands to fill the gap in which surrounds you […] sometimes I go up into the dales on the bus […] when it's nice it is a bit breezy it's really nice and you're just completely remote…

Tony was also part of a men's walking group who had known each other for many years and went for long walks in the country. Tony said he said he was respected and valued by the group.

> …the five of us were out together so like this men's walking group […] it's great to get out and walk in the country and I wouldn't do it on my own […] I feel like they respect me for what I've done…

Lastly, Geoff walked every day round his local park and then for a longer walk at weekends in the country just because he loved walking. Geoff was the most reticent participant and needed more direct questioning to elicit responses, therefore the interviewer's questions are included in the following piece to make sense.

> Geoff - This is the park. Int - How often do you go there? Geoff – Everyday. Int - Why do you walk every day at the park? Geoff - Because I love it.

Walking was beneficial for the men in this category. They thought that it lifted their mood, improved their health and was something they enjoyed, thereby improving their well-being too.

4.3.1.3.2 Other Exercise

There were other forms of exercise talked about by participants. Two participants discussed cycling as a form of exercise. Liam went adventuring on his bike. He said as it was paid for, it was free fun, and he listened to music in his headphones and cycled all over. This helped him relax when he was stressed.

> …you can go and enjoy yourself all day for for nowt […] it keeps me fit it it keeps me like keeps me alert […] way of adventuring and things isn't it you can go anywhere you want to you know on a bike…

Colin used his bike to get to and from his jobs but also knew it was better for the environment than using his car and was good exercise too.

> I use the bike to go to all my three jobs […] visit people on the bike […] it helps to keep me healthy […] better for the environment.

Alan had serious damage to his knees from childhood and had set himself a challenge to run a 10k race and was doing physio exercises to strengthen his knees.

> …disabled with my mobility […] sometimes playing football about 7 times a week […] I want to try and run a 10k eventually.

George was a big man, 6 foot 2 inches tall and 17 stone, he did weight training in the gym and played football. He was aware that he wanted to be big but not fat so did the exercise to control his weight.

> I'm always gonna be a bit big but I don't wanna look overly oversized […] running erm but mainly football […] exercise in the gym weights and stuff.

Paul C. had recently turned 70 and talked about how he had looked after his body over time to enable him to carry on as long as possible. Despite his many medical conditions, he managed to carry on walking, gardening and chopping wood for his fire due to his lifelong fitness.

> …walk the Pennine Way […] I do a lot of gardening […] I usually start in the garden about 7 o'clock […] I love cutting logs up physically it's good.

Finally, for exercise, Liam played 5-a-side football once a week with his mates. Liam said it was fun to play, there was good banter and concentrating and getting sweaty made him feel better.

> …the concentration and get a good sweat on […] go to work the next day yeah and everything is sound.

Exercise is recognised as a good way to become and remain healthy. Most of the men introduced exercise as something that affected their health and well-being. Eleven of the men discussed walking either as part of a group with added benefits of social interaction or on their own. Men walking on their own talked about scenery improving their well-being. Other forms of exercise were important for some of the men too. Cycling, football and gardening were some of the examples introduced by the men in the interviews.

4.3.1.4 External well-being support

This category relates to beneficial activities undertaken by the men where they interact with religion and spirituality or therapies. Religion and spirituality was a non-physical concept where men were utilising ideas or activities from religious practices to improve their health and well-being.

4.3.1.4.1 Religion and spirituality

Two men talked about religion and spirituality as having positive benefits for them. Dave was an alcoholic with mental health problems. He said he had recently turned to Buddhism to help him free himself of alcoholism. He said that when one dies as a Buddhist, the body must be free of earthly desires including alcohol otherwise one would be reborn with these desires. He also did not wish his death as an alcoholic on any of his friends.

> I've really gotten into Buddhism and I've found it very helpful […] understanding of of what's gone wrong in my life and how I can possibly make it better […] if you die an alcoholic you die a very painful death […] I really don't want to inflict that upon my friends…

Alan had a photograph taken of himself praying in an 800 year old abbey. He said he always had an eerie special feeling in the abbey and when he prayed there he felt better.

> …maybe there's a bit of something in that religion […] if I've had a little prayer […] I feel like the big fella upstairs has cleaned me, and I feel a bit cleansed.

Religion and spirituality were discussed by two of the participants. One appeared to be a little sceptical about religion but felt better for having prayed when he visited an ancient abbey. The other participant was using Buddhism as a tool to help him become less dependent on alcohol. He was using the teachings as motivation to stop drinking.

4.3.1.4.2 Alternative therapy

Tony and Andrew talked of the benefits that different therapies had for them. Tony had been taking part in co-counselling for about 25 years. He was sectioned in the 1970s and needed a therapeutic relationship that was equal. Co-counselling encourages giving up addictive substances, so Tony had stopped drinking and smoking through this, and it also helped with his anger issues. He explained that as a lot of his friends who did not stop smoking and drinking were now dying he saw the benefit of doing so.

> I really didn't want to do any therapy where there was somebody who had all the answers […] co-counselling which has been quite a big thing in my life […] it looks down on using you know addictive substances […] gradually I've stopped […] I've known several people now my age from my kind of generation who maybe drank more than me maybe didn't stop smoking when I did and just you know died.

Andrew suffered from a functional gut disorder that would wake him several times a night and he struggled to get back to sleep. Through his doctor he was using hypnotherapy and mindfulness to cope with the problems. Andrew said it would not change the problem for the better but the strategies he learnt would enable him to function better day to day.

> …hypnotherapy which I found quite useful it doesn't solve the problem what it does is helps you to cope with it better. The mindfulness […] if you can identify when it's going to happen and you're more resilient to deal with it.

Two of the men found alternative therapies helped them think in different ways. This helped them deal with addictive substances and long-term medical issues in a positive way.

External well-being support was the label given to any activity engaged in by the men with the intention of improving well-being that did not fit another category. Religion and spirituality and alternative therapies helped the men deal with addictive substances, cope with medical conditions and improve well-being through praying.

4.3.2 Discussion of the cluster 'beneficial activities'

As shown in chapter 2, there was minimal literature on men on low-income's positive health and well-being in qualitative research. Coupled with the exploratory nature of this thesis, it means much that was analysed is not in conventional literature. There will be many new references introduced in the discussion sections to support and understand the finding presented.

4.3.2.1 Benefit from art. Benefit from performance.

Henry (2006) found that her participants were able to express or even concretize their feelings and needs through poems, art or drama. Tony, Keith and Dave all achieved an improvement in their mental health and well-being through art and performance. All three were able to reach a greater

understanding of themselves through their preferred artistic medium. Dave through art, Keith through music and Tony through poetry. Kasser (2006) describes intrinsic values as being particularly important for personal well-being. He sees these as values which reflect one's own psychological needs and growth rather than extrinsic values such as materialism. One aspect of intrinsic values, personal growth, is being able to follow one's interests and curiosity. Again, Dave, Keith and Tony can do this in their unique ways and thus enhance their well-being accordingly. Becoming engaged with life enhances happiness. Happiness comes from knowing the trick of being creative in deploying strengths and virtues whenever possible (Seligman, 2006). When performing their art, Keith, Tony and Dave manage to do this and understand that this is the case.

Dave described visiting art galleries as being allowed to look at culture which made him feel like a citizen, removed despair, and increased his self-esteem and made him feel respected. The Royal Society for Public Health (2013) report that visitors to museums and art galleries feel increased feelings of well-being through: a sense of connectedness and belonging; optimism and hope; access to arts and culture. These mirror Dave's sense of increased well-being through his visits.

4.3.2.2 Exercise

Biddle and Ekkekakis (2005) state that scientific assessment of physical activity is fraught with problems due to validity and reliability issues with self-assessment. The data presented here is completely self-assessed but is the subjectively experienced life of men on low-income in their unique circumstance. It is unlikely that large scale assessment of men on low-income can be achieved then interventions designed to improve physical activity as men on low-income lead more chaotic lives than other men. It can be argued that this data is higher quality than scientific, controlled, homogenous data that does not account for the lived experience of men on low-income. It contains the previously hidden lives of these men in its depth and richness. These data can be used to promote improvements in the lives of other men on low-income in similar circumstances.

The participants descriptions of phenomena that affect their health and well-being in this section are the ones reflected most often in literature. Sixteen of the 21 men introduced exercise as affecting their health and well-being.

It has been known for many years that exercise reduces the severity of mental health conditions and improves mood and well-being (Fox, 1999). Morris (1994) described exercise as public health's best buy in combatting coronary heart disease while Dishman et al. (2013) describe the benefits of exercise for reducing negative mental health indicators and increasing positive mental health. This finding is reported repeatedly in the literature. Henry (2006) reported that her participants found that physical activity prevented depression, allowed access to perspective on life and made them happier. Biddle

and Ekkekakis (2005) point out that improvements in mental health and well-being occurred regardless of whether participants in research performed aerobic or non-aerobic activity. The conclusion drawn from this is that well-being improvements are concurrently occurring due to participants' social interactions and self-perception of taking control of their health and well-being. Biddle and Ekkekakis (2005) also conclude that well-being from physical activity goes beyond the benefits accrued through taking time out from hectic lives. Liam playing football provides the best example of these last two conclusions. He describes the banter with his friends and the concentration on the game while playing as making him feel better.

Linking this to the Foresight Mental Capital and Well-being Project (2008), many of the men were active. They walked, cycled, played games and did what they could, based on their level of fitness. This included Alan and David who both used two sticks to walk but this did not deter them from undertaking exercise.

4.3.2.3 Religion and spirituality

Despite difficulties in producing compelling empirical evidence that spirituality is a correlate of well-being (Burns, 2005), research has pointed to this being the case. Piedmont (1999) developed a spirituality scale that showed differences from the Big Five personality traits and correlates with well-being, pointing to a trait exclusive of the Big Five. Emmons, as cited in Burns (2005) concludes that spirituality results in higher levels of subjective well-being. Emmons (2006) sees spirituality as a motivating force that directs goals for those who invest in spirituality. Dave uses the teachings of Buddhism to attempt to free himself from the clutches of alcoholism. Helliwell and Puttnam (2005) support this argument but point to the debate about whether the increase in well-being is due to faith itself or the sense of belonging that occurs in a religious community. For the two men who introduced religion and spirituality, there was no community for them. The increase in well-being came solely from their engagement in processes associated with religion or spirituality.

4.3.2.4 Alternative Therapy

Henry (2006) examined the difference between expert led talking therapies and self-help strategies. Expert led therapy encourages discussion of problems whereas self-help therapies such as co-counselling or Alcoholics Anonymous look to the future and set achievable goals in non-expert led settings. Tony was adamant he did not want to be talked down to by an expert in his therapeutic relationship and chose co-counselling instead, thus looking to the future and setting achievable goals to help himself.

Henry (2004) reported that her participants described quietening the mind of particular use for them to achieve greater levels of well-being, greater than conscious insight through talking therapy. Andrew

found hypnotherapy and mindfulness useful in quietening his mind to enable him to cope with his irritable bowel syndrome.

Activities that were beneficial for the men were many and varied. Physical activities such as walking, cycling, gardening and playing football were viewed as healthy by the men who introduced them in the interviews. Activities that improved well-being were viewing or producing art or music. Religious activity or engagement with alternative therapy were producing positive benefits for the men who engaged in these.

4.3.3 Awareness of the everyday

Everyday events, artefacts or people are often taken for granted. This category presents analysis of the men's reflections on these everyday parts of their lives. The five categories are related to food; memories; relationships; spaces and time. Food, relationships and spaces have sub-categories as the men's narratives contained more nuanced detail than was able to be conveyed as a larger category. The table below details which men introduced things that affected their health and well-being within each category and sub-category.

Table 4.2

Categories and Sub-Categories for the Cluster 'Awareness of the everyday' by Participant Contribution

Category	Sub-category	Brian	Dave	Colin	Liam	Alan	Simon	Tony	Mark	Paul	Andrew	George	James	Stan	Peter	Will	PaulC	PaulF	Geoff	Keith	David	Derek
Food	For health		✓			✓										✓				✓		
	Well-being through the process of preparation						✓													✓		
	Grow your own							✓	✓											✓		
	Food for pleasure		✓									✓								✓		
Memories	/				✓	✓										✓						
Relationships	Friends		✓	✓	✓		✓	✓	✓	✓		✓	✓	✓								
	Partner	✓											✓	✓	✓	✓						
	Family			✓		✓						✓								✓		✓
	Other							✓									✓		✓	✓	✓	✓
Spaces	Outdoor		✓	✓	✓	✓	✓		✓		✓						✓				✓	
	Community		✓			✓		✓				✓										
Time	/					✓	✓		✓			✓										

As can be seen in Table 4.2, there were five categories of content data, food and relationships both had four separate sub-categories where the data went beyond the broad headings for the category. Each of these will be described in turn below.

4.3.3.1 Food

Many of the men took photographs and introduced the everyday concept of food in the interviews. The obvious topic of the nutritional value of food to health was talked about but the men went beyond that to talk about how it also brought well-being in many different ways.

4.3.3.1.1 For health

Health advice is that eating well improves levels of health and life expectancy. Four of the men were explicit in their awareness that this was the case.

One man was an alcoholic and one an ex-alcoholic. They both talked in some detail about the Gamma GT liver testing that showed that despite their prolonged alcoholism, they had minimal liver damage. Both described how they made sure they ate very well during their alcoholism to mitigate the effects of alcohol on their liver function. Dave, a current alcoholic had researched the effects of beetroot.

> …beetroot it does contain an alkaline chemical called betaine which helps to rebuild damaged liver cells […] I've sort of started taking more of that and sort of making my own borscht and stuff like that…

Dave was surprised how much of an effect this had on his liver function despite doing his own research and taking vitamin and omega 3 supplements.

> I find it hard to believe that because of the amount that I've drunk that there wouldn't be more damage but then when I look at the amount of borscht and the amount of beetroot that I've eaten maybe that might be a contributing factor.

Alan, an ex-alcoholic spoke about how well he has eaten all his life and that he was never ill. He talked about when he and his drinking partner were tested for liver damage and the surprising difference between the results of their tests.

> …a normal man should be between, fifty five and seventy […] me and my friend who drunk the same he had his done and he was six hundred and fifty one […] I, had the same test as him so we both drunk the same we had done for years right, I was sixty point five […] maybe my nutrients and vitamins and everything like that had not done the damage to my liver that it had done to his.

Will was an unemployed ex-student living with friends. He said his kitchen was not always clean enough to prepare food but when it was, he ate well. He explained the differences he felt when he ate well and when he did not.

> …gone back to the healthy cycle again and me realising that I've been having a really shitty diet and waking up feeling ill […] even mentally I kind of find myself sharper and sort of I've got more time […] it effects my productivity as well as how I'm feeling […] I wake up feeling better as well as going to bed feeling better so you know it just makes you feel lethargic getting a chippy.

Keith took a picture of his salad made from home grown ingredients. He thought the health went beyond the contents of the food itself.

> …it's a salad, inside it is the fruits of my labours so you know it's salad so it's healthy […] that sense of […] beautiful things healthy things made things things interwoven will create well-being yeah so in the bowl are these roots that go back to the plot…

Food for health is an everyday topic and there are well known consequences for a good and bad diet. The men who introduced the topic discussed the benefits of eating well on alcoholism, how it made a difference to their sleep, productivity and general well-being. Finally, health and well-being from the links home grown and assembled food had with the connection to the plot in which it was grown.

4.3.3.1.2 Well-being through the process of preparation

For some of the men, they were aware that the positive benefits of food went beyond the nutritional value and gave them positive well-being. Participants described that the process of cooking improved mood. For Keith food preparation appeared to improve the healthiness of the food itself:

> …so, part of the goodness is in the making of it is you making it that makes health…

Simon was aware that he found the process of researching, brewing and taking the time to sit and drink tea gave him well-being and time away from the busy schedule of his life that involved three part-time jobs.

> I can get involved and excited and over think something that is mundane as a cup of tea.

Preparation of food and drink brought benefits to well-being that went beyond the nutritional value of the food. Either through health imbued through the physical construction of the food or the time taken to research, prepare and then enjoy the final product.

4.3.3.1.3 Grow your own

Tony and Mark both lived in small houses with no garden, however, both managed to grow some food of their own and were aware of the benefits of doing so. Mark grew herbs in his back yard in pots to add flavour to his food.

> I've got thyme and tarragon in the first two so if I'm cooking, I'll nip out with a pair of scissors nick a bit off and pop that in for a bit of extra flavour…

He also worked on an elderly friend's allotment in exchange for food which he enjoyed to the full. This free food was important to him as he was unemployed and struggled to buy enough healthy food.

> Oh she gave me some tender stem broccoli the other day and straight out of the ground […] flash fried very quickly in a touch of olive oil a bit of garlic the tender stem broccoli so you've got that lovely kind of charry flavour on the outside […] it was just delicious.

Tony had a wild elderberry bush near his house and realised he had a non-conventional food supply very close to him, so he collected the berries.

> I have this elderberry bush outside my front door and I think well all these berries you know I should be you know harvesting them in these hard times […] I got a big bucket full of these elders […] boiling them up with some lemon and sugar and grated orange peel and I made this really nice kind of drink full of vitamin C…

Both men here were out of work and struggling to obtain nutritious food. They had found unconventional methods to obtain this nutrition by either working for food on an allotment or picking wild food to enjoy at home.

4.3.3.1.4 Food for pleasure

For some men, everyday pleasure came simply from eating food. Both Dave and George talked about their enjoyment of food. Dave was an unemployed alcoholic who therefore had limited financial resources for the basics in life, but food was a priority.

> I stop drinking for a while to save money and I just spend it on travel and food […] I'm eating a lot I mean I love vegetables anyway I always have I just I love I love food in general.

George took a picture of an enormous plate of food from a carvery and said he loved food. He described other instances of enjoying food with others.

> I love food but I suppose it symbols with my friends as well […] it'd always be good food but I like try to put my own little different thing on it […] a pizza Calzone it's good I didn't know how to picture it really cos I like I like cooking myself and stuff and it's a bit of an inspiration […] this is my home made calzone […] it were good.

George had not realised until he talked about the photographs how big a part food played in his life and how much he enjoyed cooking and eating. Dave explained that he loved food and despite being an alcoholic made sure he ate food he enjoyed.

Keith enjoyed the taste of the food but appreciated a deeper sense of food that he grew. He described food that looked good, tasted good and had links to the plot in which he grew it.

> …beautiful things healthy things made things things interwoven will create well-being yeah so in the bowl are these roots that go back to the plot and all of those intermingled things…

Food is consumed by us all every day and there is much written about the risks and benefits associated with food. Men on low-income in this research chose to photograph and explain examples of this everyday activity that went beyond these risks and benefits. One man did talk about food in this way and how he felt healthier when he ate well. Two men explained that eating well had limited damage to their liver function during periods of alcoholism. Another explained that creating your own food grown yourself imbued well-being due to the connections back to the soil in which it was grown. Growing your own food was captured by two participants who ate food picked in the wild or grew themselves to supplement their diets and thus improved their health while on low income. Other men discussed how the preparation of food calmed them and improved their well-being while others gained pleasure from the consumption or the look of the food itself.

4.3.3.2 Memories

Positive everyday memories of the past were captured by three participants in different ways. Will's uncle was a role model for him in his youth. When he died Will was not allowed to put a horseshoe in his coffin for good luck so planned a tattoo instead.

> I was thinking about maybe getting a tattoo of it not as a sign of respect but just like a memory […] the majority of my tattoos are either related to my art or to my history of my medical condition…

Will used tattoos as a way of reminding him of important events in his life that he thought gave him strength to persevere.

Liam had very good memories of childhood trips from the inner city suburb in which he grew up to a local market town. He explained that he felt intimidated by conditions in the inner city and needed to get away to a place that would make him feel better.

> I've just been given a flat here and all so that's definitely good for my health good for the way I think and good way for remembering and everything you know […] alcohol is alcohol you know […] it doesn't seem so menacing out here whereas if I went back home […] it's sort of like enforced a little bit you know you go and buy a paper and you're there like there's just like bottles of vodka and vodka and vodka…

The last participant in this section was Alan. He photographed a ceramic campervan from Newquay which was a memento from his holiday with his teenage daughter. Alan managed to achieve taking his daughter on holiday while he was on benefits by saving every spare penny and saving for years.

> …the deep one that really really gives me a lot of peace is my daughter won't ever forget that holiday for the rest of her life […] when I went through rehab they teach you you don't pat yourself on you back enough […] every time I look at that I think ((out breath)) you did well there 'cause to me there is no such thing as can't.

Everyday memories creating well-being were explicitly described by three participants. Will planned to have tattoo as a reminder of an influential family member. Liam had good memories of a local town he visited in his childhood. When the inner city in which he lived grew intimidating for him, he moved out to the local town to improve his well-being. Alan had a memento from a holiday with his daughter that he paid for while unemployed. He took great satisfaction from being able to do that and was reminded of this achievement when he saw the memento.

4.3.3.3 Relationships

Everyday relationships contained elements of health and well-being for the men. Nearly half the men talked of the importance of friends having significance in their lives. Some of the men talked about the importance of relationships with a partner and how it made them feel. Some of the descriptions of feelings went beyond the expected levels of emotions for this group of men on low-income. Relationships with family were described by some of the men as affecting their health and well-being in a positive way. Some of these relationships were with their children, grandchildren and two of the men talked about their children or grandchildren having indirectly saved their lives. Six of the men talked of relationships with everyday entities that were not human that improved their health and well-being.

4.3.3.3.1 Friends

Ten men in total talked in depth about the importance of friends. Some of the men appear in more than one of the sections below. Four of the men talked about friends as people with whom to enjoy shared activities. Six of the men described friends as being important to their well-being. There were three further instances of friends being important to well-being in different ways. These will be described in turn.

Dave, Liam Tony and George all talked about instances where they took part in different activities with friends. Dave mentioned walking with friends as part of his exercise regime. The other three mentioned more instances separately throughout the interviews. Liam described having a large friendship network with whom he spent a considerable amount of his time, notably sharing activities.

> I'll always go see them (Happy Mondays) whenever I can […] that were like a good day out it were like me me and me mates […] play football 'cause I go and see my mates and that you know you can you can walk on football pitch and that ey up you prick you know and it's a good laugh in it you know and it- the game kicks off again that's all I'm bothered about is getting ball you know the concentration and get a good sweat on and go home and have some tea and then I go to work the next day yeah and everything is sound […] I go to football and I'll see all me mates an- it's just a good laugh it's a good crack you know even though football team we support are crap…

A wide range of shared experiences with friends appeared to generate a greater depth of experience for Liam and give him a huge amount of pleasure.

Tony talked of many instances of sharing an activity with different groups of friends that became his social life.

> I kind of go and eat, fairly regularly at the local curry house […] my friends like it it's quite cheap and cheerful curry […] I've played in a band for about ten years like a little folky band […] a great place for meeting people you know big extended network of network of musicians […] five of us were out together so like this men's walking group and you know it is like this little group of us now we are going out tomorrow and so it is really nice actually […] being in in the environment and walking and, but it's the sociability as well […] I feel kind of valued by by them as a group really so yeah it's really nice […] I have a little groups of friends an- like to see films so you know, I like to you know go along together…

Tony managed to achieve a wide range of inexpensive social activities that bring him positive well-being.

George was living in the community in which he grew up. He was the only participant to talk about a best friend and what it meant to him. He also described the things about his friendship group that brought him well-being.

> …me and my best friend […] a few holidays together […] we look after each other if we need owt help each other out […] I enjoy the banter between your friends the actual playing I like football as I said what else, I enjoy I enjoy just being part of something as well and then after after the match going for a few beers…

The six participants who described friends as having meaning important to their well-being were Dave, Simon, Tony, Colin, Paul and James. Dave was an alcoholic who did not have a good relationship with his mum, his friends gave him support in his slow progress towards sobriety.

> Friends are indispensable really […] my real family really is in my friends […] they know you and they appreciate you for who you are and when you forget who you are and you forget the good things about yourself and you forget, the hope that you had […] they remind you of that…

Simon had a life built around his music including his three jobs and hobby collecting vinyl records. Friends got him thinking about and doing other things, thus allowing him to see that there was more to life than just music.

> Something outside of this something outside of work I mean you know generally a positive you know mental health […] I've got a few friends that will always sort of try and get me out of my comfort shell and do something a bit different […] it can only be a positive you know that having these people around you keeping you sane.

As described above in the section about friendship being about shared activities, being valued by his walking friends was important to Tony, he had known them for more than thirty years and this gave

their kind words great meaning for him. Colin said that important friends lifted his spirits and helped him see there was more to life than the hard work of having three jobs.

> …if you're good friends with people you can just catch you can just like have conversations with them like you haven't seen them since last week […] it gives you the upside of life rather than just the all the drudgery

Paul did not say much about the importance of friends, only how it made him happy when he could help them. Paul invited his friends to bring their dogs to roam free in safety in his garden and explained why this meant so much to him.

> …at least we know the dogs are okay in their selves you know and that's just a lovely feeling to me…

Finally, James had recently completed his degree and started work. Most of his friends had moved away, and he was spending more time on his own. Meeting up with friends lifted his spirits and improved his well-being.

> …sometimes when you get a bit down and lonely you just you meet up with some friends make us laugh can share experiences with them…

These six men in poverty realised that something as everyday as friendship brought many benefits that lifted them from the drudgery of poorly paid work and loneliness thus improving their well-being.

Three participants described friends in ways that were individual to them in their situations. Liam, Mark and Stan.

Liam had struggled with drug addiction and alluded to a possible criminal past. He explained he had moved to a different area for a better life that would improve his well-being. Part of the move was leaving his old friends behind and finding new ones.

> …you've got to like you've got to choose your friends wisely […] there's no point hanging around with lads who were just gonna get you back into trouble […] you've got to be selfish with them you've got to leave them leave them behind […] the only thing they understand is like is is violence and that […] if they're if they're dead in head right you've just got to leave them haven't you…

Mark had moved to a new town as an unemployed person and struggled to make friends. He communicated with many online friends but missed the human contact of talking to someone face to face.

> I've got a ton of virtual friends, but you know I talk to them like I talk to a person sat in a room the conversations are always kept very human […] You get a person in the room, you get body language eye contact, you know these are all essentials and its how we're built…

Mark's attempts to enjoy social occasions were thwarted by his poverty as he did not have the money to buy drinks in a pub or afford to go to a gig. Enjoyment of a singing group, his only social experience, suffered too when the venue moved.

> …it was happening around the corner and now they've moved it to The (name of pub) which is you know it's a fucking day rider it's four fucking quid which I can't afford…

Mark struggles with his loneliness but has the resilience to carry on each day.

> I miss proper human contact and I've got a tiny tiny amount of people I know […] some some days it's really depressing and really soul destroying and, but you know tomorrow's another day and you know you get up and you kind of try and renew that hope.

Stan's wife had recently died and had not talked about much that was positive during the interview. However, when asked what things made him feel good, he talked about friends.

> I have me mates come round keep an eye on us….

Despite having little positive in his life, Stan appreciated his friends at a difficult time.

Friends were important for health and well-being in many ways. Some men enjoyed every day shared activities with their friends that improved their well-being. Other men talked about the benefits of having friends and the positive emotions they brought to their lives. Mark talked about his loneliness and how he missed human contact but had the resilience to carry on for another day.

4.3.3.3.2 Partners

Five men talked at some point during the interviews about a partner. One of the men talked about his wife who had just died and the life they had lived together. Another talked about a relationship he had just ended and how this brought a mix of emotions. The other three men talked positively about their relationships and the emotional benefits it brought to their lives.

Stan appeared to misunderstand the instructions of what to photograph and photographed places with important memories from his life instead. Many of the photographs created narratives that contained his wife and his memories of her including where she died.

> …casino which I went into with the wife when we won some money nearly won £1,000 […] she wanted to learn how to play dominoes, so we went over and went to the pub with about a fiver and we came out drunk with a bag of chips and a bit of change in us pocket had a right good night…

Although the stories Stan told about his wife do not appear to directly point to feelings of well-being, the instructions for what to photograph asked Stan to photograph things that affected his health and well-being. Stan chose to photograph things that gave him memories of his wife pointing to how important she was to his well-being.

Brian, James, Peter and Will all talked about emotions and feelings when describing their partners. All took either a photograph or a representation of their partners to introduce the topic.
Brian introduced the topic of his girlfriend with a photograph of two teddy bears that represented them together. He was very hesitant throughout talking about his relationship but explained that their relationship was a healthy one and made him happy.

> …also I think that erm that if you're in a relationship then it's- if it's a healthy relationship and you get on really well then you, bounce stuff off each other and like help each other out and like complement each other and if you get on then it's like, spending time with someone, I consider it to make me happy.

James' girlfriend had recently moved to Prague to take up a master's degree course and described how connected he felt to her and how much she meant to him in the short time they had been together.

> She just generally makes me really really really really happy […] I'm really connected with her and she generally makes us happy just kind of affects my world […] it makes us feel nice just feel connected that way obviously not trying to be anyone I'm not don't have to pretend to do its just being really comfortable around her.

Will had a different story to tell with his partner becoming an ex-partner between the photograph being taken and the interview. He explained she was good but mostly bad, the bad preventing him producing the art that he wanted to produce for his career.

> it's nice waking up next to someone it's nice having someone that cares about you […] I had to break up with her for myself […] I had to sort of start thinking about myself as well so ever since we broke up I've done so much.

Peter was older than the three men in their 20's analysed above. He was in his 60's, divorced and living with his partner.

> Me and (partner) best thing that's happened to me in me life […] we've had loads and loads of great times together but love her to bits…

Three of the four men in this section described positive feelings from their relationship with their partners indicating that these relationships brought well-being to their lives. Will in contrast, gained a positive feeling from ending his relationship as it meant he could resume his career in art.

4.3.3.3.3 Family

For most people, family is experienced as an everyday concept and not often considered in terms of health and well-being. Some of the men took photographs of things that represented family. The sub-category family has two sections; family and children/grandchildren. Two of the six participants in this section talked of family in general terms. Derek took a picture of his siblings and their children together and explained that he took it to show that his family gave him a secure sense of well-being.

> …we're all living our own separate lives but we've very close at the same time […] what a family for me means and why it makes me happy even that mum and dad have gone but we're still there you know still there for each other […] It gives me that security you know what I mean it's and it's that warmth love feeling…

George took a picture of a barbeque for the family and described the loving supportive environment which his family creates. They all lived close together so sometimes he needed his own space.

> …it is a close family […] for help and for backing which families do anyway caring and loving […] I don't like being nagged or owt like that by my family, but I think that's just my age…

Derek, Colin, Alan and Keith all talked about their children and grandchildren as being very important to them. Derek talked in glowing terms about his grandchildren, saying how happy they made him feel and that he wouldn't be here if it wasn't for them. Derek was not pressed on this point, so it was difficult to tell if he was talking about suicide or moving away from the area.

> Just taking that picture of him makes me feel really happy […] really positive for myself knowing that someone like my grandson's in my life […] my new granddaughter she is the bees knees she is everything for me […] he just makes me so happy so joyful you know what I mean so he's just he's just I think you know at the end of the day I don't know I don't think I'd be here to be honest if it wasn't for the two kids…

Alan and Keith explained that their children saved their lives. Alan was an alcoholic who said when he worked out he could lose contact with his daughter he did reform and start on the road to recovery. He knew he only had a few years before she was eighteen and would move away so was making the most of the time he had with her.

> …lost my dignity self-respect lost everything and I was starting to lose my daughter, and I thought, ah you really need to wake up here.

Keith had mental health issues all his life and was reacting badly to what he saw as a dangerous environment where he lived.

> being a father has I think saved my life I think I'd be dead if I wasn't a father […] my depression began in 2004 […] I've grown-up in a violent place and feeling I sort of failed to be a man like everyone else obviously.

For the sake of his children he moved to somewhere safer and he said that the move saved his life.

> we got here you know we got our house in the country fucking hell how did we do that you know with no money […] I'll just be me and I like me, and I won't be afraid that doesn't make me aggressive or violent.

Both these men recognised that their behaviour was dangerous to their health and well-being. It took a realisation that this was going to harm their children to motivate them to change their behaviour.

Colin had been separated from his daughter's mother for years but made sure he had time for his daughter. Despite having little money, he spent it on a car and a television that ensured he could meet her, and she could spend time comfortably with him.

> I know I love my daughter and I know she loves me […] if I didn't have (daughter's name) I probably wouldn't have a car […] certainly when (daughter's name) was younger when she came round if I didn't have a telly that would have been a major major thing…

Across these examples, men talked of being motivated to live a certain life because of the people they loved, and the future they wanted for themselves and with them.

4.3.3.3.4 Other

Six of the men spoke about relationships with entities other than meaningful people that affected their health and well-being.

Tony's relationship with music started as a teenager when he wanted to learn his favourite songs. Singing lifted his spirits when he felt low. He started writing and perform songs and poetry. Some of these allowed him to explore and help come to terms with his mental health issues.

> I write quite a lot you know sort of do creative writing I write poems I write songs an- you know sort of perform some songs in public sometimes at open mikes. I enjoy all that. I've written are kind of humorous songs particularly about mental health issues […] definitely helps to, to come to terms with it, I think. If you're feeling pent up or you know pissed off or something you can- or just low you know if you're just a bit sad you know sing a few songs and it cheers you up you know so that's been brilliant for me music.

Paul C. had been a member of the village cricket club for many years. He wrote and compered a quiz once a month to ensure he was still seen as important in the club which he enjoyed a great deal.

> …it keeps you in the public eye round the club they know that you're not just a drinker. I'm a life member because I used to be I were treasurer for four years I've done because it's all voluntary […] it's a little oasis and our son played cricket down there for a lot of years as a junior.

Geoff lived in a high rise flat and helped look after a roof garden at a local drop in centre.

> Yeah they've got a roof garden. Int-So who looks after that? Geoff-We I do. Int-What kind of things are up there? Geoff-Flowers and plants. Int-Right brilliant who else works on it? Geoff-There's a few you do it. Int-have you got a garden at home? Geoff-No I live in a high rise flat.

David was retired and walked with two sticks. His bus pass allowed him the freedom to go where he wanted when he wanted for free. He treated himself once a week to a trip to a local tourist city.

> I'd lost my bus pass and it that were my outlook you know so I can get out and about. I've also got a bus pass which is for a companion as well just in case I'm struggling. It's just a matter of getting out […] just once a week a little treat to myself that's what I want.

Derek had been a member of a local men's group for many years. The group was for men who were long term unemployed and taught them life skills such as cooking and self-care. Derek explained why the group meant so much to him.

> I love playing board games I just adore playing board games so I'm the one who brings the games and there's a couple of guys who play there's a couple of guys are interested but don't know how to play but they're still interested. Every year we have a Christmas dinner and it's yeah it's fantastic all these people you know these guys come every year […] I really enjoyed it really loved it […] I really enjoy it's not just having the meal but enjoying the company of everybody around you.

Keith played tenor saxophone in a band and had suffered from depression for many years. He explained the importance of the saxophone to his sense of self and means of expression.

> Why is it healthy because it's it's like the lamp in which the genie lives […] you've created is a magical beast you know a magical tool this is a magical tool! […] the saxophone that's like that is one of the ways I fly and my relationship with it is that of a shaman with his or her drum like this is a fucking miracle you know and it's absolutely central to my faith my existence […] the saxophone is a way of becoming courageous […] the saxophone and going into the pub and just standing there naked…

All six of these men experienced improved well-being from their relationships with various non-human entities. These everyday things were brought to the interview by them as having meaning for them. They allowed the men who were all not working to get out of the house and be with other people, doing things they enjoyed.

Only two of the men are not featured in this category of relationships. They did talk about relationships but not as a concept to be photographed and brought to interview. This indicates that relationships as everyday interactions that affect health and well-being are of great importance to the

men. Friends, family, partners and other meaningful entities were all everyday things, but all affected the men's health and well-being in a positive way.

4.3.3.4 Spaces

As described in chapter 3, as well as a thin slice of time, a thin slice of space is included in photographs too (Sontag, 1979). These spaces were captured and discussed by the men in the interviews. Some of the spaces were outdoor spaces which improved health and well-being. Others were community spaces which allowed for inter-personal connection which improved well-being.

4.3.3.4.1 Outdoor

Ten men explained why outdoor spaces affected their health and well-being. All the men were on low income and accessing outdoor spaces was a positive experience that increased their sense of well-being for different reasons. Only two of the men owned a car, Colin and Alan, the others accessed outdoor spaces in different ways.

Dave was an alcoholic who only had money for food, travel and alcohol but walked to lift his mood.

> I walk a lot, sometimes with friends sometimes on my own, and yeah I go walking on the moors and I just, I'll walk down, I'll walk to town and back […] and I do just do feel that when you push yourself you get that endorphins rush and it is like an antidepressant It is it kills pain and it does lift your mood a lot.

Colin took his estranged daughter to a hillside overlooking a valley and described how it made him feel.

> It was a nice day an- it was just really really relaxing it was that there was a bit of wind, but the sun was out, and it was kind of a nice temperature peaceful relaxing something that I don't do enough.

Liam remembered pleasurable experiences from his childhood on his bike so bought a bike to experience the same feeling as an adult.

> You get on your bike and you can go and enjoy yourself all day for for nowt.

Liam also showed me a picture of a river valley close to where he lived and described the positive feelings it brought him whenever he went there.

> When I look I just I just feel a great feeling an- that I appreciate like being alive and that you know and just like feel like op- optimistic and think clearly.

Alan was an ex-alcoholic who saved his money to buy a car and experience outdoor spaces whenever he wanted. The feeling Alan experienced the most while in the countryside was peace. This peace contrasted with the chaos in his life he described when he was an alcoholic.

> I need to go to a beach I want a beach, I want some water and peace […] I like nature and I like hills and I like open spaces and I always have done […] beautiful countryside yeah, it's all free […] the affect that has on me I'm just, at peace just really peace with erm going and having a drive out and seeing all that and then when I come back to work, the next day I'm like totally recharge batteries […] If I feel like something's really really upsetting me I go to this little spot right and just look […] it's just total total peace and if I ever sit there I can I can be in the foulest mood in the world and once I've I see that view it all dissolves […] that's my little peace place.

Simon lived and worked in a city centre and missed the countryside he remembered from his childhood. He enjoyed the local park when he could get there in his busy life with three jobs.

> …it's nice it's green you know get some pollen in your face…

Mark was unemployed and very lonely in his small three room flat. The local park brought him release from his loneliness and he described that feeling.

> It's very easy to just be indoors and feel run down and like not doing anything even going out to the shops. I love walking past the park the smell of the blossom or when they've just mown the grass, the crown green bowling all sledging each other it's bloody hilarious you know there's various wildlife running around the park there's always something chattering flapping about or climbing trees great. I love the park it's my own little form of CBT really and sunlight I'm a spring baby by birth, and I love the sun I love the blossom I love the smell of it.

Andrew had mobility issues, worked in a city centre and felt lonely in the small town in which he lived. Getting into outdoor spaces increased his well-being and broadened his horizons.

> I live next the canal so it's like I know it's there you know if anything gets too bad and the weather's is not too bad I can just literally go out for a walk and a bit fresh air and bit of open space […] when it's nice it is a bit breezy it's really nice and you're just completely remote from you're not far from civilisation but you're just far enough to say you know this is as wild as it gets […] I always think sometimes that your mind expands to fill the gap in which surrounds you.

Paul C. enjoyed his garden before he retired. Now he had more time, he gained even more pleasure from time outdoors working in the garden or just enjoying sitting in the garden.

> …and I think really gardening is me life […] I've now got an allotment and I also do the flowerbeds in front of one of the pubs in the village […] That's the biggest part of me life my big pleasure in life is sitting out on that veranda on a sunny morning.

David walked with a stick, but this did not stop him taking enjoyable trips or walks to places with good views.

> I love it I mean when I go to York […] once a week a little treat to myself that's what I want…I like walking somewhere where I live up from here go across the top of the hill and that's the best view of (city) that you'll ever get.

All these men had awareness that they experienced well-being from enjoying outdoor spaces. No matter what their physical ability or access to transport, they managed to find a way to enjoy the outdoors.

4.3.3.4.2 Community

Five of the men had relationships with their community that were important for their health and well-being. These were all men aged fifty four or older. The examples below are everyday activities that the men chose to share in the interview as being important to their health and well-being.

Tony went walking with a group of male friends in the country and had done so for years. He enjoyed all aspects of the group.

> …the five of us were out together so like this men's walking group […] it's the sociability as well…

Paul C. was a lifetime member of his local cricket club and had been treasurer in the past. To continue to be accepted as part of the club community, he held a quiz night once a month.

> I do quizzes for the cricket club […] it keeps you in the public eye round the club they know that you're not just a drinker […] I'm a life member because I used to be I were treasurer for four years.

As a treat, Geoff walked from his high rise flat to a local village in the country for a few drinks with friends and did so whenever he had enough money. Geoff was the most reticent participant and needed more direct questioning to elicit responses, therefore the interviewer's questions are included in the following piece to make sense.

> Int-Just a beer and a chat? Geoff-Yeah. Int-How many beers do you drink when you go up there? Geoff-About six. Int-About once a week? Geoff-No I only go when I can afford to.

David had lived locally all his life and community events prompted him to go out and to meet people he had known for years.

> …one of my neighbours and if I'm struggling he'll help me out […] I just love the community like tomorrow night they have the thing at Church tomorrow night I'll make the effort to get there, there's people in there that I've known for years and years.

Derek said that visiting the local group for unemployed men and taking part in the activities was very good for him.

> I went with them for a walk […] I enjoyed it but it was <u>really</u> tiring for me […] every year we have a Christmas dinner and it's yeah it's fantastic all these people you know these guys

> come every year […] it's little things like that I really enjoy it's not just having the meal but enjoying the company of everybody around you taking part you know and just talking about what's happened over the year.

Relationships with the community and the people within it were very important for these men. They benefitted from being part of something larger and felt less lonely as a result.

4.3.3.5 Time

Time is an everyday concept that largely goes unnoticed. Four men talked about how the passing of time in different ways affected their well-being. For Mark and Simon time is a problem for different reasons where one has too much time and the other not enough. Alan and George had both made decisions to change their lives for what they thought was the better. They were not going to waste any more time on the things they had walked away from.

Mark was unemployed and did not have many friends so spent his time reading or watching films and television. He could feel his life drifting away and was just filling time.

> …sat all day in one room […] there are days when I sat and I'm nearly in tears I just feel like I'm ticking my life away.

Simon filled his time with music, either working in one of his three part time jobs in the industry or managing his extensive vinyl record collection.

> Sometimes I wish I had sort of more time to do other things, but you know I you can't do that […] to try and, pay for the flat that is quite close […] any free time I tend to have is normally related around the records […] and sometimes it makes me sad.

Alan had been an alcoholic and explained he had wasted a lot of time in the past and now was not going to waste a second of his time. He said he missed time with his daughter when she was growing up but now that had changed.

> the most important thing in life, what you can't buy and the most value is time, you can't buy anybody's time and you can't get time back […] makes me not waste my quality leisure time […] there is times where the alcohol has made me very selfish when I could've probably spent more time with her…

Finally, George who dropped out of university a few years before, was now bored with the ordinary life he was leading. He was not going to waste any more time so was going back to university to study to become a children's nurse.

> I just thought to myself I need to do something that's not gonna waste my time like not just have a normal job […] one extraordinary life because I think I want to live such a life.

Four of the men reflected that time influenced their health and well-being. George and Alan realised they had wasted time in the past and were going to use future time more productively. Mark and Simon had negative well-being from time. Mark felt his life was ticking away and Simon spent all his spare time on his vinyl collection.

4.3.4 Discussion of the cluster 'awareness of the everyday'

Ultimately, Awareness of the everyday for these men means living in the moment and appreciating the effects of artefacts and experiences on their health and well-being. Huppert (2005) defines mindfulness as "the state of being attentive to and aware of what is taking place in the present" (p324). What the men in this research are experiencing through awareness of the everyday could well be defined as mindfulness. However, what they report could be due to the process of data collection where the men are asked to reflect on things that affect their health and well-being. People that are mindful as part of their lives are more peaceful, experience more joy and have improvements in functioning (Huppert, 2005). The effects described come from being aware of the unique qualities of everyday events and objects and conscious of sensory inputs.

The NHS (2017d) suggest Connect as one of the ways to well-being. The men here are aware that connecting with friends, partners, family and community gives them improved well-being. The NHS (2017d) also suggests investing in these as these connections will support and enrich lives. The NHS (2017d) suggests Take Notice as a step to well-being. The maps onto the whole of this section on Awareness of the Everyday. Some of the suggestions are to: Be curious; Be aware of the world and how you feel; Reflect on experiences and what matters; Savour the moment and remark on the unusual. These ideas and others will be used to discuss the findings in this section of the chapter.

4.3.4.1 Food

4.3.4.1.1 Health

The men in this research possessed the cameras for a total of 1024 days and there were only four instances of food being specifically about health. The effects of nutritious food countering the effects of alcoholism made up two of these. Food was mentioned by every participant as being part of their conscious awareness of health and well-being. Being specifically introduced to do with health rather than an aside as part of another reason to talk about health was very rare. Keith talked about home grown salad being healthy and Will realising he was not as sharp mentally when he did not eat well were the only examples. If this subsection were not part of something much larger, then more time could be spent analysing food in the context of health by all these men in relation to health guidelines.

4.3.4.1.2 Preparation

Simon and Keith both describe feelings of well-being though absorption in food and drink preparation. Undertaking in a task which one is completely absorbed has been described as being in Flow (Nakamua & Csikszentmihalyi, 2011). Flow focuses the attention outward; time appears to pass faster than normal and the feeling experienced is one of enjoyment in an absorbing activity. Food

preparation also induces health in and of itself through cultural understandings of food preparation in a home setting. Food preparation has been part of the culture of creating a healthy space in the home. It emphasises the link between home as social and cultural space and ideas of well-being and health (Dyck & Dossa, 2007).

4.3.4.1.3 Grow your own

Tony, Mark and Keith grew or picked their own fruit and vegetables. Positive health benefits from growing your own fruit and vegetables are physical exercise from cultivation and cropping and nutritional improvements from fresh fruit and vegetables. Well-being is enhanced through exposure to sunlight and greenspace, senses of empowerment and achievement and if grown with others, social and community networking (Perez-Vasquez et al., 2005).

4.3.4.1.4 For pleasure

Dave and George described the act of eating food as an enjoyable experience. Pleasure from eating can either induce short lived hedonic well-being from the relief of hunger or longer term eudaemonic well-being from epicurean eating pleasure (Cornil & Chandon, 2015). They argue that the pleasure is gained from appreciating the sensory and symbolic value of the food. Keith gained this pleasure from growing his own food and sensing the connection to the soil in which it was grown.

4.3.4.2 Memories

Seligman (2006) describes several techniques to amplify pleasures, the second of which is savouring techniques. Seligman suggests taking physical souvenirs to amplify pleasures. Banal everyday objects can have emotional significance at a personal level (Curtis, 2010). Will had good memories of his uncle and planned to get a tattoo as a reminder of his role model. Alan talked about his memento of his holiday giving him pleasure whenever he looked at it.

4.3.4.3 Relationships

The role of relationships in the experience of happiness has been shown many times (Diener & Lucas, 1999; Diener & Seligman, 2001; Seligman, 2002). Burns (2000) report that the correlation between happiness and relationships works both ways and so has cause and effect. Happy people form better relationships which in turn create more happiness.

Marks and Shah (2005) argue that we spend too much time trying to earn more money and not enough time trying to foster our relationships. Chapter 2 highlights the relatively small increases in well-being from earning more than a modest amount of money. This section of this chapter will highlight the increases in well-being through close relationships. Social support shows positive correlation with life satisfaction (Henry, 2006: Myers, 2000). Socially supported individuals do better on a range of health measures and are quicker to recover from illness. Hedonic well-being is increased when people are with others than when alone (Argyle, 2013). In the previous discussion section, intrinsic values

described motivators that come from within that increase well-being (Kasser, 2006). Wanting an intimate committed relationship is an example of the intrinsic value of *affiliation*. People who place high values on intrinsic values tend to place less on extrinsic values such as materialism and are therefore happier (Kasser, 2002). The Foresight Mental Capital and Well-being Project (2008) suggest that connecting with those around you will support and enrich you every day.

4.3.4.3.1 Friends

Frequent interactions with friends and neighbours correlate with higher levels of subjective well-being. Interactions with friends creating higher levels than those with neighbours (Diener & Seligman, 2002; Helliwell & Putnam, 2005). Ten of the men reported improvements in well-being through being with friends. The examples they gave included reduced loneliness, shared activities, giving life meaning and lifting their spirits.

4.3.4.3.2 Partner

Being married increases life satisfaction and happiness, the two components of well-being. Co-habiting also increases well-being but to a less extent (Helliwell & Putnam, 2005; Marks & Shah, 2005). Both these positive correlates occur equally between men and women. The two married men in the interviews did not mention their wives but four men discussed positive feelings from the relationships with their partners. Happy and healthy was how they described their relationships. Moreover, other men reported good feelings from being cared for and that their partner was the best thing that had ever happened to them.

4.3.4.3.3 Family

Helliwell and Putnam (2005) report people with a family have higher levels of subjective well-being than those who do not, and this effect is increased when there are regular family interactions. Derek and George very specifically spoke about the closeness of family and the positive feelings of security, love and care a close family brought them. Four men talked in glowing terms about the positive well-being from their children and grandchildren, two to the point where they explained how their relationships with their children had saved their lives. Fathers report greater subjective well-being and feelings of happiness than men without children (Nelson-Coffey et al., 2019). These feelings were partially explained by mothers playing less and performing more caring duties and men's relationships following the opposite pattern (Musick et al., 2016).

4.3.4.3.4 Other

Geoff lived in a high rise flat and enjoyed cultivating a rooftop garden at his drop in centre. Milligan et al. (2004) argue that gardens and gardening offer individuals' therapeutic opportunities spiritual, physical and mental renewal. They maintain that community gardening for older people like Geoff can contribute to their health and well-being. Tony and Keith described the positives from playing musical instruments. Croom (2012) describes a positive affect in those who play musical instruments as increasing well-being. Nakamura and Csikszentmihalyi (2011) point to the process of Flow that induced states of well-being in those engaging in processes that completely absorb them. Music

allowed these two men to enter a state of flow and thereby increase their well-being. These two explanations may be the same phenomena. David reported that his bus pass gave him freedom and allowed him to have a little treat. Jones et al. (2013) explain that free bus passes also increase well-being through feelings of belonging and being treated as deserving citizens especially amongst marginalised groups. Health benefits also accrue through increased level of activity amongst those with free bus passes compared to those without.

4.3.4.4 Spaces

Space and place create environments which manufacture differences in health variation between individuals. (Kearns, 1993). Curtis (2010) constructed six ideas of landscapes of health and risk. One of these, therapeutic landscapes of well-being, explains why certain landscapes have health and healing properties. Places, social relationships and the meaning attached to geographical settings merge in different ways for individuals as they move through spaces and time.

4.3.4.4.1 Outdoor

Ten men took photographs of outdoor spaces that made them feel good. Most of the feelings described entailed views, peace and space. The evolutionary psychology concept of biophilia means humans are attracted to life supporting landscapes rich with water, edible plants, animals and safety (Curtis, 2010). Areas that are non-threatening, easily explored, understandable and accessible mean these landscapes contain mystery and legibility (Kaplan & Kaplan, 1989). The four qualities of natural environments that induce feelings of well-being are: being away from the stress of life; experiencing an altered perspective of being part of something larger; rich sensory stimulation from a multiplicity of pleasant sources and a feeling of oneness by being in a supportive environment (Kaplan & Kaplan, 1989). People living nearer greenspace in The Netherlands had better levels of mental health in a questionnaire study. The effect was greater for those in lesser educated groups (De Vries et al., 2003). The ten men understood that outside space made them feel good and all described this outdoor space as containing elements of the references included here.

4.3.4.4.2 Community

Living in a high trust community correlates with increases in subjective well-being in two ways. (Helliwell & Putnam, 2005). There is an increase in health compared with less trustworthy communities and this indirectly increase subjective well-being. There is also a direct effect of a trustworthy community on subjective well-being. Putnam (2000) describes bridging ties and bonding ties that bring different benefits. Bonding ties with people in one's close group provide a sense of solidarity and belonging. Bridging ties with people outside one's network and these confer health benefits through increased possibilities and information. David said he loved the community in which lived and enjoyed the company of people he had known for years. Tony, Geoff and Derek described bridging ties with men who were outside their regular social groups and the positive benefits these gave them. Stafford et al. (2008) reported that low income groups had greater levels of mental health in areas with higher friendship ties.

4.3.4.5 Time

Time was reported by 4 men. Mark was out of work and had too much time and could see his life slipping away. Simon had too little time to see his friends through working and his obsession with his vinyl records. Simon's regret of a lack of time through external pressures can lead to depression and more so in lower earning groups (Roxburgh, 2004). Life experience had encouraged George and Alan not to waste any more time on things that were now unimportant to them. Fox et al. (1968) describe as self-actualised those who use time effectively or competently, mirroring the use of time for George and Alan.

The cluster Awareness of the Everyday contained 5 categories; Food, Memories, Relationships. Spaces and Time. The men were able to identify everyday experiences that affected their health and well-being and explain their significance. 'Food' went beyond the stated health benefits of eating well to the pleasurable experience of consumption and calming experience of preparation. Some of the men grew their own food and explained how this improved their health and well-being. 'Memories' related to everyday things that brought back positive memories for the participants. 'Relationships' for the men meant everyday interactions with friends, partners, and family. Relationships gave the men purpose in life and increased levels of well-being by being with significant others. 'Spaces' were important for the men. Nearly half the men talked about the benefits of the outdoors that went beyond fitness and gave them positive feelings of well-being through the peace and tranquillity that contrasted with their inner city lives. 'Time' was important for four of the men. Too much or too little lowered levels of well-being. For two of the men, time was a precious commodity that was not to be wasted. The cluster, Awareness of the Everyday shows how everyday artefacts or experiences when considered, bring increased health and well-being to men on low-income. The next section will look at states of mind.

4.3.5 States of mind

The cluster states of mind refers to positive attitudes towards aspects of life that encouraged the men to either improve their lives or cope positively with potentially negative aspects. There were six categories in this cluster. 'Giving' was the title given to the cluster where men gave to others either in time or money. Often men who had very little were willing to give to others to help those who had less than they did. 'Living positively with psychological challenges' was the title of the category where men had psychological challenges that were life changing. They described dealing positively with these challenges. They either embraced the challenges to minimise the effect or countered the challenges and tried to beat them. 'Positive awareness of themselves' referred to men who took time to reflect on their position in life or in relation to external challenges and were able to see positives and look to the future. 'Seeing positives in small things' were men who experienced pleasure from things often taken for granted in life or made a special effort to appreciate good things in their lives.

Many men were actively engaged in long term ‘self-development ‘plans. Some of these were beating addiction, engaging in education or setting up their own business. Finally, ‘work has benefits other than money’ was where men saw work as having other benefits than money. This included improved social lives, increased self-respect and one man leaving a job as it did not fit his ethical principles.

Table 4.3

Categories for the Cluster ‘States of mind’, by Participant Contribution

This category has no sub-categories.

Category	Brian	Dave	Colin	Liam	Alan	Simon	Tony	Mark	Paul	Andrew	George	James	Stan	Peter	Will	PaulC	PaulF	Geoff	Keith	David	Derek
Giving							✓	✓		✓						✓	✓				
Living positively with psychological challenges		✓			✓											✓			✓		✓
Positive awareness of themselves				✓		✓			✓												
Seeing positive in small things			✓		✓				✓									✓			
Self-development		✓	✓	✓	✓			✓	✓		✓				✓					✓	
Work has benefits other than money			✓		✓	✓						✓									

As can be seen in table 4.3, there are six categories of content data. There were no sub-categories where the data went beyond the broad headings for the group. Each of these will be described in turn below.

4.3.5.1 Giving

One of the NHS five steps to mental well-being (NHS Choices, 2017d) is to give to others. Five of the men gave to others via charitable work. Paul F. was unemployed and was helped with I.T. skills at a local charity drop in centre. He was still without work at the time of the interview, so he helped others in his position and in the café at the centre.

> I first started off in there at just over two year ago and I had no idea how to use a computer and I went in and they taught me […] with time just keep using it I got better and better and now I’ve started helping other people on the computer.

Paul C. has helped his daughter collect money for a leprosy charity since she was a little girl and sung every year at a lunchtime event raising money for the same charity.

> Sometimes if I sing and I get paid £50 or £60 I give it to leprosy because I think how lucky I am.

Andrew worked at the Oxfam shop in his town and for a local conservation charity to build a social life in his new location and to help others.

> For me it was just something else to do the voluntary work. I pick them deliberately because I do some work for Oxfam…

Tony was struggling to find work so was doing some mental health voluntary work to keep himself busy.

> …if someone is willing to pay me Pension Credit to I can get money to do the things I like doing an- I do lots of voluntary work anyway…

Finally, Mark was via had set up an online community to help people who had just had their benefits sanctioned. He also volunteered for a local mental health charity helping people with mental health difficulties integrate into the community.

> I'm actually running it from Facebook and Twitter anyway as a sort of virtual service […] so if someone comes in and they're not sure what they're entitled to or they've had a letter telling them they're sanctioned I can get them welfare rights […] I volunteer for (charity) as well I do their positive pathways thing which is people coming out of units and integrating back into life.

These are all examples of men who had very little but wanted to give to others.

4.3.5.2 Living positively with psychological challenges

Five men talked about their psychological challenges and how they were managing them to live positively. Two men talked about alcoholism. Dave was an alcoholic who took Lithium for his borderline personality disorder and took anti-depressants. Dave also talked about a suicide attempt a few years before. He said that beyond the prescriptions, there was little help for him with his issues. He understood that he cannot control how he feels a lot of the time so does positive things to help himself. He walked every day if he could; visited art galleries and libraries to make himself feel normal; ate as well as he could to negate the liver damage from the alcohol; and had turned to Buddhism to try and view the world in a different light and alleviate some of his problems.

> …during those periods of sobriety I have been doing very constructive things in my life that have made me feel a lot better […] I walk a lot […] that endorphins rush and it is like an antidepressant it is it kills pain and it does lift your mood a lot and I think it does help and

> healthy eating as well eating a lot of vegetables […] look at culture, and feel like a citizen, and then interact with art and society and I think that really does help and I think I'd feel a lot worse if I didn't have those things.

Alan was an ex alcoholic who knew to the day how long he had been dry. Although he was positive about staying dry, he said sometimes he had to reset himself in dark room for twenty minutes to be able to continue positively.

> I were in a really really dark place then, but I'm in couldn't be a better place now […] if I see continually a lot of adverts on TV where they are drinking wine or beer or whatever and I just have to (pause) ((breath out)) just go and reprogram in a dark room and just think right just have a little breather here and take twenty minutes.

Derek took two photographs that showed what depression meant to him and how it affected his life. He also took photographs that showed that despite his depression, he was still able to achieve and manage himself and his life.

> I just wash a cup up or something like that and I just thought "there's no point there's just no point" and it you know that's part of the massive depression when I first one of the things I started when I lost my job and everything else I couldn't clean my house up I couldn't do anything in my house it was just spiralling down […] It took me 15 minutes to put all this up and all it was was just two chalkboards one chalkboard and two corkboards up and I felt brilliant afterwards I just I'd done something I needed to do anything you know didn't matter what it was but I needed to do something that took me 15 minutes didn't do anything else the rest of the day but that made me feel so good so positive that I'd just done this so I just had to take a picture of it and say "yeah you know what there's times where I can do stuff".

Paul C. suffered from severe insomnia for years but pointed out all he was able to achieve during the night. He enjoyed watching the family of foxes he could see in his garden in the middle of the night. Paul C. also mentioned his memory problems and how he was doing crosswords and jigsaw puzzles to stimulate his memory to reduce the effects in the long-term.

> I once went 11 weeks without sleep […] if I get up during the night […] I'll go if I can put 10 or 12 pieces in a quarter of an hour 20 minutes a warm drink back to bed […] most of this is all geared on helping me to remember…

Finally, Keith has had ongoing mental health issues. He mentioned suicide during the interview when describing his feelings dealing with government tax credits. Later, he talked about his mental health problems and said that instead of fighting them, he made friends with them and used them as a strength that made him different. He went on to say there was a massive positive from mental illness if it was channelled in the right way.

> That's I think from the tax credit people […] it creates this sense of thoughts that lead towards suicide and sort of hideous sense of powerlessness. It's not an illness it's just the way we are you know and what we need to learn is how to manage ourselves how to be ourselves to like

> ourselves. The things that terrify us are us so we're just going to have to be friends if they won't go away we'll have to make friends with them and somehow channel them and use them see them as a virtuous strength a talent […] there is a sort of positive massive positive side to mental illness […] planning, making, becoming engrossed, involved, not separating yourself, not dwelling on things but creating strategies to change your thought and pull your thought into positive areas…

Psychological challenges can often induce negative effects in those who suffer from them. The men in this category did the opposite and either saw the positives in their challenges or fought against them to try and overcome them.

4.3.5.3 Positive awareness of themselves

Tony, Paul and Liam spoke with an awareness of themselves and their lives that ensured they were able to appreciate where they were in their lives and build positively for the future. Tony was 62 and described his signs of physical deterioration but said that he felt clearer mentally now he was older and was able to put things in perspective.

> …just general signs you know that you can't really avoid that you know I am aging although in myself I you know I feel in some ways a little bit lighter than I did when I was a young man you know more healthy in, in some ways […] more in control of my life or more like I know what I am doing…

Paul, when asked what made him feel good, explained that a smoothly running life was good. He had a dodgy past but now life was enjoyable.

> I've got me demons I've had a bit of dodgy past and all that which I'm out of now, so I see things more clearly and basically life is good you know […] I enjoy my life now.

Liam was an ex-heroin addict who had gone through a lot of self-reflection. He said he was able to make informed decisions about his life and was improving it wherever he could.

> I used to take drugs I used to take a lot of drugs I took them for- took 'em for a long time and I don't I just don't wish to take any of them anymore and that's why I'm like constantly trying to improve myself and that you know like, even my eating and the smoking and things an- even my drinking…

The three men in this category were able to reflect on their lives and see many positives which they built on to live a better life.

4.3.5.4 Seeing the positive in small things

Four men talked of small everyday events that gave meaning for their lives. Alan explained that it is human nature to respond positively to treats so he made sure he treated himself regularly. He said he could go out more often but instead saved up for a few weeks and made the event more memorable; his example in photographs was a box at a local racecourse with dinner at an evening meeting.

> …you have to reward yourself […] we could have gone out every weekend […] or after five weeks saving up I can have a really nice two hundred quid day out going to races.

Colin also talked about treats but in a smaller way, like a yogurt after dinner to give a lift to the end of the meal.

> My environment and existence is quite not, I wouldn't say it's austere but it's quite Spartan I live quite minimally […] just a chocolate biscuit or a doughnut goes ooh but I've give myself some kind of uppity finish […] it might sound really stupid but it's kind of a pampering…

Geoff walked to a local village to a pub for beer with friends as an enjoyable luxury.

> Pub in the village called the Barleycorn I go up there a lot. Int - Is that your favourite? Geoff - It is cos I sort of lived near there at one time and used it then and I never stopped going since. Int - How often do you go up there? Geoff - Quite a lot. Int - Do you play cards or darts or doms? Geoff – No. Int - Just a beer and a chat? Geoff – Yeah.

Finally, Paul went on a canal barge to learn I.T. skills and saw it as a fun way of learning.

> I thought "what a boat trip?" but when he explained that there's internet access and you know you can do your job searching and that and it's just like out of the office environment he says "if you're interested" and I thought "well, yeah go on" so pardon the pun I took the plunge and decided to go and I've loved it it's been great.

The men in this category brought photographs to the interviews of small things that made positive differences to their lives. Alan saved money to go for a big treat for himself rather than many smaller repetitive treats, Colin thought a biscuit, or a doughnut gave him a lift. For Geoff, going to his favourite pub with his mates gave him pleasure. For Paul, learning IT skills on a barge to help him get a job had been a positive experience.

4.3.5.5 Self-development

Seven participants had long-term projects or plans to improve their lives in some way. Two were younger men who had no work or low paid jobs who wanted a better future and had plans to achieve this. George was supporting people with learning difficulties but was finding the work unfulfilling and frustrating so had enrolled at university for a nursing degree with plans to work in Africa.

> Next month I am starting university again, I'm doing child nursing at (name of university). I saw people growing up around me and it were just like your normal day's work go home wait for the weekend go to sit in the pub for like weekend and go back to work and then do it all over again and do that until you're sixty and I just didn't wanna do owt like that. I've also had the bad experiences of working in rubbish jobs working in factories doing like line work on a conveyor belt and all that sort of rubbish which is bad for me, so I know I know what I'll be doing if I don't put myself together.

Will had recently graduated and was without work. Will had a good upbringing but poor academic grades and had no sense of direction until he found he was good at art. Despite having a year when he

was very unwell, he graduated with a 2:1 in art from university. He was working with the Prince of Wales trust to buy some equipment to allow him to create sound installations at art galleries and music festivals.

> I got kicked out of school in Year 10 and went to college to do my GCSEs and I ended up getting an A in art […] I was one mark off a first in my final piece but it's still the best a 2:1's still the best grade I've ever got […] The long-term plan is to basically be involved in the music festival and gallery scene doing immersive environment installations and audio-visual installations.

Dave, Liam and Alan were improving their lives as a result of addiction. Liam was a heroin addict who had just graduated from university at the age of 38. He was working for a charity assisting addicts to keep them away from crime.

> I went to volunteering at an agency that that were like relevant to degree I were studying an- so it all started making sense then […] deliver sessions an- an- supervise people and it and it sort I don't know sort of like I got a lot more out of it and I sort of enjoyed it and it developed me more.

Recently, Liam had also moved away from a dangerous area to an area with happy memories from childhood to improve his life.

> I've just been luckily lucky been fortunate enough I've just been given a flat here and all so that's definitely good for my health good for the way I think and good way for remembering.

Alan was an ex drug addict who had been dry for a few years. He had recently got his first job, his own flat and a car. His goal was to run 10k race as the last piece of his plan he had written when he gave up alcohol.

> I want to try and run a 10k eventually, stopped drinking stopped smoking got a good diet so final bit is to, got a job so final bit is to get full mobility, that's me only challenge now.

Dave was an alcoholic with mental health issues and was planning to give up alcohol by turning to Buddhism.

> I've really gotten into Buddhism and I've found it very helpful um to, understanding of of what's gone wrong in my life and how I can, possibly make it better.

Dave had self-educated via the city library as he was unable to study conventionally due to his addiction.

> …books in the library and education, free education I think I can't imagine where I would be without free education because as, disturbed as I may be I think I've benefited greatly from being able to go in ever since I was a child…

Mark was unemployed, his previous employment had been physical manual work. He was running a free online service to those who had recently had their benefits sanctioned or given a mental health diagnosis and gave advice on benefits and housing. He was in talks with a local mental health charity to try and expand the service with them.

> …when I was working as a cleaner and gardener…
> …it's a virtual space at the moment [… hopefully I'll have a (name of organisation) space in a community er 'cos it's to stop mental health units are full of people that don't need to be there…

David was retired but explained that when he was younger, he wanted to achieve something. When his friends were playing out, he studied to be an electrician and appreciated the time he had spent learning as it gave him a life he was proud of.

> Uncle Albert who were a master electrician […] this knowledge book I were reading through his you see my mates went outside playing football and stuff like that and I were jotting down everything that was in his ledger so I made my own ledger and I made it my ambition in life to be an electrician…

Seven men had long term plans to change their lives. Three men had experience of substance addiction. Liam and Alan had managed to clear themselves of heroin and alcohol addictions while Dave had plans to free himself of alcohol addiction. George was going back to university to save himself from bleak work prospects. Will was applying for a loan to set up art installations. Mark was running a free online mental health benefits service and wanted to expand this with the help of a local charity. David, looking back on his life, explained he studied to be an electrician while his mates played football.

4.3.5.6 Work has benefits other than money

Four participants took photographs to explain that their work had meanings above and beyond money. Simon and Colin had jobs in music shops and a music venue and found likeminded people in those environments. Their social lives were improved by this and music was one of the main interests in their lives. Simon described this feeling in the interview.

> I've worked hard for those guys over the years you know, they are I am very close to them it's a very small- both (name of shop) and (name of shop) are very close knit you know families almost. There's only a handful of employees you feel you wanna work you know you wanna be there for them.

Colin described his other two part-time jobs as less enjoyable but necessary to provide money to live.

> …it's a small business so if everybody likes basically likes each other in a small environment then it's a it's generally a good environment […] I work for (company) sometimes I think they're a pain in the arse…

James talked about a job in a betting shop being against his ethical principles and he resigned as soon as he could.

> At the beginning I felt I was valued […] further down the line like I just understood that like gambling's like very serious like I've seen some people go and do stupid things […] just it was affecting me personally I was not feeling comfortable I was feeling like oh I was it isn't a very respectable thing I'm doing.

Another job working from home did not suit him either as he became very lonely.

> I've left my new job today […] I feel especially when you're that isolated at home it's even more whereas if you were in a normal call centre you'd be able to speak to someone in person.

Alan had recently started his first job for years after recovering from alcoholism and said that just being at work again was doing a lot for his well-being, making everything worthwhile.

> This company is very good at treating you with dignity and self-respect […] that just does so much for your self-esteem, you know but getting in the workplace and feel like you are doing something for my well-being makes everything worthwhile.

4.3.6 Discussion of the cluster 'states of mind'

4.3.6.1 Giving

Kasser and Ryan (1996) looked for alternatives to materialism for well-being and one of the intrinsic values found within those they studied was community feeling. Five participants on low income in this research found well-being away from materialism and described the charity work they did. Helliwell and Puttnam (2005) agreed by saying that civic participation is important for life satisfaction.

4.3.6.2 Living positively with psychological challenges

Five men lived with clinical diagnoses of psychological disorders. When improving their well-being over the long term, Henry's (2006) participants told her they used daring. Daring to face their fears or their pain. To face the emotions or situations rather than running away. The five men here dared to challenge themselves and their diagnoses to make a difference to their lives and improve their well-being. Henry (2006) also found that 10% of her participants developed better mastery of their lives by reflecting on and reframing understandings. The five men here did similar but not allowing themselves to become their diagnoses and reframing their understandings of what they could achieve within their new boundaried lives. Csikszentmihalyi and Csikszentmihalyi (2006) argue that it is possible for us all to live a life worth living despite any challenges we face.

4.3.6.3 Positive awareness of themselves

Henry (2006) as discussed above found her participants used strategies to reflect on and reframe their understandings of their lives. Liam, Paul and Tony could see their past lives in perspective and knew

that are happier now than they were. Tony almost reflects Henry's description of mastery and balance in life with his description of how he feels now he is older and more in control. Paul and Tony reflected on their lives and thought life was better now than when they were younger. Mirroring Vaillant (1995) who saw age bringing wisdom and less immature defence mechanisms which both men alluded to in their narratives.

4.3.6.4 Seeing positives in small things

The men in this research live in poverty and adversity. Despite this, four men were aware of positive meaning in small events or treats. One way of experiencing positive emotion in the face of adversity is to find positive meaning in ordinary events (Affleck & Tennen, 1996; Folkman & Moskovitch, 2000).

4.3.6.5 Self-development

Self-development for the men in this research means long term projects to change their lives for the better. Mill (2016) saw human beings striving beyond pleasure and pain, to improve themselves. The seven men described here were managing to do this with their limited resources. The three men beating or trying to beat addiction were developing themselves through truthful self-nurturing (Kearney, 1998), where addiction gained meaning as a problem. Thus, providing the basis for beating addiction and gaining self-development. Three other men and one ex-addict gained or were in the process of gaining an education for their self-development. Beyond the material benefits this would bring to the men, this knowledge acquisition enriches the personality (Mill, 2016). The process of the men pursuing personally meaningful goals also creates improved emotional well-being and better physical health (Emmons, 1999). Goals also lend coherence and meaning to life and lead to life satisfaction (Brandtstadter, 2006).

4.3.6.6 Work has benefits other than money

Helliwell and Puttnam (2005) point to the negative subjective well-being impact of unemployment being greater than from just that from loss of income. They conjecture this could be from loss of social capital and self-esteem. Alan described his work doing a lot for his self-esteem. Colin and Simon both described their workplaces as a good environment and close-knit implying, they gained social capital from their work. Harter et al. (2002) agree as they found opportunities for contact and friendships at work increase well-being. James left a job he felt was morally corrupt but increased his well-being by doing so. Huppert (2005) argues that one goals should be congruent with one's values and not to do less socially responsible work.

Although living with the challenges of living on low income, the men in this cluster maintained a positive outlook in many areas. The cluster 'Giving' relates to the men giving to others despite having little themselves. The men living 'positively with psychological challenges' tried their best to overcome the negative effects of alcohol addiction, depression and insomnia. Seeing the positive aspects of their problems or working towards a brighter future gave the men hope. Three men had a

'positive awareness of themselves'. They all appeared to have reached an understanding of the positive and negative parts of their personalities and past and were looking to a brighter future in front of them. 'Seeing the positives in small things' refers to the ability of 4 men to appreciate objects or occasions that brought them good feelings. 'Self-development' was part of the lives of 7 of the men. Projects, goals or plans were part of the future for 6 of the men and the past for one other. Self-development was a strategy the men undertook to make improvements in their lives. For men on low-income, work is important to provide money for the basics. However, for 4 of the men, it meant more than that. Two of the men gained from working in a pleasant working environment and one from being in the workplace for the first time in years. The fourth gained by adhering to his ethical principles and quitting a job that was making him lose self-respect. The next section will look at moving away from risk.

4.3.7 Moving away from risk

Risk in this context means risk to the participant's current levels of health and well-being. The risks in this cluster are smoking, other addictions and no money. In the smoking sub-category, the men have either stopped smoking or are aware that smoking is a problem and are trying to stop smoking. Other addictions relate to alcoholism and drug taking. Again, this is where men have moved away from the addiction or are actively trying to do so. The cluster 'no money' is concerned with the risks posed to health and well-being by having very little or no money and how the men mitigate these risks.

Table 4.4

Categories and Sub-categories for the Cluster 'Moving away from risk', by Participant Contribution

Category	Sub-category	Brian	Dave	Colin	Liam	Alan	Simon	Tony	Mark	Paul	Andrew	George	James	Stan	Peter	Will	PaulC	PaulF	Geoff	Keith	David	Derek
Addiction	Smoking	✓	✓	✓	✓	✓		✓	✓				✓									
	Other		✓		✓	✓							✓			✓						
No money	/		✓	✓		✓		✓	✓				✓	✓		✓		✓		✓		

As can be seen in table 4.4, there are two categories of content data for moving away from risk. There was one sub-category where the data went beyond the broad headings for the category. Each of these will be described in turn below.

4.3.7.1 Addiction

4.3.7.1.1 Smoking

Eight participants talked about smoking, two using photographs to introduce the topic. Five had stopped smoking (Brian Colin, Alan, James and Tony). Brian's motivation to stop came from his girlfriend.

> …my current girlfriend then she didn't really like it it's kinda like her what influenced the decision because she didn't really like the smell of smoke and she's kinda like had a big influence on me stopping smoking this time…

Colin stopped when his partner became pregnant.

> …(ex-partner) being pregnant with (daughter) 'cause (ex-partner) smoked and she wanted to stop when she was pregnant so we both stopped smoking.

Alan smoked more when he gave up alcohol and found it more of a struggle to stop smoking then to stop drinking.

> I can honestly say it was harder to stop smoking than it was to stop drinking because I replaced my alcohol addiction with nicotine, so I were using that as a crutch to lean on yeah? and erm, so then started smoking like a lunatic…

James had smoked for about 5 years and took heed of the public health warnings when deciding to stop smoking.

> …just felt like you keep seeing all these things well you know cancer and all the very bad effects […] I say I've got no interest in that now I don't plan on smoking again.

Tony smoked when he was younger but used co-counselling to help him move away from his addiction.

> I don't smoke anymore I did smoke to about probably about ten years ago […] co-counselling it's sort of the theory of it looks down on using you know addictive substances…

Mark was using an electronic cigarette; Liam expressed a wish to stop smoking and Dave was using smoking as a support to quit alcohol. Mark struggled to give up smoking so was using e-cigarettes to cut down on his nicotine intake.

> I tried to give up smoking ten times before I got it right and each time I turn into a raving maniac […] the top strength on these is 3.6 worked it down to 1.8 so I'm on the lowest one but I really like it…

Liam had changed many things in his life and wanted to stop smoking. He was aware of the effects smoking had on him and that it was going to kill him.

> …being addicted to nicotine it's just so easy just to go buy ten cigs […] the cigarettes are making me like are making me feel a bit- they are slowing me up a bit if you know what I mean so I just need to do like just get my head round it and I'll stop but I I don't intend to carry on smoking for another twenty year because it's it's that- I think that that would finish me off

Dave was an alcoholic who said he was not addicted to smoking but used it to help him when on alcohol withdrawal.

> Sometimes when I'm on the withdrawal, I don't want to drink so I'll just smoke and drink coffee or tea or whatever instead, so it's never been really a big thing for me, smoking tobacco.

Eight men introduced smoking during the interviews as they were aware that cigarettes affected their health and well-being. Five of the men had stopped smoking, two of the men wanted to stop but were struggling to do so. One man, an alcoholic, used cigarettes when withdrawing from alcohol but did not think he was addicted.

4.3.7.1.2 Other addiction

Five men talked about addictions that were not related to cigarettes. Two men talked about alcohol addiction and three men talked about illegal drugs, one with reference to addiction. Dave was an alcoholic at the time of the interview and had diagnosed mental health disorders but was positive about stopping drinking and had turned to Buddhism to help him.

> I've really gotten into Buddhism and I've found it very helpful um to understanding of of what's gone wrong in my life and how I can possibly make it better.

Liam was an ex heroin addict who said that he received treatment for his addiction. He said the treatment was hard work but did not change his identity, just got rid of the problem.

> When I went into treatment for my for my drugs taking right I thought it was going to change change me whole round me whole life around so I were unidentified to myself but but everything would be just hunky-dory and it wasn't you know. What I mean it was it were hard work at first but I just persevered and in the end I just sort of like I don't see any real difference to to me now as to what I was when I was taking drugs but I just you know I'm I'm just I'm just more mature in head.

Alan was an ex alcoholic who said he lost his dignity and self-respect but the thought of losing his daughter was the driver for him to seek help and quit drinking. He still struggles with his addiction despite not having a drink for more than three years.

> …lost my dignity self-respect lost everything and I was starting to lose my daughter and I thought ah you really need to wake up here […] if I see continually a lot of adverts on TV where they are drinking wine or beer or whatever and I just have to (pause) ((breath out)) just go and reprogram in a dark room.

Tony said he stopped drinking, smoking and drug taking with the help of co-counselling and was happier for doing so.

> I started to practice co-counselling […] it looks down on using you know addictive substances […] in a way I am kind of pleased that I have got this far […] I feel in some ways weller in myself than I ever have…

Finally, Will photographed some cocaine and explained that he went on self-destructive binges from time to time. Although he swore he would never do it again, he had not stopped doing so.

> …started drinking a lot and taking quite a lot of drugs on a regular […] just being really self-destructive […] I've acknowledged it and it's not to say that it won't happen again…

The men in this sub-category have moved away from or are in the process of moving away from addiction risk. Two men discussed alcohol addiction, one had stopped drinking, but the stopping was an ongoing process. One man had been a heroin addict who had treatment to stop using drugs and was happy now he had stopped taking them. The other two men were casual users of drugs. One had stopped taking them, the other had occasional binges.

4.3.7.2 No Money

All participants were purposively sampled as having the lowest 20% of earnings in the UK and fifteen of the men chose to talk about lack of money, with four taking photographs of this issue. For conciseness, not all the men's data is included in this category as several talked about the same issues. Three men (Colin, Dave and James) talked about their lack of money subverting their political and ethical ideals as they had to survive in a consumer society. To earn or spend their money, they went against these ideals.

> Colin - I've got I've still got ideals but I a lot of them are compromised because I'd I haven't found a way of being in a financially orientated world of keeping my ideals better because you have to have money to to survive.
> Dave - If you're going to boycott everything that is tainted by the moral decline of capitalism you'd have to walk around naked and starve.
> James - I don't want to sacrifice my personal happiness to just sacrifice myself doing something just to support myself.

Stan said that he could not get into a local dentist as they were all private in his area and it was why he had black teeth.

> That's the dentist that wouldn't let us in, they don't have 'social' people they prefer people who pays […] it's how comes me teeths black.

Will, Alan, Paul F. and Dave said they were careful or made the most of the little they had, making choices that would ensure they survived. Dave said it was needs before want but hated thinking that all he was worth was 'value' food.

> Will - it's just the struggles of being a Jobseeker and having responsibilities with council tax and things like that […] we'll give you money in 2 weeks when I had like £5 in my bank account and there's nothing you can say that will change them to speed it up…
> Alan - I put one hundred pound on my (supermarket name) card at the start of the month and that feeds me for twenty eight days so I mean not a lot of people can do that it takes some doing.
> Paul F. - that cabinet and the settee that's at the side I got them all from a charity shop just near town and I forget what it's called for 90 odd quid for the whole lot plus delivery […] Sinatra Dean Martin Elvis Nat King Cole right through to some of the modern ones but they're all on cassettes and they're still good […] I get quite a few books I put them on order at the library I once had 22 books on order…
> Dave - I can't afford to shop anywhere that's more expensive […] I can't have everything that
> I want it's always the bare essentials […] I just spend it on travel and food. I don't really buy clothes all my clothes have holes in them all have rips in my shoes fall apart. I don't buy CD's I don't buy books I borrow books…

More than half the men interviewed said that having little money affected their health and well-being. For some of the men, it affected their political or ethical ideals. One man said the local dentist would not treat him as he was on benefits. Four other men described how they budgeted carefully within their means to make sure they did not run out of money.

4.3.8 Discussion of the cluster 'moving away from risk'

Addiction (Smoking and other addiction)

Excessive alcohol consumption causes multiple issues including cancer, heart disease and diabetes (Room et al., 2005). Smoking conveys multiple health deficits such as vascular disease, cancer and chronic obstructive pulmonary disease. It causes other respiratory symptoms and diminishes general health status (Alberg, 2008). To stop smoking, drinking or taking drugs produces obvious health benefits for those in this study who stopped. The effort required to give up smoking while on low income is much harder than for those on higher income. Hiscock et al. (2015) found the ratio of smoking cessation in high income to low income cessation service users to be 1.85. They found three factors to explain this: Higher security in housing tenure promoted cessation; social smoking with other smokers (more common in low income groups) promoted smoking; low income service users had higher motivation levels to stop. The final factor places the ability of five of the men in this study to stop smoking as even more heroic. Overcoming addiction is a long-term process, utilising personal values and social resources. When overcoming without assistance, pre-resolution and social resources were higher and often motivated by the wish to reduce life stress (Blomqvist, 2002). Many other examples of behaviours described by the men when moving away from addiction mirror those found by Blomqvist (2002). Some examples of these include: Colin's partner who became pregnant and this positive event encouraged him to stop smoking; Tony's use of co-counselling was a maintenance

factor in his continuing abstinence from smoking; Dave and Liam both used substitutes to help with their abstinence from alcohol; Liam had health concerns when deciding to stop taking drugs and was also looking at quitting cigarettes.

Liam described not wanting to change himself as he recovered from drug addiction. This counters the idea that long term identity change occurs during the process of recovery (Koski-Jannes, 2002).

4.3.8.1 No money

Stan appears resigned to his black teeth despite his attempts to gain access to his local dentist. His problem may not be isolated as health problems with the mouth and teeth disproportionally affect socially disadvantaged individuals in the UK (Watt et al., 2019).

The men in this thesis displayed remarkable budgeting skills to survive on very little. However, the UK government lays the blame for want amongst the poor and food bank use on poor budgeting skills (O'Connell & Hamilton, 2017). It may be possible for the skills these men use to survive could be transferred to others in poverty to reduce foodbank use. It could also be possible that many in poverty are very good at budgeting on very little and the government is blaming the poor for their problems. Thus, reintroducing a deserving poor rhetoric similar to Victorian times.

The risks inherent in and associated with low incomes are many and varied. Smoking, alcohol and drugs are common risks associated with this group of men. Most of the men had moved away or were in the process of moving away from those risks. Having very little money had its own risks. Some of the men were subverting their political or moral ideals to either earn or spend money. Other men talked in terms of having no reserve money in case of difficulty. One man couldn't afford to go to the dentist as his dentist only took private patients.

4.4 Conclusion

The data collected for this thesis was done so using unstructured photo-elicitation interviews and captured what the men considered affected their health and well-being in some way. The data presented in this chapter was the 230,000 words transcribed from the interviews, analysed using content analysis. The analysis grouped the data into four clusters: beneficial activities; awareness of the everyday; states of mind and moving away from risk

Beneficial activities were activities that the men thought benefited their health, well-being or both. Healthy beneficial activities included walking alone or in groups, cycling, gardening and playing football. Activities which improved well-being were viewing or producing art or music. Religious activity or alternative therapy were also beneficial.

Awareness of the everyday was by far the biggest cluster. This represents the men's reflections on everyday parts of their lives that affect their health and well-being in some way. They reflected that food affected their health and well-being through consumption, preparation, growing their own food

and just the pleasure of eating. Well-being was improved through memories and things that stimulated those memories. Relationships with friends, family, partners and non-human entities affected and mostly improved health and well-being. Outdoor and community spaces were beneficial through social and environmental interactions. Finally, Time was reflected upon as not to be wasted by some and for others time was ticking away unused.

States of mind refers to positive attitudes that enabled the men to improve their lives or deal positively with negative aspects. The categories here were Giving in which the men gave to others in time or money despite having little themselves. Living positively with psychological challenges was where life changing challenges were embraced to minimise the effect or countered to conquer them. Positive awareness of themselves was men who reflected on their life position or external challenges and were able to see positives and look to the future. Seeing the positives in small things was another positive state of mind where men experienced pleasure from often taken for granted small things or made a special effort to appreciate good things in their lives. Self-development relates to men who actively engaged in long term plans to improve their lives through, for example, gaining education or ridding themselves of addiction. The last category Work has benefits other than money included men who saw other beneficial aspects of work than just money. For these men, it meant improved social lives and self-respect or in the case of one man leaving his job as it went against his ethical principles.
The final cluster was Moving away from risk. The risks were to the men's health and well-being and included addiction, be it smoking or other forms and having no money. Five men talked about stopping smoking and three others about wanting to stop or how smoking affected their lives. Other addiction relates to alcohol or drugs and how five of the men had stopped their addiction or were in the process of doing so. Having no money was a risk for these men and ten of the men described the risks to their health and well-being and how they mitigated these risks.

Chapter 4 has presented data in a descriptive way to shine a light onto the health and well-being in the lives of men on low-income. These men have courageously resisted the negative effects of at times, grinding deprivation to maintain or improve their health and well-being. They have often been highly creative in achieving a life worth living despite experiencing poverty, mental health issues and physical impairments. They have great awareness of things in their lives that affect their health and well-being. They challenge and overcome external influences that might negatively affect their health and well-being and more importantly take steps to improve their lives and others lives through their actions. Almost all the men retain a positive outlook on life despite the challenges they face through material deprivation.

The next chapter will take the same data corpus and use Interpretative Phenomenological Analysis to understand the data in a more complex and necessarily interpretative way. The lifeworld of the

participants will be viewed through a socio-political lens and presented as individual case studies threaded with themes that attempt to make sense of the lives of these men in a more nuanced way. Not all the data presented in this chapter will appear in the next chapter. The data presented will support the themes produced and attempt to explain how these men survive and thrive despite the material shortcomings their lives contain.

5 Chapter 5 – Interpretative Phenomenological Analysis

This chapter will present the Interpretative Phenomenological Analysis. It speaks to the aim of this thesis (to critically review the historical and contemporary positioning, evidence and experience of health and well-being among men on low-incomes) and two of the secondary aims (use visual methods to engage largely silenced, unidentified and often invisible community of men on low-income to given them a voice in research about them, document and categorise the forms of health behaviours that white British men on low-incomes report). Each of the 21 pen portraits presented provides an analysis of the lifeworld of one participant.

This chapter is structured in five sections based on clustering the men by way of key elements of the lifeworld which appears to have had the most impact on participants' health and well-being. These five clusters represent some of the major challenges the men face in their lives: men who are unemployed, and who live alone, and how they manage to resist loneliness; men whose partners have a meaningful influence on them and how this brings well-being to their lives; men who are or were addicts in various different ways and how their addiction impacted on their health and well-being; men who have mental or physical impairments that contributed to their poverty and how they overcome these; men who were suffering from memory loss towards the end of their lives, the impact this has and how they attempted to resist this. It also provides a detailed exposition of how that key issue has been overcome or managed by participants in each cluster. Some of the men could fit into several categories but the men selected are key representatives of that challenge who typify most strongly the clustered experience. Hence, the clusters start with men who are unemployed, and who live alone, and how they manage to resist loneliness: Geoff and Mark. This then leads to consider men whose partners have a meaningful influence on them and how this brings well-being to their lives: Brian; Peter; James; Will and George. From this to those men who are or were addicts in various different ways and how their addiction impacted on their health and well-being: Dave; Alan; Liam; Simon and Colin. The chapter then looks at men who have mental or physical impairments that contributed to their poverty and how they overcome these: Keith; Derek; Paul; Andrew; Paul F.; Tony and Stan. Finally, ending on the men who were suffering from memory loss towards the end of their lives, the impact this has and how they attempted to resist this: David and Paul C. Presentation by cluster is a level of analysis above the level of themes (next section) which helps bring together some of the challenges these men face and how they try to overcome them. This nomothetic group analysis of overlapping clusters balances with the idiographic of each man's lifeworld, keeping the sense of the men's individuality.

In additions to clusters, this chapter presents themes. Through careful IPA of the interviews, seven themes were generated across the data set as central to participants' experience of health and well-being, although not all themes are relevant to all participants. Listed in no particular order the themes are: **Journey**; **Balance**; **Space**; **Time; Resilience**; **External Resources** and **Awareness**. Where relevant, attention is drawn to these themes throughout the pen portraits and the themes are used to highlight similarities and differences between the participants' lifeworlds - themes will be subject to an integrated reflection in the next chapter. In the present chapter, a story is weaved of the participants' valiant struggle to leverage as much health and well-being into their challenging lives. It is these phenomenological similarities and differences which are used to order the presentation of the 21 pen portraits in which the total becomes greater than the sum of its parts.

The chapter ends by providing a discussion in which sets out the findings in context of extant research. Note that the term 'health and well-being' was defined by participants as anything they felt fitted the definition. It is necessarily a broad term encompassing many overlapping concepts about health and well-being. The rationale for this is laid out in chapter 3.

5.1 Themes

Each theme generated from the case studies is presented below. Themes are represented slightly differently across each of the lifeworlds. The themes represent patterns that run across these very diverse lives. The chapter is not structured by themes as the lifeworlds would dissolve and the depth of individuality across the men would be lost. The sense of how the men in their unique situations come to terms with similar challenges in their individual ways would not be apparent.

Many of the men were on a **Journey**, either away from risks such as drug dependence or suicidal thoughts, or towards a positive future with a fulfilling career or loving relationship. These **Journeys** were made possible by the men finding some kind of **Balance** in their lives where they were able to stabilise competing demands of **Time** and **Spaces** on their physical and mental health. To achieve this **Balance** the men drew on their own **Resilience** and on **External Resources** such as friends, family, volunteering or their bus pass. Finally, their own **Awareness** of their capabilities and their situation allowed them to overcome many challenging issues and enabled them to improve their health and well-being in multiple complex and resourceful ways.

5.1.1 Cluster 1: Unemployed men who live alone resisting loneliness

The first pen portrait is Geoff who lives alone in a high-rise block of flats. To gain release from the confined **Space** afforded by the tower block, Geoff walks every day in the local park and occasionally to a local village to meet with friends.

5.1.1.1 Geoff: Phenomenological Pen Portrait

Geoff is 60, unemployed and lives alone in a tower block in a large city. Geoff walks every day to improve his health and well-being, including occasionally to a local village to meet with friends for a beer. He learns I.T. skills at a local charity and makes use of their roof garden to make up for his lack of garden at home. The key for Geoff is making use of his **Time** and remaining fit and healthy by walking every day (Figure: 5.1). Four themes are central to understanding the phenomenological world in which Geoff lives and the ways in which he attempts to manage his health and well-being: **Balance**, **Space**, **Time** and **External Resources**. These are intertwined throughout his narrative but also stand alone as different aspects of his lifeworld.

Figure 5.1

Geoff's Image of his Park Where he Walks Every Day to Balance his Health and Well-being.

Geoff is unemployed and lives alone in a high-rise flat. He has plenty of **Time** on his hands and uses this **Time** constructively by walking in the wide-open **Space** of a nearby park every day shown in Figure: 5.1. Walking in the park has great benefits for Geoff's **Balance** of health and well-being and he enjoys it very much:

> [How often do you go there?] Everyday [Do you just walk round- the same route each time?] Yeah [Do you go on your own?] Yeah [Why do you walk every day in the park?] Because I love it […] I just like doing it always have done [Even when it's raining?] Yeah.

Geoff's social **Space** is limited due to his poverty and living environment. When he can afford it, he walks to a local village in the country to meet his friends for a drink and a chat. He makes use of this **External Resource** to fulfil his need for a social life:

> [How often do you go up there?] Quite a lot [Just a beer and a chat?] Yeah [About once a week?] No I only go when I can afford to.

Geoff also finds a social **Space** at a local charity that helps the unemployed. The charity is used by Geoff ostensibly to learn I.T. skills to assist him in getting a job and his **Balance** of well-being has improved by the progress he sees he is making:

> I've never used computers before they learned me how to use computers and look for jobs and then get me confidence to use them…

Figure 5.2

Geoff's Image of the Roof Garden where he Balances his Lack of Outdoor Space and Social Life at Home

However, another reason he uses this charity is that its roof garden (Figure: 5.2) helps **Balance** his lack of outdoor **Space** at home:

> Yeah, they've got a roof garden [So who looks after that?] We I do […] there's a few. You do it on a Wednesday normally [Have you got a garden at home?] No, I live in a high rise flat.

Geoff is unemployed and has little money. However, he makes good use of his **Time** by walking every day in all weathers to boost his **Balance** of health and well-being. Moreover, when he can afford to, he meets with friends for a few beers in a local village to fulfil his need for a social **Space.** He can capitalise on **External Resources**, such a roof garden, to help meet his needs for an outside space to tend.

Geoff is unemployed, lives alone and could be socially isolated, but Geoff's **Resilience** and use of the **External Resources** available to him means he gets out into the world every day and meets with others on a regular basis. Mark, in the next pen portrait, is also unemployed and lives alone but uses the world of virtual friends to give him the social **Space** he needs. Mark, whose brutal childhood produced externally aggressive and internally self-harming behaviours until a moment of revelation changed his life and he is now on a **Journey** to help others:

5.1.1.2 Mark: Phenomenological Pen Portrait

Mark is 52 and lives on his own in a privately rented flat in a middle-class suburb of a large city. Mark is unemployed, has few friends, and feels socially isolated. He has been an angry man who has underachieved all his life until a moment of clarity a few years ago. From then, he has reappraised his life and has a mission to help others, including setting up an online service for those in need of advice about benefit claims. He has a passion for food and cooking, is extremely creative in the kitchen, and eats well on a low income. The key for Mark is reducing his loneliness. He creatively achieves this though working on his neighbour's allotment, volunteering, and being an online 'knight in shining armour' for those in need of benefit advice. Seven themes are central to understanding the phenomenological world in which Mark lives with regard to the ways in which he attempts to manage his health and well-being: **Resilience**, **Balance**, **Awareness**, **External Resources**, **Time**, **Space** and

Journey. These are intertwined throughout his narrative but also stand alone as different aspects of his lifeworld.

Mark grew up on a council estate in a large city. He knew he was different from his peers and this difference meant he was bullied at school and beaten at home. His resentment over this bad treatment **Unbalanced** his mental health and turned to anger as he got older and clouded his ability to form secure relationships:

> …lots of things that made me insecure during my life and a lot of it was to do with my upbringing and being different to the other people on the estate and being battered at school going home and being battered at home…

Mark became more **Unbalanced** and turned to drugs as an **External Resource**. Although the drugs were potentially dangerous, they made life easier to face. However, after a weekend of heavy drug intake, Mark had a moment of realisation that changed his life:

> I took it right the way back and just realised I was just still a scared four year old boy underneath it all […] a lot of the anger kind of dropped away and I've always had a capacity for reason which I completely ignored for so many years because I thought my default position should be angry and unhappy and I completely ignored my capacity for reason the moment I got it back my life improved and my world improved and I improved as a person definitely and I've become much much more useful to myself and to others…

Mark's improved **Awareness** of the impact of his past allowed him to focus on his strengths and build **Resilience** with respect to **Spaces** that had caused harm to his mental health in the past. He is now on a **Journey** to help others in poor mental health **Spaces** as much as he can and be their 'knight in shining armour'.

> …I will go to extraordinary lengths to help people…

To this end, Mark has created an online **Space** via Facebook, Twitter and LinkedIn. He uses it to support those who have received decisions that reduce their benefit payments and acts as an **External Resource** for them at a time of great need:

> …lots of people who've had work capability assessments or sanctions, or they've had somebody that's been admitted to a mental health unit…

Mark has interest from a local mental health charity to develop his virtual **Space** into a presence in the community:

> … somewhere within a community. […] where people do have low expectations where there is a high risk of early mortality where food isn't great where incomes aren't great where there are food banks where there are kids who can't afford to eat school meals…

Mark's **Journey** would be complete if this plan could be realised and he could obtain a paid role within the organisation:

> I would love it to be yes, my paid job it would be fabulous…

In the meantime, he volunteers at a charity doing similar work as an **External Resource** face-to-face:

> …people coming out of units and integrating back into life er [Right] any difficulties they might bump into any support ultimately, it's to self-empower people again…

On the other hand, Mark is living alone in his own **Space** for the first time in 20 years and is struggling with the isolation of living in a new town with little social support and receiving Jobseekers Allowance. He cannot find free social **Spaces** to meet people and, when he does, the travel is unaffordable. This is negatively affecting his well-being **Balance**:

> … there isn't a place in any fucking town when you go free social area come and meet people […] there was a singing group and I used to be in bands and I thought it'd be lovely to do that again you know and it was happening around the corner and now they've moved it to a pub which is you know it's a fucking day rider it's four fucking quid which I can't afford…

Hence, Mark finds that he spends most of his time alone in his bedroom:

> I pretty much live in the bedroom […] the living room has become a corridor to get to the kitchen…

He struggles to manage his well-being **Balance** in the face of this isolation but shows a strong sense of **Resilience** to carry on to face another day:

> …sat all day in one room apart from me trips out to either going to the shop when I can afford it or down the road to work on the allotment. There are days when I sat and I'm nearly in tears I just feel like I'm ticking my life away […] some days it's really depressing and really soul destroying and but you know tomorrow's another day and you know you get up and you kind of try and renew that hope and kind of work on it…

Figure 5.3

Mark's image of the External Resources of CDs he uses to Mask the Sound of Others Chatty Lives

Within the isolated **Space** of his flat, Mark uses various **External Resources** to stave off the loneliness which affects his **Balance** of well-being negatively. CD's (Figure: 5.3) are used to blot out the sounds of the world outside his flat:

> …almost frustrating hearing everybody else's very busy chatty lives [right] it can be quite depressing music drowns out the conversation…

Books to transport him to another **Space** where his loneliness is forgotten for a short time and he can imagine a multisensory experience:

> I love to read it's like having a movie inside your head […] when I'm reading a good book I can almost smell [OK] and the sights and how cold or warm the place is and you know almost like the perfume that someone might be wearing…

Or DVDs to lift his mood:

> I love comedy I love good comedy really takes me out of myself cheers me up hugely great therapy…

Mark also has a lot of online friends he has gained through his virtual helping **Space**. However, he has **Awareness** of the limitations of this and what he is missing without personal contact:

> You get a person in the room; you get body language eye contact you know these are all essentials and it's how we're built its part of what's hot wired into us as a species…

Figure 5.4

Marks Image of the Park, he has Awareness the Multisensory Experience Balances Well-being

Mark also finds the **Resilience** to carry on from **External Resources**. He loves going to the park (captured in Figure: 5.4) and has **Awareness** that the multisensory experience it provides helps to **Balance** his well-being in contrast to the lack of stimulation in his bedroom:

> …there's various wildlife running around the park there's always something chattering flapping about or climbing trees great I love the park it's my own little form of CBT really and sunlight I'm a spring baby by birth and I love the sun I love the blossom I love the smell of it…

Figure 5.5

Marks Image of the Allotment where Social Interaction Helping a Neighbour Balances Loneliness

He is also provided this multisensory experience through helping on one of his neighbour's allotments (Figure: 5.5) which improves his **Balance** of well-being:

> I could feel the sun on me I could imagine she was standing just here about to pass me my gloves you know the smell of earth you know moving the flagstones and flicking spiders off…

The added benefits of helping on the allotment are social interaction, which he craves, and free fresh vegetables which help Mark with his nutrition while on a low income:

> …we always have a really really good chat life the universe and everything while were working […] she gave me some tender stem broccoli the other day and straight out of the ground…

In fact, despite living alone, Mark has a great passion and **Awareness** about food. His inquisitiveness is used to understand the best **Balance** of foods to fulfil the needs of his brain and his body:

> I do a lot of research on stuff I am just kind of Mr Homework really; I've got a big old hungry mind. […] I pay attention to what hits bells inside me with certain foods so foods that make me feel good…

He takes his research beyond the basics, to an understanding of which minerals he needs to keep him well:

> I don't take anything at face value and I will look at it the five a day thing […] colour of veg is very important because it tells you an awful lot so things like blueberries er things like aubergines they're all very heavy in antioxidants […] mushrooms are great for things like potassium and selenium…

Mark knows he is fortunate to live in an area with an above average level of income which provides **Space** for a greengrocer:

> I've got a great fruit and veg shop around the corner…

He has **Awareness** that the choice of shops on a nearby large council housing estate is not as good as where he lives. If he lived on that estate, and wanted to access the same quality of fruit and vegetables he gets currently, he would need to catch a bus to the nearest big city, and this would be an **External Resource** he could not afford on benefits:

> …giant Tesco's and you've got Greggs and a couple of betting shops and a Cash Convertors erm so I'm really lucky where I am […] had I been living elsewhere I might have to get a day rider into town and go to the market for that veg […] who's going to be able to afford to do that?

The process of cooking is also a **Space** that allows Mark to be creative and to restore his well-being **Balance** with its stress purging effects:

> …and it's a great form of creativity it's always been cathartic to me […] you'd work out your frustrations during the cooking process and you'd sit down, and a mouthful of carbs and you'd just instantly feel better.

Hence, Mark takes **Time** and has the **Awareness** to enjoy the multisensory experience that the food he creates can provide. His knowledge allows him to eat well on a low income, enjoy the experience, and know that it is improving the **Balance** of his health and well-being:

> …food is more than just fuel or it should be it should be a sensory delight on every level to make you feel better in so many ways cooking and eating should be bloody good therapy […] should be a really good sensory experience why should you be precluded from that because you're on that bloody low income.

Mark is unemployed, has little money and is socially isolated in a new city. To counter this, he volunteers at a local mental health charity, helps a neighbour on her allotment and has set up an online space for those needing benefits and mental health advice. Mark has a passion for food and cooking and will research the best foods to maintain and improve his health and well-being and eats well on a low income.

As we see from Mark, moving to a new area as a man on low income brings with it the challenge of making friends. Mark highlights how lack of money means he moves in a very small **Space** as travel costs are a large part of his disposable income. He has **Balanced** the lack of physical relationships with virtual relationships online to attempt to alleviate his loneliness. Brian, the next pen portrait, moved to a new area to be with his girlfriend when she moved away to go to university. His girlfriend is an **External Resource** to alleviate his loneliness and to provide continuity at a time of major upheaval in his life:

5.1.2 Cluster 2: Meaningful influence of partners to bring well-being

5.1.2.1 Brian: Phenomenological Pen Portrait

Brian is 24 and lives in his girlfriend's flat in a university hall of residence. He recently moved to the area to be with his girlfriend when she left home to go to university. He was struggling to find work and did not have any social life other than his girlfriend. The key for Brian is his inability to find work after his recent home move, subsequent lack of money, and excess time on his hands. Six themes are central to understanding the phenomenological world in which Brian lives with regard to the ways in which he attempts to manage his health and well-being: **External Resources**, **Balance**, **Space**, **Time**, **Resilience** and **Awareness**. These are intertwined throughout his narrative but also stand alone as different aspects of his lifeworld.

Brian recently moved home to a different area to be with his girlfriend and is struggling to find work. He has tried various ways to earn money, including commission only jobs, and is currently working for an agency doing bar work. It appears, therefore, that he has the **Resilience** to continue his search for work and survive despite his setbacks:

> …that's kinda like healthy because erm otherwise you'd just be sat erm at home doing erm doing nothing and stuff really. Working earns you earns you money and that as well so you can end up like living and like buying food and like and surviving really.

Lack of work means lack of money and this has reduced Brian's ability to explore social **Spaces** such as playing football previously open to him:

> I'm not signed up this season but one thing I've been wanting to do this season I just not been like getting round to it and also it costs to play footy like you have to pay like subs and this and that so and signing on fees and stuff for if you get a red card then you're probably going to have to pay that so.

Figure 5.6

Brian's Image of Filling Time by Playing on the X-Box (Redacted Image)

Minimal work and no social life other than his girlfriend mean that Brian has a lot of **Time** to fill. He does this by playing on his X-Box (Figure: 5.6).

> Sometimes when I'm not working and that I could spend hours playing on the X-Box just and it's practically not doing anything but it's, so I thought that it is kinda unhealthy looking at erm looking at the screen and stuff…

However, Brian's sense that playing on his X-Box is unhealthy is, perhaps, **Balanced** by the feeling of achievement he gets from doing well with the games. Brian is using this **External Resource** to produce a positive feeling he does not get from other aspects of his life:

> …when stuffs going right then on the X-Box then it makes you erm it just makes you feel good that you've managed to do a small thing like that and turned it into something like really good so it is a positive feeling.

Figure 5.7

Brian's Image of Healthy Relationship as an Important External Resource

Brian's girlfriend is the reason he moved to a new area and is also his only social **Space**. However, he benefits greatly from this relationship (Figure: 5.7) and, as an important **External Resource**, she relieves the disappointment and tedium of his life:

> …if you're in a like in a relationship and stuff then it's kinda like if it's a healthy relationship and you get on really well then you kinda like erm erm you bounce like erm stuff off each other and like help each other out and erm and like complement each other and like erm and if you get on then it's like spending time with someone and erm I consider it to make me happy really that erm spending time with someone on instead of being on my own […] I consider it as healthy…

Brian's eating and drinking habits appear to be in **Balance** and he has a keen **Awareness** of the types of food he eats:

> …I do eat like unhealthy food but then also I eat erm I eat some healthy food as well…

To help **Balance** his intake, he can utilise the **External Resource** of government health advice to guide his drinking:

> I know they say like a bit of wines like erm good for you but and it's meant to like clean the blood and stuff so it's like one glass is alright and stuff but erm if you have like four five six or whatever then I consider it to be unhealthy…

His **Awareness** and ideals about keeping his health in **Balance** extends to food and exercise:

> …what I eat and stuff I erm I kinda like counteract it with like the amount of walking and stuff I do […] I walk most places so I don't drive and erm and the reason I thought it's to do with health and well-being is because it's kinda like healthy and like fitness and stuff and it was erm it just helps you with your fitness and stuff.

He also manages to achieve his physical health ideals despite his poverty:

> …at a gym you're just going to go on a treadmill which is like walking or jogging anyway so it's kind of like the same thing and erm the gym can cost like forty quid a month as well…

Brian's recent home move, lack of permanent employment and poverty means he is social isolated. However, he makes the most of the **External Resources** available to him. He is driven to find work and makes use of an agency in a new city and he is aware of the importance of the relationship with his girlfriend to alleviate his isolation. He also finds fulfilment in his X-Box despite its' association with being an unhealthy activity.

Brian knows that his girlfriend is an important **External Resource** during a major change in his life. He does not have any friends in his new area and like Mark, cannot access friendship groups due to lack of money. Brian is looking for permanent work and inconsistent income through agency work means he cannot afford to meet others in social **Spaces**. The next pen portrait features Peter. Peter was abused by one of his teachers in his childhood and therefore struggled to form meaningful long-term relationships through his life. Like Brian, Peter's partner has brought stability to his life and this has given him the **Space** to build a meaningful long term relationship.

5.1.2.2 Peter: Phenomenological Pen Portrait

Peter is 64 and lives with his partner in social housing in a large city. He was abused as a child by his teacher and, despite confronting his abuser as an adult and involving the police, no charges were brought. Peter has had a series of failed romantic relationships but has now found happiness with his partner of many years. The key for Peter is his **Journey** from childhood through many turbulent years to the comparatively settled happy life he has now with his long-time partner. Five themes are central to understanding the phenomenological world in which Peter lives with regard to the ways in which he attempts to manage his health and well-being: **Journey**, **Resilience**, **Balance**, **Awareness** and **External Resources**. These are intertwined throughout his narrative but also stand alone as different aspects of his lifeworld.

Figure 5.8

Peter's Image to Represent his Journey to Find happiness After Childhood Abuse (Redacted Image)

Peter has been on a lifelong **Journey** to find happiness and live a settled life after he was abused as a child at school (Figure: 5.8).

> …my English teacher at school […] he abused me when I was a child erm he conditioned me groomed me and made me feel important you know what I mean, and he took advantage of me.

Peter's mental health **Balance**, already fragile, was challenged further after his girlfriend died in a house fire and so he sought counselling as an **External Resource**. He disclosed to his counsellor that he had been abused as a child and the police were informed. However, after an investigation, no charges were brought due to insufficient evidence. The police mistakenly told Peter where his former teacher lived and he had the **Resilience** to confront him in a non-violent way to ask him to admit to the abuse, but the man refused. However, Peter has **Awareness** that he has enough **Resilience** to deal with the experience now as an adult:

> …so I still think about it it still comes back to my mind and stuff you know what I mean but that's that […] once I started talking about it I found it easier to talk about it so I have filled up in the past and started crying and stuff but I can live with it now.

Peter's unstable mental health **Balance** has meant he has made some decisions in his life that he does not really understand:

> I must have been going through summat myself like some sort of a breakdown that's my only reason I can say what I did it for cos what sort of logic would a man who who's got a nice bungalow a lovely daughter who were only eight year old leave all that behind to go with a woman who I hardly knew […] I were probably already weakened through what I were going through mentally.

He left his wife and daughter to move to a different city to be with someone that turned out to be entirely unsuitable:

> …she turned out to be the worst thing that's ever happened in my life and she divorced me five year later…

Figure 5.9

Peter's Image of Finding Love and Happiness after a Long Journey (Redacted Image)

As he grew older, Peter's improved mental health **Balance** meant he was able meet and settle down with someone who makes him happy and plan for a happy future together (Figure: 5.9):

> …best thing that's happened to me in me life […] we've had loads and loads of great times together but love her to bits […] hopefully we can get some good quality of life the time I retire get me lump sum use it enjoy ourselves.

However, the situation is still quite insecure in that Peter has the **Awareness** that if his partner died, he would be homeless:

> …if the worst happened I'm out on the street cos I'm not on the rent book here which I do find a bit of a worry…

Peter's life has been dominated by his unstable mental health **Balance** and difficult relationships at least from the time he was sexually abused by his teacher as a boy. He has been on a long **Journey** to build some **Resilience** over the course of his life and has now found happiness with his current partner of 13 years.

Peter's life has been a **Journey** of emotional self-discovery after being abused as a child. He has now found a long term partner with whom he feels secure and confident. In the next pen portrait James, like Peter, is dependent on his girlfriend as an **External Resource** but for James this is through a time of change rather than in a settled life. James is a recent graduate, just starting out on his life who has the capability to increase his future earning potential as a **Resource,** but who has not found the career that suits him yet:

5.1.2.3 James: Phenomenological Pen Portrait

James is 22, unemployed, and lives with friends in a rented house in a large city. He was separated from his mum as a child as she was an alcoholic and this has affected the way he perceives addiction. James recently graduated from university with a degree in music technology and is struggling to find work he enjoys. This transition is also reducing his close friendships and he has a strong sense of isolation. The key for James is his responses to his mother's alcohol addiction when he was young and his separation from her. Five themes are central to understanding the phenomenological world in which James lives with regard to the ways in which he attempts to manage his health and well-being: **Awareness**, **Balance**, **Journey, Space and External Resources**. These are intertwined throughout his narrative but also stand alone as different aspects of his lifeworld.

James was separated from his mother as a child because she was an alcoholic. Hence, this vital **External Resource** was denied to him at a vulnerable age. Even now, this occasionally negatively affects his **Balance** of well-being:

> …my mother's an alcoholic and I got separated from her when I was quite young […] I lost my mum for a long period of my life and that really affects us if I do it I can go a day where I can just think about it a lot and I do get upset and then I'm absolutely fine. I still see my mum now she's better.

James has an **Awareness** of his heightened chances of becoming an alcoholic:

> They do say that like its- it can be passed down […] I'm fully aware of that I'm more susceptible than a normal person…

However, his alcohol consumption has diminished since leaving university due to the reduction in his income and social circle:

> I'm not conscious I'm trying to drink less […] it has decreased since I've not been at university […] I don't follow that sort of social life any more…

James was pleased that he did not have to apply for benefits after leaving university by getting a job as counter staff in a betting shop. Although not in his chosen career, it pushed his **Balance** of well-being in a positive direction:

> …it was my first proper real job I would say I felt like I was contributing to my own er income and to a company I felt like I was at the beginning I felt I was valued…

However, his well-being **Balance** was soon being pushed back the other way when he gained **Awareness** of the issues of gambling addiction. James' increased **Awareness** of the effects of this addiction **Space** meant he was negatively affected by what he saw and especially how powerless he felt to help people:

> I've seen some people go and do stupid things but to them it's not and the money just what some peoples lifestyles are being there from nine o'clock in the morning till ten o'clock at night […] it's actually illegal for me to stop them doing so […] it isn't a very respectable thing I'm doing but I also didn't want to not have a job as well at the same time so I kind of went through with it.

James needed the job and the money, but his conscience won the **Balance** of the argument and he left and became unemployed:

> …at the end I just felt like Oh I can't do it any more I just feel like this it isn't right I don't support the industry…

James also closed his online betting account as he had the **Awareness** that his perception of gambling had become negative:

> …maybe I shouldn't do that that would be a bit silly…

James, like many others, started smoking because it was 'what the cool kids did'. However, he has stopped smoking and left this addiction **Space** because of the way he feels about the **External Resource** of his girlfriend:

> …obviously comes down to addiction again but as I say I've got no interest in that now er I don't plan on smoking again […] I kind of listen to her more than I would listen to say an advert on the TV or a health leaflet I kind of trust what she's saying and just respecting her that I don't shouldn't do it…

James **Balance** of well-being has improved since his decision to stop smoking and his subsequent behaviours have given him an **Awareness** of the effect of nicotine:

> …maybe mentally I feel better for it actually […] always biting my nails and stuff and chewing pens kind of shows that obviously there was the routine there er it's getting less and less as time goes on…

James' **Awareness** of addiction **Spaces** even extends to coffee, but he appreciates that he can gain pleasure from drinking coffee and the effects of caffeine addiction are not devastating:

> …like I was saying before I enjoy drinking coffee a lot but if I drink too much or too little I feel really anxious or on edge or and that definitely is the caffeine doing that […] you wouldn't hear in the news someone died of a coffee overdose.

Figure 5.10

James' Image of his Music Balancing Negative Feelings due to Separation from his Mum

Music plays a large part in James' life (Figure: 5.10). He uses music as an **External Resource** to help **Balance** the negative feelings induced by his separation from his mum:

> I kind of find solace in listening or making or hearing music all the time it's just constantly there…

He started on his **Journey** into music by listening to his dad's 1970's vinyl collection, turning into a devotion that took him through his academic career:

> … just listening to music throughout school […] then college and university it just kept building up into more a passion…

James' **Journey** took him into the intricacies of music technology and philosophy:

> … knowing how it works making sense out of the chaotic world of sound […] you can enjoy a song but if you know how it's made or how you're playing it that interests me […] I just love time I just I think that comes down from music keeping time and making sure it's all in time…

However, James' **Journey** was interrupted when he stopped studying and this has negatively affected his well-being **Balance**. James left a job that was not bringing him happiness or was part of his **Journey,** but he does not have a plan to continue his positive **Journey**:

> …since I've left uni I'm a bit annoyed that I'm not doing it as much […] I've left my new job today because I just I couldn't focus it's just not what I planned on doing […] at the minute it's just I don't want to sacrifice my personal happiness to just sacrifice myself doing something just to support myself.

Since leaving university, money has been an issue for James that negatively affects his **Balance** of well-being. Although not a major issue, he has the **Awareness** of what it would be like not to have electricity and this may become more imminent as he recently left his job:

> I have this worry and it's just you know it doesn't keep us up at night but like it's there I think about it very often it's nice when you have money but it's not nice when you don't have money […] the constantly fear of not having like the money to put it on

The other issue for James after leaving university is that most of his friends moved away and this negatively affected his social **Space**:

> …sometimes when you get a bit down and lonely you just you meet up with some friends make us laugh can share experiences with them with because basically obviously everyone left university a lot of my friends went home…

Figure 5.11

James' Image of his Girlfriend, an External Resource that Improves his Well-being (Redacted Image)

The sense of isolation has increased because his girlfriend (Figure: 5.11) moved to Prague to study and he has very strong feelings for her:

> …she just generally makes me really really really really happy […] I'm really connected with her and she generally makes us happy just kind of affects my world…

James **External Resources** of friends and girlfriend have moved away and negatively affected his well-being **Balance**. However, a friend from his hometown is moving close to him:

> …my friend who's just moved down for Freshers' […] I just feel like Oh I've got a friend now […] and it's just nice to have a friend to kind of just do something with […] very important to me…

James' well-being **Balance** was negatively affected by media reports about the food industry, so he switched to a vegan diet. He has found there has been a positive improvement in his health since he started:

> …it's a vegan diet with no meat and dairy […] I've felt some changes in my I guess well-being and body I feel like I'm less heavy and chunky […] I'm having less problems with I guess my functions and how it goes through the body and I say I feel lighter and more energetic.

James struggled at first but turned to the **External Resource** of friends to help him find a vegan diet that worked for him:

> …gave us some advice and tips and just slowly build up sort of what I would consider a balanced diet for myself…

Although he has adjusted his diet since leaving university James has been doing less exercise and is unsure how this will affect his health **Balance** long term:

> I've stopped doing exercise and I don't know if that's an unhealthy balance or that it balances that out…

James was separated from his mother as a child and this has affected the **Balance** of his well-being all his life. He escaped into music as a child and this has become a **Journey** for him to the extent that he has graduated with a degree in music. However, he is struggling to follow this **Journey** into work as a graduate or to find a job that is in tune with his ideals. Recently most of his friends and his girlfriend have moved away and James is struggling with the isolation this brings.

As a recent graduate, James' life has gone through a major transition. He is struggling to find permanent work and his lack of money results in anxiety about whether he can even afford electricity. During this time of change, the importance of James' girlfriend as an **External Resource** has increased. This is in contrast to Will, in the next pen portrait, who has recently parted with his girlfriend as she was stopping him from progressing with his life plan. Will is also a recent graduate and in contrast with James has a strong sense of his **Journey** to pursue his career in art:

5.1.2.4 Will: Phenomenological Pen Portrait

Will is 24 and lives with friends in a rented house in a large city. He recently graduated from university with a degree in art and is currently unemployed. Will was a 'troubled teenager' and expelled from school when he was 14 years old. He discovered he loved art, and this was his route out of trouble. He wants a career creating art installations and is applying for funding to get him started. Due to his poverty and unclean living environment Will eats poorly and is regularly ill, occasionally for months at a time. The key for Will is his **Journey** away from trouble after he discovered he enjoyed and was good at art. Seven themes are central to understanding the phenomenological world in which Will lives with regard to the ways in which he attempts to manage his health and well-being: **Journey**, **Awareness**, **Resilience**, **Balance**, **Space**, **External Resources** and **Time**. These are intertwined throughout his narrative but also stand alone as different aspects of his lifeworld.

Will grew up in a middle-class family and went to private school. He did not like school or relate to learning and was viewed as stupid. This negatively tipped his **Balance** of well-being and he was expelled from school in year ten. At college, he discovered he enjoyed and was good at art although at this time he did not have the **Awareness** that this could be something he could pursue for his livelihood:

> I ended up getting an A in art so I was like hang on, this is something that I can actually do. I used it as an excuse not as a career path.

Will was still directionless but received unconditional offers from several universities based on his portfolio. However, he had the **Awareness** that he would need some resources and so dropped out of college to earn some money instead of taking his A-levels:

> I dropped out of college and started decorating earned a bit of money to come to uni.

When Will arrived at university, the freedom from responsibility became a negative **Space** in which he went on a downward spiral of self-destruction:

> I used to drink way too much and get into way too much trouble and then I sort of mid-way through second year got really quite ill and I was pretty much bed-ridden I was bed-ridden for the whole year…

However, this allowed him **Time** to reflect on his life and was crucial for Will to build the **Resilience** he needed to make changes:

> Jesus have I been up to these last twenty years […] what have I been doing my whole life no one wants to be friends with this guy thinks he's hard as nails and is going to flip out at any moment…

Will changed the **Balance** of his life and commenced on his **Journey** to making art his career and his life rather than a way out of doing academic work at school:

> …changed my whole view of life sort of changed my view of my parents my old friends […] to being told I should never go to college to being the best student on the course so I just really went to town on my final piece and I ended up getting I got 75 and 75 for my final pieces […] I'm the first person in the family to graduate…

Since graduation Will has been unemployed but is still on his **Journey** through working as an unpaid intern in exchange for free studio **Space** for his artwork. He is working hard but earning no money and his **Time** is very important to him:

> I'm meeting important people who are putting me in the right direction and I'm learning new skills which I need to so it's all about balancing what's worth my time and what isn't.

Will is applying for a loan from the Prince's Trust to purchase the equipment he needs for his art installations and to continue his **Journey**. He has tentative plans for his first installation and the **External Resources** he needs to make it happen. He is just waiting for a loan:

> I'm in talks with some people from a Swiss music festival at the moment […] I've got people willing to help me and to teach me and stuff like that so everything's all the wheels are in motion it's just I need to put the car on it…

It appears that Will is building the **Resilience** to see the **Journey** to the end:

> I'm prepared to not have much money for the foreseeable future as long as it keeps me doing what I want to do.

Will's **Journey** means that he will lack money for the foreseeable future, this is having a negative effect on his health **Space**:

> …sometimes go through phases of being run down because of you know the cleanliness of the house and the amount of food I've been able to eat…

He has **Awareness** of what a good diet does for his health and well-being **Space** and the negative consequences of relying on takeaways:

> …it just makes you feel lethargic getting a chippy […] mentally I kind of find myself sharper and sort of I've got more time you know if I'd just sat there had fish and chips I'm not going to want to sit at my computer and do something constructive I'd rather sort of sit there with my belly out and watch 4 on Demand…

Will also has **Awareness** that the lack of cleanliness of his shared house also affects his health **Space** lowering his **Resilience** to illness:

> …it had an effect on my health before my operation because I was prone to illnesses and stuff a lot more…

However, persuading his housemates to keep the house clean is problematic and Will has **Awareness** of the dangers to his precious **Time** of doing it all himself:

> …because if I tidy up after them all the time then they'll just get used to it…

Will does try to keep his cleanliness and food consumption the best it can while attempting to **Balance** sharing the household responsibilities with his housemates.

Figure 5.12

Will's Image depicting his Awareness of the Negative Consequences of Destructive behaviour

Will has **Awareness** that his self-destructive behaviour in the past could have long term, negative consequences. However, when his uncle died and Will broke up with his girlfriend, he drank more alcohol than he was comfortable with (Figure: 5.12):

> I realised every train I got on I'd find myself walking down looking for the bar and after about two or three weeks of getting four or five trains and I realised I'd done it on every train I was like shit this is actually a bit of a problem…

Will had the **Awareness** to acknowledge the problem and the **Resilience** to overcome it, but this does not stop him having the occasional binge:

> …started drinking a lot and taking quite a lot of drugs on a regular basis and really just like no not depressed just being really self-destructive […] but I've acknowledged it and it's not to say that it won't happen again…

Figure 5.13

Will's Image of his Ex-girlfriend who Absorbed all his Time (Redacted Image)

Will knows that his **Time** is precious to him which is why he recently split up with his girlfriend even though she was important to him (Figure: 5.13):

> …it's nice waking up next to someone it's nice having someone that cares about you…

However, Will is **Aware** that he needs to devote a lot of **Time** to his career in this early stage and he has the **Resilience** to make the difficult decision to leave her behind to continue his **Journey**:

> I literally did no artwork during the time that we were together at all and then I came to that realisation and even though she was having the problems that she was that I had to break up with her for myself…

Will is on a Journey from drop-out from private school to setting up his own art installation business. It does mean he is in poverty while he arranges a loan to finance his vision. His poverty and living conditions result in poor nutrition, health and have exacerbated a recent illness. Will has great **Awareness** of who he is and what he needs to do, understanding the risks of his occasional self-destructive binges and a relationship which pushed his **Journey** off course.

Will's **Journey** away from risk towards a brighter future has been a long one and Will has the **Resilience** to see his life plan come to fruition. George, in the next pen portrait, unlike Will dropped out of university and returned to his home town. While living and working in his home town George gained the **Awareness** that this life was risky for his well-being. He has therefore created a life plan of going back to university and subsequently living an extraordinary life away from the risky 'ordinary' life at home:

5.1.2.5 George: Phenomenological Pen Portrait

George is 23, works part-time as a support worker for people with learning disabilities and lives with his parents in a provincial town. George has previously been to university but dropped out. After eighteen months working abroad, he has returned home with a resolve to live an 'extraordinary life'. He does not want the 'ordinary' life he sees around him in the provincial town in which he lives so

has gained a place at university to study child nursing with a plan to do a placement in Africa. He enjoys his close, loving family and many friends who he invites for social events at his house whenever he can.

The key for George is his **Journey** away from ordinary that he sees around him towards the extraordinary life he believes he should lead. Seven themes are central to understanding the phenomenological world in which George lives with regard to the ways in which he attempts to manage his health and well-being: **Journey**, **Awareness**, **Balance**, **Space**, **Time**, **External Resources** and **Resilience**. These are intertwined throughout his narrative but also stand alone as different aspects of his lifeworld.

George has previously studied at university but dropped out. He saw people from his community doing the same job every day until retirement and became **Aware** that this 'ordinary' life was not for him and that his **Time** was very precious:

> I saw people growing up around me and it were just like your normal day's work go home wait for the weekend go to sit in the pub for like weekend and go back to work and then do it all over again and do that until you're sixty and I just didn't wanna do owt like that […] I need to do something that's not gonna waste my time.

He did not want to move back to the 'ordinary' **Space** he grew up in, so worked abroad in holiday resorts for several seasons and returned to his hometown to work supporting people with learning difficulties:

> …went to work in Tenerife for 6 months erm then I managed to get a winter in Finland erm working in Lapland and then I did when I came home I did another summer in Ibiza […] I work with work in a residential place for adults with learning disabilities…

George worked in a similar role in a nearby large city and found the work very fulfilling:

> …it were the best year of my life it were brilliant as I was an outreach worker…

However, working in a residential setting in his hometown is monotonous and affects his well-being **Balance** as he does not have the **Resilience** to overcome the tedium:

> I do a lot of sitting around […] you sit there and get paid or go home and don't get paid […] That were my day and so from 11 o clock in the morning to 10 o clock at night […] no praise at all off my manager…

Figure 5.14

George's Image Symbolising his Awareness he Would like Lead an Extraordinary Life

These life experiences have given George the **Awareness** that he does not want what his friends have in his hometown and would like to live an 'extraordinary' life. He commemorated his decision by getting a tattoo on his arm (Figure 5.14):

> Ordinary is not something I want […] just don't settle for mediocre […] a tattoo that I was getting erm this here is one extraordinary life, erm because I think, I want to live such a life…

George is therefore planning to go to university and study child nursing on his **Journey** away from the inherent risks for him of mediocrity, towards an extraordinary life helping others:

> I'm doing child nursing at (name of university) [yeah] and within that erm I was hoping that I would be able to like go to such as Africa erm cos I think you can do like placements […] go out there and get a different experience […] Africa what they do over there is going to be completely different…

George has student debt from his previously wasted **Time** at university and he is prepared for this financially and is motivated by the opportunity in front of him:

> I get a bursary as well while I'm there and my course is paid for by the NHS […] I'm ready to get my head into something and proper like knuckle down sort of thing and study…

George is planning to continue living in his parents' house and commute to university. He has **Awareness** that he would be frustrated by those around him who would be not as prepared to work:

> I'm 23 and I reckon if I were to commit to university, I'd be living with people who would be trying to get the experiences I've already had.

Living in his hometown **Space** will provide many other benefits for George than just an environment in which to study productively. He is very close to his family and the added **Resilience** they provide:

> …it is a close family […] for help and for backing which families do anyway erm caring and loving…

This closeness can be intrusive sometimes as George sometimes struggles with the **Balance** of being an adult in his parents' house:

> I do try to keep myself to myself sometimes with things that are going on in my life…

The good far outweighs the bad as George appreciates the social **Space** the **External Resource** his family provides:

> This is the first barbeque of the summer […] a nice a nice thing to do to socialise […] and it's just nice to try and have a few drinks with family.

George plays football with friends he grew up with. Knowing them well means the enjoyment is greater in this safe, trusting **Space** and improves both his **Balance** of health and well-being;

> played centre midfield and I enjoyed it because I played with my friends so it were good fun, it didn't really matter if we lost or anything […] I enjoy the run out erm the erm fitness side of it I enjoy the banter between your friends erm the actual playing I like football […] I enjoy I enjoy just being part of something as well and then after after the match going for a few beers…

George has **Awareness** of the importance of the exercise he gets playing football:

> …it's good to have a run out now and again it keeps you keeps you fresh and you feel good afterwards…

Living in the family home provides George with the **External Resources** he needs to be able to host barbeques and create a social **Space** for friends. He enjoys cooking and experimenting with new recipes, so his friends benefit from this passion:

> My house is quite well catered for people to come round and stuff […] I love it in the summer and so like I say if I've got the place to myself […] I enjoy it a lot it's good really good […] always be good food bit I like try to put my own little different thing on it…

Figure 5.15

George's Image of his Awareness that the Pleasure from an Expensive Luxury Balances the Sacrifice of Money While on Low Income

Occasionally when he can afford it, George indulges one of his passions by going to watch Arsenal play in the Premier League with a friend. He has the **Awareness** that this is an expensive luxury for him as he has little money but the experience more than **Balances** the sacrifice (Figure: 5.15):

> Through my travels working abroad and stuff I met a friend who is an Arsenal fan and he could get me tickets […] being able to go to a sporting event like it […] so a brilliant day erm chanting there was loads of people there […] I paid a bit too much for the ticket, but it was worth it.

As George is well known in his local pub, he and his friends are given extra large portions at the carvery:

> …and because they know us, they sort of let us do that […] there's a big mountain of food.

George is **Aware** that his **Balance** of health is tipped towards unhealthy because he eats too much food. His well-being **Balance** is also negatively affected as his self-image is of a tall, broad man and not an oversized man:

> I eat more than I should […] I do see it as more of a comfort […] I don't wanna look too too big […] I don't wanna be too skinny either…

To bring some **Balance** to his battle with weight, George uses the **External Resources** of weight management supplements:

> I'll eat whatever food I want to eat and then I'll worry about it later […] I'm forever bulking up and then trying to lose it again […] I don't do like normal diets you know like erm eating healthy I'll do like a Herbalife diet…

Whenever he gets the chance to eat out, George tries new food and uses the experience as an **External Resource** for inspiration for cooking at home:

> …this was my the best the meal that I had down there erm a pizza Calzone […] this is my home made calzone my own attempt massive […] wasn't as nice as the one that erm that I ate in the restaurant but erm but I were happy with it, it were good.

George experiences have given him the resolve to lead an extraordinary life and he hopes his child nursing degree and possible placement in Africa will lead him to lead such a life. His well-being is supported at home while he studies by his loving family and close network of friends with whom he has grown up.

George dropped out of university and after experiencing the 'normal' life available in his hometown, he planned to lead an extraordinary life and not waste any more of his **Time**. He has a long-term plan which he hopes will bring him happiness in the future. In the next pen portrait, Dave also dropped out of university for very different reasons. Dave experienced anxiety and lack of confidence at university but found these could be alleviated by self-medicating with alcohol. Unfortunately, this led to an alcohol addiction and at a particularly low point, a suicide attempt. Dave has since gained the **Awareness** that his health and well-being improves without alcohol and so commenced the arduous **Journey** towards sobriety and normality:

5.1.3 Cluster 3: Countering addiction to improve health and well-being

5.1.3.1 Dave: Phenomenological Pen Portrait

Dave is 28 and lives with his mother on a council estate. Dave is an alcoholic and takes medication for anxiety and Borderline Personality Disorder. At the time of interview, Dave was attempting to rid himself of alcoholism and improve his mental health motivated by a wish to take a more active role in society. Six themes are central to understanding the phenomenological world in which Dave lives

with regard to the ways in which he attempts to manage his health and well-being: **Journey**, **Balance**, **Resilience**, **Space**, **External Resources** and **Awareness**. These are intertwined throughout his narrative but also stand alone as different aspects of his lifeworld.

The key issue for Dave is his **Journey** towards sobriety and improved mental health. He makes progress on his **Journey** by living as normal a life as possible. He does this by keeping his life in **Balance** despite physical and mental health **Spaces** that affect his **Balance** of health and well-being. The tools Dave uses to maintain his **Balance** are **Resilience**, **External Resources** and **Awareness**.

Figure 5.16

Dave's Image of Mood Stabilisers, Antidepressants and Dietary Supplements that Help Manage his Balance of Health and Well-being

The **Balances** that Dave seeks might not be considered 'healthy' by normative standards but, arguably, would constitute a considerable achievement in the context of the challenges he faces. These challenges include severe mental health problems, alcoholism, and poverty. Dave has had mental health issues most of his life and has received different diagnoses at different times. He said that he could not access talking therapies unless suicidal so, currently, is taking prescribed medication for anxiety and Borderline Personality Disorder (Figure: 5.16). The delicate **Balance** provided by prescription drugs is, however, put in jeopardy by his alcoholism. Dave attempts to rectify this by researching foods that might help him stop drinking and, in consequence, help stabilise his mental health:

> …through erm having a good diet and having erm good nutrition you can help yourself have erm good mental health, so I've kind of looked into that and […] I think with having a good immune system, having vitamins really does help you feel better erm and when you're not worrying about those things it's just something less off your mind to worry about erm and I know it just sort of seems that you really are what you eat in some ways. Like what you're taking into yourself really does kind of predict what you're going to bring out…

Dave spoke with ease about his mental health difficulties and how he takes prescribed medication for anxiety and Borderline Personality Disorders. In fact, the psychological **Spaces** constituted by these diagnoses appeared to be a normal state of existence for Dave. However, Dave shows **Awareness** of the limitations of the mental health system and takes some responsibility for trying to tip the **Balance** of his life towards better mental health beyond his medicalised regime, He does so through researching different foods and attempting to improve his diet and reduce the liver damage caused by alcohol abuse. He tries to achieve this despite poverty, alcoholism, and mental health difficulties:

> …I am an alcoholic and I do drink a lot, and the studies that I've read about beetroot it does contain erm an alkaline chemical called betaine which helps to rebuild damaged liver cells…

Trying to eat well on top of taking medication means Dave attempts, as much as he can, to improve his mental and physical health **Space**.

Dave is also on a **Journey** of self-understanding to achieve a better mental health **Balance**. Although he spoke with ease about his diagnoses, these labels are not helping him with this self-understanding, and he believed they were primarily to help health professionals feel that they had something to offer:

> …health professionals want to put you in a category so they can give you a drug essentially that they cannot make you better but make themselves feel like they've done something…

On the other hand, Dave has an **Awareness** of the benefits of his medication despite reservations about the effectiveness of the labels associated with them. Specifically, he appreciated that the drugs were helping him on his **Journey** if he took them the way they were intended:

> …it's not really magic but of not drinking and taking your meds properly because when you are taking meds but you're drinking they don't really work properly but when you- when you take your meds properly and you don't drink and you do positive things with your life lo and behold um you feel a lot better about yourself and you think a lot more positively.

However, Dave has **Awareness** that he is not in complete control of his **Balance** and it is the success of staying in **Balance** that appears to dictate the pace of his **Journey**:

> …I feel like I'm going in the right direction but it's not a, straightforward linear process it's a zigzag, kind of process.
> *Do you have some control over this process?*
> Some. Not entirely. Not entire control but I have more control than anyone else does.

Having **Awareness** that there would be setbacks on the **Journey** means Dave manages his mental health **Spaces** accordingly, thus having the best chance of keeping the **Balance** he needs to progress.

Figure 5.17

Dave's Image Symbolising the Low Point from Which he Commenced his Journey away from Danger

Dave used a photograph to introduce a low point when he made a drunken suicide attempt with co-codamol (Figure 5.17). Luckily, he recovered without needing medical attention, and he describes this event as providing him some self-understanding in terms of how far he could push himself. Recently, Dave has been using art as a safer way of understanding his mental health **Space**. He describes exploring the darkness inside him through drawing a black and white self-portrait:

> …I've always drawn things in black and white sometimes with shades of grey, but I enjoy the sort of conflict of the lines and patterns and the black and white and somehow that expresses my emotions…

Art helps Dave to move his mental health **Balance** towards a more stable state by exploring his mental health **Spaces**. He is then able to achieve a greater **Awareness** of himself and to facilitate his **Journey** by being positive.

Dave describes himself as an alcoholic, although he considers himself more moderate in this regard than many others:

> …I'm not as hard-core […] but there are some alcoholics out there who'd just be like, they wouldn't care…

Hence, he distances himself from physical and psychological **Space** occupied by those who have given up and, in contrast, suggests that he is in a **Space** in which removing alcohol from his life is a destination on his **Journey**. Alcoholic **Space** is normalised for Dave, given his description of not knowing anyone who drinks less that the recommended limits. He attempts to integrate drinking as a strategy of **Resilience** in his **Journey** towards **Balance** in that alcohol helps him to forget about his problems. However, Dave's alcoholism started in this way, and he knows alcohol is only a temporary solution. When Dave drinks, the **Balance** tips towards improved mental health: he has more confidence and less anxiety. But the following morning, the **Balance** tips the other way as the hangover brings back his problems 'tenfold'. Interestingly, what seems important to understand is that, for Dave, alcohol is a *normalising* factor in his life in that, with alcohol, he can occupy a 'normal' mental health **Space** in which he is confident and worry-free. This context offers insight into why Dave's **Journey** towards sobriety is incredibly hard.

Dave describes different aspects of his **Journey** towards sobriety. The first stage is withdrawal: a gradual movement away from alcoholism that was potentially fatal:

> …one of the things about um alcohol the withdrawal that even when you go to alcohol councillors as I have, they tell you don't come off it straightaway because it can kill you…

Dave understands that his **Journey** to sobriety must be carefully managed and he demonstrates his **Resilience** through engaging with professional help.

Dave works hard to create a safe financial **Space** in which to be an alcoholic and he describes budgeting for his alcoholic binges:

> …I stop drinking for a while to save money […] occasionally it gets to the point where I get so annoyed, I'm just like well fuck it. I'm just going to get drunk and then I get drunk and I spend too much but then I kind of have already budgeted for that…

Forward planning allows him to **Balance** his resources to re-enter the unsafe **Space** of alcoholism without leaving the financial safe **Space** he has created for himself. As described above, Dave can only spend money on travel and food therefore this financial safe **Space** ensures his ability to buy the food he needs for his health **Space**. However, he is unable to buy music, books or new clothes. His shoes are falling apart, and his clothes have holes and rips. Dave demonstrates strong **Resilience** in

the face of these deprivations and immense motivation to maintain his mental health **Balance** although he describes how, at times, he can become overwhelmed by annoyance at his poverty and seek release in a drunken binge. Dave has been suicidal in the past and feels that the occasional alcoholic binge is better solution for his anguish than the possibility of making another attempt to end his life. Hence, although it appears that Dave's **Balance** can tip towards very unhealthy behaviour, it is a managed risk in the context of intense and chronic frustration.

Poverty means tatty clothes and Dave explained the effect his appearance had on others when he went shopping:

> …I tentatively walk into a Marks & Spencer's if it's the nearest one around and get followed around by the security guard…

Figure 5.18

Dave's Image of Welcoming Spaces Where he Feels he is Treated with Respect and Like a Citizen

This kind of harassment contributes to the annoyance Dave experiences due to his poverty, but he can **Balance** this with visits to more welcoming public **Spaces**, including art galleries and libraries as you can see in Figure: 5.18:

> …it's a public space where anyone can enter and I think it does help the self-esteem and mental health of anyone who is suffering from a mental health problem to be able to go into a building where you don't have to pay to go in where you don't have to be anyone of any particular class or any standing to go in […] it's sometimes under- undervalued because you look at people who have certain problems with their mental health and it's like well they need Lithium or they need tranquilisers or they need this kind of therapy or that, maybe they just need to be treated with respect and allowed to look at culture and feel like a citizen, and then interact with art and society and I think that really does help and I think I'd feel a lot worse if I didn't have those things…

Interestingly, Dave talks about himself in the third person in this extract, possibly, in context, to underscore his identification with a group of people like himself who rely on free and welcoming community **Spaces**. The effect of these **Spaces** on his mental health is enormous. It enables him to reconnect with society and feel like a 'citizen'. These **External Resources** help provide Dave with the **Resilience** he needs to counter his experience of negativity when he feels excluded from society.

Friends are also important and provide Dave with a connection to others through being welcomed into a social **Space**. Within this safe **Space** his friends are allowed to constructively criticise him and remind him of hope for the future:

> …they appreciate you for who you are and when you forget who you are and you forget the good things about yourself and you forget, the hope that you had about where you were going they remind you of that and when they they tell you about things that you're doing wrong, […] they're allowed to tell you […] you accept it and you learn from it and move on.

Friends are an **External Resource** which supports Dave's **Resilience** and mental health **Balance** for his **Journey** towards sobriety: support Dave feels is denied him by his family:

> …friends are indispensable really, […] my real family really is in my friends.

On the other hand, although Dave describes having an uncomfortable relationship with his mum, she is also an important **External Resource** in provided him a safe **Space** in which to live:

> …it's better than being homeless which some people are homeless who are struggling with similar issues, so I appreciate what I have.

He is now building a set of **Resources** to allow him to continue the **Journey** unaided and has developed some **Resilience** strategies of his own to prevent his **Balance** tipping into areas of unsafe behaviour:

> …when I feel something bad like I don't necessarily have to go out and smash up a car…

One important strategy is exercise and, when he has a desire for alcohol, he knows a brisk walk can lift his mood and alleviate some of his pain:

> …I do just do feel that when you push yourself you get that endorphins rush and it is like an antidepressant It is it kills pain and it does lift your mood a lot…

Dave attempts to eat well and has strong feelings about the small amount and poor quality of food he can purchase. He experiences making a 'sacrifice' in order to buy even the essentials to survive. A skill he has learned, and demonstrating his **Resilience**, Dave talked about knowing when to 'hunt' in the reduced section to get the best bargains. Even though, he often fails to achieve a **Balance** of quality food in his diet due to lack of money and says that when he opens the cupboard and can only see condiments, he feels disheartened. However, he takes some responsibility explaining that:

> …sometimes it's my fault because I drunk too much and I didn't get a job […] Am I just drinking because there are no jobs for people like me? I don't know […] I just feel shit I don't really think about it and I sometimes sort of think well I'm going to get paid in x number of days, so I'll be alright until then…

Figure 5.19

Dave's Image of Feeling like he is Only Worth Value

When his finances mean he only purchases budget food in supermarkets, captured in Figure: 5.19. Thus, he feels that he is only worth 'value'. This deprivation negatively affects Dave's well-being, but he tries to maintain his **Resilience** through comparing himself to people who may be worse off than himself:

> …I live in quite a deprived area and you're surrounded by people who are in the same boat as you and then they've got kids to feed as well so you don't complain…

Even so, his struggle to have a decent diet could destabilise his mental health **Balance** and occasionally tip him into an alcoholic binge which sets him back on his **Journey** to rid himself of alcohol.

An important **External Resource** in Dave's **Journey** towards sobriety, is his religious conversion to Buddhism:

> …I still have a long way to go because of the addiction that I have. The thing about- the thing about alcoholism and Buddhism that I've been reading up on it's like one of the worst things that you can do because it's clinging to a substance that is really bad for you and makes you behave very improperly and um and makes you think that you need it and if you die an alcoholic you die a very painful death as everyone knows training to be a Buddhist you know and any doctors will tell you but you die clinging to something that is in this world and from an Eastern point of view when you die you need to be free of the body. You need to be free of the desires you need to be able to pass on from that and so I really don't want to die like that um and I really don't want to inflict that upon my friends either [*OK*] and people that I know so I'm I'm working towards giving it up…

Dave's new perspective on life has contributed to his use of more constructive ways of staying in a safe mental **Space** and, hence, periods of sobriety through spending more time with friends and increased exercise. Dave feels that these changes are positively affecting his health and well-being and believes he is headed in the right direction and is no longer suicidal. Moreover, he has an **Awareness** that it is when he is drunk that he loses his focus on the future and the positive goals he wishes to pursue on his **Journey**:

> …you lose control you lose focus. You lose focus of why you decided to not do this anymore…

He also has an **Awareness** that his access to psychiatric and psychological help is limited and that the responsibility for maintain his positive **Journey** is his own. The important thing is that he can see progress and continues making steps in the right direction:

> …I am sort of making steps toward […] alcoholics need to do and what addicts need to do. It's like you can't just stop and say I'm never going to drink again or I'm never going to shoot up ever again because you probably will but it's you need to it's usually progress and a few steps forwards and one or two steps back and then a few steps forwards again and it takes time and I sort of feel like I'm getting there but it's taking a little while…

He has an **Awareness** that it will take time and he has a long way to go but the positive experiences of sobriety are reinforcing his desire to give up alcohol and lead a more fulfilling life.

Dave has commenced the **Journey** towards sobriety. His **Resilience** and intelligent use of the **External Resources** available to him allow him to make progress albeit sporadically. He can keep himself well on a low income by **Balancing** different aspects of his health and well-being at different times. The next pen portrait features Alan, an ex-alcoholic. Alan has just started his first full time job since becoming sober three years ago. Alan does not want to waste any more of his **Time** and wants to spend as much of it as he can with his daughter:

5.1.3.2 Alan: Phenomenological Pen Portrait

Alan is 50 and lives alone in a rented flat. Alan is an ex-alcoholic who had recently started his first job in 7 years. Alan's journey has been a long one since he decided to stop drinking, re-join society, and live a life others might consider 'normal'. His journey is still in progress at the time of the interview. Seven themes are central to understanding the phenomenological world in which Alan lives with regard to the ways he attempts to manage his health and well-being: **Balance**, **Journey**, **Space**, **Time**, **Resilience**, **External Resources** and **Awareness**. These are intertwined throughout his narrative but also stand alone as different aspects of his lifeworld. The key for Alan is to keep his life in **Balance** to allow him to continue the **Journey** away from alcoholism and towards improving his health and well-being. His new perspective post-alcoholism means **Time** is very important to him and he attempts to make effective use of every second. Alan has many physical and mental Spaces that exert pressure on his **Journey** towards health and well-being **Balance**. The tools Alan uses to maintain his **Balance** are: **Resilience**, **External Resources** and **Awareness**.

As a recovering alcoholic on low income, the **Balance** Alan seeks is a sense of 'normality' which, for him, means a **Space** where nothing goes wrong. Through the process of recovery, he gained an **Awareness** that his addiction led to his life being chaotic. However, since his decision to stop drinking, the **Balance** has tipped the other way and he has gained more control:

> …addiction equals chaos […] as soon as you put the drink down erm nothing goes wrong and everything goes right […] simple equation is addiction equals chaos. You beat the addiction you don't have any chaos 'cause you're in control…

The route into alcoholism was an easy one for Alan. Living in a pub and having plenty of money meant his **Balance** was tipped down the 'slippery slope' towards risky behaviour. Alan said the bottom of the slope was when he was homeless and sleeping in an alley. However, he still had the **Resilience** and **Awareness** to understand he was about to lose the most important things in his life and that he must do something about it:

> …lost my dignity self-respect lost everything and I was starting to lose my daughter and I thought ah you really need to wake up here…

His daughter was the **Resource** he needed to start tipping the **Balance** away from behaviour that was likely to kill him:

> … if I die, I die it doesn't matter you know what I mean. It wont a problem 'cause the drink were more important than living you know. That's addiction […] you get absolutely smashed out of your head for three days yeah sometimes two days right and then you stay indoors for twelve days shaking and shivering and you can't eat…

Alan tried to start his **Journey** on his own but failed attempts meant he needed **External Resources** to give him the **Resilience** to continue:

> … it's such a long hill to climb so one day down…

Alan's **Journey** from homeless alcoholic to having a full-time job, renting a flat and owning a car has been long and difficult. The skills he learnt in rehabilitation supplied the **External Resources** to get him started on his long **Journey** and the **Balance** he has needed to continue his **Journey** has come from his building **Resilience** over time:

> …they teach you you don't pat yourself on you back enough because erm it's your journey…

These **External Resources** Alan gained in rehab were life skills to beat addiction and to view the world differently:

> … my euphoria now is I've changed that in my brain to normality. When things are running smooth that's my high…

Nearly three years after his last drink, Alan continues to take medication for his addiction and occasionally struggles to resist alcohol. In particular, he uses the skills gained in rehab to build up **Resilience** to reset his **Balance** when under stress:

> …it's still a bit of a fight. It's just management now […] if I see continually a lot of adverts on TV where they are drinking wine or beer I just have to (pause) ((breaths out)) just go and re-programme in a dark room […] they give you load of tools right so just do some scales. It's like err a pint of lager err gorgeous apartment new car nice girlfriend beautiful daughter. You've spend ten grand on your house or a pint of lager and lager just gets thrown out not worth it…

On the **Journey** to beat alcohol addiction, Alan used smoking as a 'crutch' to **Balance** one addiction with another. However, he found smoking became a bigger problem once he has started to beat alcohol:

> …so then started smoking like a lunatic and I think smoking is a lot worse for you than drinking…

Even so, Alan has come a very long way. On the day he stopped drinking, he made a plan for his **Journey**: to get a job, a car, his own place furnished how he wanted and a decent holiday. To date, he has achieved all except his holiday on this remarkable **Journey** from being a homeless alcoholic. However, he continues to seek to make improvements:

> …I've beat erm alcohol abuse. I've beat smoking err. I've got a really good diet. I were homeless 4 years ago so got a job now and everything is- my life is just improved so much over the last three years that my only thing that I would like to erm seriously improve is my mobility…

Alan's mobility has been affected playing football in his youth and he can only walk with the help of two sticks. This affected his mental health **Space** when he could not teach his daughter to play football when she was younger:

> …it disturbed me mentally when err about ((pause)) about six or seven years ago […] when my little girl was just starting to play football and stuff like that erm and I just couldn't really do any sport with her to teach her [right] and that was mentally ((pause)) ((breaths out)) hard…

Operations on his knees have repaired some of the damage and Alan completes a programme of exercises three times a day on his **Journey** to full mobility, with a self-set target of being able to run a 10k race. Hence, Alan shows **Resilience** in his determination to improve his life further:

> …so, we are trying to, get it right by err physio. So yeah so that's my erm conquest for the next twelve months. I've done everything else you know err my life's really fantastically in order and erm and that's my last challenge…

Figure 5.20

Alan's Image Depicting Eating Well to Keep Physical Health in Balance

Despite being an alcoholic, Alan retained **Awareness** of his physical health and kept it in **Balance** by eating well (Figure: 5.20):

> …I were still getting fruit and veg, erm and meat, all the time, […] but I eat really well without hardly spending any money making it and then all the rest of the money gets spent on alcohol…

This **Awareness** meant Alan kept his liver function within a normal range when fellow alcoholics did not fare as well. To progress on his **Journey** away from alcoholism, Alan continues to eat well on a budget and described food on a typical day with lots of fruit to keep his physical health in **Balance**:

> … I eat so much fruit and veg and drink err gallons of water and erm I just think err I'm never poorly and so that keeps me- keeps me healthy…

Awareness of the benefits of a good diet comes from a belief in modern medicine and that prevention is better than cure. Alan says he also looks to the personal research and doctors' advice to help him on the **Journey** to a good physical health **Space**:

> …when I've spoke to different doctors erm they've sort of said to me erm don't stop your diet if you keep on your diet erm I think you've given yourself a good chance of erm not getting alcohol damage. So that's why I've sort of kept on that road really. Doctors' advice…

Figure 5.21

Alan's Image: Work Space Important for Well-being Balance (Redacted Image)

Alan introduced the photograph in Figure: 5.21 to highlight one of the milestones on his **Journey**, returning to a full-time job for the first time in six years. The importance of his work **Space** is more than financial as it means so much for his mental well-being **Balance**:

> …this company is very good at treating you with erm dignity and self-respect and erm they appreciate all the- all the staff and err that just does so much for your self-esteem…

Alans greatest **Awareness** gained through alcoholism is how much **Time** he has wasted. Life now is about redressing this **Balance** by not wasting his **Time** and in better valuing other people's **Time**:

> …the most important thing in life- what you can't buy erm and the most value is time. You can't buy anybody's time and you can't get time back that you've missed you know what I mean erm. So that's priceless. So, if someone gives me their time that's priceless…

Alan's **Journey** away from alcoholism to his adjusted form of normality includes working full time. The change in circumstances has altered his **Awareness** of **Time** and of its value:

> I've got aims and goals that I'm aiming at but it it also makes, me, not, waste, my quality leisure time, yeah [yeah] I- I'm here to erm I work to live. I don't live to work […] now I'm doing err working full time so when I had all the time in the world you get bored and you don't appreciate your time so now when I'm working full time then when I do have some time off I make the best of it…

The possibility of losing his daughter was the tipping point to start on the **Journey** to recovery. This is linked to Alan's **Awareness** that, as his daughter gets older, she will probably want to spend less **Time** with him so values it more:

> …there is times where the alcohol has made me very selfish when I I could've probably spent more time with her […] she's gonna be off soon, you know […] yeah, the time with her I really appreciate…

Figure 5.22

Alan's Image of Awareness to Reward Himself for Continuing his Journey (Redacted Image)

Time is also important to Alan in other areas of his life. **Balancing** his low income with his desire to use his **Time** fruitfully, he uses his **Resilience** to save money to do something he will remember rather than to treat himself more often but in trivial ways. He has the **Awareness** that he needs to reward himself for continuing his **Journey** in a way that makes him feel special (Figure: 5.22):

> …that's at (name) races and erm my quality leisure time and I'd thought I'd spoil her and a bit of a present to me […] just a nice day out to get dressed well err get dressed up…

Alan also gave an example of making the most of his **Time** when, on the same day, he went swimming in a river in the country before work and then after work to the same spot for a barbeque with his girlfriend:

> …it were like we were on our holidays but this work thing got in the way a little bit erm so that day yeah felt like I'd had like two massive days off…

Hence, Alan is now in a psychological **Space** in which he can achieve a **Balance** in his life, both working and experiencing pleasurable leisure activities, by making the most of his **Time**.

His experience of homelessness appears to have a big impact on Alan's perception and **Awareness** of his living **Space.** The bad times of sleeping in an alleyway or in hostels are now **Balanced** by the good times of having a safe **Space** he has created himself through saving his money. Indeed, he showed great **Resilience** to save hard on a low income to have a home that gives him pleasure:

> …that is mine and erm you've got that err because you have stopped drinking […] that's mine because I saved and saved and saved and saved and saved […] I sit in my home sometimes and think yeah you created all this [mmm] You made all this. So that gives me a lot of satisfaction…

Balancing the public **Spaces** he endured as a homeless alcoholic, Alan has developed an **Awareness** of his need for privacy. Pertinently, the interview with Alan took place in a meeting room at his work, and not at his home. He explained:

> …once the door's locked that's my sanctuary […] no one's allowed in my house at all unless by appointment if anyone comes to my door […] when me door's locked again I like me own peace…

Peace was a recurring theme for Alan. The turmoil of homelessness in the city created the need to **Balance** this with peaceful country **Spaces.** His enduring mobility issues and former alcoholism means his car has immense value in allowing him to reach otherwise inaccessible **Spaces** that bring him peace:

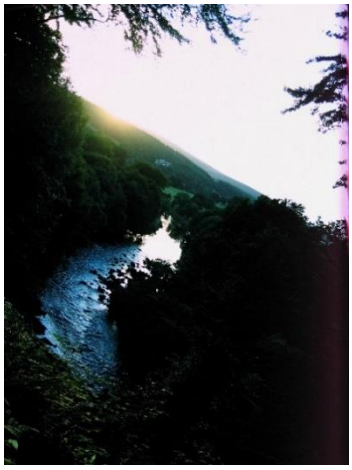
> … it's a normal thing in life driving but erm yeah where a lot of people will erm, I don't really take it for granted […] car erm convenience pleasure lot of mental well-being because it's just like erm yeah I couldn't do half the things err I do as in socially in my own personal social life.

Hence, Alan's city centre living and working **Spaces** are **Balanced** with the freedom and mental relaxation of peaceful country **Spaces**. The additional benefit is that there is no cost involved beyond the fuel for his journey:

> …I want some water and err peace and I'm on a beach in (northern town) at quarter to seven […] my release and total change of environment which makes me feel comfortable mentally is erm I again maybe being tight but err I go back to nature because it's free…

Figure 5.23

Alan's Image of his Peace Space Bringing Mental Balance



These peaceful, and free, **External Resources** help Alan maintain his **Resilience** and he describes one **Space** on which he can rely when he needs to **Balance** himself mentally (Figure: 5.23):

> that to me is my- one of my nicest spots in world […] it's just total total peace and if I ever sit there I can I can be in the foulest mood in the world and once I've I see that view ((out breath)) it all dissolves […] That's my little peace place…

Alan is also beginning to develop an **External Resource** in spirituality, describing how he found some peace and **Balance** by praying in an old abbey:

> … I feel like the big fella upstairs has cleaned me and I feel a bit cleansed…

Alan's alcoholism plunged him into homelessness and poverty. The thought of losing contact with his daughter was the trigger for him to start on the **Journey** to recovery. He now has a full-time job, and as he is careful with money and Time, his own flat and a car despite being on minimum wage.

Post alcoholism, Alan strives to live as normal life as possible. He has **Awareness** that he wasted a lot of **Time** as an alcoholic and is making sure he makes the best use of every second. He keeps his life as **Balanced** as he can and regularly rewards himself for staying sober. Like Alan, Liam in the next pen portrait, is an ex addict. Liam became a drug addict during the 1990s rave scene, he is now clean and is making sure he stays that way by moving away from the risky places and people that influenced him in the past. He also has recently started a full time job as a recent graduate and is looking to expand his horizons as much as possible.

5.1.3.3 Liam: Phenomenological Pen Portrait

Liam is 38 and lives in a council housing flat in a market town. He has recently moved away from a rundown council estate in a big city to, what he hopes will be, a better life. Liam became a drug addict during his participation in the rave scene in the early 90s and has since conquered his addiction. He is trying hard to create the best life he can for himself, not just through personal development but through improving his environment and removing negative influences from his life.

The key for Liam is the **Journey** he is on from the life he led as a drug addict to the life he leads without drugs. The **Journey** continues as he leaves behind all the negative influences in his life in order to create a better **Balance** in which to further his personal development and achieve the goals he has set for himself. Seven themes are central to understanding the phenomenological world in which Liam lives with regard to the ways in which he attempts to manage his health and well-being: **Journey**, **Awareness**, **Balance**, **Space**, **Time, Resilience** and **External Resources**. These are intertwined throughout his narrative but also stand alone as different aspects of his lifeworld.

As a teenager, Liam took an active part in the rave scene of the early 1990s. He took drugs to be like others and to enhance his enjoyment, but he tipped his **Balance** too far and became addicted:

> I used to take drugs I used to take a lot of drugs erm I took them for- took 'em for a long time and I don't I just don't wish to take any of them anymore…

Figure 5.24

Liam's Image Representing Finding the Resilience to Complete the Journey away from Drug Addiction

The **Awareness** that he wanted to start on the **Journey** to a better life led him to engage seriously in rehabilitation. This was hard to begin with but Liam had the **Resilience** to see the process through to the end (Figure: 5.24). However, Liam was surprised to leave rehab feeling little different than before apart from understanding that he was more mature and able to lead a more **Balanced** life than previously:

> …when I went into treatment for my for my drugs taking right I thought it was going to change change me whole round me whole life around […] it was it were hard work at first but I just persevered […] I don't see any real difference to to me now as to what I was when I was taking drugs but I just you know I'm I'm just I'm just more mature in head…

This new maturity and **Awareness** indicates that Liam wants to continue to make improvements with regard to the worst aspects of his life and keep hold of the best. For example, he started smoking to look cool in front of girls and now has the **Awareness** that it is damaging his health. He is building on

the **Resilience** he developed during his recovery from drug addiction and the **External Resource** of others' success to drive him towards conquering his smoking addiction too:

> I'm smoking you know erm but it's bad it's just like erm same old same old in it it's a form of addiction in it being addicted to nicotine it's just so easy just to go buy ten cigs […] if other people can do it I can do it…

Liam's **Journey** to improvement does not mean he will give up all the things he enjoys in life. He will keep a **Balance** of those things that give him the most pleasure even if they are not good for him:

> …I'm like constantly trying to improve myself and that you know like even my eating and and and the smoking and things an- even my drinking and that you know I still like- I like going out on a Saturday I think I'll always do that you know I don't see any problem with that whatsoever you know I'm never going to be a puritan…

Liam's **Awareness** of his **Balance** of strengths and limitations is allowing him to develop as a person and move away from the risky behaviours and situations that caused problems in the past:

> I think I'm growing up a bit now […] I'm appreciating and finding out other things now about myself that I like that I like doing.

His increased ability for self-reflection since conquering his drug addiction gives Liam greater **Awareness** of himself and helps him to develop a better **Balance** of mental health and improves his well-being:

> I think is once you start taking things really serious then that's dangerous for for for like likes of me […] it might come across as a bit of anxiety in some you know which so err which it's took me a while to learn how to do that you know but you know I'm I'm more chilled out person but with a better out- better outlook on life and focus…

Liam is then able to able to move forward on his **Journey** of self-development without upsetting his **Balance** of health and well-being:

> …trying to always constantly trying to improve myself but without obsessing over it an- and seeing through seeing things that's that's like my overall general good mental and physical.

This **Journey** of self-development includes completing the education he missed out on in his youth. This has also allowed him to move on from his dangerous job as a roofer into a job with a charity helping vulnerable adults stay away from crime.

> … I didn't think I were gonna fail I was always determined to pass the degree […] was roofing which was bad for my health with still saws and carrying tiles etc. […] I've just got this job and it's it's quite it's it's a decent job an- all it's a responsible job…

Hence, Liam's self-development and increasing **Awareness** of who he is and who he wants to be, is helping him to move away from risky **Spaces**, such as working as a roofer, but also his drug **Space** that caused him so many problems in the past:

> …do things that (pause) that are enjoyable and away from like trouble and this this past stigma of erm you know of of the past…

Liam has the **Awareness** to understand that he does not always have the **Resilience** to resist the temptations of some of his old friends when he is with them so, to move on, he has to put physical distance between himself and the risky **Space** they occupy:

> …there's no point hanging around with lads who were just gonna get you back into trouble you know you've just got to be ab- you've got to be selfish with them you've got to leave them leave them behind […] the only thing they understand is like is is violence and that you know so you've just got to- if they're if they're dead in head right you've just got to leave them haven't you well I think I I'm gonna choose to do it anyway…

Liam also has the **Awareness** to understand he needs a **Balance** in his working life. He wants to work but knows he does not have the **Resilience** to deal with a lot of pressure:

> …trying to slow down with mine. I am I definitely I'd- I mean I want to work. I'll always want to work but I don't want to be in this like big erm how can I say it this big fake erm rat race thing…

To help Liam slow down and get a better **Balance** in his life, he moved from a council flat in an inner city suburb to a flat in a nearby market town. He feels that the inner city environment is poor for his mental health particularly because of the ubiquitous presence of alcohol:

> …buy a paper and you're there like there's just like bottles of vodka and vodka and vodka staring at you and that I've noticed a lot now right drinking like problematic drinking…

He chose this market town **Space** to slow down as it has good childhood memories for him. The positive effects of his recent move are already improving his well-being:

> …like I used to come here erm with my Nanna and Grandad when I were when I were about seven year old and I've <u>always</u> always enjoyed it an- that an- I've just been luckily lucky been fortunate enough I've just been given a flat here and all so that's definitely erm (pause) good for my health good for the way I think […] I feel lucky now that I can can live out here an- an- be myself and be chilled out…

Figure 5.25

Liam's Image of a Space that Helps Liam to Feel Optimistic and Think Clearly

When he travels to a local beauty spot and encounters the wide open **Space** in the valley that runs through the town the effect on his well-being is enormous (Figure: 5.25):

> …I appreciate like erm like like being alive and that you know and just like feel like op- optimistic and think clearly when I when I look at that…

Liam has in the past travelled all over the city but this has had variable effects on his health and well-being. The positive **Balance** came from being on the move and keeping busy; the negative from rarely eating home-cooked food:

> …I were always liked travelling about you know. I don't know I've always kept busy kept busy in like a positive sort of like way but erm the negative side to that is the things I eat…

He has friends who are an **External Resource** who enable him to explore new **Spaces** safely and feed his travel bug in creative ways:

> …he sorted it so we just flew to Munich stayed there and hired this car and driving round Alps and that and we ended up in Salzburg for New Year's Eve […] years ago I thought well I'll never go to the Alps…

Although travel can be very positive for Liam, he has the **Awareness** that he cannot sit still for long periods. This could interfere with his ability to complete his degree on his **Journey** to a better life, so Liam turned to a pastime he enjoyed as a child – cycling – to help **Balance** these needs. The bike helps create **Spaces** for adventure and exploration, and provides him with exercise:

> …what did I like doing when I was a kid an- and that were like the thing that sprang to my mind that was cycling […] it's more like a way of relaxing sort of you know but like like I say like erm (pause) I don't I don't like sitting about for too much for too long doing in in any aspects of my life […] it's a way it's a way of getting you can way of adventuring…

Although Liam has made many recent changes to his life on his **Journey** to improve his well-being, a couple of areas, although in **Balance,** still particularly concerns him: his smoking and his diet:

> I mean I play football go cycling and I err I've got a good appetite erm I'm always hungry you know […] I do do a lot of exercise I do a lot of cycling a lot of jogging a lot of football but it's the smoking an- an- an- the food that I eat that's…

While he remains active, he has **Awareness** that he may eat too many fried breakfasts because the alternatives are not palatable:

> …that's my favourite meal and I like 'em an- I eat too many of them though it's definitely erm something that I associate with with bad health you know I can't eat them forever you know […] if I ate a bowl of cornflakes before I went to work or even when I got to work I I reckon I'd still be hungry…

Liam also justifies his poor diet through being too busy and that his **Time** is not in **Balance**. He does get a great deal of satisfaction from his new life but has **Awareness** that it is his preference for some less healthy foods that is the issue, rather than his inability to prepare healthy food:

> …all of us lives have got a bit more busier that we've been eating less healthy because we haven't got enough time it's the <u>time</u> that you need to do it not the choice of of, eating healthy or eating unhealthy…

Liam became a drug addict during the rave scene in the early nineties and is now clean. He is now focusing on changing other aspects of his life to improve his health and well-being. He has physically moved from a run-down inner city suburb to be away from people and places that were causing him distress. He has recently completed a psychology degree and is working with others who are at risk of being drawn into crime. Liam is intending to make further improvements to his life without losing touch with his core identity.

Liam acknowledged he had a problem with drugs and received medical treatment to help him conquer his addiction. His **Journey** away from risk has involved a new place to live with new friends while retaining positive influences such as music, football and his dependable friends. Simon, the next pen portrait has a different type of addiction. He has **Awareness** he has a problem with his addiction to buying vinyl records and the effect it is having on his health and well-being. However, he does not have the **Resilience** to take positive steps to amending his behaviour.

5.1.3.4 Simon: Phenomenological Pen Portrait

Simon is 33 and lives alone in a privately rented flat in the city centre. Simon's life revolves around music, which absorbs all his time and money as he is obsessed with vinyl records. He has an unhealthy lifestyle, again dictated by his obsession with vinyl and, although he says that he wishes he could change, is not making an attempt to do so. Six themes are central to understanding the phenomenological world in which Simon lives with regard to the ways in which he attempts to manage his health and well-being: **Balance, Space**, **Time**, **Resilience**, **External Resources**, and **Awareness**. These are intertwined throughout his narrative but also stand alone as different aspects of his lifeworld.

The key issues for Simon are his obsession with vinyl and the work he must do to afford it. These vinyl and work **Spaces** are intertwined as Simon needs money to fuel his obsession. The **Space** in his life taken up by his three part-time jobs tips his health and well-being out of **Balance** and, although Simon has **Awareness** of this **imBalance**, he appears unable to alter his lifestyle to rectify the problem. Moreover, despite Simon's **Awareness** that he is out of **Balance**, he has few **External Resources** on which to call and little **Resilience** to manage his obsession and improve his well-being. Simon rents a city centre flat to be close to these jobs which, itself, is expensive:

> …I wish I had sort of more time to do other things […] I like all my jobs but they don't pay very well so it's all sort of mixed together to to try and pay for the flat that is quite close […] my own fault you know I don't have to work as much as I work erm, I just need to stop myself spending money…

Vinyl pushed Simon's well-being **Balance** in both a positive and negative direction. While the 'spinning disc' controls his life, Simon's three jobs are all in the music industry and these work **Spaces** fulfil some of Simon's need. He had previously worked for a bank and the levels of responsibility and long hours were tipping his **Balance** towards unhappiness. He therefore took a pay cut to work in record shops part-time to secure a happier work **Space**:

> …all my jobs are music related and you know that is something that gives me joy […] I spend a lot of time at these places there's no point doing it if you don't want to be there…

The people in Simon's working **Spaces** also support his positive well-being. The staff are like 'close knit families' and being the expert means he can generate a connection with customers that means a lot to him:

> … it puts a smile on your face just having that sort of connection […] at the moment I enjoy it and I think that's half the battle really work wise…

However, the downside of his working **Balance** is night employment at a music venue. He needs this job to fund his vinyl obsession but the long hours and negative effect on his social life exerts a toll on his health and well-being:

> …I don't get out there until normally about four possibly working the next day at (name of shop) as well, erm it's just, it's not soul destroying […] it's not quite the family it used to be…

Simon has also found a novel way of tipping well-being **Balance** toward the positive by working at European music festivals while on holiday from his jobs. And, despite never taking a break from working **Spaces**, Simon manages to have a kind of 'alternative' European holiday:

> … it means I get to go to a festival for free better still I get paid to go […] it's brilliant it means that finally I get to go away get away from all my jobs…

Simon's vinyl obsession takes up most of his spare **Time** and appears to provide him both positives and negatives. The positive comes from the acquisition of the vinyl, ensuring that his spare **Time** is satisfying:

> … there's a sense of achievement isn't there with you know hunting down a certain record […] or when you do find it for a cheap price […] you know you feel brilliant […] it's nice to have something to focus on […]some people would say my savings account is my records there is a few thousand worth of records there…

However, Simon appears not to have the **Resilience** to resist the temptation of over-doing his obsession and lacks control over adding to his vinyl collection. He feels under pressure to buy and sell his vinyl and this is negatively affecting his well-being:

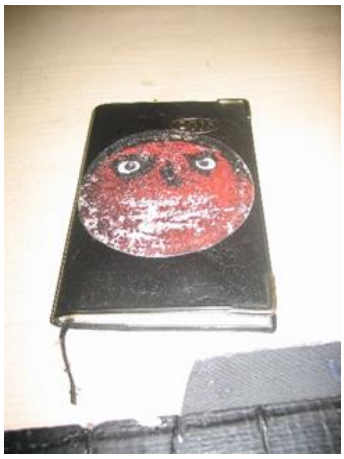
> …the spinning disc is controlling my life very much and sometimes it makes me sad […] it is getting a bit out of hand […] that's why I get a bit down with how much I have sometimes because you don't have time to listen to any of it…

Moreover, his health and social **Spaces** are negatively impacted through having insufficient **Time** for decent food, friends, and other plans that remain unfulfilled due to lack of money:

> …if I prioritised <u>less</u> on (pause) records and DVDs and bluerays and things like that then I'd have more food in the cupboard […] I despise McDonalds but I honestly eat there at least two or three times a week […] I keep making these plans and then money sort of I I'm not a saver…

Figure 5.26

Simon's Image the External Resource of his Diary to Make Sense of his Chaotic Life



Simon has **Awareness** of his vulnerability to stress and uses his **Resilience** and **External Resources** to try and manage this. For example, Simon's diary is his main **External Resource** and he uses this to plan his life sufficiently so that he does not need to worry (Figure: 5.26):

> …I fall apart without that book […] it's almost erm not a crutch but that controls me more that I control it…

Although Simon's diary helps **Balance** his well-being through removing some unnecessary stress from his life, he still struggles to schedule a social life:

> …anyway it is a bit of a shame that I do need to rely on something like that […] I even get to the stage where it's just going out for a pint with someone you know I have to book it in a few weeks in advance rather than just it's a lovely day Thursday let's let's ring someone up…

The rigidity of Simon's life and long working hours are negatively affecting the **Balance** of social **Spaces** and means he is unable to see his friends as often as he would like:

> … wish I could make, didn't have to make as much of an effort to stay in touch, but it's how it goes you know, too many jobs.

However, when Simon does meet his friends, the effect on his well-being is enormous and his **Balance** tips back toward positive well-being:

> …something outside of work I mean you know generally a positive you know mental health it just it makes (pause) gets you thinking about other things and (pause) gets you out doing other stuff […] I've got a few friends that will always sort of try and get me out of my comfort shell and do something a bit different […] it can only be a positive you know that having these people around you keeping you, sane.

It is unfortunate that the important **External Resource** of meeting with friends is an infrequent event due to his busy work schedule and inability to be flexible with his **Time**.

Simon has chosen not to follow a traditional career path with a bank and thus finds himself in unskilled low paid jobs. Coupled with his expensive vinyl obsession, he finds himself in poverty. He enjoys his work and the 'family' he works with but does not have much free time for his friends. However, when he does, he finds the experience beneficial to his well-being.

Simon's addiction to vinyl controls his life and negatively affects his health and well-being. He has **Awareness** that he has a problem and finds ways to experience the positive aspects of his life. Like

Simon, Colin in the next portrait, also has three part time jobs. Colin uses the money to pay for **External Resources** that allow him to enjoy time with his teenage daughter who lives with Colin's ex-partner. Colin spend the majority of his spare income on these **External Resources** and has recently gained Awareness he was getting into a rut. He is now treating himself to nights out to counter the drudgery of his life.

5.1.3.5 Colin: Phenomenological Pen Portrait

Colin is 50 and lives alone in a privately owned terraced house in a rundown inner city suburb of Leeds. Colin has one teenage daughter and has been separated from her mother for many years. To afford the essentials he needs to ensure enough time with his daughter, Colin has three part time jobs. Colin is unskilled and low-paid so works long hours and has recently realised his work routine leaves little time for pleasure so is taking steps to alter this. Five themes are central to understanding the phenomenological world in which Colin lives with regard to the ways in which he attempts to manage his health and well-being: **Time**, **Balance**, **Awareness**, **External Resources** and **Space**. These are intertwined throughout his narrative but also stand alone as different aspects of his lifeworld.

The key issues for Colin are wanting to spend quality **Time** with his daughter as she grows up and to create a better **Balance** in his life where he can take **Time** to enjoy himself. He is doing this by using his **Awareness** to understand the 'drudgery' of his life, improving his living **Space** and using the **External Resources** his friends provide to get himself out of his 'rut.

Colin has a high level of political **Awareness** and political ideals which are corrupted and tipped out of **Balance** by the need to earn money in order to live.

> I've got I've still got ideals but I, a lot of them are compromised because, I'd I haven't found a way of, being in a financially orientated world of, keeping my ideals better because you have to have money, to to survive I might be might be quite minimalistic and might be quite happy surviving off the small amount of money that I've got […] money's a necessity but an an evil sort of an evil necessity a lot of the time because it's just erm it corrupts people and things…

He has the **Awareness** that he would be very happy living on no money at all if possible but understands he cannot do that because of the responsibility he has for his daughter. Colin also has the **Awareness** to appreciate the pleasure and increase in well-being gained from simple things in life and how this **Balances** his simple existence.

> …it it's appreciation of, there's lots of, simple natural things that erm, are good […] like a piece like a piece of fruit or som- it just, it's just something nice it hits the spot that's all you need sometimes […] biscuit and the yoghurt or whatever it is is erm supposed to be a treat [ok] or it's supposed err right, it's an indulgence […] my erm, environment and existence is quite not, I wouldn't say it's austere but it's quite Spartan I live quite minimally […] know just a chocolate biscuit or a doughnut goes ooh […] it's it might sound really stupid but it's kind of a pampering…

His political and self-**Awareness** allows him to see beyond the 'middle of the road mainstream' and to see that his existence would be **Unbalanced** if he were to want all the latest gadgets as **External Resources**.

> …a lot of it is just material stuff and it's all very well if you have shit loads of money excuse my err but not everybody's got loads of money […] it's bad habits people get into you get it and then they get used to it…

He understands that the **External Resources** he needs to keep him **Balanced** living on a low income are simple and easy to obtain. He distances himself from potential **External Resources** that he sees as meaningless fripperies that he cannot afford and so increases his well-being **Balance.**

> …stuff that makes me happy is like like people and like going out and nice view and wh- like just beans on toast sometimes you know it's doesn't have to be erm, it doesn't have to be what media shoves down your throat…

The only items Colin classes as luxury are the essentials he needs to be able to spend **Time** with his daughter. He therefore owns a car and a television from when his daughter was younger.

> …so I've got a car, which is an expensive luxury in effect because I don't use it I only use it once or twice a week but I have to have it taxed every day of the week and insured for every day of the week […] if I didn't have (daughter's name) I probably wouldn't have a car […] well certainly when (daughter's name) was younger when she came round if I didn't have a telly that would have been a major major thing…

He is currently making his living **Space** a more comfortable **Space** in which to live. Partly to make life better for him but part of the motivation comes from the **External Resource** of his daughter.

> …if you could be really extreme about it you go so, erm you do-don't see your daughter anymore because she doesn't want to come and see you because of the state of your house…

Figure 5.27

Colin's Image Depicting Time with his Daughter as the Most Important Element in his Life (Redacted Image)

Colin's daughter appears to be the most important thing in his life (Figure 5.27). Whenever he does have **Time**, he makes sure he spends as much of it with her as possible. The relationship provides Colin with love in an equal relationship which he does not get from anywhere else.

> I know I love my daughter and I know she loves me and I do get to see her and on a daily basis because I've got other things to do when I get that and I spend a bit of time with her…

He has **Awareness** that he does not get much **Time** with her which does not feel good, so he **Balances** this by making sure that the **Time** he has with his daughter is used well.

> I appreciate the time that I spend with her more, erm but I also feel aggrieved that I only spend a bit of time with her […] So yeah I enjoy time with my daughter […] I've been making myself more aware of that and making time to do that but I might not do it as often as I should but, I'm actually doing it…

Colin's life is very busy with his three jobs and making **Time** for his daughter. To do this effectively, he needs a routine but he has **Awareness** that this is negatively affecting his well-being and he needs a **Balance**.

> I think a lot of things yeah are of sort of in a rut probably but, erm, but there's some things that I do in a routine an- you do in a routine that's because they work an-, it's getting a balance […] I'm trying to get a bit of a better balance, of, the drudgery or chaos of what has been my day-to-day life and improve it so it's not so much drudgery and chaos.

Figure 5.28

Colin's Image depicting Gigs Lifting him from Drudgery and Rebalancing his Well-being (Redacted Image)

Colin has been spending **Time** with and going to gigs with an old friend, shown in Figure 5.28. He has met more old friends in this rediscovered social **Space**. For Colin, this means reconnecting with people and events that provide him with the **External Resources** he needs to improve and **Rebalance** his well-being.

> …other people's company other people's company that you like 'cause you've got similar thing- or you're in in a bit more in tune with people that you hang out with more or or people that you used to hang out with so you've got, similar ways of looking at the world […] helps you get through life an- and but it gives you the upside of life rather than just the all the drudgery…

One of the gigs Colin enjoyed was a band he had not seen for many years and the experience was particularly good.

> …I had quite a euphoric feeling at the end of the night…

Colin has been in poverty as he has worked in unskilled jobs all his life. Although politically opposed to the concept of money as a necessity, he compromises his ideals to survive and to spend time with his daughter who lives with his ex-partner. His only luxuries are those that allow him to spend time with her as he admits to living a 'Spartan' existence. To lift himself from the drudgery of his life, he has social time at gigs where he can enjoy the music and meet up with old friends.

Colin's minimal earning potential is geared to provide time with his daughter until she moves away from home. The next pen portrait features Keith whose children are also very important to him. Keith was **Aware** that his previous living environment was injurious to his mental health and therefore dangerous for his children. He moved away to the country to save his life for the sake of his children.

5.1.4 Cluster 4: Overcoming challenges to health and well-being from mental and physical impairments

5.1.4.1 Keith: Phenomenological Pen Portrait

Keith is 52 and is a self-employed musician. He lives in a privately rented house in a small village with his wife and two children aged 16 and 11. Keith has suffered from depression for ten years and has experienced a subsequent loss of income as a result. Keith felt threatened by his neighbourhood and moving to the country to protect his children saved his life. Keith finds great joy and an otherwise inaccessible way to express himself through playing his tenor saxophone. The key for Keith is his **Journey** with depression away from a dangerous neighbourhood to a better life in the country with his family. Seven themes are central to understanding the phenomenological world in which Keith lives with regard to the ways in which he attempts to manage his health and well-being: **Journey**, **Awareness**, **Balance**, **Space**, **External Resources**, **Resilience** and **Time**. These are intertwined throughout his narrative but also stand alone as different aspects of his lifeworld.

Keith was diagnosed with depression in 2004 and lived in a part of a medium sized town that he found threatening. He grew up in a tough part of London and had been bullied when younger and was not going to let that happen again. This combination of depression and physical resistance to a **Space** he found threatening was potentially lethal to him and he did not have the **Resilience** to back down:

> I was not going to back down to anyone and I got into some very- things that could be quite dangerous just because I was sort of trying to be the big man […] no fucker you know was going to stand over me ever again and it was getting insane just the situation…

Figure 5.29

Keith's Image of a Child's Footprint: Being a Father Saved his Life

The solution was to move to a safer **Space** away from the danger he saw. This move tipped the **Balance** of his mental health away from a dangerous place and he started on the **Journey** to a more positive mental health **Space** (Figure; 5.29):

> … moving here was a way of not dying you know was a way of getting all of us out of that to a place where we could flower […] being a father has I think saved my life I think I'd be dead if I wasn't a father…

Figure 5.30

Keith's Image of *a Long Climb to the top of the House Symbolising the Climb away from Depression*

Keith is **Aware** of the appreciation he has for the **Space** in the countryside in which he now lives and the benefit this **External Resource** gives to him and his family. He symbolises the climb to the top of his house to experience the view as similar to his climb away from depression where he now experiences a better life view (Figure: 5.30):

> …it's that sense of well it was a long climb you know this is the fruit again of a long climb…

Living in a safer **Space** in the country has given Keith **Time** and space to reflect on his life and continue his **Journey** towards a more positive mental health **Balance**:

> … death has been a big part of my life and has a it's certainly an obsession […] I sort of failed to be a man […] it's taken all my life and it's sort of taken that long for me to start to push back you know to sort of say well I know I'll be me I'll just be me and I like me and I won't be afraid that doesn't make me aggressive or violent…

Keith rejects the notion that he has a mental illness. He believes that this is how he is and strives to find a **Balance** of being that allows him to function in a positive way:

> with mental illness so much of what you're dealing with is that sense of that you're wrong that you don't work and what I've learnt is I do work I just work the way I work […] it's not an illness it's just the way we are […] we need to learn is how to manage ourselves how to be ourselves to like ourselves…

Keith had the **Resilience** to persevere with his positive attitude towards his mental illness and has the **Awareness** that as a performing artist he benefits from accepting the sides of him that do not function the way they do with others:

> I think at this stage in my life you know the not giving up has become really important because I'm starting to be able to enjoy the fruits of some of my labours […] massive positive side to mental illness it's just many people can't they struggle…

However, he is **Aware** that the finding the positive side of his poor mental health has **Balanced** with the negative side of living in poverty:

> …the depression kind of coincided with a downturn or a cause it's impossible to say but my fortunes literally financial fortunes…

Keith is a professional musician and plays the tenor saxophone as part of a band in venues near where he lives. His is **Aware** that his relationship with his saxophone is of a conjunction of power, where they combine to make something greater than the sum of the parts:

> …this is my tenor saxophone it's not a tenor saxophone […] it allows me to flow through it […] It's like the lamp in which the genie lives […] when you put all of this together […] you've created is a magical beast you know a magical tool this is a magical tool […] but I don't consider myself separate from that piece of metal in being an artist…

For Keith, his saxophone is not inanimate. It is the catalytic **External Resource** that allows his inner being to express itself in public in ways otherwise inaccessible:

> …the saxophone that's like that is one of the ways I fly and my relationship with it is that of a shaman with his or her drum like this is a fucking miracle you know and it's absolutely central to my faith my existence […] so the saxophone is a way of becoming courageous sort of like I couldn't stand in a pub and say those things with words very easily I could possibly but it would be a bit strange so it facilitates this sort of absurdly open display of whatever I am […] the saxophone and going into the pub and just standing there naked…

While playing his saxophone, Keith has times where he experiences **Spaces** of altered perception that give him strength and **Resilience**:

> …shamanic journeys where you learn to take imaginative flights into areas of perception […] they are moments of great power and hugely important […] as a performer I see those places as the best you know that sort of ultimate catharsis to be born again…

Keith has **Awareness** of the world from which spring insights and connections that increase his well-being **Balance**. Years of working in a hospice with a visual artist taught him these skills:

> …this works because of this and look at that you know look [name] just done that. That's so good for him and not necessarily articulating it saying why it was beautiful saying look there look there you can see something's happening…

Keith is able to see himself in the world and increase his well-being from seeing the influences he has on his environment:

> I love the neatness […] that's the sort of fruit of my labours […] a beautiful harmony of different processes and forces which include me…

At the rear of his house was a wasteland. From this Keith has created a vegetable patch that radiates health and **Balances** and reflects the efforts expended to make it a healthy **Space**:

> …literally represents health in that they're growing so that means they're healthy and that's really satisfying […] our efforts have made them healthy…

Keith again sees himself in connection with the world and this connection brings with it an **Awareness** of power and happiness that goes beyond the health giving benefits of the food produced:

> The compost is our food waste so it's sort of all you know it's this sense of kind of a really tight web of things working together which in itself is health to me you know that sense of connectedness […] we remain in our relationship with it and that that is it's giving you know before we even eat it it's giving us something healthy it gives you happiness […] the plot is this sort of powerful vibrating engine of connection…

Eating home grown food gives Keith's family a **Balance** of health benefits that go beyond the nutritional value of the food on the plate. Keith is **Aware** of a connection from the vegetable patch to the plate that brings with it a huge increase in his sense of well-being:

> …it's healthy […] that sense of although those elements of beautiful things, healthy things, made things things interwoven will create well-being yeah so in the bowl are these roots that go back to the plot and all of those intermingled things…

Keith is **Aware** that home cooked food automatically represents health beyond the value of the food itself. The process of production is an **External Resource** that improves the **Balance** of well-being this healthier mood is infused into the food. Food everyone enjoys also brings the family together, bringing with it a social **Space** that benefits everyone:

> …part of the goodness is in the making of it is you making it that makes health […] but often if I'm feeling down cooking will make me feel better anyway so it's sort of symbiotic […] it brings us around the table you know makes everyone happy.

Keith's well-being **Balance** is negatively affected by his interactions with the bureaucracy surrounding benefit payments. He does not have sufficient **Resilience** to withstand the weight of bureaucracy represented by those who supply the **External Resources** of money that he needs.

> …bureaucracy reaches out and push down […] powerlessness and impotence […] and they are merciless and they have no feelings they're like the Terminator […] sense of impotence is that sense of shame that you can't do anything you can't oppose bureaucracy […] hideous centralised sort of Orwellian cruelty…

Keith's **Balance** of well-being is affected to the point where it negatively impacts his mental health, bringing back feelings of depression and suicide:

> I find that immensely scary there are days where I find that terrifying you know that I can't get out of bed because it terrifies me […] thoughts that lead towards suicide […] it creates a spiral…

Keith draws his **Resilience** to carry on through his strong sense of self and his commitment to his family:

> I think of all the other things I am that they know nothing about and that they will never own all the talents I possess all the things I've done all the things I've seen […] it doesn't matter how poor I am I just have to stay alive I mean I want to look after my kids too.

Keith has struggled for depression for many years. Ten years ago, his environment was threatening him and his reaction to this threat was potentially fatal. To save his life he moved his family away to the country where they can all flower. Keith gains much from his cathartic relationship with his saxophone as it allows him to express himself in ways he cannot do with words.

Keith's struggle with depression meant he moved to the country to stay safe and this has serendipitously meant his family can flower in their new environment. However, his lack of mental

health means he is now in poverty bringing different challenges for him and his family. Derek, in the next pen portrait also struggles with depression but he has the **Awareness** of the **External Resources** in his life that increase his well-being and drive him forward.

5.1.4.2 Derek: Phenomenological Pen Portrait

Derek is 54, long-term unemployed and lives alone in a council house in a large city. Derek is taking prescription medicine for depression, is overweight, and has problems with his mobility. He takes a great deal of pleasure form his membership of a men's group, utilising many of their activities and events to improve his social life and well-being. His is very involved with his grandchildren and realises the importance of family as a source of love and security. The key for Derek is overcoming the inertia of his depression and continuing to do the things that bring him pleasure. Six themes are central to understanding the phenomenological world in which Derek lives with regard to the ways in which he attempts to manage his health and well-being: **Resilience**, **External Resources**, **Balance Awareness, Space** and **Time**. These are intertwined throughout his narrative but also stand alone as different aspects of his lifeworld.

Derek's situation fluctuates and on some days he has the **Resilience** to overcome his depression and improve his living **Space**:

> I just wash a cup up or something like that and I just thought "there's no point there's just no point" […] I couldn't clean my house up I couldn't do anything in my house it was just spiralling down…

Figure 5.31

Derek's Image depicting his Mental Health Balance Improved Through Prescription Drugs

Derek has been prescribed medication as an **External Resource** to help with his depression (Figure: 5.31). He has **Awareness** that it makes him able to cope with life but this feeling is **Balanced** with the notion that he should have the **Resilience** to cope on his own:

> The life of being ill drugs you know what I mean it's a positive and a negative thing at the same time […] but like everybody else you know I prefer not to take anything.

Derek's situation fluctuates and on some days he has the **Resilience** to overcome his depression and improve his living **Space**:

> It took me 15 minutes to put all this up […] I felt brilliant afterwards I just I'd done something I needed to do anything you know didn't matter what it was but I needed to do something […] that made me feel so good so positive…

Figure 5.32

Derek's Image of his Smaller Plate as an External Resource to Lose Weight

The NHS mental health clinic assigned Derek a support worker who suggested he join a men's group for those living alone and long-term unemployed. This **External Resource** has made a significant improvement to Derek's well-being and health **Balance,** in part, through providing helpful events for him to attend. For example, a recent talk at the group suggested a simple way for Derek to lose weight and this is making an appreciable difference to his health (Figure: 5.32):

> I actually have a smaller plate so smaller meals […] from 26 stone for eight years I've lost 2 stone but I'm actually more happy that I've lost something like 5 inches round my waist…

Other events, such as on art and photography, offered by the men's group have also improved Derek's well-being **Balance** enormously:

> … me and this guy called [man's name] we loved it because we could paint there was so much light coming through the windows […] I was in my photography course […] I decided in the end not to do a qualification a BTEC qualification I just did it for the fun of it.

The men's group provides a meal at the end of each weekly meeting and encourages the men to try new cooking themselves. Derek has tried a few times, expanding his cooking skills and thus improving the **Balance** of both his health and well-being:

> …alternative meat the vegetarian stuff I wanted to see if I could make burgers up so I could do burgers in it yeah did pretty well actually so I was quite impressed with that one.

Moreover, the men's group provides a Christmas dinner for all the members, which is well attended. Derek enjoys this event most, improving both his health and well-being **Balance**:

> It's little things like that I really enjoy it's not just having the meal but enjoying the company of everybody around you taking part you know and just talking about what's happened over the year.

Derek suffers from Fibromyalgia and improving the physical side of health is another **External Resource** provided for by the men's groups in that they organise walks. The one at Christmas was to see the local lights:

> I enjoyed it but it was <u>really</u> tiring for me […] I like walking actually I love walking really.

However, the best **External Resource** for Derek at the men's group is the **Space** to play board games:

> …I just adore playing board games so I'm the one who brings the games and there's a couple of guys who play […] it's my big plus sign to do board games…

His love of board games was fostered in childhood and his time in the army. Derek has the **Awareness** that when playing, he can leave some of his worries behind him and immerse himself in the games:

> …always played in the Army […] it's amazing how many people used to join in and it's a really nice feeling as well […] I really enjoy it because of the past my childhood and it makes me still feel a bit young when I'm sort of like you know playing with other people…

Another **External Resource** that provides Derek with a huge amount of joy is his family. In particular, Derek enjoys a very close relationship with his grandchildren, possibly because he missed out on his own children's childhood whilst in the army and is making the most of this **Time** now…

> Just taking that picture of him makes me feel really happy taking him to school bringing him home from school you know what I mean so and just having interaction with my grandson talking about education talking about school all that makes really positive for myself knowing that someone like my grandson's in my life […] my new granddaughter she is the bees knees she is everything for me […] and I even wake up middle of the night thinking of hugging her because she's so cuddly…

Figure 5.33

Derek's Image Representing his Grandchildren who Improve his Well-being Balance

Derek feels needed by his daughter and her children and this improves his well-being **Balance**. He feels able to achieve with them despite his depression (Figure: 5.33):

> …he just makes me so happy so joyful you know what I mean so he's just he's just I think you know at the end of the day I don't know I don't think I'd be here to be honest if it wasn't for the two kids…

Derek recently enjoyed a family meal with his siblings and their children and the event raised the **Awareness** in Derek of the importance of his family and how much it improves his **Resilience**:

> …that feeling of a family what a family for me means and why it makes me happy […] It gives me that security you know what I mean it's and it's that warmth love feeling…

Derek has endured poverty since the onset of depression after he lost his last job. At times, he has low levels of **Resilience** to battle his depression but, when he can overcome his lethargy and inertia, he appreciates his loving family, particularly his grandchildren. The men's group Derek attends provides him with many **External Resources**. He particularly enjoys the talks from visitors to the group and the chance to play board games with like-minded men.

Derek's depression keeps him in poverty as he is unable to work. He takes great pleasure in many aspects of his life including his family and his regular visits to the men's groups he attends. He enjoys

the group walks with other men despite his fibromyalgia and the pain he experiences while walking. Paul, in the next pen portrait also struggles with walking. He, like Derek is unable to work due to his knee damage. This does not stop Paul experiencing enormous well-being from helping walk his neighbour's dogs. This **External Resource** is incredibly important to Paul as he is unable to own a dog himself and also enables him to enjoy an active social life.

5.1.4.3 Paul: Phenomenological Pen Portrait

Paul is 55 and lives alone in a council house in a large city. Paul has serious problems with his knees so he walks with two sticks and is currently unemployed. Paul is an outgoing friendly person who encourages his friends to visit him with their dogs. He particularly enjoys the social aspect of his job-search sessions with other unemployed men on a barge on the river.

The key for Paul is having an active social life to **Balance** his loneliness at home. He does not work and is limited in his mobility so manages to achieve this **Balance** in creative ways. Five themes are central to understanding the phenomenological world in which Paul lives with regard to the ways in which he attempts to manage his health and well-being: **Awareness**, **Space**, **External Resources**, **Resilience** and **Balance**. These are intertwined throughout his narrative but also stand alone as different aspects of his lifeworld.

Paul has damage to his knees that requires him to walk with two sticks. He is unemployed and is likely to be out of work for some time. He had no I.T. skills to apply for jobs online and, like many men in his position, is undertaking training to learn the skills to apply for jobs online independently:

> …in my day when I were growing up there were none of this you could write a letter or you could phone somebody up […] you've got to learn all this to get an interview somewhere so that to me is a little bit annoying but if that's the way it is that's the way it is…

Paul struggled to learn in a classroom setting but had the **Awareness** and **Resilience** to ask for extra support:

> …it's not always one-to-one but it's sometimes it is and at the start it was er but I've got enough because it was one-to-one I felt more confident in sort of saying "can you show me that again".

The **External Resources** this extra support provides have made a huge difference for Paul:

> …if somebody would have said to me six months ago within six months' time you'll be able to send people emails and reply to this that and the other I'd have thought they were absolutely loopy…

Part of this extra support was to go on a barge trip to do his job search once a week. Paul found his fellow learners in this learning **Space** on the barge good for his well-being and gave him an added aspect to his social life:

> …two really good blokes erm get on like a house on fire with them er we have quite a good camaraderie […] it's just <u>good</u> <u>fun</u> it shouldn't be fun when we're on it because we're supposed to be doing the serious bit but it's a good team.

Paul has the **Awareness** that this comfortable close relationship is limited to the barge trip and a more public **Space** for learning is not suitable for the same level of fun:

> …they very well might be there but there might be three or four other people that I don't know so I could be a little bit limited to what we talk about whereas because it's like us three on the boat we can have a laugh and a joke…

Paul's damaged knees affects his well-being **Balance** because he cannot to own a dog and experience the pleasure that this would bring him:

> …me ex-wife did say to me that "oh we're getting a dog" and I remember saying to her "what do we need a dog for?" […] I just saw this little bundle of fluff come charging up my path and I thought "oh God" you know "why did you say no" […] they decided to run I'd probably "whoa!" like that you see and I'm not very agile if I fall on the floor I've got to have somebody to help pick me up.

Paul overcomes this setback by creating a safe **Space** in his garden for his neighbours to bring their dogs to him for his social **Space**. He is able to experience the pleasure dogs bring and improve his well-being **Balance** through social interaction:

> …when they come over I need to just block it off with a couple of bins so then that the dogs have got free reign then to have a run round erm just a bit of freedom for them you know and my mate and maybe her friend as well can come over we can have cups of tea chat and blah de blah de blah and at least we know the dogs are okay in their selves you know and that's just a lovely feeling to me you know I know they're not my dogs but erm I just think they're fantastic.

Some other dogs in the area cause problems for his friends' dogs so Paul is happy he can provide a safe **Space** for them to play:

> …they can just, themselves relax knowing that they're not outside you know and they have to go chasing after them and all that and that to me that's a good feeling to me…

Paul has also increased his sense of ownership by proxy by paying the vets bills for one of his friend's dogs:

> …fund a little bit of treatment for them erm about a month ago so that's sort of like I feel closer to them by doing that.

Paul makes the most of these dogs as an **External Resource** to replace his inability to own a dog himself and he goes walking with them as often as he can:

> I go dog walking with 'em erm, most evenings […] it's just fantastic to see 'em run round…

He treats the dogs with great care and affection just as if they were his own responsibility:

> I usually take a big plastic bottle full of water and a drinking container […] so they can have a drink especially in that warm weather […] so again I feel sort of like involved and part of this you know rather than just walk round with them you know I take treats sometimes you know some biscuits broken up biscuits…

Paul is restricted from leading a normal life by the damage to his knees. He is unable to work, own a dog, or lead an active social life. However, he shows great **Awareness** about how to overcome some of these restrictions by creatively enmeshing himself in his neighbours' lives in a highly positive and mutually beneficial way and, by so doing, experience great pleasure from his interactions with their dogs.

Paul is unable to work or pursue his preferred activities due to damage to his knees. He creatively increases his well-being however, by accessing the **External Resources** of his neighbour's dogs for walking and while doing so, ensures he has an active social life too. Andrew, in the next pen portrait, also has a restricted social and working life due to health issues. Andrew is using different **External Resources** to ensure an active social life by volunteering in his local town. He is able to give back to the community while reducing his loneliness and thus increasing his well-being.

5.1.4.4 Andrew: Phenomenological Pen Portrait

Andrew is 54 and lives on his own in a privately-rented house in a market town. Andrew has Functional Gut Disorder and has had a stomach bypass operation to help relieve the symptoms. To improve his well-being he uses psychological therapies and goes for walks in open spaces, near home or in the country. Andrew recently moved to the market town and works in a nearby large city. He uses a network of voluntary organisations to supplement his social life and stays networked with his previous colleagues. The key for Andrew is to remain working full time while he manages his physical impairment. This will reduce his poverty and keep him from feeling isolated. Six themes are central to understanding the phenomenological world in which Andrew lives with regard to the ways in which he attempts to manage his health and well-being: **Resilience**, **External Resources**, **Awareness**, **Space**, **Balance** and **Time**. These are intertwined throughout his narrative but also stand alone as different aspects of his lifeworld.

Andrew is overweight and has Functional Gut Disorder. He had a stomach bypass which enabled him to lose eight stones in weight. Although this has provided him some physical relief from his condition, he does not appear to have much **Resilience** to manage his well-being. He has, therefore turned to the **External Resource** of psychological therapy. This has helped him gain **Awareness** of his mental health issues and build more **Resilience** to cope with his physical health issues:

> …just finishing a course of hypnotherapy […] you need to be able to accept what's going on and then to be able to park it to one side and then you know have some time for yourself […] you shouldn't get excessively concerned about it just let it happen…

Being mentally and physically well enough to work is important to Andrew as he has little money. He does not want to work part time but his full time work is on fixed term contracts:

> I've either got to come into work or stay at home sick and there's no flexibility […] it's being able to manage them cos it's affecting my work…

Figure 5.34

Andrew's Image of the Open Space near his Home that balance the Enclosed Space of his House

Although he sometimes needs to spend time at home because of his condition, Andrew appreciates the country **Spaces** near where he lives. Hence, he is able to **Balance** his enclosed **Spaces** of home and work with wilder open **Spaces** to improve his well-being (Figure: 5.34):

> …being able to get out and about and bit of fresh air a bit of exercise and it was a pleasant day […] I always think sometimes that your mind expands to fill the gap in which surrounds you […] this time of year when it's nice it is a bit breezy it's really nice and you're just completely remote from you're not far from civilisation but you're just far enough to say you know this is as wild as it gets.

Andrew is involved in voluntary work in the town in which he lives. He works in a different city and does not have the **Resilience** to pursue a social life after work:

> …with fatigue and everything when I get home sometimes the last thing I want to do is go out again…

Figure 5.35

Andrew's Image of using his Time Productively and Prevent Social Isolation

Voluntary work allows Andrew to achieve a **Balance** and use his limited productive **Time** usefully (Figure: 5.35). He has the **Awareness** that his paid employment is always short term so he cannot overcommit to the voluntary work, but he does not want to give it up entirely as this would cut relationships with people he values:

> …it's an alternative to work and gives me a focus you know something to do but it's also about if you like its stuff that I do there it's it keeps things ticking over you know the relationships that I have got with certain organisations and groups whereas I think with my current work I would forget about them […] I can have contact with people who live locally some people who are coming from the outside like me and some people who have been there all the lives and it's been very very useful in that respect so you meet people who are interesting to talk to […] I don't feel as isolated as I think I might do…

Despite his physical and subsequent mental health challenges, Andrew is trying very hard to build **Resilience** to be able to stay in full time employment and stay out of poverty. His fatigue and lack of social life at work means he cannot enjoy what is considered a normal social life. He therefore creatively seeks a social life built around sustainable voluntary work which can be flexible around his changing work patterns.

Volunteering is a valuable **External Resource** for Andrew who can maintain important working contacts and enjoy a varied social life despite his physical and mental health difficulties. Paul F., the next pen portrait also gains important well-being from volunteering. Unlike Andrew, Paul F. is unable to work and uses his **Time** volunteering at his local church and at the charity which helped him learn I.T. skills.

5.1.4.5 Paul F.: Phenomenological Pen Portrait

Paul F. is 62 and lives alone in a privately rented flat in a suburb of a large city. He is unemployed and will retire in a few months' time. Paul F. uses his time volunteering at a local church and at the charity that taught him I.T. skills when he was first unemployed. Although he lives alone, Paul F. uses the volunteering and a men's group for his social life. He also manages to entertain himself at home on a low income by buying his TV from a charity, listening to his dad's cassette tapes, and reading books from the library. The key for Paul F. is keeping active, despite being unemployed and approaching retirement. He manages this in lots of creative ways that help him and others. six themes are central to understanding the phenomenological world in which Paul F. lives with regard to the ways in which he attempts to manage his health and well-being: **Balance**, **Time**, **External Resources**, **Resilience** and **Space.** These are intertwined throughout his narrative but also stand alone as different aspects of his lifeworld.

Paul F. has been unemployed for a long time. He has had three phone interviews for jobs but has been rejected each time reportedly because of his medical history:

> I've told them what I've got which is arthritis asthma and three discs in my neck compressing inwards the bloke said that I'm sorry but our insurance won't cover you if you have an accident.

As Paul F. will transfer from Jobseekers Allowance to Pension Credit in a few months, his well-being **Balance** will improve greatly as he does not need to spend his **Time** on a futile attempt to get a job:

> March the 6th I've finished looking for jobs I'm retired and I'm on Pension Credit […] I don't want to stay on Jobseekers where I do have to look for a job I don't think it's any contest…

When Paul F. retires, he will be given a free bus pass. This will improve his health and well-being **Balance** because it will give him the freedom to travel more while on a low income:

> …but I'll be going out and about a bit more so yeah I can go anywhere then once I get the pass I get the bus pass at the same time as I retire…

Paul F. tries hard to increase his **Balance** of well-being and so is creative with his social life and makes the most of the opportunities the local **External Resources** provide. Paul F. has been unemployed for over two years and has learned I.T. skills to be able to use the technology at the Job Centre. He learnt these skills at a local charity provider and is now using his **Time** volunteering to train others in his position:

> I had no idea how to use a computer and I went in and they taught me […] I've just got better and better with time […] now I've started helping other people on the computer…

He visits the local food bank and different events put on by a men's group:

> …the church where I live […] they put a meal on for anyone you know people that are on the dole and what have you or living on their own who want to go in they put a meal on and at the end you have a chat and at the end they give you a bag of food […] We've got a walking group on a- it's usually Thursdays…

He also volunteers as a catering assistant at the charity and at a local church at Christmas:

> …I help out with the café side you know making the coffee […] I'll be going to another church where we do where it's winter gala is because we'll be putting the trees up inside the church…

Figure 5.36

Volunteering at a Local Charity and at a Local Church Increases his Health and Well-being

Hence, Paul F. gives **Time** to help others and this charity work is an **External Resource** for him because it increases his health and well-being by being with others and staying active (Figure: 5.36):

> It gets me out it gets me active […] it's something to do and it keeps you busy.

This is the case even though his health is negatively affected by his arthritis and asthma.

Figure 5.37

Paul F's Image of Resilience to Climb Long Hill to Help with Fitness and Rebalance Health.

In an attempt to **Rebalance** his health, Paul F. shows great **Resilience** by walking home from the bottom of a long hill rather than catch the bus as he has been told it will improve his health (Figure: 5.37) :

> …that's that great big hill that I have to walk up […] you get your exercise bit doesn't it? […] me exercise with the feet and arthritis…

On top of this, he has **Awareness** that eating well will maintain his nutritional health **Balance**. Years of catering experience are being applied to this end:

> …usually do stir fries and curries or sometimes I make Yorkshire pudding and have them aye I look after myself well with the cooking…

Moreover, Paul F. shows **Awareness** of both his physical and well-being needs by maintaining his living **Space** and keeping it clean:

> …they're dead easy to wash net curtains take them down wash them bring them out and then hang them back up […] I've got hob on the top and it's black I can get the racks done but trying to get all the stuff off the oven…

He makes good use of **External Resources** to furnish his living Space comfortably while in poverty:

> …a big TV I've got […] and the settee that's at the side I got them all from a charity shop just near town and I forget what it's called for 90 odd quid for the whole lot plus delivery…

And he shows **Resilience** by creatively using free **External Resources** to fill his **Time** with entertainment at home:

> …radio and cassette player […] all cassettes going back to Sinatra Dean Martin Elvis Nat King Cole right through to some of the modern […] got them in a red case that my dad had as well and I added a few to them so I've got that and I play all them now and again […] put that on and read 'cos I've got quite a I get quite a few books I put them on order at the library…

Paul F. has been physically unable to work for two years. In this time, he was trained in I.T. skills at a local charity and now keeps socially active by volunteering to train others in his position. He maintains his health and well-being by eating well and pushing himself to walk as much as he can despite his infirmities.

Paul F. will soon start receiving pension credits. This will enable him to use more of his **Time** volunteering and for other activities which increase his well-being rather than pointlessly looking for

work. The subject of the next pen portrait, Tony, is currently in receipt of pension credit. However this has been wrongly calculated and Tony is struggling financially. He has the **Resilience** to manage this set back and the **External Resources** of friends to help him access cheap food sources at this difficult time.

5.1.4.6 Tony: Phenomenological Pen Portrait

Tony is 62 and lives alone in a privately owned terraced house in a rundown inner city suburb of a large city. Tony is approaching retirement age and is subsequently finding it hard to find work. His resultant poverty impacts daily on his health and well-being as it affects his ability to access nutritious food and lead an active social life. Tony was sectioned in his youth and this has had an impact on his well-being all his life. He attempts to counter this by using poetry and music as mental health self-therapy. Seven themes are central to understanding the phenomenological world in which Tony lives with regard to the ways in which he attempts to manage his health and well-being: **Balance, Space**, **Journey**, **Time**, **Resilience**, **External Resources**, and **Awareness**. These are intertwined throughout his narrative but also stand alone as different aspects of his lifeworld.

The key issue for Tony is a lack of money due to his changing employment situation. This impacts on his ability to source nutritious food and visit shared social **Spaces** with his friends. This is tipping his **Balance** of health and well-being **Space** towards an unhealthy state. However, Tony is tipping the **Balance** back using the great **Resilience** he gained from his time working in the Mental Health system and the self-therapy strategies he employs.

Tony has been employed in low paid jobs all his life and at the age of 62 is finding employment harder to come by as his work contacts are retiring or moving on. He has the **Awareness** that the he would rather use his **Time** in a more fulfilling way than putting in the effort to find and perform paid work.

> …to be honest I am less enthusiastic about you know err finding work you know I'm not err I'm not that kind of dynamic yeah dying to get out there and work anymore […] I do find work the kind of work I do quite stressful…

To achieve the desired **Balance** of well-being to which Tony aspires, he must have enough income to do more than just survive. The Pension Credit awarded to him recently was much less than anticipated and this has tipped his well-being **Balance** in the opposite direction than intended.

> …I don't really have a living wage at the minute […] so that is a bit of a grim reality really…

Figure 5.38

Tony's Image Depicting Poverty Affecting his Balance of Health and Well-being

Lack of income is affecting both Tony's well-being and health **Balance**. Tony's ability to source cheap nutritious food has been compromised by his lack of income. He was advised by his GP to use a 'cholesterol busting' margarine to lower his cholesterol levels, Tony did this and his cholesterol went down improving his health **Balance**. However, he now cannot afford this (Figure: 5.38).

> …this change in my current poverty stricken situation this is a huge tub of kind of ordinary flora which is on offer that was a quid for that big tub so it's like I'm now on the real cheap flora…

Other poverty impacts on his health choices and **Balance** are that he cannot buy food in bulk if on offer nor buy nothing but essentials. Sometimes, the situation is worse.

> …I've had erm made a meal out of a bag of chips you know like you think well this is not it's not really sustainable to do this you know you can't do this every day 'cause- erm, yeah I've had days where I've had no erm vegetables or no fruit or vegetables…

Figure 5.39

Tony's Image of Resilience to Sustain his Health in Poverty

To counter this and improve his health **Balance**, Tony has used his **Resilience** and adopted several strategies to **reBalance** his poverty related health issues. Tony's poverty has recently reached new depths so has harvested some wild elderberries growing near his house and made a Ribena like syrup (Figure: 5.39).

> …I've been very broke these last few months particularly and thought okay I'm going to go out and harvest this lot and I went out and I I got a big bucket full of these elders […] and I made this really nice kind of drink full of vitamin C […] after the success of the first lot I went and did it again so I was quite pleased with that really…

Having the **Time** and **Awareness** to be able to create nutritious food from the wild means Tony can stay healthy despite his poverty. Food security means a lot to Tony and through the **External Resource** of one his friends he able to purchase large bulk supplies of rice and porridge.

> …if you've got absolutely no money and nothing to eat in the house you can always boil a you know a pan of brown rice or you can eat some porridge […] I feel it makes me feel kind of secure really to have that as I mean there have been times when really I have run out of food and you know it's not it's not really a great nice situation to be in…

Tony can make a meal from rice, onion and chickpeas.

> I kind of think that if you have brown rice an- vegetables you know actually that's pretty much as good as anyone can eat isn't it.

Despite living with nearly no money, Tony tries to keep his nutrition in **Balance** to keep him healthy and shows great **Awareness** and **Resilience** by managing to eat well in such circumstances.

The process of cooking was something Tony enjoys not only to maintain his health but also his well-being. He has the **Awareness** that it helps **Balance** himself from stress.

> …it's nice it kind of slows you down as well that that's what I quite like about cooking […] you have to pay attention maybe put the radio on and it's pretty relaxing…

Tony also has **Awareness** that relaxing with a bath a book and a cup of tea **Balances** his stresses and relaxes him before bed.

> …I finish the day with a bath really and kind of climb into bed and go to sleep so at the minute I'll probably get this massive energy bill and I'll have to stop doing it…

One of the many stressors on Tony's well-being **Balance** where his choices are limited by his poverty. Tony's poverty also limits contact with friends in a social **Space** as he cannot afford it thus affecting his well-being **Balance** negatively.

> …things I like doing are probably going out to see films erm, going out to see live music an b-b-both those things are affected by not having cash to do that really you need money to do that…

Friends are **External Resources** Tony calls upon enabling him to live a fulfilling life. Meeting for a curry, going to gigs together or the cinema, they offer him a different **Space** to be in than alone in his house.

> …I suppose it is a bit of a holiday to do that you know to to take you out of yourself an err, err, yeah particularly films you know it's good to- I go go with- I have a little groups of friends an- like to see films…

This 'holiday' enables Tony to forget about his poverty worries and **Balance** his well-being.

Figure 5.40

Tony's Image of Beneficial aspects of the Space his Walking Group Occupies

The **Space** his men's walking group occupies is particularly beneficial to him (Figure 5.40). Not only does it benefit his health to be walking in the country, but also his well-being as his friends think highly of him.

> …it's great to get out and walk in the country and I wouldn't do it on my own so err, it's that it's actually you know being in in the environment and walking and, but it's the sociability as well […] they know the work I've done I feel like they respect me for what I've done and the work I've done and that I'm you know somewhere where I feel kind of valued by by them as a group really so yeah it's really nice…

Tony met some of the friends in his walking group when they were all in the mental health system in the 1970's. Tony thought he was experiencing life but ended up labelled as Paranoid Schizophrenic on a mental health ward. This experience has affected his health and mental health **Spaces** for the rest of his life and led to his lifelong distrust of doctors.

Tony has had problems with his thyroid but instead of relying on the untrusted medical profession, he turned to herbal remedies and acupuncture to **Rebalance** his body. Tony valuing his well-being **Space** over his health **Space** in this instance. Ultimately, his condition got worse and Tony sacrificed his ideals in his commitment to **Balance** his health **Space** and now takes a prescribed medicine for his condition.

The other major effect on Tony was that to keep his well-being **Balance** in the face of ongoing problems with his mental health **Space** he did not want therapy.

> …I really didn't want to do any therapy where there was somebody who had all the answers and I was in the lowly position I I you know had a bit of a phobia about it…

He turned to co-counselling twenty five years ago as a way of **Rebalancing** his mental health **Space** without **Unbalancing** his well-being.

> …it's an equal relationship really which is what appealed to me […] when it came along I thought I would try that and I got hooked with it really it worked I I joined erm, there was a support group for people who have been in the mental health system [mm] four or five of us and that was <u>really</u> helpful to me to kind of work through my <u>anger</u> about what had happened to me…

The additional benefit of co-counselling has been to help Tony **Balance** his physical health also as co-counselling looks down on addictive substances.

> …I don't smoke anymore I did smoke to about probably about ten years ago an- and I've I've pretty much given up alcohol I I've not had any alcohol now for probably about three months […] and I've stopped taking err other kinds of drugs…

This has had demonstrable benefits to Tony in terms of his physical health **Space** where he has outlived his peers.

> …I've known several people now my age and my- from my kind of err generation who maybe drank more than me maybe didn't stop smoking when I did and err just you know died so err in a way I am kind of pleased that I have got this far…

Figure 5.41

Tony's Image Depicting Music and Poetry Spaces Balancing his Health and Well-being

Tony's creative **Spaces** have been of great benefit to him throughout his life, enabling him to **Balance** his well-being and open new social **Spaces** for him. He has sung and played guitar since his youth and found this therapeutic for **Balancing** his well-being (Figure: 5.41).

> …and I think that's really important to my err health really you know it feels- erm, and it's a great thing if you're if you're feeling pent up or you know pissed off or something you can- or just low you know if you're just a bit sad you know sing a few songs and it cheers you up…

This creativity has opened up social **Spaces** for him too.

> …that's been brilliant for me err music you know err, I've played in a band for about ten years like a little folky band […] it was just err a great place for meeting people you know…

Tony's creativity has recently extended to a poetry evening class. This has enabled him to explore his mental health **Space** and achieve a better well-being **Balance** by performing humourous songs and poetry at open mike events.

> …something about being able to express it especially humorously that's really therapeutic I think an- an- in writing generally you know like in poems about your li- in erm yeah definitely helps to, to come to terms with it…

Tony finds the experience of performing his own material a **Balance** of emotions in itself.

> …it's very exciting […] it's some- a piece you've written about something that's meaningful to you and you're kind of putting it out […] quite nerve wracking though so it's a bit of a double edge sword that one…

Ageing is a **Journey** that Tony is finds creates a **Balance** within him. The physical aspect of ageing is something he finds difficult. He described his glasses, hearing aids and false tooth. However, he able to put a humourous gloss on this.

> …something about being attractive to the- you know to other people who might be possible sexual partners it's like ah this doesn't look great really does it when you know imagine waking up with me and you know finding all this by the bedside…

The other side of the **Balance** is his well-being **Space** is easier to live with than when he was younger.

> …I feel err in some ways a little bit lighter than I did when I was a young man you know more healthy in, in some ways you know more, err in control of my life…

Tony has been in poverty all his life after being sectioned in his youth. He is struggling to find work and is waiting on an increase in benefits so has little money for anything but food. Poetry, music and co-counselling have all improved his well-being over his life and allowed him to combat some of his mental health issues successfully. Although his physical appearance is deteriorating, he is feeling 'lighter' and under less stress than earlier in his life.

Tony had expected life to improve as soon as he moved onto pension credit but in the short term, due to a miscalculation, Tony's financial situation has worsened. With the support of the **External Resource** of his friend, Tony is able to source cheap carbohydrates in bulk to enable him to survive. Stan, in the next pen portrait, has recently become a widower but has seen his horizons broadened at the age of 65 with the receipt of his free bus pass with his pension. He is able to get out with no money in his pocket thus increasing his health and well-being.

5.1.4.7 Stan: Phenomenological Pen Portrait

Stan is 65 and lives alone in a council flat in a large city. He is recently widowed and looked after his wife during her illness prior to her death. Stan withdrew from social pursuits during his wife's illness. With the free bus pass he received at retirement age, he is again able to pursue these pursuits despite his poverty. His bus pass means the world has opened up to him again and he is able to travel freely. The key for Stan is the way in which his bus pass has helped him to retain health and well-being now he has reached retirement age. Four themes are central to understanding the phenomenological world in which Stan lives with regard to the ways in which he attempts to manage his health and well-being: **External Resources, Balance, Space**, and **Time**. These are intertwined throughout his narrative but also stand alone as different aspects of his lifeworld.

Stan was recently widowed and cared for his wife during her illness prior to her death. This was a difficult **Time** in his life, made worse through social isolation and the fact that Stan was unable take time out to enjoy his usual recreational pursuit of fishing:

> I were just looking after the wife like with her being poorly and er I've started going back as I've just got me bus pass and so I've been able to get out as it's a lot of money is four pound…

Poverty and, in particular the cost of travel, means that Stan has had to endure poor dental health because his local dentist only treats private patients:

> That's the dentist that wouldn't let us in they don't have social people they prefer people who pays if you're on the social they very rarely give you [so where do you go?] I don't I haven't got one it's how comes me teeth's black.

Figure 5.42

Stan's Image Representing the External Resource of a Free Bus Pass Balances his Health and Well-being

The **External Resource** of his bus pass enables Stan to enjoy a better **Balance** of health and well-being despite his poverty as he now has the freedom to explore **Spaces** hitherto inaccessible to him (Figure 5.42):

> I hadn't been out for that long and I just got me bus pass, so I thought I'll take a trip out […] I thought well I'm not doing owt so I'll get bus pass out and I'll go for a ride cos I haven't been out haven't been able to get out for a while […] I had no money on me I only had me pass […] just had a spot of tea from me flask of tea which I brought.

When Stan is not out travelling, he fills his **Time** with a variety of activities. Although these activities are not all healthy, they are in **Balance** and help to meet his social needs:

> Get drunk er watch tele not a lot really no it depends I have me mates come round keep an eye on us…

Hence, Stan, although recently widowed and living in poverty, has an active social life with friends and a new found freedom to explore with his free bus pass enabling him to keep active.

Stan's horizons had become quite small because of his dedication to care for his wife who recently passed away coupled with the prohibitive cost of public transport. However, now he has reached pension age, he receives a free bus pass which enables him to explore the world again thus increasing his well-being. In the next pen portrait, David has been in receipt of a bus pass for many years due to his reduced mobility. He enjoys the freedoms it brings but has **Awareness** of the limits of his capabilities so makes sure he keeps himself safe.

5.1.5 Cluster 5: Memory loss and its implications

5.1.5.1 David: Phenomenological Pen Portrait

David is 66 and lives alone in a tower block in a large city. He is a retired electrician and has lived in the same deprived neighbourhood all his life. David has impaired mobility and is aware his memory is starting to fail him. He shows great **Resilience** by walking every day and travelling to a local city with his free bus pass once a week, improving both his health and his well-being. The key for David is his freedom of mobility, both through walking every day and broadening his horizons with free bus travel. Four themes are central to understanding the phenomenological world in which David lives with regard to the ways in which he attempts to manage his health and well-being: **Resilience**, **Space**, **External Resources** and **Balance**. These are intertwined throughout his narrative but also stand alone as different aspects of his lifeworld.

David has lived his whole life in the council estate in which he was born. This **Space**, while very deprived, holds many positives for David:

> I loved it and dragged up here but it didn't bother me didn't bother me at all because it made me streetwise…

In particular, the sense of community is strong and a very important **External Resource** for David now that he struggles with his mobility:

> I just love the community […] so somebody can help me home […] I class him as one of my neighbours and if I'm struggling, he'll help me out you know for walking stuff like that…

David showed **Resilience** by learning to be an electrician from his uncle and being different from the other boys on the estate:

> …my mates went outside playing football […] I were jotting down everything that was in his ledger so I made my own ledger and I made it my ambition in life to be an electrician- did it they all thought I was sort of like a bit of a boffin.

Although David saw his career as a success, he now sees himself as a failure. However, despite issues with his memory and mobility, David shows great strength and **Resilience** by **Balancing** these deficits and wanting to enjoy every day that comes:

> I've failed […] because I can't remember anything now it's only certain conversations that I can recall […] every morning so I can get up up and at 'em I'm out no matter what the weather…

This **Resilience** drives David forward with a resolve to keep walking as long as he can. He will make an extra effort, even when easier options are available:

> As long as I can as long as these little things are walking underneath me I've got to follow them […] down community centre I really enjoy walking down there now [name] the neighbour he says oh there's a bus at such and such a time and I just say well it's a fine day I'm walking it down but I'm I've always been so determined in life to achieve what I want to do.

Figure 5.43

David's Image Representing External resource of Free Bus Pass Improves Balance of Health and Well-being with a Weekly Trip Out

David's ability to travel is greatly enhanced by his bus pass which entitles him to free travel. This **External Resource** widens his horizons and improves the **Balance** of his well-being (Figure: 5.43):

> …I've also got a bus pass which is for a companion as well just in case I'm struggling […] [name of city]- I try and go there once a week […] it's just a matter of getting out…

However, David knows the boundaries of his available **Space** and limits his travel to what is safe for him:

> I wouldn't trust myself going any further […] I get on the bus and I know for a fact I'm going to fall asleep […] it were [name of town].

While David is struggling with his memory and his mobility, he is showing great drive and **Resilience** to maintain his health by walking every day. His horizons are widened by the **External Resource** of his free bus pass which he uses to travel to local city once a week, thus improving his well-being **Balance**.

Despite his reduced mobility, David's **Resilience** means he walks as much as he can to prolong his ability to walk unaided. His free bus pass broadens his horizons enabling him to travel further than he would otherwise. David is starting to struggle with his short term memory and so sees himself as a failure. Paul C. in the next pen portrait is also suffering short term memory loss but his **Resilience** means he is doing all he can to ensure he maintains what he has for as long as possible.

5.1.5.2 Paul C: Phenomenological Pen Portrait

Paul C is 71 and lives with his wife in a privately owned house in a large village. He is retired and suffered a heart attack at the age of 60. After recovery, and despite poor sleep and ongoing memory problems, Paul C. has devoted his life to his pleasures, singing, gardening and the local cricket club. The key for Paul C. is retaining his health and memory for as long as he can to enjoy the things that bring him pleasure. Six themes are central to understanding the phenomenological world in which Paul C. lives with regard to the ways in which he attempts to manage his health and well-being: **Time**, **Awareness**, **External Resources**, **Balance**, **Space**, and **Resilience**. These are intertwined throughout his narrative but also stand alone as different aspects of his lifeworld.

Figure 5.44

Maintaining a Healthy Body is Important

Paul C. has been **Aware** of the importance of his health all his life and has maintained the parts of his body important to him in different ways (Figure: 5.44):

> …two things in life you should have that are good a good pair of boots and a good bed because if you're not in one you're in the other […] oral hygiene is a big thing […] forget the medicine get you some pomegranate it's as good as a bottle of tonic…

At the age of 60 Paul C. suffered a heart attack and took a long time to recover. Since then he has made the most of his **Time** and filled his life with hobbies and with helping others. However, he is **Aware** that he had to keep a **Balance** of being busy and resting:

> I had my heart attack I'd just had my 60th birthday […] If I do a busy day then the next day I'm shattered I just sit and I sit it out I keep doing little bits.

Paul C. has struggled with sleep for many years and the situation worsened until his **Balance** of well-being was being threatened. He took action to try and help himself rather than rely on increasing the **External Resource** of sleeping tablets:

> I've stopped the sleeping tablets […] I once went 11 weeks without sleep […] Dr [name] says he'd have to increase the antidepressant element of it he says which is the one you will get addicted…

To keep his health in **Balance** during his sleeplessness, Paul C. turned to a different **External Resource** to keep himself well:

> …that's my best friend during the night Oxos if I get up during the night, I'll have a cup of Oxo…

Paul C. is **Aware** he is starting to struggle to remember and has the **Resilience** to do all he can to retain the **Balance** of his memory:

> …no two ways about it most of this is all geared on helping me to remember […] nothing wrong with my long term memory I'm struggling now to remember what's the next picture…

Two strategies to help Paul C. remember have the dual benefit of helping him when he struggles to sleep, and help pass the **Time** during the night:

> …it gets to the point that you don't even sleep with sleeping tablets so I started reading a lot and I started doing jigsaws […] even though they're spread out all it's just good for your

> memory better retentive […] really it's very testing to remember who's who […] I'll go upstairs and read for an hour and a half until me eyes are dropping…

Figure 5.45

Paul C.'s Image Representing Challenging Himself to help Prevent Memory Loss

Other **External Resources** Paul C. uses as strategies for memory retention are a giant weekly newspaper crossword which he has never completed but has the **Resilience** to keep trying. He also complies one quiz a month for the local Cricket Club (Figure: 5.45):

> I have never completed it I've got as near as one question unanswered […] when I've done the quiz I can't remember half of the answers meself…

Paul C's long term memory is good and his mantelpiece is covered with photographs of his children and grandchildren who mean a lot to him:

> …photographs you just acquire and it's just nice I sit there and I can remember each one being taken…

Paul C's short term memory worries also affect his singing. Sometimes he needs an **External Resource** to remind him of the words to some of the songs in his repertoire:

> …that's me book of songs […] I sit with it on me knee quite a lot if I just feel that I'm falling back on a song struggling to remember the words…

The ageing process has also affected his energy levels and ability to project his voice for long periods when he performs in pubs and clubs:

> I'm not singing without a mic anymore it's too hard it's too tiring…

Singing has been important to Paul C. all his life and had increased his well-being. Singing also gives him motivation to live longer to continue to enjoy it:

> …everywhere I walk I used to sing and people love it you know […] it has kept me a long interest and long may I be able to sing…

When first married, singing was a shared passion for him and his wife and a **Space** they could enjoy together. However, the arrival of children meant that although they could not share this **Space** anymore, it did not dim their passion for singing:

> …started going to folk clubs when we first got married […] done all the Gilbert & Sullivan operas […] and (name of wife) sings with (name of city) Festival Chorus and a church choir and so I just started singing in pubs…

Paul C. combines his passion for singing and his interest in helping those with leprosy in India by giving his **Time** to raise money for the charity:

> …let's charge £5 a ticket let them have their lunch and let me sing for an hour and I says it's good money you know £500 for the morning […] I sung for one night at (name of pub) and we had a raffle and I raised £120…

Gardening is another passion which Paul C. uses to fill his **Time** and increase his **Balance** of well-being. He pays eight pounds a year for his allotment which allows him the space to grow things he cannot at home:

> I think really gardening is me life […] just at the side of (name) Park it's an oasis […] I've got irises in here […] grow carrots hot beds…

At home he uses his greenhouse as an extra growing **Space** to grow cuttings to give away and enhance his village:

> …my garden's full but I've now got an allotment and I also do the flowerbeds in front of one of the pubs in the village.

The village cricket club is a **Space** in which Paul C. has spent a lot of **Time** and has given him and his family much pleasure. He coached his son at junior cricket for twelve years and has also been club treasurer:

> that's another big part of me life […] I'm a life member because I used to be I were treasurer…

The club is where Paul C. does his quiz night once a month and this is important for his identity at the club:

> …it keeps you in the public eye round the club they know that you're not just a drinker…

The club is also an **External Resource** for free beer once a week in exchange for a few hours work:

> …go Wednesday night for men's well we clean pumps so we get three or four pints apiece…

Paul C. has looked after his physical health all his life. However, after a major heart attack and being aware he has started to have memory problems, Paul C. doing all he can to manage this deterioration so that he can continue to continue to enjoy life as much as he can for as long as he can.

5.2 Discussion

This chapter has presented the outputs of the Interpretative Phenomenological Analysis in the format detailed in chapter 3. Each of the pen portraits above provided an analysis of the lifeworld of one participant. The pen portraits were clustered according to the key element of that lifeworld which appeared to have the most impact on that participant's health and well-being. The clusters were: unemployed men who live alone resisting loneliness; meaningful influence of partners to bring well-

being; countering addiction to improve health and well-being; overcoming challenges to health and well-being from mental and physical impairments; and, memory loss and its implications. Seven themes were also generated across the data set as central to participants' experience of health and well-being, although not all themes were relevant to all participants. Listed in no particular order the themes were: **Journey**; **Balance**; **Space**; **Time; Resilience**; **External Resources** and **Awareness**. Where relevant, attention was drawn to these themes throughout the pen portraits and the themes were used to highlight similarities and differences between the participants' lifeworlds. This discussion will firstly discuss each of the seven themes in the order presented above. It will then follow that by discussing each of the five clusters in the order listed above.

5.2.1 Themes

5.2.1.1 Journey

Anderson (2006) views the work of Bloch (1986) as fundamental to understanding the drive motivating human beings to improve their lives. The darkness of lived experience creates dreams of a better life that move one away from lack towards something better that is not yet realised. These dreams are conceivable now and partially present but in a problematic manner that requires more effort to achieve realisation. The darkness of lived experience for these men comes from living in financial adversity. Power et al. (2019) propose individuals counter adversity by negotiating new strategies or routines to create a sense of well-being or health in adversity in their lives. They see many people who create goals for improvement but are constantly negotiating and renegotiating their paths through the difficulties they face. They often fail but remedy these difficulties or correct their paths. They describe this struggle to progress as journeying. The move towards a better now for the men in this thesis is their **Journey** as espoused in the analysis above. **Journeys** towards improved health and well-being exist on a spectrum from measures to nullify the worse health effects to recovery **Journeys** that create health and well-being anew (Power et al., 2019).

5.2.1.2 Balance

Creating health and well-being anew is a dynamic process by a motivated, active, experimenting human being (Fox, 2002). The dynamic process works by keeping adversity and health/well-being in **Balance**. **Balance** was the second theme created to understand the lived experience of the men in this thesis. Health and well-being **Balance** is not only affected by changes to financial adversity but many other factors including energy and attention between different life demands (Grawitch et al., 2013).

5.2.1.3 Time

Time devoted to employment and commitment to family and community was something to be carefully managed (Drago, 2007). **Time** was another theme that influenced the health and well-being of the men on low-income. Some had too much and some too little but for both groups it affected their ability to maintain their health and well-being.

5.2.1.4 Space

Spaces occupied by the men either physically or metaphorically had both positive and negative effects on health and well-being. Marmot (2006) clearly saw social and spatial inequalities in rates of smoking amongst men with higher rates in disadvantaged places. However, men talked of the positive effects of community in disadvantaged **Spaces** offering security and inclusion (Conradson, 2005; Smyth, 2005; Wakefield & McMullen, 2005). Many men also described the positive effects of the countryside on their health and well-being. This mirrored similar effects for working city dwellers in Victorian Britain (National Archives, 2019). The therapeutic effect of **Spaces** has been documented by many with particular focus on: silence and a **Space** apart (Conradson, 2005); spiritual **Spaces** (Maddrell & Della Dora, 2019); environments conducive to healing (Gesler, 1996); walking in green **Space** (Gatrell, 2013) and **Spaces** that produce positive experiences through relational subjective positivity (Cattell et al., 2008; Conradson, 2005).

5.2.1.5 External Resources

Positive locations act as **External Resources** for the men. They draw on the positive feelings generated from being in these places to continue working towards improving their health and well-being. **External Resources** to improve health and well-being extend beyond uplifting places to supportive emotional relationships with friends, loved ones or meeting people in organised groups (Kinsel, 2005). Friends described here tended be trusted long term friends that supported the participants emotionally and were seen almost as extended family. Organised groups were either structured groups such as that for long-term unemployed men to a loose group of friends who went for regular walks in the country.

5.2.1.6 Awareness

Pagis (2009) describes physical self-**Awareness** by meditation practitioners and Perez (2011) discusses educating children in emotional self-**Awareness** but the men here describe both types of **Awareness** throughout out their narratives. Thus, allowing them to negotiate their reflections on past experiences to improve their future experiences. This ranged from ex-addicts understanding which triggers created problems for their health and well-being, a survivor of sexual abuse in childhood knowing he now understands how to deal with that experience and live a fulfilling life and a man with three part time jobs living in what he described as drudgery understanding he has to have fun and improve his health and well-being.

5.2.1.7 Resilience

Resilience was displayed by all the men to some degree. **Resilience** appears to have some essential qualities that apply to men on low-income. Walsh (1998) sees **Resilience** as more than merely surviving, allowing people take charge of their lives and go on to live well. Rebounding from adversity strengthened and more resourceful (McCubbin et al., 1997) and thriving despite adversity (Seccombe, 2002) is how resilience has been seen for groups in poverty. Richardson (2002) sees resilience as a motivational force that drives everyone to seek wisdom, altruism, self-actualisation and

be in harmony. Many of the men here sought wisdom in many forms, were altruistic by giving to others and were constantly attempting to be in harmony by actively reflecting on their situation.

5.3 Lifeworld clusters

Interpretative Phenomenological Analysis in this thesis examined accounts of how health and well-being is understood and experienced by men who fall into the lowest income bracket, placed within the wider socio-economic context of poverty for men in the UK in the 2010s. There were multiple causes of poverty causing many threatening issues for the health and well-being of the 21 men interviewed. However, the responses of the men to these threats were remarkable in their creativity, complexity and capability to in the most part see them off.

5.3.1 Unemployed men who live alone resisting loneliness

Ong et al. (2016) describe loneliness as the disparity between the social engagement people have and what they would like. Being alone and loneliness are correlated with a high mortality risk and are risk factors for cardiovascular disease (Xia & Li, 2018). However, in a controlled sample, the adverse physiological effects of loneliness were removed when participants scored highly on a eudaemonic well-being questionnaire (Cole et al., 2015). Eudaemonic well-being is associated with self-actualization, personal expressiveness, and vitality. Lincoln (2000) found that social support from friends improved mental health and life satisfaction. Geoff talked of the benefit of meeting friends at a local community group and at a nearby pub when he could afford it. Moreover, loneliness is reduced and perceived social support increased when there is good access to green space in the environment near peoples' homes (Maas et al., 2008). Similarly, both Geoff and Mark, who lived alone, described the positive benefits of visiting parks close to their homes.

5.3.2 Meaningful influence of partners to bring well-being

Brian, Peter, James, Will and George talked about their partners having positive influences on their lives and bringing them happiness. Lai and Cummins (2013) found 4% of Global Life Satisfaction to be associated with Partner Satisfaction. Burns (2005) concurs in a review of research into happiness and positive relationships, stating that happy people experience better relationships and that people in a positive relationships, in turn, report greater happiness. This appears to be true for all of the men whose partners have a meaningful influence on their well-being.

5.3.3 Countering addiction to improve health and well-being

Addition comes in many forms. Five men who countered addiction to improve their health and well-being: Dave, Alan, Liam, Simon and Colin, experienced addiction problems with alcohol, drugs, vinyl and nicotine. Although de Visser et al. (2016) suggest cautiously that there has been no evaluation of the effects of long term voluntary abstinence from alcohol, there are some such term benefits such as reduced blood glucose level and liver fat, coupled with improved sleep and concentration (Coghlan, 2014). Additionally, de Visser and Nicholls (2020) report increased levels of self-efficacy and well-being. These latter benefits were noted by Alan and Dave in relation to alcohol abstinence.

Engagement with drug rehabilitation services can also improve goal setting, self-understanding and boundary setting (mentalhelp.net, 2020) and Liam describes these improvements in his own experience with regard to the changes he had made to his life since drug cessation. Colin, like many of the men interviewed had stopped smoking. The benefits of this are multiple and include living longer, having more money, improving general health and quality of life (NHS, 2020b).

5.3.4 Overcoming challenges to health and well-being from mental and physical impairments

Persson and Ryden (2006) interviewed persons with disability and some of the themes resonated with the participants who overcame challenges to their health and well-being from mental and physical impairments self-trust, social trust, problem reducing actions, and minimising threats to well-being. Paul, Andrew, Derek and Paul F. described the benefits of undertaking actions that mirrored these themes. Those with physical disabilities who maintain positive levels of mental health were found to have life goals and a clear idea of personal identity (Psarra & Kleftaras, 2013), and this is also true of all of the men in this cluster. Keith and Derek who live with depression and Tony, sectioned in his youth, overcame challenges from mental impairments. NAMI (2019) illustrate techniques beneficial to coping with mental illness and, interestingly, many of the men employed these already. Techniques employed by the men in this cluster include radical acceptance of the issues confronting them, awareness of their emotions, and being in touch with their sense impressions.

5.3.5 Memory loss and its implications

David and Paul C. both talked about experiencing reduced capacity in their short term memory. Sadly, David did not discuss any positive behaviours and described himself as a failure due to his reduced memory capacity. On the other hand, Paul C. appeared to be trying to take positive action by engaging with memory enhancing activities such as reading, jigsaw puzzles, and quizzes. However, both David and Paul C. remained socially active, looked after their health, and were able to discuss their issues with memory loss during the interview. All these activities are recommended by the NHS (2020a) on their living well with dementia guide.

5.4 Conclusion

All the men on low-income here experienced threats to their health and well-being through living in poverty. The phenomenological approach to understanding the men's lifeworld and lived experience of health and well-being in poverty has unearthed many ways in which these men strived to counter these threats. Through interpretative analysis, these ways were grouped into five clusters in which seven themes permeate the men's account and provides meaning to help understand their lived experience. Key elements of the lifeworld which appeared to have the most impact on participant's health and well-being are: unemployed men who live alone resisting loneliness; meaningful influence of partners to bring well-being; countering addiction to improve health and well-being; overcoming challenges to health and well-being from mental and physical impairments; and, memory loss and its implications, In terms of theme, **Journey** encapsulates the drive the men experience to move towards

growth (Maslow, 1998). **Balance** is a way of understanding how the men experience positive and negative effects on their health and well-being. **Time** and **Space**, be it real or metaphorical, can have negative effects on the men's balance and upset their ability to continue on their **Journeys**. **Resilience**, **External Resources** and **Awareness** are the tools the men use to regain their **Balance** to enable them to continue on their **Journeys**. These themes will be integrated conceptually in the next chapter.

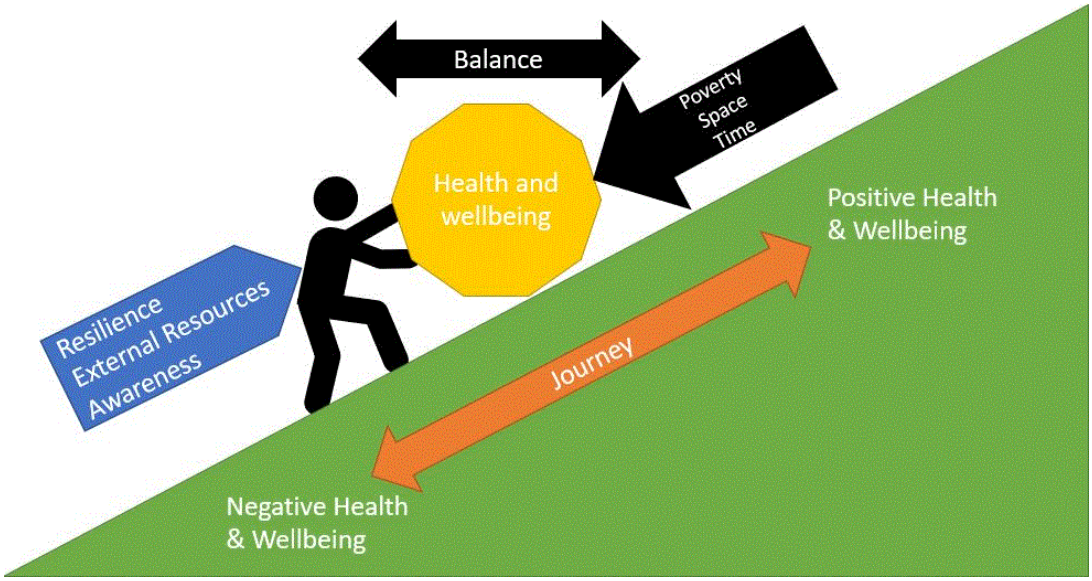
6 Chapter 6 - Model of Health and Well-being for Men on low-income.

This chapter will present a preliminary model of health and well-being generated from the data and the themes in the previous chapter. It speaks to the aim of this thesis (to critically review the historical and contemporary positioning, evidence and experience of health and well-being among men on low-incomes) and one of the secondary aims (document and categorise the forms of health behaviours that white British men on low-incomes report). As previously noted, health and well-being was defined by participants. The rationale for this was given in chapter 3. This chapter starts with a visual representation of the model of health and well-being accompanied by a brief description of how each theme fits within the model. The model presents a mechanism by which health and well-being for men on low-income improves and declines alongside the ways in which each theme, as detailed in chapter 5, impacts health and well-being. Each theme is then explored in turn with data extracts from the interviews highlighting salient points. Photographs were included where participants introduce the topic using the photographs or the photographs increase the understandings of a topic.

The themes from chapter 5 and metaphors the men used at various times in the interviews are reminiscent of the myth of Sisyphus. Sisyphus' fate was to push a large boulder up a hill and, as it reached the top, it would slip from his grasp and Sisyphus would commence his eternal task once more (Ancient History Encyclopaedia, 2020). The individual themes, as well as the holistic stories told by the men, seemed resonant of this myth and, hence, is drawn upon to conceptually and visually represent the synthesis of the main study findings (see Fig.6.1).

Figure 6.1

Representation of the Pursuit of Health and Well-being for Men on low-income



For men on low-incomes, the large boulder represents their health and well-being and the hill their level of health and well-being. The higher the boulder is on the hill, the more positive their health and well-being. All the men were on a **Journey** represented by the movement potential of the boulder. Figure 6.1 shows the men's ambition for self-improvement and willingness to invest in their **Journey**. Moving the boulder towards an improved and maintain this improved state of health and well-being required considerable effort, just as it would to hold or push a boulder up a hill. However, for this group of men in poverty, this effort was not always possible and illness, unemployment, and other negative life events could lead to the boulder rolling down the hill. Hence, Poverty, **Time** and **Space** are contingencies, impeding or facilitating the men's health and well-being. Moreover, the boulder (health and well-being) must be kept **Balanced** for the men to be efficient at managing the returns on their effort. Specifically, **External Resources**, **Awareness** and **Resilience** were the tools the men drew on to facilitate progress up the hill towards positive health and well-being. The forces that push up and down the hill are as they are because the data in the **Space** and **Time** themes produced the most negative effects of health and well-being on the men. For the three positive themes, it was their absence that created effects of negative health and well-being.

The next section will detail the three different **Journeys** of health and well-being experienced by the participants. Namely (i) a **Journey of progress** where the men are actively working to improve their health and well-being; (ii) a **Journey of maintenance** where the men are conscious of their health and well-being and working hard to maintain its current level; and (iii) a **Journey of decline** where, despite their best efforts, the men's health and well-being gets worse. The other six themes are then explored in terms of their effect on the participant's **Journey**. So, **Balance** is considered for its effect on the men's ability to improve, maintain or prevent decline in health and well-being. **Time** and **Space** are then explicated in terms of their negative impact on the participants' health and well-being. Finally, **External Resources** and **Awareness** are explored for their positive impact on health and well-being, **Resilience** is integrated into the discussion of these two themes to aid understanding of how the three themes interact.

6.1 Theme 1: Journey

Journey is key to understanding the participants' health and well-being needs, behaviours and aspirations. There were three types of **Journey**: progress, maintenance, and decline. This is represented in Figure 6.1 as the man's effort, momentum, and movement towards, and away from, health and well-being.

6.1.1 Journey of progress

Eleven men (Mark, Will, George, Dave, Alan, Liam, Keith Paul F., Tony, Stan and Peter) appeared to be on a **Journey** of improvement to their health and well-being. For most of these men their present

was better than their past and for all eleven men, they anticipated their future to be better than their present.

Five (Peter, James, Keith, Mark and Tony) of these men had experienced negative events early in life that affected their mental health to different degrees and contributed to their feeling of being trapped in poverty. James and Peter both suffered blows to their emotional development. James' mother was an alcoholic and could not look after James "and I got separated from her when I was quite young". Peter was abused by one of his teachers causing him emotional problems throughout his life: "he conditioned me groomed me and made me feel important you know what I mean and he took advantage of me". In terms of the model, for them, the hill appeared steeper and their **Journey** started further down the hill than for many others. These five men had moments of realisation where they questioned the mental or physical risks in their lives and started their **Journey of progress** upwards. For example, Peter challenged the way he felt about his abuse and sought help: "I bottled it up for years not telling anybody […] you can have so many visits to see this psychologist if you think it'll help you". These men found determination and motivation to start pursuing new levels of mental health and well-being for themselves, akin to beginning to push the boulder up the hill. Keith explained in relation to psychological well-being: "It's taken all my life and its sort of taken that long for me to start to push back you know to sort of say well I know I'll be me I'll just be me and I like me and I won't be afraid"

With considerable effort to push the boulder uphill, the five men reduced the risks to their health and well-being. Keith managed this by leaving a location that was dangerous for his whole family: "moving here was a way of not dying you know was a way of getting all of us out of that to a place where we could flower". This illustrates also how the men were able to develop greater care for themselves and others and lead more fulfilling lives. Mark, for example, used his knowledge and skills with mental health issues to help others "volunteer for (charity) as well I do their positive pathways thing which is people coming out of units and integrating back into life". A tough start to life had cast a shadow over the lives of these five men in ways that affected their health and well-being, yet they each found motivation, energy and solutions to progress towards a brighter future with improved health and well-being. For these men, the boulder was on the move and it appeared it would continue to have this momentum towards 'progress' for the foreseeable future.

Three (Alan, Dave and Liam) of the eleven men who were on a **Journey of progress** had experienced addiction to drugs or alcohol, contributing to their feeling of being trapped in poverty. Two had conquered their addictions and one was in the process of doing so. Liam took recreational drugs during the rave scene but "ended up with like a problem". Alan enjoyed drinking and explained how he lost control: "Alcohol addiction […] slippery slope". All three had been drawn into addiction

without noticing it and they 'slipped' downwards towards worsened health and well-being. These three men all reached a low point where they realised they had the ambition to start the long climb back to better health. Alan described the feeling of realisation when he wanted to change his behaviour and the difference it made to his life: "just decided like, I'm really tired I'm just so tired of, erm, chaos because addiction equals chaos right nothing, goes right, everything always goes wrong, yeah? as soon as you put the drink down, erm, nothing goes wrong and everything goes right". The boulder stopped rolling down the hill at this point. All needed help to start their upward **Journeys**, because it felt a huge and daunting task. However, they eventually got to a point where they could manage their **Journeys** on their own. Dave described his thoughts on the process "I feel like I'm going in the right direction […] it's a zigzag […] it takes time and I sort of feel like I'm getting there". Hence, these three men found the energy and skills to keep the boulder moving upwards, albeit with some 'zigzags'.

The other three men (George, Will and Paul F.) who were on a **Journey of progress** had also chosen to make progress away from something unwanted towards a better future. George was fed up with line work on a conveyor belt: "I am starting university […] I'm doing child nursing […] hoping that I would be able to like go to such as Africa". A moment in life where the boulder had been static and the men found the motivation or discovered the possibility to be able push the boulder upwards again.

All eleven men here were on a **Journey of progress**. They talked of a difficult past filled with abuse, addiction and separation that left them with much lower levels of health and well-being than most. They all experienced moments of insight or inspiration where they realised their lives did not have to be miserable and their health did not have to be, in some cases, fatally damaged. They realised they had the ambition and the capability to live better and feel better and started to make positive changes to their lives. However, not all the men had the capacity to undertake the necessary changes, so reached out and sought support from others. The use of the boulder and the hill in Figure 6.1 illustrates the strikingly immense effort all these men expended in preventing further decline in their health, and the even greater levels of energy they had to muster to get the boulder moving back up the hill. All were still on their **Journey**, pushing their boulders up the hill. Some found this a harder struggle than others with many setbacks, but their realisation that it has been worth the effort and that improvement continues, means they have not stopped pushing despite the challenges faced.

6.1.2 Journey of maintenance.

Seven men (Geoff, Brian, James, Colin, Derek, Paul and Andrew) were on a **Journey of maintenance** of health and well-being. They were expending a huge amount of effort just to keep on their **Journey**. In the interviews, they did not talk in terms of progression or decline, just of maintenance.

Three of the men (Derek, Paul and Andrew) were in their fifties and had a medical condition that affected their ability to gain long-term permanent employment. Derek suffered from depression and fibromyalgia, Paul had knee damage that required him to walk with two sticks, and Andrew had Functional Gut Disorder. Andrew was the only man of the three currently working, but he struggled to maintain a social life because he experienced low energy levels. Despite their difficulties, all three were creative with their social lives. Andrew volunteered with local charities. Paul was unable to own a dog due to his lack of mobility, so invited friends with dogs to his garden. He explained: "the dogs have got free reign then to have a run […] my mate and maybe her friend as well can come over we can have cups of tea, chat". Derek had recently joined a weekly group for unemployed men which gave him an outlet for one of his passions, playing board games: "it's very hard to get people to play board games […] I just adore playing board games". The weekly group was on the other side of a large city: "It's like an hour away from here do you know two buses to get there and stuff like that". Hence, Derek expended a lot of time and energy to reach this group, but the benefits were worth it for him.

Colin felt he was not progressing or declining in health. However, he was working very hard to maintain his well-being centred on spending quality time with his teenage daughter who lived with her mum. Otherwise, he described his life as drudgery and in a rut, working three part time jobs so he could afford a car to make sure he could "appreciate the time that I spend with her". Similarly, Geoff, in his 60's, lived alone in a tower block but maintained his health by walking in the nearby park every day whatever the weather. Geoff does not visit his local pub as "it's too dear" but walks several miles to drink with his friends in a local village when he "can afford to".

These men are on a **Journey of maintenance**. However, given the challenges of their lives, this requires of them a heroic effort just to hold their boulder in place.

6.1.3 Journey of decline

Three men (Simon, David and Paul C.) appeared to be on a **Journey of decline**. Two were over 65 years old and talked about physical and mental age-related challenges. However, the third man, Simon, was only in his late 20's. He worked hard at three jobs and did not focus on his health and well-being, and this appeared to be having a negative impact on him. Vinyl records were Simon's life. His obsession meant he did not eat well, took little exercise, saw his friends rarely and appeared to have no other outlet: "the spinning disc is controlling my life […] sometimes it makes me sad, that that's all I have". He openly discussed his negative health behaviours and how these were affecting his well-being.

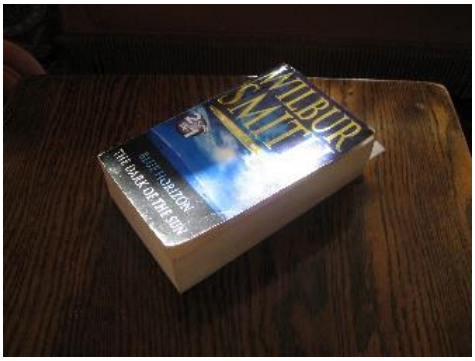
Figure 6.2

Simon's Decline in Health and Well-being was Directly Associated with his Vinyl Obsession

Simon introduced his obsession with a photograph of the spinning disc (Figure 6.2). Later he photographed the extent of his collection. The interview was conducted in his two-room flat almost entirely taken over by vinyl and equipment. His experience of decline was, for him, associated with his vinyl obsession. He seemed unable to rectify the issues he saw affecting his life which were leading him on a **Journey of gradual decline**. It is as if the weight of this 'boulder' was pushing him down the hill and threatening to crush him on the way. Simon felt aware but unable to act to improve his situation.

Figure 6.3

Paul C. was Unable to Prevent his Memory Decline Despite his Valiant Attempts



Paul C. and David were retired men with health conditions that affected their ability to lead a normal life and both described trouble remembering things. In particular, Paul C. experienced memory as pivotal for his sense of well-being and was undertaking many projects geared to: "helping me to remember and I have quite a good memory but I struggle". He took several photographs to highlight his failing memory (Figure 6.3). Paul C. and David were also trying very hard to retain their physical fitness. Paul C. regularly did strenuous exercise: "it's the bending up and down picking all the logs up and stacking them and when I've done it I feel so good absolutely knackered then for two days after". David used two sticks to walk but tried to make a bus ride a luxury: "it's a fine day I'm walking it down but I'm I've always been so determined in life to achieve what I want to do". Interestingly, the experience of decline was in some ways different for these two men. For example, David appeared to have resigned himself to his failing memory whereas Paul C. tried to

challenge his problems, “struggling to remember the words”. However, sadly, although Paul C. and David were taking action against decline, their boulder was slowly falling down the hill.

These 21 men living in poverty demonstrated awareness of how their **Journey** could span the miserable existence ‘lower down the hill’ to a more fulfilling life ‘higher up the hill’ and how an aspiration and ambition for improved health and well-being could drive a positive **Journey**. However, knowledge of their personal limitations, and an understanding of the impact of unforeseen events and setbacks, mean that many are realistic about what they can achieve. All demonstrate some personal responsibility for their own health and well-being and most are able to manage their **Journeys** with creativity and determination. None of this is easy and sometimes they struggle to overcome setbacks. Even so, most are motivated to apply effort to regain momentum with their **Journey**.

The next section explore how the theme of **Balance** affects the men’s ability to apply themselves to improve, maintain, or prevent decline in their health and well-being.

6.2 Theme 2: Balance

Balance refers to the state the men must achieve to be most efficient at applying pressure to their health and well-being boulder and therefore make the greatest progress on their **Journey**. Hence, if they are in **Balance**, they have the best chance of fulfilling their health and well-being projects. However, if their **Balance** is upset, progress with improving or maintaining their health and well-being is lost or slowed until they are able to regain **Balance**. There were two elements to this: Negative effects on **Balance**, and **Managed threat.**

6.2.1 Negative effects on Balance

The most pressing challenge to **Balance** discussed by the men was poverty. All the men lived in poverty and seven explicitly described negative effects of this on their **Balance**, more pertinently lack of choice due to lack of money. For example, Tony explained how this impacted negatively his social life: “going out to see films, going out to see live music an b-b-both those things are affected by not having cash […] I suppose it is a bit of a holiday to do that”. Lacking his ‘holidays’ meant Tony was less in **Balance** and less able to maintain the desired ‘pressure on his boulder’.

Figure 6.4

Faceless Brutality of the Benefits System Induces Feelings of Powerlessness and Suicide

Although, Keith was usually able to stay in **Balance** on his health and well-being **Journey**, he described how his **Balance** was upset by official benefits letters: "terrifies me and I or I have to get out of it and it creates this sense of thoughts that lead towards suicide and sort of hideous sense of powerlessness". In Figure 6.4 Keith highlighted what he saw as the faceless brutality of the benefits system and the huge negative effect on his mental health. This was the only time in the interview Keith lost his calm demeanour and became agitated, angry and sweary. The sense of rage and impotence radiating from him was palpable indicting the negative effect on his **Balance**.

Three of the men (Colin, George and Peter) were working, but the low paying jobs they performed were having a negative effect on their **Balance**. Colin needed to work hard to earn money to spend quality time with his daughter. His **Balance** is much improved by the time he spends with his daughter, but the jobs he performs **unBalance** him: "the drudgery or chaos of what has been my day-to-day life," and his health and well-being suffer. However, Colin accepts this as what he needs to do to spend time with his daughter. George, who has aspirations to return to university, is in a similar position. He is motivated and has positive plans for the future but, in the meantime, needs to earn money. However, being unqualified means he has to undertake work which he finds uninspiring: "monotonous boring repetitive […] it just drags on me." His **Balance** is affected and this means, in the short term, so is his health and well-being.

The negative influence on **Balance** affected the men's ability to apply the desired optimal pressure on their boulders to keep-up progress, maintain position, or prevent decline on their health and well-being hills. Some of the challenges which **unBalance** the men are constant, such as the poverty, while others are intermittent or finite, such as struggles with benefits bureaucracy.

6.2.2 Managed threat

The other element in the theme of **Balance** was '**Managed threat'** where the men had experienced a challenge to their **Balance**, but one for which they had a strategy to minimise its impact and actively **reBalanced** their life.

Figure 6.5

Andrew's Well-being was Improved when he Visited the Park as he said his Mind Expanded to Fill the gap Surrounding You

Many of the men used outdoor spaces to **Balance** threats to their health and well-being. For example, Andrew took a photograph (Figure 6.5) to highlight the difference between the loneliness of the enclosed space of his house with the mind-expanding space of a park close to his home. He expresses the **Balance** between the two and the benefit to his well-being: "I always think sometimes that your mind expands to fill the gap in which surrounds you." He understood the threat to his **Balance** and countered it with a deliberate **reBalancing** strategy.

Unfortunately, some strategies were not so healthy. For example, three men used addictive substances to attempt to **reBalance** (other) negative influences in their lives. Although seen by many as harmful, these men chose to use addictive substances because their effects were preferable to what was confronting them. For example, Mark was in an unhappy relationship from which he could see no escape due to the poverty in which they lived: "I'd become really unstable, er and I was depressing my partner I was behaving like an arsehole […] the only times I ever felt happy was doing MDMA". Hence, he found an escape from his unhappiness through drug taking.

The men wanted to invest in their health and well-being. **Balance** is needed to enable maximum pressure to be applied to the boulder to push it up the hill, hold it steady or slow its progress down the hill. This section contains some of the ideas the men brought to the interviews about things they perceived as affecting their **Balance** in a negative way: i.e., poverty, tedious jobs, and official letters. Some of these were countered by strategies that **reBalanced** them in positive ways - use of outdoor space – and less positive ways - use of substances.

The next section looks at how **Time** negatively affects health and well-being.

6.3 Theme 3: Time

The theme of **Time** captures one of the two themes that exert negative pressure on the participants health and well-being, the other being **Space** which will be presented next. **Time** has three elements:

too much Time, wasted Time, and not balancing Time. These show how **Time** affect the men's health and well-being and slows or stops their **Journey**.

6.3.1 Too much Time

Six unemployed, (Geoff, Mark, Brian, Dave, Tony and Paul F.) two retired, (Paul C. and Stan) and one man with a chronic illness (Derek) described having **too much Time**. Specifically, loneliness and boredom weighed heavy on some of the men. For example, Mark's loneliness meant his tiny flat felt even smaller: "the living room has become a corridor to get to the kitchen or the bathroom. I pretty much live in the bedroom". And, given that Brian's employment agency did not find him much work, he needed something to do to relieve the boredom, even if it meant an unhealthy pursuit: "sometimes when I'm not working and that, I could spend hours playing on the X-Box […] just playing on the X-Box is, quite unhealthy". As all were living in poverty, relief from boredom and loneliness could be difficult to find. Many, like Stan, could not afford to travel on the bus: "it's a lot of money is 4 pound", and, like Tony, ability to maintain a social life was dictated by minimal finances: "Things I like doing are probably going out to see films, going out to see live music an both those things are affected by not having cash". Challenge finding things to do to fill **Time**, mostly alone, are echoed by all nine men. These feelings exert negative pressure on their boulders and reduce progress on their respective **Journeys**.

6.3.2 Wasted Time

Three men (Alan, Paul F and Tony) indicated that there was **wasted Time** in their lives. Alan, an ex-alcoholic, said he wasted a lot of **Time** to alcoholism. The other two men were in their early sixties and indicated that they were wasting a lot of **Time** trying to find employment to be able to receive their job seekers allowance. Paul F. looked forward to when he could give up this futile search: "I don't want to stay on Jobseekers where I do have to look for a job I don't think it's any contest." The switch to pension credits would free up **Time** to allow them to do the things they valued. All three men indicated that they would rather be engaged in activities other than those that wasted their **Time** - **Time** lost, never to be used fruitfully - and this contributed to poorer health and well-being.

6.3.3 Time not balanced

Four men (Simon, Colin, Stan and Peter) were focused on one aspect of their lives to the detriment of their health and well-being. For example, as described above, Simon's obsession with vinyl records and the work he needed to do to fund this obsession meant his **Time** was out of **Balance**: "wish I didn't have to make as much of an effort to stay in touch […] too many jobs […] if I could plan my food out better I'd be eating better". Hence, Simon's **Time imBalance** affected his physical health, his nutrition and his social life.

Stan's had been caring for his wife until recently when she had died. His desire to ensure she was well cared for meant he had given up his friends and usual pursuits, affecting his health and well-being. He

had recently taken up fishing although “not as much as I used to as I were just looking after the wife like with her being poorly” and enthusiastically described having a good days fishing.

Too much Time, wasted Time, and Time not Balanced had a negative effect on the men’s health and well-being. **Space**, outlined the next section, also had a negative impact.

6.4 Theme 4: Space

The **Spaces** here are inner and outer metaphorical environments which negatively impacted the men’s health and well-being and thus impeded their **Journey**. The three relevant **Spaces** are: Money, Home, and Addiction.

6.4.1 Money

Money as a negative metaphorical **Space** was by definition a problem for all of the men given that their income was less than £14,000 a year at time of interview. Sixteen of the men included **Money** as something that had some form of impact on their lives, but seven (Will, Tony, Mark, Brian, Dave, Simon and Stan) saw it as something that affected their health and well-being rather than it being just an inconvenience. For example, Will had recently switched benefits payments and struggled for a while during the transition: “we’ll give you **Money** in 2 weeks when I had like £5 in my bank account […] shit I’ve got no money”. No **Money** meant no food and this was a direct and immediate threat to both his health and well-being.

Figure 6.6

Lack of Money is a Risk, Wholesale Rice Made Efficient use of Tony's Money

Tony was in a similar position having been switched from jobseekers allowance to pension credit which gave him less: “There have been times when really I have run out of food and you know it’s not it’s not really a great nice situation to be in.” Tony took a photograph of a large bag of rice to highlight his poverty and subsequent poor nutrition (Figure 6.6). This what was left from a trip to a wholesalers with a friend in an attempt to be as efficient as possible with his **Money**. He made meals from chickpeas, rice and onion and went days without any fresh fruit or vegetables.

6.4.2 Home

Far from being a place of safety, many men found their health and well-being negatively affected by their **Home Space**. Twelve of the men lived alone (see Table 3.1) and some, like Geoff and Andrew, appeared to spend as much time as possible away from their **Homes**. For Mark, the thin walls meant that he could hear other people enjoying a social life. Being very lonely, himself, this had an

enormous impact on Mark's well-being: "it's not the most private of places and when you don't know many people it's almost frustrating hearing everybody else's very busy chatty lives it can be quite depressing." On the other hand, George knew if he stayed in his home town he would not fulfil his potential due to limited opportunities. He had decided to live an 'extraordinary life' by studying for a nursing degree and travelling abroad to practice his nursing.

6.4.3 Addiction

The 'head-**Space'** of **Addiction** had been overcome by many of the men. Drugs, alcohol and nicotine **Addiction** has been beaten, enabling the men to improve their health and well-being.

Figure 6.7

Stopping Smoking was the Next Challenge for Liam to Improve his Health and Well-being

Liam knew the difference it made if he did not smoke for a while and this was motivating him to stop: "I don't intend to carry on smoking for another twenty year, I think that that would finish me off". Liam introduced cigarette smoking in one of his photographs (Figure 6.7) but returned to the topic several times in the interview in other contexts. He likened cigarettes to his drug **Addiction** as easy to maintain but hard to stop. He had recently started a new job which entailed three bus **Journeys** but with not enough time for a cigarette between. He said he felt fresh and alert when he arrived at work and that feeling was motivating him to stop. He wanted more of that feeling and also knew he would live a shorter life if he did not stop.

Presented next are the three positive themes that represent how the men fuel their ambition to improve, maintain, or prevent decline to their health and well-being: **External Resources** and **Awareness,** with **Resilience** integrated into the discussion of these two themes to aid understanding of how the three themes interact.

6.5 Theme 5: External Resources

Sometimes to continue to progress on their **Journey** the men need help from outside. This theme has two aspects: External Resources that support health and well-being, and when External Resources are absent.

6.5.1 External Resources that support health and well-being

For health and well-being, the majority of **External Resources** were provided by friends and family who supported by advising, supporting and protecting the men through their **Journey**. Derek supported his social life through meeting others regularly at a men's group and improved his health

through their regular walking trips: “That walk you know for the lights […] hopefully they’ll do more […] I love walking really”. David appreciated the sense of community on the housing estate on which he had lived all his life: “ I loved it and dragged up in (name of town) but it didn’t bother me at all because it made me streetwise […] I just love the community […] people in there that I've known for years and years”. George felt emotionally close to his family and they provided him with Resilience when times were tough: “It is a close family so yeah it’s what we do”. On the other hand, although Dave and his mum were not close it was the lesser of two evils for him to live with her: “I live with my mother at the moment, not really out of choice […] it’s better than being homeless”. Similarly, Alan’s uncle and aunt saved him from homelessness when he had managed to stop drinking: “when I needed a deposit, for my apartment, they, put me up”. This relationship extended to doing each other favours: “cutting my Uncle’s hair and er, tinting my Aunty (name)’s hair […] gives me, well-being doing a really good creative piece of work […] he’s at my house now tiling my en-suite and he wouldn’t even dream of charging me”. Hence, this **External Resource** in the form of a supportive relationship extended beyond a time of desperate need for Alan to a time where they could exchange skills and all save money.

Friends and family were the most frequent **External Resource** that increased health and well-being. For men who lived alone, they reduced loneliness. For others friends and family brought joy, got them out of their “shell” or “rut” and meant a more fulfilling life.

6.5.2 When External Resources are absent

Occasionally, the men gave examples of what happens when they were not available to draw on **External Resources**. For example, Mark did not have enough money for bus fares so when his choir group moved to another part of the city he was unable to attend and one of his few social outlets was removed which intensified his loneliness. On the other hand, Simon’s many jobs which supported his record collection meant that he did not have time to maintain his friendships: “wish I could make, didn’t have to make as much of an effort to stay in touch, but it’s how it goes you know, too many jobs”.

External Resources were important for all the men. Some used them to improve their health and well-being and a few highlighted what happened when **External Resources** were absent.

6.6 Theme 6: Awareness

Awareness captures the men’s understanding of themselves, their behaviours, and potential threats to their health and well-being that might impede their **Journey**. There are two aspects: Positive **Awareness** and behaviours, and **Awareness** of risks.

6.6.1 Positive Awareness and behaviours

Positive Awareness and behaviours is by far the largest aspect in this section.

Positive health examples were around eating well with good nutrition but included how the experience of food preparation and eating contributed also to well-being. Mark was particularly passionate about food and the benefits of cooking: "…you'd work out your frustrations during the cooking process and you'd sit down and a mouthful of carbs and you'd just instantly feel better there's nothing because food is more than just fuel or it should be it should be a sensory delight on every level to make you feel better in so many ways cooking and eating should be bloody good therapy and when you know where it comes from that's absolutely what it is". Many other men talked about positive nutrition and the benefits for their health from that perspective.

Twelve of the men described an **Awareness** of the benefits of exercise for both health and well-being. Liam played football with his friends once a week and knew the benefits. "…the concentration and get a good sweat on and go home and have some tea and then I go to work the next day yeah and everything is sound". George played football with old school friends he had known for many years. "…enjoy the run out the fitness side of it I enjoy the banter between your friends".

Even with the odds stacked against them in terms of income and opportunities, all of the men persevered on their **Journeys**. The most striking examples are those where the men had the **Awareness** they take an easy option but chose to show the **Resilience** to persevere and expend extra effort while experiencing discomfort to do so. Thirteen of the men referred or alluded to behaviours that carried benefits for their future.
David's impaired mobility does not stop his enthusiasm. "…every morning so I can get up, up and at 'em I'm out no matter what the weather". Mark experienced extreme loneliness "and did not give up on their being a brighter tomorrow. "I talk to myself a lot these days […] there are days when I sat and I'm nearly in tears […] tomorrow's another day and you know you get up and you kind of try and renew that hope". He did not give up on the dream of life becoming better in the future.

Other men showing **Resilience** are trying to rid themselves of addictions, working hard physically to improve their mobility issues and persevering with ongoing mental health problems. Keith used his **Awareness** of himself to work with his difficulties which was more positive and fruitful than trying to change them. "I think with mental illness so much of what you're dealing with is that sense of that you're wrong that you don't work and what I've learnt is I do work I just work the way I work".

Using their **Resilience** to persevere means the men continue their **Journeys** despite the privations of poverty.

Some of the men had medical conditions that precluded exercise that would be seen as normal but this did not deter them.

Figure 6.8

The Benefits of Climbing this Long Hill are Worth the Struggle

Despite having several pre-existing medical conditions, Paul F. challenged himself to improve his health. Paul's first photograph (Figure 6.8) was one of those that inspired the idea of Sisyphus representing the struggle with health and well-being for these men. Paul had asthma and arthritis but walked up this very long hill to get to his home as he knew that despite the struggle (including a stop for his inhaler), it was doing him good in the long term and maintaining his position on his hill. "…great big hill that I have to walk up […] I suffer asthma and arthritis and in the foot […] you get your exercise bit"

The men here had positive **Awareness** of themselves and their capabilities, also positive **Awareness** of experiences that improve their health and well-being.

Keith had a clinical diagnosis of depression and described how he tried to work with his issues and take the best from them. Keith used the positives of his mental health issues to improve his ability as a musician. "I think with mental illness so much of what you're dealing with is that sense of that you're wrong that you don't work and what I've learnt is I do work I just work the way I work so to have something that helps you to say that this is me" Keith had **Awareness** of how to utilise a strength that others saw as a weakness to his advantage.

Figure 6.9

Keith's Saxophone was Essential to his Health and Well-being

Keith followed up and contrasted his earlier rage about his impotence against the benefit system with this photograph (Figure 6.9) showing the mouthpiece of his saxophone. The saxophone was an External Resource that improved his mental health immensely. He described the feeling of flowing through the saxophone, being able to fly, being courageous and facilitating an open display of whatever he is "The saxophone is a way of becoming courageous sort of like I couldn't stand in a pub and say those things with words very easily" The courage and **Resilience** gained from playing his saxophone in front of others gave him the strength to carry on pushing the boulder up the hill.

The three men who overcame or who were in the process of overcoming their drug or alcohol addictions showed impressive inner strength and **Resilience** to do this. Alan overcame temptation to remain dry and also overcame smoking. He had **Awareness** of the triggers for his alcoholism so could manage those triggers effectively. "If I see continually a lot of adverts on TV where they are drinking wine or beer or whatever and I just go and reprogram in a dark room".

Other men in this section resisted recreational drug temptations, they were **Aware** it will have detrimental effects on their health and well-being. Peter showed inner strength to start to manage his feelings about his childhood abuse to the point where he felt strong enough to confront his abuser in a non-violent way.

The men in the element of positive **Awareness** and behaviours are able to apply their knowledge of themselves and their environment to improve their health and well-being using positive perspectives as well as positive action.

6.6.2 Awareness of Risks

Some men were **Aware** that there were risks to their health and well-being and consequently their ability to maintain progress on their **Journeys** would be impaired. These risks were managed within their capabilities and were for the most part negated. George was **Aware** of the risks inherent in staying in his hometown, taking an unfulfilling job and living an unfulfilling life. "Ordinary is not something I want […] I get bored if I do ordinary all the time". As George was **Aware** of this risk he was doing his best to remove this risk from his life.

Three men (James, George and Dave) had **Awareness** of current risks in their lives.

Figure 6.10

James Worried that no Money Meant no Electricity

James shared a house and had recently lost his job. His house mates also did not earn much so it was a tangible risk to them all that they might run out of money to top up the meter (Figure 6.10). James explained they had to scrape together the money in the past. James was **Aware** that no electricity would be a big risk to his health and well-being and this enabled him to focus his energy on ameliorating this risk. "…spare money goes on electricity […] I would hate to be in the situation where Im where I just don't have enough money to live". As with George, **Awareness** of these risks meant James could take action to prevent a detrimental effect to his health and well-being.

The risks outlined above could impact the health and well-being of these men. Their **Awareness** allows them to try and mitigate the impact on their **Journey** towards improved or maintained health and well-being.

The men's understandings of themselves, their behaviours and potential threats to their health and well-being allowed them to stabilise their pressure on their boulder.

6.7 Comparison to other models and approaches

6.7.1 The biomedical model

The biomedical model of health tends to be reductionist through explaining higher level process (such as culture) through reference to, what is considered to be, the foundational biological level. This enables medical science to build mechanical models of bodily systems and describe its functions in quantifiable terms but can reduce the body to an afflicted organism to be mended by the medical profession. Health is defined by this model as the absence of disease (Tamm, 1993). Despite making huge strides in curing disease and infirmity throughout the world this remains a model of health as absence of disease model with no place for well-being (Larson. 1999). Wade and Halligan (2004) deconstruct the medical model into its component parts. Similar to Tamm (1993), they define health as the absence of disease. Furthermore, they argue in a cyclical way that all disease gives rise to symptoms and these symptoms (and illness) arise from abnormalities known as disease. The individual with disease is labelled as a patient and is a passive recipient of healthcare. Moreover, that the patient has little responsibility for the cause, presence of, or recovery from the illness.

There is very little similarity between the biomedical model and the model proposed in this chapter. The participants described their experiences of ill-health but not in a passive state, there were many descriptions of their **Resilience** through agentic actions to alleviate symptoms of illness. The biomedical model could be developed further by incorporating elements of the agentic patient who takes responsibility to reduce the causes of illness and takes joint responsibility for recovery. More fundamentally, the men talked about health and well-being as a complex, holistic experience shaped by their environment, with all of its health inhibiting and health promoting features.

6.7.2 *The WHO definition of health and wellbeing.*

The World health Organisation definition of health includes the absence of disease or infirmity as seen in the biomedical model above but also includes complete physical, mental and social well-being (Grad, 2002). However, well-being is ill defined and has been the subject of much discussion about the merits of such a vague definition (Larson, 1999). It is apparent from the data presented in this thesis that there are synergies with viewing health as an interplay between physical, mental and social

well-being. However, very few of the men were able to achieve complete physical, mental or social well-being. The model presented here indicates the route towards this state through their **Journeys** with **Awareness**, E**xternal Resources** and **Resilience** applied to achieve this. As can be seen from the data presented here, many, even in affluent countries cannot achieve health as defined by the World Health Organisation. This definition of health could be broadened to include working towards complete physical, mental and social well-being as a goal. The model presented here can be used as a template to help people understand that health and well-being may mean different things to people living in different circumstances. Moreover, it illustrates the interplay of factors such as poverty, unhealthy **Time** and **Spaces** as impediments to achieving health and the positive factors employed to improve physical health, mental health and social well-being.

6.7.3 *The social model of health*

The social model examines factors that affect health, social, cultural, political and environmental. This model tends to look at the negative aspects of these and provides evidence for those trying to improve these, thereby improving health. McGarvey (2017) argues that managing and maintaining oneself are the way to seize the means of production to transform oneself and then one's community. Marmot (2003) argues that social inequalities create low levels of autonomy and self-esteem. For the majority of the participants in this thesis, this did not appear to be the case. Many showed that they are autonomous in areas of their own health and although they reported mental health problems, many of the men were capable of overcoming these to an extent where they were still able to enjoy life. The model proposed here defines how to manage and maintain oneself. In poverty, that downward pressure is constant but to move away from risky **Spaces** and poor use of **Time** and enable **Resilience**, **Awareness** and **External Resources** appeared to create higher levels of self-esteem and autonomy for the men. The focus still needs to be on improving the lived environment to facilitate reduction in social inequalities.

6.7.4 *The salutogenic model*

Antonovsky (1990) rejected the health/ill health dichotomy and proposed a continuum where we are all ill (rather than healthy) to a lesser or greater extent but also that health is not an absence of illness. It is our general resistance resources that we mobilise when we experience various degrees of stressors that defines whether we succumb to the stressors and become ill or not. The greatest of these resources is an individual's Sense of Coherence which speaks to the individual by motivating and encouraging them to continue in a particular successful way of life, similar to the **Journey** in the model presented here. Sense of Coherence has three elements: Comprehensibility, a sense that life is predictable and life events are within a person's understanding; Manageability, a belief that a person has the skills or resources to manage life and that life is under control; and Meaningfulness, a belief

that things in life are interesting or satisfying and there is a good purpose to life or a reason to care about what happens in life.

Each element of the sense of coherence will be discussed in turn with respect to the model of health and well-being presented here. Within comprehensibility, life for men on low-income is not predictable. Fluctuating income and employment lead to uncertainty over housing and as seen in the data, uncertainty over electricity supply and food availability. However, for the other part of comprehensibility, events are within these men's understanding as they show a high level of **Awareness** of themselves and their situations. They understand they may not always be able to counter negative events but their **Awareness** allows them to reduce their problems for the most part. Within manageability, there are two parts: a belief that a person has the skills and ability to manage life and also that life is under control. As discussed in the above point, life being predictable and life being under control are not always available commodities for men on low-income. The men's **Resilience** and **External Resources** are drawn upon as skills and ability to manage life. The skills and abilities they deploy may not be similar to those on higher incomes but adapted to their situation. Again, there are two parts to Meaningfulness: a belief that things in life are interesting or satisfying and there is a good purpose or reason to care about what happens. Many men showed the **Awareness** that they found life interesting or satisfying. Their **Journey**s exemplified that for many there was a good purpose to life or a reason to care about what happens.

There are strong resonances between the salutogenic model and the model of health and well-being presented in this thesis. Poverty is an important negative element of the model of health and well-being and accounts for many of the major differences between the models. The similarities allow avenues for future research discussed in chapter 7.

6.8 Conclusion

This chapter has introduced the preliminary model of health and well-being drawn from the data presented in chapters 4 and 5 and constructed using the themes created in chapter 5. The model demonstrates the extraordinary amount of effort expended by eleven of the men on low-income who showed immense ambition to improve their health and well-being. These men, akin to Sisyphus pushing the boulder up the hill, are on a **Journey of progression**. However, seven were expending a lot of effort just to keep their boulder as stationary as possible and were identified as on a **Journey of maintenance**. Three, despite their best efforts, were finding the weight of the boulder too much and experiencing a worsening of health and well-being on a **Journey of decline**. To enable the men to apply the most efficient amount of energy on the boulder, they must not be pushed off **Balance** by life events. Some men struggled with this at times while others found ways of countering these

unBalancing effects. Various aspects of **Time** and **Space,** some due to poverty, created experiences of negative health and well-being for the men causing their boulders to slip down their hills. However, they drew on: the **External Resources** - mostly provided by their friends and family - to help resist the downward push of the boulder; their own **Awareness** of themselves and negative factors in their environments; and their personal **Resilience** to negative factors to enable them to apply as much pressure on the boulder as possible and make progress on their respective **Journeys.** Hence, the myth of Sisyphus is as relevant today as much as it was to the ancients and offers a heroic counter narrative to the way in which men living in poverty are often positioned in contemporary discourse with respect to engagement with their own health and well-being.

7 Chapter 7 Discussion

This chapter will initially focus on how this thesis answered the main and secondary aims of the research. It will then move on to a summary of the contribution to the literature. Strengths and limitations of the study will be considered next, finishing by considering the practical implications and recommendations for future research.

7.1 How does the thesis answer the aims of the research?

7.1.1 The aim of the research

The primary aim was to critically review the historical and contemporary positioning, evidence and experience of health and well-being among men on low-incomes. This was done by the work in the historical and literature review and then by asking men to photograph things in their lives that affected their health and well-being and positive aspects discussed in unstructured interviews. Content Analysis in chapter 4 categorised the men's health and well-being behaviours and how they created positive health and well-being in their lives. Interpretative Phenomenological Analysis in chapter 5 turned the lens on how the men experienced and created positive health and well-being for themselves. Analytic outcomes were integrated in a conceptual model of health and well-being that incorporated the seven themes generated from the Interpretative Phenomenological Analysis.

This section will now detail a summary of how this thesis answered the primary aim. It will summarise the historical and contemporary positioning of health and well-being for men on low-income. It will then summarise the findings of the Content Analysis which categorised men's health and well-being behaviours and how they create health and well-being in their lives. Moving on to a summary of the Interpretative Phenomenological Analysis and the themes that captured how men on low-incomes experienced and created positive health and well-being for themselves. Finally, this section will summarise the model of health and well-being in Chapter 6.

Black (DHSS, 1980), Acheson (1998), Scambler and Scambler (2007) and Baggott (2011) all point to material deprivation impacting on health outcomes. Eight of the men (Dave, Liam, Simon, Mark, George, Stan, Geoff and Keith) agree and give examples of ways in which material deprivation impact on their health and well-being in various ways. Dave pointed to the high unemployment and lack of facilities where he lives and said benefits were spent in the pub, bookies or off-licence.

Alcock (2006) argued there was little evidence to show the poorest are excluded from society. However, since then, Shameless (Abbott, 2013) (a black comedy set on a Manchester council estate with the anti-hero, an alcoholic father of 6) and Benefits Street (Smith, 2015) (a reality Television

show set on street in Birmingham, reported to have 90% of residents on benefits and depicted committing crimes) both aired in the UK on Channel 4, have produced mainstream media depicting the poorest in a bad light. Dave was the only man to include exclusion in the interviews when he explained that because of his scruffy clothing he was followed by the security guard if he walked into the department store Marks and Spencer.

The World Health Organisation (Grad, 2002) defined health in 1948 as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Six of the men were experiencing chronic physical infirmities and another five had clinical diagnoses of mental health disorders. Despite this, all of the men reported aspects of mental and social well-being gained through many different avenues in their lives. For all the men, their complex lives with continually fluctuating fortunes meant they often saw positives in the smallest things, a nice view (Liam), a tasty biscuit (Colin) or the smell of the park (Mark). These examples are the ways in which we all could increase our well-being, by doing as the Foresight Mental Capital and Well-being Project (2008) suggested and take notice of what is around us.

The World Health Organisation described mental health as more than a lack of mental disorders and includes a state of well-being where everyone realises their potential, can cope with life's stresses, work fruitfully and productively and contribute to their community (WHO, 2014). This definition of mental health is also Keyes (2002) definition with a continuum from flourishing to languishing. Flourishing is a state of positive psychological, emotional and social functioning with high levels of well-being. Languishing conversely is stagnation, emptiness and quiet despair with low levels of well-being. Sayers (2010) reports men on low-income in his practice who are languishing. This research counters Sayers report. As Macnicol (1999) pointed out in chapter 1, those assessing others should not use their own frame of reference but must see behaviours in context. Using this premise and referring to the model in Chapter 6 where eleven of the men are on a journey of progress, they can be interpreted as working towards a form of positive psychological emotional and social functioning to be able to do this. Their life circumstances were deprived and often chaotic but to, in some cases, dramatically improve their health and well-being, we can understand them to be flourishing or approaching a state of flourishing. Although some of the men were maintaining their health and well-being and some were declining, only Simon appeared to be languishing, living in quiet despair with low levels of well-being. All the other men in the declining or maintaining categories of health and well-being (Geoff, Brian, James, Colin, Derek, Paul, Andrew, David and Paul C.) had many challenges in their lives but were outward looking and gained increased well-being through the people in their lives and the activities they undertook. It may be that men who were stagnating or languishing might not choose to take part in this research. However, the aim was to explore evidence for

overlooked positive health practices in this demographic, and it is accepted that many men living in poverty will struggle to do this.

The Foresight Mental Capital and Well-being Project (2008) proposed that to increase our well-being we should: connect; be active; take notice; keep learning; and give. All the men achieved at least one of these actions and many achieved three or more. It was a function of the camera based research that the men would reflect from a distance on their lives (Rose, 2012) so some of the data contained take notice. Interestingly, the majority of the day to day taking notice was of well-being. If the men were not noticing their health, then their health was, if not optimal, then not causing them concern.

Ryff (2018) proposes a six component model of eudaemonic well-being: Autonomy; Environmental Mastery; Personal Growth; Positive Relationships with Others; Purpose in Life and Self-acceptance. The data is littered with examples of the men displaying these behaviours, extending current research of eudaemonic well-being into the lives of men on low-income.

- Almost all the men could be seen as having **autonomy**, they are self-determining, self-regulating and independent. They occasionally need to rely on external resources such as friends, family or agencies to support them, just the same as other population groups.
- **Environmental mastery** is choosing, creating and participating in environments conducive to one's psychic needs. Many men showed this aspect of eudaemonic well-being. Liam, chose to be away from risky people who he knew would lead him astray, Dave away from other alcoholics, Alan knew his 'peace place' where he could reset himself and Stan enjoyed going fishing.
- **Personal growth** focuses on achieving human potential and self-realisation. Many men showed great self-awareness and self-understanding, creating environments away from risks and towards areas that aided self-improvement. More than half the men were on journeys of progress where they were improving themselves.
- **Positive relationships with others** is key for many of the men's lives, all of the men gave examples of positive relationships with others. Some were friends who freed them from drudgery, others families where they felt loved, and some partners where the men expressed love in the interviews.
- Career orientation is a common **purpose** in life. For these men with higher levels of unemployment and short term employment opportunities, purpose in life is necessarily contextually different. Creating meaning in life during adversity (Frankl, 1984) resonates with some of the men's stories. From Brian's achievements while playing FIFA on his X-Box to

Peter finding love in a secure relationship following his childhood abuse and Liam and Alan deciding to and subsequently conquering their addictions.

- Many men showed **self-acceptance**, accepting their strengths and weaknesses and coming to terms with their dark sides. Mark, Paul, Liam and Alan are all men who gave examples of this and who now are experiencing greater levels of eudaemonic well-being as a result.

Hegemonic masculinity (Connell, 1995) has been the most common framework with which to research men's health in recent years. It characterises men as encouraged to be tough, competitive, unemotional, desiring success and to be envied by other men (Lee & Owens, 2002). When men on low-income are researched with masculinities as a framework, the data produced positions them as exhibiting negative behaviours (Emslie et al., 2006; O'Brien et al., 2005; O'Brien at al., 2009).

More recently, multiple masculinities (Connell, 2005) have allowed men's health behaviours to be researched with more subtlety and flexibility. In understanding caring masculinities (Hanlon, 2012) argued a link between masculinities and the emotional lives of men. Connell's (2005) argued that there were levels of masculinity with local level caring masculinities being rewarding for men helping them to feel responsible, proud and wanted. Salutogenic masculinities (MacDonald (2011) create and promote good health by building on existing positives. These practices should be championed (Roy et al., 2017). Lomas (2013) found that some men resist or reinterpret masculinities in a positive way. de Visser and McDonnell (2013) report the use of man points to build masculine capital in a positive rather than negative way. This more recent research with positive messages shows that masculinity can be positive in outlook and highlight the positives in men's health. However, in practice its reductionist nature draws attention away from men's situated health practices (Gough, 2018).

For this reason, I have not featured masculinities within my research except as a counterpoint to the phenomenological situatedness of my data. From the theory and published research I have read, using masculinities, there is little scope for positive health behaviours. The aims of the research and research question explicitly aim to generate data on positive health behaviours therefore a situated phenomenological approach was used. Masculinities would have pulled me too far from the data and the phenomenological approach. There is scope for mixed qualitative methods using IPA and masculinities to further understandings of men's health.

The Content Analysis in chapter 4 provided a decontexualised account of the range of health practices alluded to by participants and illuminated potential patterns - similarities and differences - between them. Deliberately descriptive to foreground health and well-being practices without a theoretical overlay. Four clusters of behaviours were created to aid understanding, these were: beneficial activities; awareness of the everyday; states of mind and moving away from risk. All clusters and

categories within the clusters were grounded in the data to ensure the descriptions remained close to the participant's accounts.

Interpretative Phenomenological Analysis in chapter 5 then turned the lens on how the men experienced and created positive health and well-being for themselves. Situated experiences and reflections from participants are highlighted using the wider socio-political context of poverty. This is supplemented by the use of photographs where appropriate to further situate health and well-being experiences in the otherwise invisible poverty of their lives. Ideographic accounts of the men's lives were used to highlight the differences between the men's lives as they experience and integrate positive health and well-being into their lives. Seven themes were created: Journey; Balance; Space; Time; Resilience; External Resources and Awareness to spotlight the similarities between the men's lives. These themes interweave the accounts and create a more complete understanding of how the men experience and create positive health and well-being in their lives.

In chapter 6 the phenomenological themes from chapter 5 were integrated into a model of positive health and well-being for these men on low-income. The metaphor of Sisyphus pushing the heavy boulder up the hill was used to show the heroic nature of the men's struggle with experiencing and creating positive health and well-being in their lives. The model demonstrated how the themes were interlinked and how the men resisted negative events and influences on their health and well-being to create positive experiences anew and flourish despite their poverty and deprivation.

7.1.2 Secondary aims

The **secondary aims** are presented again below. The ways in which each was engaged with in the thesis are described briefly and an evaluation offered of the extent to which each aim was met.

(i) Detail the importance of situating the study of men's health within a historical and political context.

This aim was met in Chapters 1 and 2, which demonstrated a number of key issues.

Historical review

Historically, the medical profession was dominated by men and thus to be healthy was to be male, strong and powerful, reflecting the traits proposed by Connell (1995) in the theory of hegemonic masculinity. Being female was associated with fragility, vulnerability and being not healthy. To be male was to be normal, to be female was to be abnormal (Clare, 2004). Under these conditions, 'abnormality' was researched and specific interventions designed for women's needs. Coupled with the female 'role' to present children to the medical profession, women were much more visible to medicine. Men's invisibility, the need be strong and powerful and higher level of occupational danger was a triple whammy for men's ill health resulting in part to women's higher life expectancy since records began. Focusing research on men's health as a separate entity started in earnest after Calman's

(1992) Chief Medical Officers report. The emergence of hegemonic masculinity (Connell, 1995) in the mid 1990's as a way of critically examining men's health furthered political and sociological understandings. Hegemonic masculinity situates men as stoic, unemotional and unlikely to seek help for mental or physical health problems. Hegemonic masculinity has been helpful in understanding some of the reasons for men's mortality disadvantage but the theory does not have the capacity to create a climate for change. The next step is to create a climate of positive change that will improve men's health and enable men to live longer, healthier lives.

7.1.2.1 Literature review

The literature review in chapter 2 had three aims: To review the positive health and well-being behaviours in the literature for men on low-income; to understand how positive health and well-being behaviours are framed using hegemonic masculinity; to reflect on missed opportunities from research with low income populations or men on low-income.

The literature review aimed to discover the research focused on the positive health and well-being behaviours of men on low-incomes. Of the 170,000 papers reviewed from the last twenty years, two had this as their focus and these were published in the last two years showing the lens is shifting towards improving men's health and mental health. Of the other nine papers that reported positive health and well-being behaviours in men, the reporting of positive health was incidental and only had one sample that was exclusively low-income. The two papers (Robertson et al., 2018; Simpson & Richards, 2019) which had the health and well-being of men on low-incomes as their focus, researched support groups as an intervention to improve health and well-being. No research has been undertaken into how white British men on low-incomes understand, experience and create positive health and well-being for themselves.

Research framing health using hegemonic masculinity struggles to acknowledge the existence of positive behaviours. They are ignored (Emslie et al., 2006), seen as exceptional (O'Brien et al., 2009), rejecting expectations of hegemonic masculinity (de Visser & Smith, 2006), framed as power and control (McVittie & Willock, 2006) or hegemonic masculinity prevents help seeking in men unless a medical diagnosis is applied (O'Brien et al., 2005). There has not been a piece of hegemonic masculinity research into men's health that I have read that promotes, encourages or champions positive health behaviours. If all the news is bad, it does not promote a climate of possibilities, positivity or change for men's health.

There were many examples of missed opportunities to report positive health and well-being behaviours from research with low income populations or men on low-income. They fell into four broad categories. (a) Research with a narrow paradigm that failed to understand wider socio-economic

influences on poverty and poor health behaviours. (b) Research found that low income groups do not have the worst health in the population in the area under scrutiny and then explained these data as anomalous and a limitation of the research. (c) Research that recruited a hard to recruit group, men on low-income, then does not research positive health. (d) Research into lay perspectives on men's health. Positioning participants as 'lay' immediately manipulates the perspective towards 'researcher as expert' thus away from opening up the research to explore with anything other than a narrow viewpoint.

(ii) Use visual methods to engage the largely silenced, unidentified and often invisible community of men on low-income to given them a voice in research about them.

In chapter 3, Rose (2012) gives three reasons for using photo-elicitation with this group of men. First, different topics of discussion emerge compared to talk only interviews. Second, photo-elicitation is particularly good at encouraging participants to talk about every day, taken for granted things such as health and well-being. Thirdly, participants are empowered to be the experts in the process which demands collaboration between researcher and participant but allows them to tell their story, the way they want it to be told in the interview. Asking participants to take photographs boosts recruitment because taking photographs is fun and easy to do (Derbyshire et al., 2005; Wright et al., 2010). Finally, Creighton et al. (2018) posit that photo-elicitation encourages hard to reach participants to take part in research that they may not have been invited to otherwise.

My experience with this research supports the three points made by Rose (2012). (a) Different topics of discussion emerged. Men talked about how they feel about their relationships with their partners, and about their fears and vulnerabilities. The men could boundary what they wanted to say prior to the interview and therefore felt comfortable doing so. (b) Participants talked about every day, taken for granted things. Friends, rice, parks, buses, books, jigsaws, cleaning and walking were all introduced using photographs and discussed in relation to health and well-being. (c) Participants were empowered to be the experts and tell their story the way they wanted. I reflected on this in every interview and ensured they could tell me what they wanted the way they wanted. I asked a question of a participant in one interview and he felt empowered to say he did not want to tell me about the topic and this felt normal. I asked participants if they wanted me to use a pseudonym in the research, one participant told me to use their name and tell their story.

The initial seven participants were recruited quite quickly through existing contacts and snowballing but there was a hiatus of twenty months between the seventh and eighth interview. However, the remaining thirteen interviews were completed within ten months. No participant expressed the opinion that the task of taking photographs encouraged them to take part. It is difficult to assert from this that asking participants take photographs boosts recruitment. Participants' opinions of the process

of using photographs in research is discussed in the next section on strengths and limitations of the research.

(iii) Document and categorise the forms of health behaviours that white British men on low-incomes report.

Chapter 4 includes an extensive summation of the categories and form of health behaviours reported by white British men on low-incomes. The complete data set was coded, 27 sub categories were created from the codes. Ideas were compared across sub categories and from these, 16 categories were created. Finally, the categories were assessed and 4 clusters of categories were formed: beneficial activities; awareness of the everyday; states of mind and moving away from risk. As this was novel data with no specific phenomenon or theoretical overlay in mind, there was data that did not fit sub-categories and some of the categories or clusters are clumsy in their construction and name. Thus, there could be alternative categories or forms documented if undertaken by another researcher. The forms of health behaviours that white British men on low-incomes report are not separated from their well-being behaviours. More teasing out of these behaviours would be needed but this is necessarily very difficult due to the overlap in categorisation of health and well-being.

(iv) To critically consider findings in terms of White's (2001) four areas of concern for men's mental health: lack of awareness of their own needs; inability to express emotions; lack of access to mental health services; and men's lack of social networks.

Taking each these points in turn.

7.1.2.1.1 Lack of awareness of their own needs.

It became apparent early in the analysis that awareness of their own needs was a major strength of most of the men, to the point that is became a cluster (awareness of the everyday, 20 men included) in the content analysis in chapter 4 and a theme (awareness, 17 men included) in the interpretative phenomenological analysis in chapter 5. All men were aware of their own needs when it came to health and well-being. Not all were able to use this awareness to improve their health and well-being, but they were aware nonetheless. The unbiased instructions for participants to 'take photos of anything in your life that reflects your feelings of health and well-being in a positive or negative way' meant that needs in conscious awareness were captured to be brought to interview. Any needs they were unaware of could not be photographed and discussed in the interviews. The data was reviewed to attempt to discover whether there were any instances of needs of which they were unaware. There appeared to be none. As claims can only be made if the data supports those claims, it appears I am unable to say if there was a lack of awareness of their own mental health needs. A limitation of this research that I will address in the appropriate section.

7.1.2.1.2 An inability to express emotions.

Fifteen of the participants expressed emotions of varying intensity in the interviews, almost an equal amount of positive and negative emotions. This in itself is remarkable, these are men traditionally seen as reticent in interviews (Bahn & Barratt-Pugh, 2011). They live lives with deprivation and little material comfort and nearly half the expressed emotions were positive. Brian, James and Peter spoke about the emotions they felt for their girlfriends/partners, Peter used the word love in the interview. Colin and Alan loved their daughters and Derek loved his granddaughter and felt love when he was with his family. Brian, Colin, Liam, Mark, Paul and George expressed positive emotions of varying degrees. Dave, Simon, Paul and Keith expressed vulnerabilities during the interviews. Dave and Simon felt guilty and ashamed of their actions that lowered their health and well-being. Paul felt like the class dunce when he did not learn as fast as others while Keith failed to be a man when he did not stand up to others. Mark and Keith expressed anger at their impotence at changing a difficult situation but were lucid and clear about their anger. The rest of the negative emotions were described by Dave, Tony, Andrew, George and Derek who felt pissed off, stressed or anxious while Colin felt aggrieved he could not spend more time with his daughter. The men chose the topics for the interview and there was no mention of emotions in any of the paperwork the men saw or the instructions they were given. Despite this, fifteen men chose to talk about emotions. With a participant group traditionally reticent in interviews, the quantity and range of emotions expressed to a stranger was remarkable and appears to counter White's (2001) concern for men's mental health in this instance.

7.1.2.1.3 Access to mental health services.

Seven of the men talked of accessing mental health services during the interviews and only Dave, diagnosed with, and taking medication for, Borderline Personality Disorder and Anxiety discussed access problems. It could be contended that access to mental health services have improved since White (2001) wrote his report.

7.1.2.1.4 Lack of social networks.

All the men but two described their social networks and the benefits of these. The two men explained that could not access their social network of choice due to lack of money for a bus fare or football club subscription. This would appear to counter this area of concern for White (2001). White was right to see this as an area of concern as all 21 men touted the benefits of their social networks.

(v) To critically assess the position of hegemonic and alternative masculinities in relation to men's positive health and well-being.

In chapter 2, I posited that Connell's (2005) description of a masculine person meant that caring, loving and vulnerable actions are unmasculine as they sit outside this framework. Masculine behaviours as described in the literature reported in table 2.3 are all negative, there was no space for

positive health and well-being behaviours using a masculinity lens. Gough (2018) argues that masculinity research draws attention away situated practices. The phenomenological lens used here stayed close to the men in the interviews when they talked mostly about positive health and well-being practices. These behaviours were seen as genuine and legitimate for men to exhibit in their struggle with health and well-being in the face of deprivation.

7.2 Summary of the contribution to the literature

The review of positive health and well-being in the literature review Chapter 2 highlighted studies that revealed positive health and well-being behaviours as incidental to the main findings or reviewed interventions to create positive behaviours. There appeared to be little or no literature exploring directly the positive health and well-being of men on low-income. This thesis spotlights the myriad lived experiences of health and well-being for men on low-incomes and the complex ways in which they experience and understand health and well-being. It then highlights the imaginative and courageous ways the men create positive health and well-being for themselves in the light of almost overwhelming poverty, deprivation and life circumstances.

The seven themes created to explain positive health and well-being in chapter 5 encapsulate the majority of the data generated from the interviews. There was little that could not be captured by one of these themes. As can be seen from the pen portraits, the themes interweave throughout the narratives and aid understanding of the various aspects of positive health and well-being introduced by the men and how they interact.

Based on the study data, Chapter 6 presented a new conceptual model of low-income men's experience of health and well-being. The model presents how the men's Journey of health and well-being can be progressive, maintained or declining. Furthermore, it presents how aspects of Balance, Time, Space, Resilience, Awareness and External Resources all impact on the men's Journeys in different ways. This could be a tool to aid understanding and to improve, not only the health and well-being of men on low-income, but of everyone (see section 7.4.1).

7.3 Strengths and limitations of the study

In this section, I will reflect on the strengths and limitation of the methods used in this research. These are partly drawn from the participants' accounts of using photo-elicitation and partly my reflexive notes made during the data collection process.

7.3.1 Strengths of the study

7.3.1.1 Empowering participants

As described in section 3.1.10, there is inevitably a power difference between researcher and participant in psychological research. Participants have power and this is taken away either consciously or unconsciously. I recognised the power the men had to make choices at different stages

of the research and did my utmost not to take this away. There were tasks to perform such as consenting to the research, taking photographs and being interviewed but these could be undertaken anywhere. When I was contacted for the first time by a participant, I asked them where they would like to meet to consent and receive the camera and instructions. Only four chose their own home and these either knew about me from a friend or trusted the University of Leeds research as safe. At point of interview, I asked where they would like to be interviewed. Eleven chose their own home for the interview, six visited the university as they wanted the experience, one their place of work and the other three a café. During the interviews, I made no attempts to handle the camera indicating they had the authority and self-determination to conduct their aspect of the research process in their own way.

7.3.1.2 Phenomenological approach exploring health and well-being of men on low-income

Section 2.3.6 highlighted recent masculinity research that moves away from the fixed negative viewpoint of hegemonic masculinity. Caring (Hanlon, 2012), Inclusive (Anderson,2010), Salutogenic (MacDonald, 2011) masculinities, de Visser and MacDonnell's (2013) man points and Lomas (2013) critical review discovering men resisting masculinities in a positive way. These re-interpretations of masculinities provide a positive route forward for masculinity theory. However, masculinities reductionist nature and jigsaw puzzle effect continue to remove the possibilities for a holistic view of men's health within masculinity theory. This is particularly true for men on low-income who are seen as marginalised by nomothetic masculinity theory.

The phenomenological and thereby holistic approach to understanding the men's lifeworld and lived experience of health and well-being in poverty unearthed many creative ways in which these men strived to counter these threats and many were flourishing despite their deprivation. The lens by which to view the men and their lives was not clouded by a particular viewpoint. The viewpoint was theirs and foregrounded by the phenomenological approach. The idiographic nature of the phenomenological approach allows an examination and comprehension of lived experience (Smith et al., 2011), in this case, the health and well-being of men on low income Thus, illustrating the immense pressure poverty exerts and the extra, sometimes extraordinary effort these men have to exert just to maintain their health and well-being, let alone flourish.

7.3.1.3 Self-Pilot

The use of self-pilot was a strength of this research. Despite conducting qualitative interviews at undergraduate level, and completing a counselling qualification to gain listening skills and having designed the research, I had not been a participant in qualitative research before. As described in chapter 3, I engaged in a full self-pilot to immerse myself in the process and thereby improve the design and my approach from a position of experiential empathy. I took photographs of phenomena that I felt affected my health and well-being and took them to a more experienced PhD student who interviewed me about the photographs and then using the semi-structured interview schedule. Recording the interview and listening to my responses to the interventions posed and the style of the

interventions taught me many things that I carried through to my interviews. I wrote 'listen' and 'silence' on my interview schedules to remind me that these were the most important tools at my disposal in the interviews. Understanding how participants might feel at every stage meant I could try to tailor my questioning appropriately.

7.3.1.4 Photo-elicitation

After the fourth interview, each over an hour in length, it was clear the photo-elicitation was working extremely well. At supervision it was decided that I should ask the participants to give some idea of the process involved in choosing the photographs and then how it helped them in the interview. Thirteen participants were asked to contribute their thoughts at the end of the interviews. From the data the men provided, I theorise there are three phases to the process with all the hard work done by participants prior to the interview. Each phase will be briefly described with extracts from participants to support the theory.

The first phase is preparation and choosing what photographs to take. Photo-elicitation encouraged the participants to stop and think about their lives and think about what health and well-being meant to them. It made them think about the photographs they had taken and whether they wanted to talk about them or not. If they wanted to talk about them, what did they want to say in the interview? (Ian, below was the participant who earned more than £14,000 a year and was excluded from the data set (chapter 3))

> Simon: I it makes you think about what you're doing and what and what you'd be ashamed to talk about and what you wouldn't (Duara et al., 2018).
>
> Tony: I suppose it makes you focus on really think about health and what it really means to you it was really interesting experience to try and, isolate what are issues about health
>
> Ian: I took lots of photos and then scrubbed them again.
>
> Andrew: it forces you to think, something you take for granted that you do every day or something that happens but it forces you to step back and give it some thought (Rose 2013) about what am I actually going to say then and how am I gonna phrase it (Knowles & Sweetman, 2004).

The second phase is reflection. Participants reflect more deeply about the motivations for their behaviours to enable them to be clear in the interview about the reasons for taking the photograph and what it meant.

> Simon: take a photograph and then verbalise it it's just possibly giving me a kick to think a bit more and may be do something.
>
> Mark: it made me reflect more as to why I do what the roots of my motivations are for doing these things […] it made me think an awful lot about me my situation how I relate to others how others relate to me and how I perceive those relations (Duara, et al., 2018)…but it made

> me look at my current situation and it made me question certain things and it made me reflect on certain things it was an incredibly intriguing thing.
> Ian: it also makes you aware of what issues you have got I suppose in your life but either good or bad it brings to the fore.

The third phase is recollection.

> Alan: really did remind me, of that moment, in time and behind that picture there is a story to me that picture means something to me.
> Tony: it has seemed easier you know rather than if you were asking me straight questions about my health it's like it gives it something to hang on you know.
> Ian: if you're just sat there just talking it probably leave some things out or oh I forgot to mention that sort of thing so they're a bit of trigger point aren't they to remind you of what you want to talk about.
> Mark: Well if you like it was a kind of springboard […] it was great looking at the pictures I mean it was like looking at that row of lettuces and for a moment as I'm talking about it I could feel the sun on me I could imagine Maria was standing just here about to pass me my gloves you know the smell of earth you know moving the flagstones and flicking spiders off not great with spiders you know, kind of laying the flagstones down the other day and me back cricked and I could feel all that as I was relating it and the picture helped me connect to what I was saying.

So, this is a multi-sensory experience for this participant, allowing him to feel what he felt when taking that photograph and relating those feelings to me in the interview. Frith (2011) says that feelings evoked by photographs don't reside in the past, they are felt there and then in the interview. All of the participants talk about trigger points or springboards for the interview. The participants make sure they include everything they want to talk about in the interview and nothing is forgotten. The participant's preparation means their head is full of thoughts of health and well-being, the reflection allows them to isolate the things that are important to them. The photographs in the interview, are triggers points or springboards for those thoughts, allowing the participants to remember everything they wanted to say.

Chapter 2 points out that hedonic well-being moves beyond physical pleasure to include happiness from goal attainments and hobbies. Chapter 3 proposed that participants are able to describe the emotions attached to their feelings of subjective well-being when showing phenomena. The aim was to critically review the historical and contemporary positioning, evidence and experience of health and well-being among men on low-incomes. I would propose that photo-elicitation achieved this with considerable success. Photographs provided much evidence of men experiencing physical pleasure.

There many instances of this among the 1000+ photographs, one included in chapter 5 shows Keith's saxophone mouthpiece and Keith links this to a description of his subjective well-being when he plays. Goal attainments and hobbies were captured using photographs and described often with passion. Tony's music, Geoff's roof garden, George's tattoo and Paul's dogs are just some of the goal attainments and hobbies captured and examined as part of the analysis. Situating the analysis phenomenologically meant I attempted to see behaviours in context and if possible not apply my own frame of reference. My frame of reference is apparent in the analysis to an extent as I am not context free but I attempted to notice this and reduce it if possible.

7.3.1.5 Unstructured Interviews

Coupled with photo-elicitation and listening skills it can be a remarkably easy and effective way of conducting interviews if the researcher, participants and interviewer are well matched in terms of demographics as they were in this case. I might struggle in different contexts just as other might struggle with this group of men. Burgess (1984) recommends the best approach for an unstructured interviewer to be one of a person who has a sympathetic interest in the life of the interviewee and are willing to try and understand it. This is exactly what I tried to do in the interviews and the benefits were enormous. As expressed in the above strength, photo-elicitation can engage participants in the process strongly prior to the interview, preparing them well to tell their story with minimum facilitation from the researcher. Photo-elicitation also supports their control of the direction and content of the interview and the story they tell.

7.3.1.6 Grounding the analysis in data examples

In Chapter 4 (Content Analysis), Chapter 5 (Interpretative Phenomenological Analysis) and Chapter 6 (Model of Health and Well-being) all analytical claims are evidenced with extracts from the data. Care was taken that analysis was data led and that extracts were interpreted with attention to the context in which they were offered. Moreover, examples were drawn from every participant in all three analysis chapters. Care was taken to avoid cherry picking and counter-examples were considered where relevant in the interpretation process.

7.3.1.7 Myself in the research

Gough (2003) makes the distinction between personal and functional reflexivity. Personal refers to the researcher's interests, attitudes and motivations towards the research and its outcomes. Functional refers to the role of the researcher in the process and the different identities and power relations that may occur within the research paradigm. In this research I attempted to identify where my interests, attitudes and motivations influence the research and foreground these in reflexivity boxes. These boxes attempted to convey my reflections of how I felt I influenced the research and how the research

influences me. I understand I influenced every aspect of the research from the first proposal to the final conclusion written in the thesis but the most pertinent issues are foregrounded.
My background is that I am a white British man in his early 50's who has been employed in the lowest quartile of earners for almost the entirety of his working life. I have lived and worked with other white British men on low-income and the depiction of my ex-housemates and ex-colleagues is not one I see depicted in the academic literature or the media. I saw these men around me as having a positive attitude towards their health and well-being contra what I began to read in some of the academic literature. I believe that my background, and way I come across as a down to earth, mature and easy-going guy, helped me gain the trust of the men, oriented me to the meaningful questions to ask, allowed me to contribute to creating the right tone in the interviews, and facilitated my analysis of the material with some phenomenological understanding of a life as a man on a low income.

7.3.2 Limitations of the research

7.3.2.1 Literature review

The large gaps in the literature identified during the extensive review of the literature meant that the review could not be reported in depth in a standard way. The initial boundaries of the review which stated that no studies that included prior medical conditions should be included had to be relaxed so as to include more literature within the review. To provide a more in depth review of the literature a critique of current theoretical underpinnings of health research, coupled with a review of research where men on low-income were recruited but not interviewed about their positive health and well-being.

7.3.2.2 Participant agency

Despite attempts to empower participants, they were still required to undertake specific tasks within a time frame. These were part of the process and could not be altered or ignored. Some of the participants were known to friends or colleagues of the researcher and thus were under a social obligation to complete the research which limited their agency within the process. There was no involvement of the target population or men apart from myself in the design of the research or its processes This study could have been improved with greater participation of men on low-income in the research design and conduct. There was no involvement of the target population or men apart from me in the design of the research or its processes. If participants or others with understanding had been involved in the research design, knowledgeable input may have been received on such aspects of the work as the information sheets, participant instructions, and the interview schedule. This may have led to recruitment of a more diverse sample and possibly a more effective interview. It could also have been useful to receive feedback on the process of analysis and development of the model of health and well-being. The latter would have been particularly useful in checking if the model resonated with the men's lifeworlds and if any modifications would have improved this fit. However, returning to

participants with one's analytic outcomes is not unproblematic (Bygstad & Munkvold, 2007; Koelsch, 2013; Mays & Pope, 2000), and needs to be factored into timelines and analysis plans. Finally, men with lived experience can be involved in the dissemination process, particularly if they were willing to waive their anonymity although there are currently no plans to do this. It can be argued that the participants were involved in the co-creation of data as they had free reign to decide what to photograph and what they wanted to say about each photograph. Involving interested groups in enabling a broader range of participants within the demographic of interest could strengthen the utility of the model to a wider group of men. Plans for future research include working with a collaboration of third-party organisations who may be interested in supporting this research.

7.3.2.3 Pre-interview photograph collection

Participant recruitment was slow throughout and was hindered by allowing participants to take as long as they needed with the camera. The average time between initial meeting and interview was 48 days, longer than originally anticipated. The initial pool of two cameras was quickly exhausted and by the end there were seven cameras being used by participants prior to interview. If I were to conduct similar research in the future, I would put a time limit for participants to take photographs.

7.3.2.4 Sample and sampling

The participants that volunteered to take part were necessarily attracted to the process of taking photographs, providing an interview, and talking about well-being. However, the participants that responded were ones who felt they could identify with this topic, were capable of completing the task and engaged with society. There will have been many men who may not have been as positive as those in this research who may have been more representative of the population of men on low-income in the UK. The sample was from a restricted geographic location and therefore would not capture the depth and breadth of experiences of health and well-being in poverty across the UK. Moreover, restricting the simple to white British men meant cultural and ethnic variation were not included thus restricting the experience of health and well-being in poverty. The sample size was limited by difficulties with recruitment and although 29 participants were recruited, the data of 21 was included in the analysis. There were issues with participants not responding after initial recruitment, deciding they did not wish to complete the process or not being part of the required demographic.

It would have been more representative of the experiences of men on low-income in the geographic boundaries to include men from different cultural and ethnic backgrounds. This is a consideration for future research in this topic. There may be other ways in which this demographic of men create positive health and well-being that is not able to be captured by photo-elicitation and I look forward to this being revealed in continuing research using different methods.

7.3.2.5 Participant instructions

Two participants appeared to misread the instructions for collecting photographs. The instruction 'Please take photos of anything in your life that reflects your feelings of health and well-being in a positive or negative way.' was read by two participants in their 60's (Peter and Stan) to recount their life history in the interview. It was not until the second of the two interviews that I understood what was happening in that interview and the previous one of the same style. After this realisation, I confirmed instructions verbally with remaining participants to ensure they understood what was expected of them.

7.3.2.6 Myself in the research

The way I have conceptualised my own subjectivity with respect to this research is a strength and a limitation. My assumptions about myself as a man on low-income may have led me to be overconfident about my ability to interpret participants in the interviews and in the data analysis. This may mean I have missed important data in the interviews or misinterpreted data in the analysis. If there was time and resources, I could have a colleague listen to interviews and to engage in a dialogue with me about my possible blind spots and biases. Discussing participant experiences in supervision meant I could do this with unexpected results. When discussing Paul's friends bringing their dogs to him so he could enjoy a social life, my supervisors were struck by how creative he had been in doing this, opening up a new angle on which to view participant creativity which I had overlooked. I also did not live at the poverty levels of some of the men and had missed the differences this brought such as the extra emotional and physical energy needed just to survive lower down the poverty gradient. Understanding this point was one of the triggers for the creation of the model of health and well-being. Myself in the research brought strengths (7.3.1.6) and weaknesses. Acknowledging these has been challenging but important in understanding how researchers help or hinder research in different ways.

7.3.2.7 Inability to meet one of the aims of the research

The instructions for taking photographs was for the men to take photographs of things that affect their health and well-being. This precluded the research from being able to meet one of its secondary aims, namely, to identify whether the men had a lack of awareness of their own mental health needs (White, 2001). The interviews were unstructured and the men brought what they wanted to talk about and talked about it the way they wanted. It was not possible for me to ask or ascertain about their needs without breaking the flow of the narrative in the interviews. To obtain an understanding of this topic was incompatible with other aims of the research. This is one small sub-section of one secondary aim of this thesis 7.1.4.2.1, the other 3 sub-sections of this aim were achieved.

7.4 Practical implications and future research

7.4.1 Values with respect to other models of health and well-being

Here, the model of health and well-being presented in this thesis is considered in comparison with the models/definition of health and well-being described in section 6.7. Ideas for advancing knowledge in the field are proposed.

The biomedical model has little in common with the proposed model due to its reductionist nature. However, the biomedical model could be extended by appreciating the resilience of patients and incorporating elements of the agentic patient who takes responsibility to reduce the causes of illness and takes joint responsibility for recovery.

As described in section 6.7, the World Health Organisation definition of health (Grad, 2002) is difficult to achieve even in affluent countries. It could be broadened to include working towards complete physical, mental and social well-being as a goal. The model presented here can be used as a template to help people understand the interplay of factors such as poverty, unhealthy Spaces and Time as impediments to achieving health and the positive factors employed to improve physical health, mental health and social well-being.

Marmot (2003) argues that social inequalities create low levels of autonomy and self-esteem. The model proposed here defines how to manage and maintain oneself. In poverty, that downward pressure is constant but to move away from risky Spaces and poor use of Time and enable Resilience, Awareness and External Resources will create higher levels of self-esteem and autonomy. These elements of this model can introduce positives within the model of social inequalities. Thereby creating opportunities for men on low-income to improve their lives without structural changes that are unlikely to arrive in the near future.

Antonovsky's (1990) Sense of Coherence has some similarities with the model of health and well-being presented here. Events are within these men's understanding as they show a high level of Awareness of themselves and their situations. The men's Resilience and External Resources are drawn upon as skills and ability to manage life. The skills and abilities they deploy may not be similar to those on higher incomes but adapted to their situation in poverty. Many men showed the Awareness that they found life interesting or satisfying. Their Journeys exemplified that for many there was a good purpose to life or a reason to care about what happens. The Sense of Coherence part of the salutogenic model can be developed for men on low-income through qualitative research focusing on these elements of Sense of Coherence. Semi-structured interviews designed to capture experiences of all the elements would develop this model further and create the opportunity for an intervention that could increase the sense of coherence for low income-men.

7.4.2 Practical implications

I collaborated with the Orion Well Man Programme men's group for long-term unemployed men to recruit the last five participants. Following recruitment, we collaborated again, using photo-elicitation to 'research and develop ways of supporting vulnerable and isolated men with their physical and emotional health and well-being'. The benefits for those supporting vulnerable men were that it: supports reflection; mutually beneficial monitoring; is creative and engaging for the participant; gives staff insight into the men's lives; encourages action and gives confidence. The results of this collaboration were presented at the Leeds Trinity University Health Summit in 2018. Unfortunately, the Orion team found the method too resource heavy and did not repeat the research.

For men on low income who are in contact with third sector support organisations, a health and wellbeing wheel could be created. Men utilising these services could self-assess their health and well-being on the wheel with support from staff within the organisations. Staff could then highlight aspects of their lives within the model of health and well-being. The risks of **Time**, **Space** and poverty could be highlighted to the men to encourage them to be aware of their potential effects. The men could then be encouraged to focus on the three tools at their disposal namely, **Resilience**, **Awareness** and **External Resources**.

To further understand the complexities of the situation for third sector providers for men on low-income, I am presenting my model of health and well-being to the Men's Health Unlocked networking meeting in Leeds. The aim is to understand how this model may help them improve the health and well-being of men on low-income they support. Moreover, it is an opportunity to listen to the questions and ideas they may have about the model and how they feel it can be improved.

Relating to health policy and other factors outlined in chapters 1 and 2, the situation is complicated for men on low-income. Statistically, they have the worst health and mental health outcomes. They have low levels of engagement with preventative healthcare (Emslie & Hunt, 2009; Jackson et al., 2002; McPherson & Turnbull, 2005; Stead et al., 2001). They are misleadingly stigmatised by government and the media (Shildrick, 2018). Well Man clinics are not universal and have poor uptake of usage. There is little focus in policy and unknown funding levels for mental health or well-being support for men on low-income (Fell & Hewstone, 2015). Hegemonic masculinity is essentially a negative concept so when applied to research into the health, mental health and well-being of men on low-income negative data about men on low-income is produced.

Keyes (2002) introduced the idea of a mental health continuum from flourishing to languishing. Flourishing is a state of positive psychological, emotional and social functioning with high levels of well-being. Languishing conversely is stagnation, emptiness and quiet despair with low levels of well-being. Men on low-income are reported to be at the languishing end of the continuum. A 2008 government report highlighted five things we must do to stay well mentally: Connect; Be active; Take notice; Keep learning; Give. (Foresight Mental Capital and Well-being Project, 2008, pp. 23).

The men in this research gave many exemplars of these five behaviours and I would posit that many were flourishing rather than languishing. They also gave many examples of positive ambitions for better health.

As can be seen in 1.2.10 and 2.3.2 there appears to be no will from the NHS, Public Health England or the UK government to specifically address the health of men on low-income. It then falls to non-statutory bodies to pick up the pieces and attempt to do this.

To effect improvements in health, mental health and well-being for men on low-income there must be positive exemplars to position as ideals for these men to aspire to. Positive exemplars in terms of behaviours or multiple outcomes that show men on low-income are flourishing in their lives despite the deprivations caused by poverty. The data from this research combined with nudge theory (Thaler & Sunstein, 2008) could be applied to men on low-income to improve their health and well-being. On a national level, letters to benefits recipients and poster campaigns in areas of high poverty could target men to improve their health and well-being using the data form this research. Posters could give positive examples of health and well-being behaviours with slogans like '9 out of 10 men in your area have stopped smoking' or 'most men in your area meet with their friends twice a week'. The posters will show that it is possible to live in poverty and have improved health and well-being. This is in contrast to the negative stigmatic messages from the media and government that portray men on low-income as incompetent and to blame for their own predicament.

The analysis details how men on low-income value their health and well-being and can be very creative in how they maintain or make improvements to their lives. However, it must be remembered that this group of men manage to do this with very few resources and in the face of multiple challenges from poverty and its associated issues. These multiple challenges may prevent buy-in to many of the current health and well-being promotion campaigns and messages. Health and well-being are not narrow concepts around 5-a-day or 10,000 steps a day. As has been argued in this thesis, the abject lack of knowledge of the positive health and well-being practices of men on low-income prevents policy makers from designing interventions that build on their current positive practices. Encouraging these men to build on their current practices will increase buy-in by being understandable and achievable. Examples for policy informed by practices from this research could be emphasising the benefits of walking, especially in groups; maintaining positive relationships with others; distancing themselves from risks to their health and well-being and eating well with little money. Focusing on small changes at a time to make it achievable and to build on current practices.

As has been seen through some of the men volunteering, this group of men have a lot to offer their communities through knowledge, enthusiasm and time. Groups like Men's Sheds and other

community groups that have a practical base that allow men to meet through ‘doing’ can be a fulcrum around which health and well-being promotions can be based. Isolated, unemployed men can be accessed through foodbanks and benefits letters to try and connect them with their communities and produce reciprocal benefits for both. Health and well-being promotion can be developed by giving these men the message that they have a lot offer their communities. Make them feel wanted, give them a purpose and start them on their journey to improved health and well-being.

7.4.3 Future research

The research presented in this thesis has provided the first qualitative investigation into the positive health and well-being of men on low-income. The complexities of the lives of this population, and the creativity and courage shown in improving their health and well-being has opened many avenues requiring further exploration in future research. This thesis has shown that it is possible to recruit large numbers of men on low-income to qualitative research and that photo-elicitation is the perfect tool to encourage these men to talk openly about difficult topics.

As this group of men lead lives filled with instability due to poverty and insecure employment, a longitudinal approach in future would allow researchers to develop the model to show how these changes over time impact on participants’ journey. Fine tuning different aspects of the model with this data to show how each element is impacted and how these impacts interact on the overall journey. Understanding how aspirations and ambitions alter and develop over time will create a greater understanding how best to support these men to achieve their ambitions.

To understand the workings of this model in a systematic way, valid and reliable questionnaires could be created for each of the elements of the model and regression analysis applied to the results. This would identify the contribution each element made to the model and focus on improvements to health and well-being applied to the elements that make the most significant contribution to the journey.

Developing the preliminary model of health and well-being presented here with the similarities with Antonovsky’s salutogenic model would be a worthwhile contribution. It would lead to a form of research that moves away from the dominant medical model that is often inaccessible and incomprehensible to men on low-income. The model presented in this thesis was purely inductive. If the data was re-analysed in a deductive way to incorporate Antonovsky’s model, it would be interesting to see which elements were presented by the men and how these could be incorporated in developing the salutogenic model for men on low-income.

Involving interested groups in enabling a broader range of participants within the demographic of interest could strengthen the utility of the model to a wider group of men. I am working with a collaboration of third-party organisations who may be interested in supporting this research.

7.5 Conclusion

The present study presents an in-depth analysis of how white British men on low-income understand, experience and create positive health and well-being. Central to their understanding and experience is their journey with health and well-being. Sisyphus eternal struggle pushing a boulder up a hill was used as a metaphor for this journey. A huge effort was required to maintain health and well-being at its present position and immense ambition to exert the extra effort to move the boulder up the hill towards creating improved health and well-being. Not all the men were able to achieve this journey of progress, some were maintaining their position and a few others were unable to prevent the weight of the boulder slipping down the hill and were experiencing worsened health and well-being. The impact of internal and external influences on health and well-being was explored and how the men countered the negative influences and created many more positive influences. This is the first research to focus on the positive health and well-being with men on low-income foregrounding the wealth of creativity and ambition the men display to improve their health and well-being wherever possible. It counters the negative theory, stigma and data of men on low-income and creates an opportunity to improve the lives of the millions of men in the UK.

Reflexive conclusion

Researching and writing this PhD has taken eight years. I am an entirely different person to the one who started the process and I shall try to reflect on some of the ways in which my understandings have been altered over that time.

I had earned what classifies as a low income for many years and was able to keep myself active and eat healthily through my knowledge from catering. I had not reflected on that and assumed others ate and kept active like me. When I read about the prevalence of obesity and all the other life altering behaviours that were most prevalent in low income groups I was truly shocked. I had not fully appreciated the effect of poverty on life expectancy or the reduction in the number of years of health life. Again, this did not tally with what I had experience, but then I had worked with other men on low-income so those I saw the most were working and earning, I knew that some of my friends smoked and drank excessively but had not realised the effect this was having until I saw the statistics. The same can be said for the statistics that showed that men in the UK have had a lower life expectancy than women in every year since 1841 when records began. Coupled with understanding that there is no country on the planet where on average, men outlive women stiffened my resolve to try and make a difference for men on low-income, my friends and ex-colleagues.
Later I gained a deeper understanding of how socialist Labour and neo-liberal Conservative ideologies affect health and well-being. As I have written in the reflexive boxes above, I was horrified to discover the extent to which neo-liberal economics can be put before people's health and well-being. Not just on a small scale but for millions of people over and over again. These are choices made by governments that harm the people who voted for them. There are millions of people who can make alternative choices that can change their health and well-being for the better but there are also millions of people who cannot. The political system will not change so people must change. However, they can only change if they are given choices they understand and are capable of achieving. I am hoping the data I have collected and analysed and the model I created can go some way towards this happening.

I have reflected in the body of the thesis but I conclude by saying that I had read theory on Hegemonic Masculinity but not engaged fully with it until I came to write this thesis. I can see that the concept and its derivations allow room for men to improve their health and well-being. However, the ideas are too often presented in an overly theoretical way that obscures men's behaviours which makes it hard for a lay person to understand. I think the theory could be a real driver of change for men on low-income if it was presented in an applicable way that was easy to put into practice for those wishing to make a difference in men's lives. There does not appear to be any practical holistic application of masculinity theory to the issue of men's health. Again, I am hoping that is what the data and the model can achieve.

Finding a methodology that worked so well from the start felt like striking gold on the first swing of the pick-axe. We had discussed the merits of this method in supervision and felt it might need adapting or scaffolding with supplementary questions. However, it worked really well throughout even when there were issues with the cameras, it did not bar the men from engaging fully and providing novel data on their health and well-being. I would certainly use this method and even the cameras again for exploratory research with this group of men. I received many interesting questions when the method was presented at national and international conferences and been used to inform my teaching practice.

I have spoken about the participants within a reflexive box. My final reflections are that I initially felt a little intimidated by the men. Despite living and working with men on low-income, I still felt apprehensive about meeting them and asking for their help. Looking back, I was utterly mistaken. Even those who had very little were warm and generous and could not do enough to help, to the point where some refused the voucher I had promised for completing the research. In future, I know that I will still feel apprehensive about engaging participants but will take confidence from the success of this research.

I have learnt a great deal about myself during the research. From the basics of 'I can do research' and 'I can write (mostly) academically' to discovering my ability to engage strangers in research successfully and learning how to present research that wins awards. My determination and commitment to the research despite research setbacks. Overcoming mental and physical issues that required study suspension have shown me that I can succeed and achieve anything I set my mind to. There are many challenges yet to come but I know that I can overcome these with my amazing support network that believe in me.

IPA was the perfect tool to use to understand how these men on low-income understood, experienced and created positive health and well-being for themselves. The use of idiographic case studies meant their lifeworld was at the forefront of the analysis. The appreciation of metaphor through IPA made a real difference for me in getting to grips with the novel data presented by the men and helped with theme formation. Creating themes was an interesting process that still leaves me wondering. I had for months wrestled with themes appeared to be in the data but when applied back to the data did not adequately capture the concepts. Some of the themes just felt wrong, seemed to be forced and not doing what I wanted them to do in capturing the nuances of the men's stories. In supervision I was told to say the most important concepts that captured the men's data without thinking about it and out came 5 themes in about 10 seconds. That really surprised me that the themes were in my head but needed a different approach to reach in and pull them out. Once the 5 themes fitted the data, the other

two soon followed to capture all the data. That gave me a surprising sense of completeness that I was not expecting.

The model of health and well-being is something I am particularly proud of. Several participants used expressions that chimed with me. Paul C. talk about a long hill he has to climb. Alan talked about the slippery slope of alcoholism and beating alcoholism is a long climb, one day at a time. These put me in mind of the legend of Sisyphus. Fitting balance was the hardest part of the model in terms of the image. I had toyed with a tightrope walker but this could not be on a slope so compromised with the balance on the hill itself from side to side. I hope that the model's practical applications are as good as I would like them to be.

From the moment of realisation that the thesis was complete until now has been an anti-climax. Instead of the extra formatting to justify the text, printing the thesis twice and binding it to be handed in at the graduate school, I pressed a button on a screen to send it electronically. Instead of a rare visit to the University of Leeds and undertaking my viva in person and celebrating afterwards with my examiners and my supervisors, I had another Teams call in an empty house. I thought passing the viva was the end of the process but even now writing the last of the 10,000 words that have been the corrections, I do not feel a sense of completion. I know that I will not graduate in the Great Hall in the summer as I had always intended, there will be no sense of closure on something that has consumed me for the last 8 years. I have requested that I be considered for graduation in the future should the situation change. I am hoping that not too much time has passed by then to make the event irrelevant.

I am a competent researcher and academic now. The future is hopefully a paid role commensurate with that ability. In the meantime, I will be writing papers to publicise what I have found with my supervisors as quickly as possible. I would like to research in this area further, I have made connections with Forum Central and Men's Health Unlocked in Leeds and I am hoping to be able to collaborate with some of the groups there to undertake meaningful research in the area of health and well-being of low income-men.

References

Abbott, P. (Producer). (2013, May 28). *Shameless.* [Television Broadcast]. Manchester: Company Pictures.

Acheson. D. (1998). *Independent Inquiry into Inequalities in Health Report.* HMSO.

Affleck, G., & Tennen, H. (1996). Construing benefits from adversity: Adaptational significance and dispositional underpinnings. *Journal of personality*, *64*(4), 899–922.

Ahmed, S. (2006). Queer phenomenology: orientations, objects, others. Duke University.

Alberg, A. J. (2008). Cigarette smoking: health effects and control strategies. *Drugs of today*, *44*(12), 895–904.

Alcock, P. (2006) *Understanding Poverty.* Palgrave Macmillan.

Ancient History Encyclopaedia. (2020). The punishment of Sisyphus. Retrieved 28 May, 2020 from https://www.ancient.eu/image/6157/the-punishment-of-sisyphus/

Anderson, B. (2006). "Transcending without transcendence": utopianism and an ethos of hope. *Antipode*, *38*(4), 691–710.

Anderson, E. (2010). *Inclusive masculinity: The changing nature of masculinities*. Routledge.

Argyle, M. (2013). *The psychology of happiness*. (2nd ed.). Routledge.

Austad, S. N. (2006). Why women live longer than men: sex differences in longevity. *Gender medicine*, *3*(2), 79–92.

Ayo, N. (2012). Understanding health promotion in a neoliberal climate and the making of health conscious citizens. Critical public health, 22(1), 99-105.

Backett, K. C., & Davison, C. (1995). Lifecourse and lifestyle: the social and cultural location of health behaviours. *Social Science & Medicine*, *40*(5), 629–638.

Baggott, R. (2011). *Public Health: Policy & Politics.* Palgrave Macmillan.

Bahn, S., & Barratt-Pugh, L. (2011). Getting reticent young male participants to talk: Using artefact-mediated interviews to promote discursive interaction. *Qualitative Social Work*, *12*(2), 186–199.

Baker, A., Bentley, C., Carr, D., Connolly, A. M., Heasman, M., & Johnson, C. (2017). Reducing health inequalities: system, scale and sustainability. Public Health England.

Baker, P., Dworkin, S. L., Tong, S., Banks, I., Shand, T., & Yamey, G. (2014). The men's health gap: men must be included in the global health equity agenda. *Bulletin of the World Health Organization*, *92*(8), 618–620.

Banks, M., & Zeitlyn, D. (2015). *Visual methods in social research*. Sage.

Barclay, P. (1995). *The Inquiry into Income and Wealth*. Joseph Rowntree Foundation.

Barker, W., & Chalmers, C. (2000). Inequalities in health service provision: how research findings are ignored. In C. Pantazis & D. Gordon (Eds.), *Tackling Inequalities: Where are we now and what can be done* (pp. 159–180). The Policy Press.

Barnard, R. (2019a). End the benefit freeze to stop people being swept into poverty. Retrieved 18 October, 2019 from https://www.jrf.org.uk/report/end-benefit-freeze-stop-people-being-swept-poverty

Barnard, R. (2019b). Where next for Universal credit and tackling poverty? Retrieved 18 October, 2019 from https://www.jrf.org.uk/report/where-next-universal-credit-and-tackling-poverty

Baumberg, B. (2016). The stigma of claiming benefits: a quantitative study. *Journal of Social Policy*, *45*(02), 181–199.

Bem, S. L. (1974). The measurement of psychological androgyny. *Journal of consulting and clinical psychology*, *42*(2), 155.

Bennett, E. F., & Daly, M. (2014). Poverty through a gender lens: Evidence and policy review on gender and poverty. Joseph Rowntree Foundation.

Benzeval, M., Judge, K., & Shouls, S. (2001). Understanding the relationship between income and health: How much can be gleaned from cross-sectional data? *Social Policy & Administration, 35*(4), 376–396.

Berger, J. (1992). *Keeping a Rendezvous*. Granta.

Berridge, V. (1999). *Health and Society in Britain since 1939.* University Press.

Bhopal, R., Hayes, L., White, M., Unwin, N., Harland, J., Ayis, S., & Alberti, G. (2002). Ethnic and socio-economic inequalities in coronary heart disease, diabetes and risk factors in Europeans and South Asians. *Journal of Public Health, 24*(2), 95–105.

Biddle, S. J. H., & Ekkekakis, P. (2005). Physically active lifestyles and well-being in F. A. Huppert, N. Baylis & B. Keverne (Eds.), *The science of well-being* (pp. 141–170). Oxford University Press.

Bloch, E. (1986). *The principle of hope.* (N. Plaice, S. Plaice, & P. Knight, trans.). MIT.

Blomqvist, J. (2002). Recovery with and without treatment: A comparison of resolutions of alcohol and drug problems. *Addiction Research & Theory, 10*(2), 119–158.

Bonevski, B., Randell, M., Paul, C., Chapman, K., Twyman, L., Bryant, J., Brozek, I., & Hughes, C. (2014). Reaching the hard-to-reach: a systematic review of strategies for improving health and medical research with socially disadvantaged groups. *BMC medical research methodology, 14*(1), 42.

Brandtstädter, J. (2006). Adaptive resources in later life: Tenacious goal pursuit and flexible goal adjustment. In M. Csikszentmihalyi & I. S. Csikszentmihalyi (Eds.), *A life worth living: Contributions to positive psychology* (pp. 143–164). Oxford University Press.

Branney, P., Witty, K., Bagnall, A-M., South, J., & White, A. (2012). 'Straight to the GP; that would be where I would go': An analysis of male frequent attenders' constructions of their decisions to use or not use health-care services in the UK. *Psychology and health, 27*(7), 865–880.

Braunholtz, S., Davidson, S., King, S., & MORI Scotland. (2004). *Well? What do you think?: The second national Scottish survey of public attitudes to mental health, mental well-being and mental health problems*. Scottish Executive, Social Research.

British Psychological Society. (2010). *Code of human research ethics.* The British Psychological Society.

Brothers in Arms. (2017). Retrieved 21April, 2020 from https://www.brothersinarmsscotland.co.uk/about/

Brownhill, S., Wilhelm, K., Barclay, L., & Schmeid, V. (2005). 'Big build': Hidden depression in men. *Australian and New Zealand Journal of Psychiatry, 39,* 921–931.

Burgess, R.G. (1984). *In the field: An introduction to field research*. Unwin Hyman.

Burgoine, T., Forouhi, N. G., Griffin, S. J., Brage, S., Wareham, N. J., & Monsivais, P. (2016). Does neighborhood fast-food outlet exposure amplify inequalities in diet and obesity? A cross-sectional study. *The American journal of clinical nutrition*, *103*(6), 1540–1547.

Burns, G. (2000). When watching a sunset can help a relationship dawn anew: Nature-guided therapy for couples and families. *Australian and New Zealand Journal of Family Therapy*, *21*(4), 184–190.

Burns, G. W. (2005). Naturally happy, naturally healthy: The role of the natural environment in well-being in F. A. Huppert, N. Baylis & B. Keverne (Eds.), *The science of well-being* (pp. 405–431). Oxford University Press.

Bygstad, B., & Munkvold, B. E. (2007). The significance of member validation in qualitative analysis: Experiences from a longitudinal case study. In *2007 40th Annual Hawaii International Conference on System Sciences (HICSS'07)*. IEEE.

CALM. (2020). Retrieved 21 April, 2020 from https://www.thecalmzone.net/

Calman, K. C. (1993). *On the state of the public health.* HMSO.

Canvin, K., Marttila, A., Burstrom, B., & Whitehead, M. (2009). Tales of the unexpected? Hidden resilience in poor households in Britain. *Social science & medicine*, *69*(2), 238–245.

Cattell, V., Dines, N., Gesler, W., & Curtis, S. (2008). Mingling, observing, and lingering: Everyday public spaces and their implications for well-being and social relations. *Health & place*, *14*(3), 544–561.

Cole, S. W., Levine, M. E., Arevalo, J. M., Ma, J., Weir, D. R., & Crimmins, E. M. (2015). Loneliness, eudaimonia, and the human conserved transcriptional response to adversity. *Psychoneuroendocrinology, 62*, 11–17.

Clare, A. W. (2004). Foreword. In R. S. Kirby, C. C. Carson, M. G. Kirby & R. N. Farah (Eds.), *Men's Health* (2nd ed.). Taylor & Francis.

Clark-Ibanez, M. (2004). Framing the social world with photo-elicitation interviews. *American Behavioral Scientist 47*(12), 1507–1527.

Clarkson, P. (2009). *The therapeutic relationship*. Whurr.

Cockerham, W., Dingwall, R., & Quah, S. R. (2014) *The Wiley Encyclopaedia of health, illness, behaviour and society.* Wiley-Blackwell.

Coghlan, A. (2014). Our liver vacation: Is a dry January really worth it. *New Scientist*, *2950*(13.1).

Collier, J. (1957). Photography in anthropology: a report on two experiments. *American anthropologist*, *59*(5), 843–859.

Collins. (2006). *Collins English Dictionary: Reference Edition.* Collins.

Connell, R. W. (1987). *Gender and power: Society, the person and sexual politics*. Polity Press.

Connell, R. W. (1995). *Masculinities.* Polity Press.

Connell, R. W. (2005). *Masculinities*. University of California.

Connell, R. W., & Messerschmidt, J. W. (2005). Hegemonic masculinity: Rethinking the concept. *Gender & Society, 19*(6), 829–859.

Connolly, A-M., Baker, A., & Fellows, C. (2017) *Understanding health inequalities in England.* Retrieved January 4, 2021 from https://publichealthmatters.blog.gov.uk/2017/07/13/understanding-health-inequalities-in-england/

Conrad, D. (2010). Social capital and men's health. In D. Conrad & K. A. White (Eds.), *Promoting Men's Mental Health* (pp. 26–38). Radcliffe.

Conrad, D., & Warwick-Booth. (2010). Cultural representations of masculinity and mental health. In D. Conrad & K. A. White (Eds.), *Promoting Men's Mental Health* (pp. 18–25). Radcliffe.

Conradson, D. (2005). Landscape, care and the relational self: Therapeutic encounters in rural England. *Health & place*, *11*(4), 337–348.

Constantinople, A. (1973). Masculinity-femininity: An exception to a famous dictum?. *Psychological bulletin*, *80*(5), 389.

Cooper, S., Lund, C., & Kakuma, R. (2012). The measurement of poverty in psychiatric epidemiology in LMICs: Critical review and recommendations. *Social psychiatry and psychiatric epidemiology*, *47*(9), 1499–1516.

Cornil, Y., & Chandon, P. (2016). Pleasure as an ally of healthy eating? Contrasting visceral and Epicurean eating pleasure and their association with portion size preferences and wellbeing. *Appetite*, *104*, 52–59.

Courtenay, W. H. (2000). Constructions of masculinity and their influence on men's well-being: a theory of gender and health. *Social science & medicine*, *50*(10), 1385–1401.

Crawford, R. (2006). Health as a meaningful social practice. *Health:*, *10*(4), 401–420.

Creighton, G. M., Brussoni, M., Oliffe, J. L., & Han, C. (2017). Picturing masculinities: Using photo-elicitation in men's health research. *American journal of men's health*, *11*(5), 1472–1485.

Creighton, G., Oliffe, J. L., Ferlatte, O., Bottorff, J., Broom, A., & Jenkins, E. K. (2018). Photovoice ethics: Critical reflections from men's mental health research. *Qualitative health research*, *28*(3), 446–455.

Croom, A. M. (2012). Music, neuroscience, and the psychology of well-being: a précis. *Frontiers in psychology*, *2*, 393.

Csikszentmihalyi, M., & Csikszentmihalyi, I. S. (Eds.). (2006). *A life worth living: Contributions to positive psychology*. Oxford University Press.

Curtis, S. (2010). Space, *place and mental health*. Ashgate.

Dawson, G. (1992). *Inflation and unemployment: Causes, consequences and cures*. Edward Elgar.

De Beauvoir, S. (2015). *The Second Sex*. Vintage Classics.

de Visser, R. O., & Smith, J. (2006). Mister in-between: A case study of masculine identity and health related behaviour. *Journal of health psychology*, *11*(5), 685–695.

de Visser, R. O. & McDonnell, E. J. (2013) 'Man points': Masculine capital and young men's health. *Health Psychology*, 32(1): 5-14.

de Visser, R. O., & Nicholls, J. (2020). Temporary abstinence during Dry January: predictors of success; impact on well-being and self-efficacy. *Psychology & Health*, 1–13.

de Visser, R. O., Robinson, E., & Bond, R. (2016). Voluntary temporary abstinence from alcohol during "Dry January" and subsequent alcohol use. *Health Psychology*, *35*(3), 281.

De Vries, S., Verheij, R. A., Groenewegen, P. P., & Spreeuwenberg, P. (2003). Natural environments—healthy environments? An exploratory analysis of the relationship between greenspace and health. *Environment and planning A*, *35*(10), 1717–1731.

Deitch, R. (1981). The debate on the Black Report. *The Lancet*, *318*(8238), 158–159.

Del Busso, (2011). L. Using photographs to explore the embodiment of pleasure in everyday life. In P. Reavey (Ed.), *Visual Methods in Psychology* (pp 43–54). Psychology Press.

Demetriou, D. Z. (2001). Connell's concept of hegemonic masculinity: A critique. *Theory and Society 30*, 337–361.

Department for Education. (2010). *The impact of Sure Start Local Programmes on five year olds and their families.* Department for Education.

Department for Education. (2015). *The impact of children's centres: studying the effects of children's centres in promoting better outcomes for young children and their families.* Department for Education.

Department for Environment, Food and Rural Affairs (2011). *Family Food 2010.* Department for Environment, Food and Rural Affairs.

Department of Health. (2004). *Tackling health inequalities: the spearhead group of Local Authorities and Primary Care Trusts*. Department of Health.

Department of Health. (2010). *Healthy Lives, Healthy People: Our strategy for public health in England.* The Stationery Office.

Department of Health. (2014). Wellbeing *Why it matters to health policy*. Department of Health.

Department of Health and Social Security. (1980). *Inequalities in health: Report of a research working group*. Department of Health and Social Security.

Department of Health and Social Security Department of Work and Pensions. (2016). *Households below average incomes (HBAI) statistics.* Department of Work and Pensions.

Derbyshire, P., MacDougall, C., and Schiller, W. (2005). Multiple methods in qualitative research with children: more insight or just more? *Qualitative Research, 5*, 417–436.

Diener, E. & Lucas, R. E. (1999). Subjective emotional wellbeing. In M. Lewis & J. M. Hariland-Jones (Eds.), *Handbook of emotions.* (pp. 325–337). Guildford Press.

Diener, E., Oishi, S., & Tay, L. (2018). Advances in subjective well-being research. *Nature Human Behaviour, 2*(4), 253.

Diener, E., & Seligman, M. E. (2002). Very happy people. *Psychological science*, *13*(1), 81–84.

Dishman, R. K., Heath, G. W., & Lee, I. M. (2013). *Physical activity epidemiology*. Human Kinetics.

Dixon, A., Le Grand, J., Henderson, J., Murray, R., & Poteliakhoff, E. (2003). *Is the NHS equitable?: a review of the evidence*. LSE.

Dominey, S., & Dominey, P. (2010). Anger management and violence prevention with men. In D. Conrad & A. K. White (Eds.), *Promoting Men's Mental Health* (pp 142–149). Radcliffe.

Donaldson, L. (2004). Inequalities and men's health. In R. S. Kirby, C. C. Carson, M. G. Kirby & R. N. Farah (Eds.), *Men's Health* (pp. 9–14) (2nd ed.). Taylor & Francis.

Drago, R. W. (2007). *Striking a balance: Work, family, life*. Dollars & Sense.

Dragon Naturally Speaking Home [Computer software]. Version 12.0, Nuance Communications.

Duara, R., Hugh-Jones, S., & Madill, A. (2018). Photo-elicitation and time-lining to enhance the research interview: exploring the quarterlife crisis of young adults in India and the United Kingdom. *Qualitative Research in Psychology*, 1–24.

DuBois, J.W., Schuetze-Coburn, S., Cumming, S., & Paolino, D. (1993). Outline of discourse transcription. In J. A. Edwards & M. D. Lampert (Eds.), *Talking data: Transcription and coding in discourse research* (pp. 45–90). Lawrence Erlbaum.

Dunn, P. M. (2004). Louise Bourgeois (1563–1636): royal midwife of France. *Archives of Disease in Childhood-Fetal and Neonatal Edition*, *89*(2), F185–F187.

Dyck, I., & Dossa, P. (2007). Place, health and home: gender and migration in the constitution of healthy space. *Health & place*, *13*(3), 691–701.

Ellard-Gray, A., Jeffrey, N. K., Choubak, M., & Crann, S. E. (2015). Finding the hidden participant: Solutions for recruiting hidden, hard-to-reach, and vulnerable populations. *International Journal of Qualitative Methods*, *14*(5)

Elliott, K. (2016). Caring masculinities: Theorizing an emerging concept. *Men and masculinities*, *19*(3), 240-259.

Emmons, R. A. (1999). *The psychology of ultimate concerns: Motivation and spirituality in personality*. Guilford.

Emmons, R. A. (2006). Spirituality: Recent Progress. In M. Csikszentmihalyi & I. S. Csikszentmihalyi (Eds.), *A life worth living: Contributions to positive psychology* (pp. 62–81). Oxford University Press.

Emslie, C., & Hunt, K. (2009). Men, Masculinities and heart disease. *Current Sociology*, *57*(2), 155–191.

Emslie, C., Ridge, D., Ziebland, S., & Hunt, K. (2006). Men's accounts of depression: reconstructing or resisting hegemonic masculinity. *Social science & Medicine*, *62*(9), 2246–2257.

Encyclopaedia Britannica. (2018). John Snow. Retrieved 29 June, 2018 from https://www.britannica.com/biography/John-Snow-British-physician

Entwistle, V. A., Renfrew, M. J., Yearley, S., Forrester, J., & Lamont, T. (1998). Lay perspectives: advantages for health research. *Bmj*, *316*(7129), 463–466.

Farrimond, H. (2012). Beyond the caveman: rethinking masculinity in relation to men's health seeking. *Health*, *16*(2), 205–225.

Fell, B., & Hewstone, M. (2015). *Psychological perspectives on poverty: A review of psychological research into the causes and consequences of poverty*. Joseph Rowntree Foundation.

Field, F. (1989). *Losing Out: the emergence of Britain's underclass*. Blackwell.

Fildes, D., Cass, Y., Wallner, F., & Owen, A. (2010). Shedding light on men: the Building Healthy Men Project. *Journal of Men's health*, *7(*3), 233–240.

Finlay, L. (2003). Through the looking glass: Intersubjectivity and hermeneutic reflection. *Reflexivity: A practical guide for researchers in health and social sciences*, 106–119. Blackwell.

Folkman, S., & Moskowitz, J. T. (2000). Positive affect and the other side of coping. *American psychologist*, *55*(6), 647.

Foresight Mental Capital and Wellbeing Project. (2008). *Final Project Report – Executive Summary*. The Government Office for Science.

Fox, J., Knapp, R. R., & Michael, W. B. (1968). Assessment of self-actualization of psychiatric patients: Validity of the Personal Orientation Inventory. *Educational and Psychological Measurement*, *28*(2), 565–569.

Fox, K. R. (1999). The influence of physical activity on mental well-being. *Public health nutrition*, *2*(3a), 411–418.

Fox, N. J. (2002). Refracting 'health': Deleuze, Guattari and body-self. *Health*, *6*(3), 347–363.

Frank, R. H. (1999). *Luxury fever: Why money fails to satisfy in an era of excess.* Free Press.

Frankl, V. (1984). *Man's search for meaning: An introduction to logotherapy*. Simon & Schuster.

Fraser, D. (2009). *The Evolution of the Welfare State*. Palgrave Macmillan.

Frith, H. (2011). Narrating biographical disruption and repair: exploring the place of absent images in women's experiences of cancer and chemotherapy in. P. Reavey (Ed.), *Visual Methods in Psychology* (pp 55–68). Psychology Press.

Gabriel, Y. (2018). Interpretation, Reflexivity and Imagination in Qualitative Research. In M. Ciesielska & D. Jemielniak (Eds.), *Qualitative Methodologies in Organization Studies* (pp. 137–157). Palgrave Macmillan.

Gatrell, A. C. (2013). Therapeutic mobilities: walking and 'steps' to wellbeing and health. *Health & place*, *22*, 98–106.

Gergen, K. J. (1991). The saturated self: Dilemmas of identity in contemporary life. Basic Books.

Gernsheim, H. (1977). The 150th anniversary of photography. *History of photography*, *1*(1), 3–8.

Gesler, W. (1996) Lourdes: Healing in a place of pilgrimage. *Health & Place, 2*, 95–105.

Gordon, D. (2000). Inequalities in income, wealth and standard of living in Britain. In C. Pantazis & D. Gordon (Eds.), *Tackling Inequalities: Where are we now and what can be done* (pp. 25–58). The Policy Press.

Gorman, D., Buikstra, E., Hegney, D., Pearce, S., Rodgers-Clark, C., Weir, J., & McCullagh, B. (2007). Rural men and mental health: Their experiences and how they managed. *International Journal of Mental Health Nursing*, *16*(5), 298–306.

Gough, B. (2003). Deconstructing reflexivity. In L. Finlay & B. Gough (Eds.), *Reflexivity: A practical guide for researchers in health and social sciences* (pp. 21–35). Blackwell.

Gough, B. (2018). *Contemporary masculinities: Embodiment, emotion and wellbeing*. Springer.

Gough, B., & Robertson, S. (Eds.). (2009). *Men, masculinities and health: Critical perspectives*. Palgrave Macmillan.

Grad, F. P. (2002). The preamble of the constitution of the World Health Organization. *Bulletin of the World Health Organization*, *80*(12), 981–982.

Graham, H. (2000). *Understanding Health Inequalities.* Open University.

Graham, H. (2009). *Understanding Health Inequalities.* Open University.

Gramsci, A., & Hoare, Q. (1971). *Selections from the prison notebooks* (Vol. 294). Lawrence and Wishart.

Grawitch, M. J., Maloney, P. W., Barber, L. K., & Mooshegian, S. E. (2013). Examining the nomological network of satisfaction with work–life balance. *Journal of Occupational Health Psychology*, *18*(3), 276.

Griffiths, S. (2001). Inequalities in Men's Health. In N. Davidson & T. Lloyd (Eds.), *Promoting Men's Health: A Guide for Practitioners* (pp. 35–43). Bailliere Tindall.

Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review. *BMC psychiatry*, *10*(1), 113.

Halpern, D. 2005) *Social Capital.* Polity Press.

Hanlon, N. (2012). *Masculinities, care and equality: Identity and nurture in men's lives*. Palgrave Macmillan.

Ham, C. (2009). *Health Policy in Britain.* Palgrave Macmillan.

Harter, J. K., Schmidt, F. L., & Hayes, T. L. (2002). Business-unit-level relationship between employee satisfaction, employee engagement, and business outcomes: A meta-analysis. *Journal of applied psychology*, *87*(2), 268.

Health for all. (2020). Health for all. Retrieved December 28, 2020 from http://www.healthforall.org.uk/?pid=55

Heidegger, M. (1962). *Being and time*. Blackwell.

Helliwell, J. F., & Putnam, R. D. (2005). The social context of wellbeing. In F. A. Huppert, N. Baylis & B. Keverne (Eds.), *The science of wellbeing.* (pp. 435–460). Oxford University Press.

Henry, J. (2004). A comparison of strategies for achieving well-being in non-clinical populations. *Ricerche di Psychologia*, *27*(1), 135–158.

Henry, J. (2006). Strategies for achieving well-being. In M. Csikszentmihalyi & I. S. Csikszentmihalyi (Eds.), *A life worth living: Contributions to positive psychology* (pp. 120–138). Oxford University Press.

Herzlich, C. (1973). *Health and illness.* Academic Press.

Hey, J. D., & Patel, M. S. (1983). Prevention and cure?: Or: Is an ounce of prevention worth a pound of cure?. *Journal of Health Economics*, *2*(2), 119–138.

Hiscock, R., Dobbie, F., & Bauld, L. (2015). Smoking cessation and socioeconomic status: an update of existing evidence from a national evaluation of English stop smoking services. *BioMed research international*.

Hodgetts, D., Chamberlain, K., & Groot, S. (2011) Reflections of the visual in community research and action. In P. Reavey (Ed.), *Visual Methods in Psychology* (pp 299–314). Psychology Press.

Hodgetts, D., Chamberlain, K., & Radley, A. (2007). Considering photographs never taken during photo-production projects. *Qualitative Research in Psychology*, *4*(4), 263–280.

Hollnagel, H., Malterud, K., & Witt, K. (2000). Men's self-assessed personal health resources: approaching patients' strong points in general practice. *Family Practice*, *17*(6), 529–534.

Holman, B. (1997). *Towards equality: A Christian Manifesto.* Society for Promoting Christian Knowledge.

Home Office. (2016*). Drug Misuse: Findings from the 2015/16 Crime Survey for England and Wales.* Home Office Statistics.

Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative health research*, *15*(9), 1277–1288.

Hugh-Jones, S., & Madill, A. (2009), ‘‘The air’s got to be far cleaner here’: a discursive analysis of place-identity threat’, *British Journal of Social Psychology*, *48*, 601–624.

Huppert, F. A. (2005). Positive mental health in individuals and populations. In F. A. Huppert, N. Baylis & B. Keverne (Eds.), *The science of well-being (*pp. 307–340). Oxford University Press.

Huppert, F. A. (2009). Psychological well-being: Evidence regarding its causes and consequences. *Applied Psychology: Health and Well-Being*, *1*(2), 137–164.

IJsselmuiden, C., & Matlin, S. (2006). *Why health research?.* Global Forum for Health Research.

Jackson, N., Prebble, A., & Rose, C. S. (2002). *Perceptions of smoking cessation products and services among low income smokers*. Health Development Agency.

Jadad, A., & O’Grady, L. (2008). How should health be defined? *British Medical Journal; 337.*

Jahoda, M. (1958). *Current concepts of positive mental health.* Basic Books.

Jebb, A. T., Tay, L., Diener, E., & Oishi, S. (2018). Happiness, income satiation and turning points around the world. *Nature Human Behaviour*, *2*(1), 33.

Jewell, D. (2001). Primary care. In N. Davidson & T. Lloyd (Eds.), *Promoting Men’s Health: A Guide for Practitioners* (pp. 151-163). Bailliere Tindall.

Jones, A., Goodman, A., Roberts, H., Steinbach, R., & Green, J. (2013). Entitlement to concessionary public transport and wellbeing: a qualitative study of young people and older citizens in London, UK. *Social Science & Medicine*, *91*, 202–209.

Jones, K. (1994). *The Making of Social Policy in Britain 1830-1990.* Athlone Press.

Jones, K. (2000). *The Making of Social Policy in Britain: From the Poor Law to New Labour.* Athlone Press.

Jung, C. G. (2001). *Modern Man in Search of a Soul*. Routledge.

Kahneman, D., Diener, E., & Schwarz, N. (Eds.). (1999). *Well-being: Foundations of hedonic psychology*. Russell Sage Foundation.

Kaplan, R. & Kaplan, S. (1989). *The experience of nature: a psychological perspective*. Cambridge University Press.

Kasser, T. (2002). *The high price of materialism*. MIT Press.

Kasser, T. (2006). Materialism and its alternatives. In M. Csikszentmihalyi & I. S. Csikszentmihalyi (Eds.), *A life worth living: Contributions to positive psychology* (pp. 200–214). Oxford University Press.

Kasser, T., & Ryan, R. M. (1996). Further examining the American dream: Differential correlates of intrinsic and extrinsic goals. *Personality and social psychology bulletin*, *22*(3), 280–287.

Kearney, M. H. (1998). Truthful self-nurturing: A grounded formal theory of women's addiction recovery. *Qualitative Health Research*, *8*(4), 495–512.

Kearns, R. A. (1993). Place and health: towards a reformed medical geography. *The Professional Geographer*, *45*(2), 139–147.

Keyes, C. L. (2002). The mental health continuum: From languishing to flourishing in life. *Journal of health and social behavior*, 207–222.

King, N., & Horrocks, C. (2010). *Interviews in qualitative research.* Sage.

Kinsel, B. (2005). Resilience as adaptation in older women. *Journal of women & aging*, *17*(3), 23-39.

Kirby, M. (2004) Men's Health in Primary Care. In R. S. Kirby, C. C. Carson, M. G. Kirby & R. N. Farah (Eds.), *Men's Health*. (2nd ed.). Taylor & Francis.

Knowles, C., & Sweetman, P. (Eds.). (2004). *Picturing the social landscape: Visual methods and the sociological imagination.* Routledge.

Koelsch, L. E. (2013). Reconceptualizing the member check interview. *International journal of qualitative methods*, *12*(1), 168-179.

Koski-Jannes, A. (2002). Social and personal identity projects in the recovery from addictive behaviours. *Addiction Research and Theory, 10*(2), 183–202.

Kotila, L. E., & Dush, C. M. K. (2013). Involvement with children and low-income fathers' psychological well-being. *Fathering, 11*(3), 306.

Lai, L. C., & Cummins, R. A. (2013). The contribution of job and partner satisfaction to the homeostatic defense of subjective wellbeing. *Social Indicators Research, 111*(1), 203–217.

Larkin, M. (2014). Phenomenological psychology. In P. Rohleder & A. Lyons (Eds.), *Qualitative research in clinical and health psychology* (pp. 154–174). Palgrave Macmillan.

Larkin, M., & Thompson, A. (2012), Interpretative phenomenological analysis. In D. Harper & A. R. Thompson (Eds.), (2011). *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 101–116). Wiley.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology, 3,* 102–120.

Larson, J. S. (1999). The conceptualization of health. *Medical care research and review,* 56(2), 123-136.

Lee, C., & Owens, R. G. (2002). *The psychology of men's health*. Open University.

Leeds CCG. (2021). Retrieved January 21, 2021 from https://www.leedsccg.nhs.uk/

Leeds City Council. (2020. Walking football. Retrieved December 28, 2020 from https://active.leeds.gov.uk/classesandactivities/sports/football/walking-football

Legrand, J. (1978). The distribution of public expenditure: the case of health care. *Economica, 45*(178), 125–142.

Lewis, J. (1999). The voluntary sector and the state. In H. Fawcett &R. Lowe (Eds.), *Welfare Policy in Britain: The Road from 1945* (pp. 52–68). Macmillan.

Livingston, M. (2014). Socioeconomic differences in alcohol-related risk-taking behaviours. *Drug and alcohol review, 33*(6), 588–595.

Lloyd, T. (2001). Men and health: the context for practice. In N. Davidson & T. Lloyd (Eds.), *Promoting Men's Health: A Guide for Practitioners* (pp. 3–34). London: Bailliere Tindall.

Lund, C., Breen, A., Flisher, A. J., Kakuma, R., Corrigall, J., Joska, J. A., Swartz, S., & Patel, V. (2010). Poverty and common mental disorders in low and middle income countries: A systematic review. *Social science & medicine*, *71*(3), 517–528.

Lupton, D. (Ed.). (1999). Risk and sociocultural theory: New directions and perspectives. Cambridge University Press.

Maas, J., Van Dillen, S. M., Verheij, R. A., & Groenewegen, P. P. (2009). Social contacts as a possible mechanism behind the relation between green space and health. *Health & place*, *15*(2), 586–595.

Macdonald, J. (2011). Building on the strengths of Australian males. International Journal of Men's Health, 10(1), 82.

MacInnes, T., Tinson, A., Hughes, C., Born, T. B., & Aldridge, H. (2015). *Monitoring poverty and social exclusion.* Joseph Rowntree Foundation.

Macintyre, S., Hiscock, R., Kearns, A., & Ellaway, A. (2001). Housing tenure and car access: further exploration of the nature of their relations with health in a UK setting. *Journal of Epidemiology and Community Health*, *55*(5), 330–331.

Mackenzie, K., & Harpham, T. (Eds.) (2006). *Social capital and Mental Health.* Jessica Kingsley.

Macnicol, J. (1999). Problem family to underclass. In H. Fawcett & R. Lowe (Eds.), *Welfare Policy in Britain: The Road from 1945* (pp. 69–93). Macmillan.

Maddrell, A., & Della Dora, V. (2013). Crossing surfaces in search of the Holy: Landscape and liminality in contemporary Christian pilgrimage. *Environment and Planning A*, *45*(5), 1105–1126.

Majumdar, A. (2011). Using photographs of places, spaces and objects to explore South Asian women's experiences of close relationships and marriage. In. P. Reavey (Ed.), *Visual Methods in Psychology* (pp. 69–84). Psychology Press.

Marks, N., & Shah, H. (2005). A well-being manifesto for a flourishing society. In F. A. Huppert, N. Baylis & B. Keverne (Eds.), *The science of wellbeing* (pp. 435–460). Oxford University Press.

Markula-Denison, P., & Pringle, R. (2007). Foucault, sport and exercise: Power, knowledge and transforming the self. Routledge.

Marmot, M. (2004). *Status syndrome*. Bloomsbury.

Marmot, M. (2006) Smoking and Inequalities. *Lancet 368*, 341–342.

Marmot, M., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., Grady, M., & Geddes, I. (2010). The Marmot review: Fair society, healthy lives. Strategic review of health inequalities in England post-2010. The Marmot Review.

Marttila, A., Johansson, E., Whitehead, M., & Burstrom, B. (2013). Keep going in adversity – using a resilience perspective to understand the narratives of long-term social assistance recipients in Sweden. *International Journal for Equity in Health*, *12*(1), 1.

Maslow, A. H. (1998). Towards a psychology of being. (3rd ed.). Wiley.

Mays, N., & Pope, C. (2000). Assessing quality in qualitative research. *Bmj*, *320*(7226), 50-52.

McBee, T. P. (2014). *Man Alive: A true story of violence, forgiveness and becoming a man*. City Lights.

McConnell, A. R. (2011). The multiple self-aspects framework: Self-concept representation and its implications. *Personality and social psychology review*, *15*(1), 3–27.

McCubbin, H. I., McCubbin, M. A., Thompson, A. I., Sae-Young, H., & Allen, C. T. (1997). Families under stress: What makes them resilient. *Journal of Family and Consumer Sciences*, *89*(3), 2.

McGarvey, D. (2017). Poverty safari. Luath.

McKay, A., Campbell, J., Thomson, E., & Ross, S. (2013). Economic recession and recovery in the UK: what's gender got to do with it?. *Feminist Economics*, *19*(3), 108-123.

McPherson, K. E., & Turnbull, J. D. (2005). Body image satisfaction in Scottish men and its implications for promoting healthy behaviors. *International Journal of Men's Health*, *4*(1), 3–12.

McVittie, C., & Willock, J. (2006). "You can't fight windmills": How older men do health, ill health and masculinities. *Qualitative Health Research, 16*(6), 788–801.

Men's Sheds. (2020). Men's sheds association. Retreived December 28, 2020 from https://menssheds.org.uk/

Mentalhelp.net. (2020). 5 Life-changing benefits of completing drug rehab. Retrieved 6 May, 2020 from https://www.mentalhelp.net/blogs/5-life-changing-benefits-of-completing-drug-rehab/

Merleau-Ponty, M. (1962) *Phenomenology of Perception.*: Routledge.

Meuser, M., & Behnke, C. (1998). Tausendundeine Männlichkeit? Männlichkeitsmuster und sozialstrukturelle Einbindungen. *Widersprüche*, *18*(67), 7–25.

MIDUS. (2018). Midlife in the United States: A national longitudinal study of health and well-being. Retrieved 29 April, 2020 from http://www.midus.wisc.edu/

Mill, J. S. (2016). *On Liberty*. Enhanced Media.

Miller, S. M. (1987). Introduction: The legacy of Richard Titmuss. In B. Abel-Smith & K. Titmuss (Eds.), *The Philosophy of Welfare* (pp. 1–17). Routledge.

Milligan, C., Gatrell, A., & Bingley, A. (2004). 'Cultivating health': therapeutic landscapes and older people in northern England. *Social science & medicine*, *58*(9), 1781–1793.

Mindwell. (2020). Men's groups. Retrieved December 28, 2020 from https://www.mindwell-leeds.org.uk/myself/right-service-or-support/peer-support-and-support-groups/men-s-groups

Mitchell, B. R., and Deane, D. (1971). *Abstract of British historical statistics.* Cambridge University Press.

Monaghan. L., & Goodman, J.E. (2007). *A cultural approach to interpersonal communication*. Blackwell.

Monk, S., & Kleinmann, M. (1989). Housing. In P. Brown & R. Sparks (Eds.), *Beyond Thatcherism.* Open University Press.

Morris, J. N. (1994). Exercise in the prevention of coronary heart disease: today's best buy in public health. *Medicine and science in sports and exercise*, *26*(7), 807–814.

Morrison, D. (2003). New labour and the ideological fantasy of the good citizen. *Journal for the Psychoanalysis of Culture and Society*, *8*(2), 273–278.

Movember. (2020). Retrieved 21 April, 2020 from https://uk.movember.com/mens-health/mental-health

Musick, K., Meier, A., & Flood, S. (2016). How parents fare: Mothers' and fathers' subjective well-being in time with children. *American Sociological Review*, *81*(5), 1069–1095.

Myers, D. G. (2000). The funds, friends, and faith of happy people. *American psychologist*, *55*(1), 56.

Nakamura, J., & Csikszentmihalyi, M. (2011). Flow theory and research. In C. R. Snyder & S. J. Lopez, (Eds.), *Handbook of Positive Psychology* (pp. 195–206). (2nd ed.). Oxford University Press.

NAMI. (2019). Self-Help techniques for coping with mental illness. Retrieved 6 May, 2020 from https://www.nami.org/Blogs/NAMI-Blog/January-2019/Self-Help-Techniques-for-Coping-with-Mental-Illness

National Archives. (2019). Victorian Britain. Retrieved 27 December, 2019 from https://www.nationalarchives.gov.uk/education/victorianbritain/happy/

Naylor, C., Parsonage, M., McDaid, D., Knapp, M., Fossey, M., & Galea, A. (2012). Long-term conditions and mental health: the cost of co-morbidities. King's Fund.

Nelson-Coffey, S., Killingsworth, M., Layous, K., Cole, S., & Lyubomirsky, S. (2019). Parenthood is associated with greater well-being for fathers than mothers. *Personality & Social Psychology Bulletin*, 1–13.

NHS. (2013). Smoking and drinking down survey reveals. Retrieved January 3, 2019 from https://www.nhs.uk/news/lifestyle-and-exercise/smoking-and-drinking-down-survey-reveals/

NHS. (2018). Exercise. Retrieved April 9, 2019 from https://www.nhs.uk/live-well/exercise

NHS Choices. (2016). What are well man clinics? Retrieved December 30, 2016 from http://www.nhs.uk/chq/Pages/2378.aspx?CategoryID=61

NHS Choices. (2017a). Health. Retrieved May 24, 2017 from http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhscoreprinciples.aspx

NHS Choices. (2017b). Health. Retrieved May 24, 2017 from http://www.nhs.uk/search?collection=nhs-meta&query=health

NHS Choices. (2017c). Health. Retrieved June 14, 2017 from http://www.nhs.uk/Conditions/stress-anxiety-depression/Pages/improve-mental-wellbeing.aspx

NHS Choices. (2017d). Five steps to mental wellbeing. Retrieved November 9 2017 from https://www.nhs.uk/Conditions/stress-anxiety-depression/Pages/improve-mental-wellbeing.aspx

NHS Digital. (2019). Statistics on obesity, physical activity and diet, England, 2019. Retrieved January 3, 2020 from https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-obesity-physical-activity-and-diet/statistics-on-obesity-physical-activity-and-diet-england-2019/part-3-adult-obesity

NHS Health Scotland. (2019). Child poverty overview: Impact of child poverty. Retrieved on January 2, 2020 from http://www.healthscotland.scot/population-groups/children/child-poverty/child-poverty-overview/impact-of-child-poverty

NHS. (2020a). Dementia guide: Living well with dementia. Retrieved May 6, 2020 from https://www.nhs.uk/conditions/dementia/living-well-with-dementia/

NHS. (2020b). Live well: Quit smoking. Retrieved May 6, 2020 from https://www.nhs.uk/live-well/quit-smoking/

NHS. (2021a). NHS. Retrieved on January 21, 2021 from https://www.nhs.uk

NHS. (2021b). Men's health. Retrieved on January 21, 2021 from https://www.nhs.uk/common-health-questions/mens-health/

NHS. (2021c). NHS Screening. Retrieved on January 21, 2021 from https://www.nhs.uk/conditions/nhs-screening/

NHS. (2021d). Prostate Screening. Retrieved on January 21, 2021 from https://www.nhs.uk/search/results?q=prostate%20screening&page=1

Nobis, R., & Sanden, I. (2008). Young men's health: A balance between self-reliance and vulnerability in the light of hegemonic masculinity. *Contemporary Nurse, 29,* 205–217.

Novak, T. (1988). *Poverty and the state.* Open University.

O'Brien, R., Hunt, K., & Hart, G. (2005). It's cavemen stuff, but that is to a certain extent how guys still operate': men's accounts of masculinity and help seeking. *Social Science & Medicine, 61*, 503–516.

O'Brien, R., Hunt, K., & Hart, G. (2009). 'The average Scottish man has a cigarette hanging out of his mouth, lying there with a portion of chips': prospects for change in Scottish man's constructions of masculinity and their health-related beliefs and behaviours. *Critical Public Health, 19*(3–4), 363–381.

O'Connell, R. E., & Hamilton, L. (2017). Hunger and food poverty. In V. Cooper & D. Whyte (Eds.), *The violence of austerity* (pp. 94–100). Pluto Press.

Office for National Statistics. (2015a). *Household disposable income and inequality: financial year ending 2015*. The Stationery Office.

Office for National Statistics. (2015b). *Trends in ONS longitudinal study Estimates of Life Expectancy by Social Class.* The Stationery Office.

Office for National Statistics. (2019). *National Life Tables, United Kingdom, 2016-2018*. Office for National Statistics.

Ong, A. D., Uchino, B. N., & Wethington, E. (2016). Loneliness and health in older adults: A mini-review and synthesis. *Gerontology*, *62*(4), 443–449.

Orion Partnership. (2020). Orion Partnership. Retrieved December 28, 2020 from https://space2.org.uk/about-us/orion-partnership/

Oxford Mail. (2017). Twelve more under-threat children's centres across Oxfordshire handed more than £300,000 between them. Retrieved December 28, 2020 from https://www.oxfordmail.co.uk/news/15088183.twelve-under-threat-childrens-centres-across-oxfordshire-handed-300-000/

Packard, J. (2008). I'm gonna show you what it's really like out here': the power and limitations of participatory visual methods. *Visual Studies*, *23*(1).

Pagis, M. (2009). Embodied self-reflexivity. *Social Psychology Quarterly*, *72*(3), 265–283.

Pantazis, C. (2000). Introduction. In C. Pantazis, & D. Gordon (Eds.), *Tackling inequalities: Where are we now and what can be done* (pp. 1–24). The Policy Press.

Parker, I. (1992). *Discourse dynamics: Critical analysis for social and individual psychology*. Routledge.

Parker, I. (2005). *Qualitative psychology: Introducing radical research*. McGraw-Hill.

Pauwels, L. (2015). 'Participatory' visual research revisited: a critical-constructive assessment of epistemological, methodological and social activist tenets. *Ethnography*, *16*(1), 95–117.

Pearce, M., & Stewart, G. (2002). *British political history 1867–2001: Democracy and decline*. Routledge.

Pechey, R., Jebb, S.A., Kelly, M.P., Almiron-Roig, E., Conde, S., Nakamura, R., Shemilt, I., Suhrcke, M. & Marteau, T.M. (2013). Socioeconomic differences in purchases of more vs. less healthy foods and beverages: analysis of over 25,000 British households in 2010. *Social Science & Medicine*, *92*, 22–26.

Pechey, R., Monsivais, P., Ng, Y-L., & Marteau, T. M. (2015). Why don't poor men eat fruit? Socioeconomic differences in motivations for fruit consumption. *Appetite*, *84*, 271–279.

Perez, L. M. (2011). Teaching emotional self-awareness through inquiry-based education. *Early childhood research & practice, 13*(2), n2.

Perez-Vazquez, A., Anderson, S., Rogers, A.W. (2005). Assessing benefits from allotments as a component of urban agriculture in England. In L. J. A. Mougeot (Ed.), *Agropolis: The social, political and environmental dimensions of urban agriculture* (pp. 239–266). Earthscan Books.

Persson, L. O., & Rydén, A. (2006). Themes of effective coping in physical disability: an interview study of 26 persons who have learnt to live with their disability. *Scandinavian journal of caring sciences, 20*(3), 355–363.

Phillips, A. W. (1958) The relationship between unemployment and the rate of change of money wage rates in the United Kingdom. *Economica, 25(*100), 283–299.

Piedmont, R. L. (1999). Does spirituality represent the sixth factor of personality? Spiritual transcendence and the five-factor model. *Journal of personality, 67*(6), 985–1013.

Popay, J., Bennett, S., Thomas, C., Williams, G., Gattrell, A., & Bostock, L. (2003). Beyond 'beer, fags, egg and chips'? Exploring lay understandings of social inequalities in health. *Sociology of Health and Illness, 25*(1), 1–23.

Population Reference Bureau. (2015). World population data sheet 2015. Population Reference Bureau.

Porter, E., & Coles, L. (2011). *Policy and strategy for improving health and wellbeing*. Learning Matters.

Porter, R. (1999). *The greatest benefit to mankind: a medical history of humanity from antiquity to the Present.* Fontana.

Porter, R. (2006). *The Cambridge history of medicine.* Cambridge University Press.

Power, A., Bell, S. L., Kyle, R. G., & Andrews, G. J. (2019). 'Hopeful adaptation' in health geographies: Seeking health and wellbeing in times of adversity. *Social Science & Medicine, 231,* 1–5.

Prayogo, E., Chater, A., Chapman, S., Barker, M., Rahmawati, N., Waterfall, T., & Grimble, G. (2017). Who uses foodbanks and why? Exploring the impact of financial strain and adverse life events on food insecurity. *Journal of Public Health*, *40*(4), 676–683.

Psarra, E., & Kleftaras, G. (2013). Adaptation to physical disabilities: The role of meaning in life and depression. *The European Journal of Counselling Psychology*, *2*(1), 79–99.

Public Health England. (2017a) Accessed May 9, 2017 from https://www.gov.uk/government/organisations/public-health-england

Public Health England. (2017b). Social determinants of health. Retrieved December 28, 2020 from https://www.gov.uk/government/publications/health-profile-for-england/chapter-6-social-determinants-of-health#fn:1

Public Health England. (2018). *Local action on health inequalities: Understanding and reducing ethnic inequalities in health*. Public Health England.

Putnam, R. D. (2001). *Bowling alone: The collapse and revival of American community*. Simon and Schuster.

Radley, A. (2009). *Works of illness: Narrative, picturing and the social response to serious disease*. InkerMen.

Radley, A. (2011). Image and Imagination. In P. Reavey (Ed,), *Visual Methods in Psychology* (pp. 17–28). Psychology Press.

Radley, A., Hodgetts, D., & Cullen, A. (2005). Visualizing homelessness: A study in photography and estrangement. *Journal of community & applied social psychology*, *15*(4), 273–295.

Raphael, D. (2006). Social determinants of health: Present status, unanswered questions, and future directions. *International journal of health services*, *36*(4), 651–677.

Reavey, P. (2011). The return to experience: Psychology and the visual. In P. Reavey (Ed,), *Visual Methods in Psychology* (pp. 1–13). Psychology Press.

Reavey, P. & Johnson, K. (2008). Visual approaches using and interpreting images in qualitative research. In C. Willig & K. Stainton-Rodgers (Eds.), *The Sage handbook of qualitative research in psychology* (pp. 296–314). Sage.

Rieker, P. P., & Bird, C. E. (2005). Rethinking gender differences in health: why we need to integrate social and biological perspectives. *The journals of gerontology series B: Psychological sciences and social sciences*, *60*(S2), S40–S47.

Richardson, G. E. (2002). The metatheory of resilience and resiliency. *Journal of clinical psychology*, *58*(3), 307–321.

Robertson, S. (2006). 'Not living life in too much of an excess': lay men understanding health and well-being. *Health, 10*(2), 175–189.

Robertson, S. (2007). *Understanding men and health: Masculinities, identity and well-being.* Open University.

Robertson, S., & Baker, P. (2017). Men and health promotion in the United Kingdom: 20 years further forward?. *Health Education Journal*, *76*(1), 102-113.

Robertson, S., Woodall, J., Henry, H., Hanna, E., Rowlands, S., Horrocks, J., Livesley, J., & Long, T. (2018). Evaluating a community-led project for improving fathers' and children's wellbeing in England. *Health promotion international*, *33*(3), 410–421.

Rodgers. C. R. (2004). *On becoming a person.* Constable & Robinson.

Room, R., Babor, T., & Rehm, J. (2005). Alcohol and public health. *The lancet*, *365*(9458), 519–530.

Rose, G. (2012). *Visual methodologies: An introduction to researching with visual methods.* Sage.

Rowntree, B. S. (1902). *A Study of Town Life.* Macmillan.

Roxburgh, S. (2004). "There Just Aren't Enough Hours in the Day': The Mental Health Consequences of Time Pressure. *Journal of health and social behavior*, *45*(2), 115–131.

Roy, P., Tremblay, G., Robertson, S., & Houle, J. (2017). “Do it all by myself”: A salutogenic approach of masculine health practice among farming men coping with stress. *American journal of men's health*, *11*(5), 1536-1546.

Royal Society for Public Health. (2013). *Arts, health and wellbeing beyond the millennium: How far have we come and where do we want to go?* Royal Society for Public health.

Rutter, M., & Madge, N. (1976). *Cycles of transmitted* deprivation. Heinemann.

Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American psychologist*, *55*(1), 68.

Ryan, R. M., & Deci, E. L. (2001). On happiness and human potentials: A review of research on hedonic and eudaimonic well-being. *Annual review of psychology*, *52*(1), 141–166.

Ryan, R., M., Huta, V., & Deci, E. L. (2013). Living well: A self-determination theory perspective on eudaimonia. In A. Delle Fave (Ed.), *The exploration of happiness: Present and future perspectives* (pp. 117–140). Springer.

Ryff, C. D. (2018). Eudaimonic Well-being: Highlights from 25 years of inquiry. In *Diversity in harmony–insights from psychology: Proceedings of the 31st international congress of psychology* (pp. 375–395). Wiley.

St. George’s Crypt. (2020). St. George’s Crypt. Retreived December 28, 2020 from https://www.stgeorgescrypt.org.uk/

Samaritans. (2019) *Suicide Statistics Report 2018.* Samaritans.

Sayers, P. (2010) Men and Suicide. In D. Conrad & A. K. White (Eds.), *Promoting men’s mental health* (pp. 96–105). Radcliffe.

Scambler, G., & Scambler, S. 2007). Social patterning of health behaviours. In A. Scriven & S. Garman (Eds.), *Public health: social context and action* (pp. 34–47). Open University Press.

Schwab, J. R., Addis, M. E., Reigeluth, C. S., & Berger, J. L. (2016). Silence and (in) visibility in men’s accounts of coping with stressful life events. *Gender & Society*, *30*(2), 289–311.

Schwalbe, M. L., & Wolkomir, M. (2002). Interviewing men. In J. F. Gubrium & J. A. Holstein (Eds.), *Handbook of interview research: Context & Method* (pp. 203–219). Sage.

Scott-Samuel, A. J., Crawshaw, P., & Oakley, A. (2015). "Men behaving badly": patriarchy, public policy and health inequalities. International Journal of Men's Health, 14(3), 250-258.

Seccombe, K. (2002). "Beating the odds" versus "changing the odds": Poverty, resilience, and family policy. *Journal of marriage and family*, *64*(2), 384–394.

Seligman, M. E. P. (2002). Authentic happiness: using the new positive psychology to realize your potential for lasting fulfilment. Random House.

Seligman, M. E. P. (2006) Afterword: Breaking the 65 percent barrier. In M. Csikszentmihalyi & I. S. Csikszentmihalyi (Eds.), *A life worth living: Contributions to positive psychology* (230–236). Oxford University Press.

Shaw, R. (2010). Embedding reflexivity within experiential qualitative psychology. *Qualitative research in psychology*, *7*(3), 233–243.

Shildrick, T. (2018). Lessons from Grenfell: Poverty propaganda, stigma and class power. *The Sociological Review*, *66*(4), 783–798.

Short, S. E., Yang, Y. C., & Jenkins, T. M. (2013). Sex, gender, genetics, and health. *American journal of public health*, *103*(S1), S93–S101.

Simon on the Streets. (2020). Sion on the Streets. Retrieved December 28, 2020 from https://simononthestreets.co.uk/

Simpson, P., & Richards, M. (2019). Reflexivity denied? The emotional and health-seeking resources of men facing disadvantage. *Sociology of health & illness*, *41*(5), 900–916.

Simpson, R., & Lewis, P.M.J. (2007). *Voice, visibility and the gendering of organizations, management, work and organisations*. Palgrave MacMillan.

Singh-Manoux, A., & Marmot, M. (2005). Role of socialization in explaining social inequalities in health. *Social science & medicine*, *60*(9), 2129–2133.

Sixsmith, J., & Boneham, M. (2002). Men and masculinities: accounts of health and social capital. In C. Swann & A. Morgan (Eds.), *Social capital for health: Insights from qualitative research*. Health Development Agency.

Sloan, C., Gough, B., & Conner, M. (2010). Healthy masculinities? How ostensibly healthy men talk about lifestyle, health and gender. *Psychology and Health*, *25*(7), 783–803.

Smiler, A. P. (2004). Thirty years after the discovery of gender: Psychological concepts and measures of masculinity. *Sex roles*, *50*(1-2), 15–26.

Smith, J. A. (2011a). "We could be diving for pearls": the value of the gem in experiential qualitative psychology. *Qualitative Methods in Psychology Bulletin, (12)*, 6–15.

Smith, J. A. (2011b). Evaluating the contribution of interpretative phenomenological analysis. *Health psychology review*, *5*(1), 9–27.

Smith, J. A. (2011c). Evaluating the contribution of interpretative phenomenological analysis: A reply to the commentaries and further development of criteria. *Health psychology review*, *5*(1), 55–61.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* Sage.

Smith, K. (Producer). (2015, June 1). *Benefits Street.* [Television Broadcast]. Love Productions.

Smyth, F. (2005). Medical geography: therapeutic places, spaces and networks. *Progress in human geography*, *29*(4), 488–495.

Sontag, S. (1979). *On Photography*. Penguin.

South East London CCG. (2021). Retrieved on January 21, 2021 from https://selondonccg.nhs.uk/

Southwark CCG. (2017). Retrieved on January 21, 2021 from https://www.southwarkccg.nhs.uk/Pages/Home.aspx

Springer, K. W., Stellman, J. M., & Jordan-Young, R. M. (2012). Beyond a catalogue of differences: a theoretical frame and good practice guidelines for researching sex/gender in human health. *Social science & medicine*, *74*(11), 1817–1824.

Stafford, M., De Silva, M., Stansfeld, S., & Marmot, M. (2008). Neighbourhood social capital and common mental disorder: testing the link in a general population sample. *Health & place*, *14*(3), 394–405.

Stead, M., MacAskill, S., MacKintosh, A-M., Reece, J., & Eadie, D. (2001). "It's as if you're locked in": qualitative explanations for area effects on smoking in disadvantaged communities. (2001). *Health & Place, 7,* 333–343.

Stephenson, J., & Cook, C. (1998). *Britain in the depression: Society and politics 1929-1939.* Longman.

SurveyAnyPlace. (2019). 10 advantages and disadvantages of questionnaires. Retrieved June 23, 2019 from https://surveyanyplace.com/questionnaire-pros-and-cons/

Swann, C., & Morgan, A. (2002). *Social capital for health: Insights from qualitative research*. Health Development Agency.

Szreter, S., and Mooney, G. (1998). Urbanization, mortality, and the standard of living debate: New estimates of the expectation of life at birth in nineteenth-century British cities. *The Economic History Review*, *51*(1), 84–112.

Tamm, M. E. (1993). Models of health and disease. *British Journal of Medical Psychology*, *66*(3), 213-228.

Thaler, R. H., & Sunstein, C. R. (2008). *Nudge: Improving decisions about health, wealth and happiness*. Yale University Press.

The Writer. (2018). How readable is your writing? Retrieved October 4, 2018 from http://www.thewriter.com/what-we-think/readability-checker/

Thompson, J., Bissell, P., Cooper, C. L., Armitage, C. J., & Barber, R. (2014). Exploring the impact of patient and public involvement in a cancer research setting. *Qualitative health research*, *24*(1), 46–54.

Todorova, I. (2011). Explorations with interpretative phenomenological analysis in different socio-cultural contexts: Commentary on J. Smith: 'Evaluating the contribution of interpretative phenomenological analysis'. *Health Psychology Review*, *5*(1), 34–38.

Townsend, P., & Davidson, N. (1992) *Inequalities in health: The Black report*. Penguin.

Townsend, P., Phillimore, P., & Beattie, A. (1988). *Health and deprivation: Inequality and the north.* London.

Trussell Trust. (2019). End of year stats. Retrieved October 18, 2019 from https://www.trusselltrust.org/news-and-blog/latest-stats/end-year-stats/

Tudor-Hart, J. (1971). The Inverse Care Law. *The Lancet*, *297*(7696), 405–412.

UN. (2016). Concluding observations on the sixth periodic report of the United Kingdom of Great Britain and Northern Ireland. Retrieved 18 October, 2019 from http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmlBEDzFEovLCuW3XRinAE8KCBFoqOHNz%2FvuCC%2BTxEKAI18bzE0UtfQhJkxxOSGuoMUxHGypYLjNFkwxnMR6GmqogLJF8BzscMe9zpGfTXBkZ4pEaigi44xqiL

Vaillant, G. E. (1995). *Adaptation to life*. University Press.

Valentine, G., & Harris, C. (2014). Strivers vs skivers: Class prejudice and the demonisation of dependency in everyday life. *Geoforum*, *53*, 84–92.

Vandoros, S., & Carman, K. G. (2011). *Demand and pricing of preventative health care*. London School of economics.

Värnik, P., Sisask, M., Värnik, A., Laido, Z., Meise, U., Ibelshäuser, A., Van Audenhove, C., Reynders, A., Kocalevent, R.D., Kopp, M., & Dosa, A. (2010). Suicide registration in eight European countries: A qualitative analysis of procedures and practices. *Forensic Science International*, *202*(1), 86–92.

Verbrugge, L. M. (1989). The twain meet: empirical explanations of sex differences in health and mortality. *Journal of health and social behavior*, 282–304.

Viet-Wilson, J. (1999). The National Assistance Board and the 'rediscovery' of poverty. In H. Fawcett & R. Lowe (Eds.), *Welfare Policy in Britain: The Road from 1945* (pp. 116–157) Macmillan.

Vine, A. (2014, January 28). These scrounging deadbeats on TV's Benefits Street. *Yorkshire Post*. Retrieved July 14, 2020 from https://www.yorkshirepost.co.uk/news/opinion/columnists/these-scrounging-deadbeats-tvs-benefits-street-1847606

Vittersø, J. (Ed.), (2016). *Handbook of Eudaimonic Well-Being*. Springer.

Vuori, A., & Åstedt-Kurki, P. (2013). Experiences of health and well-being among Finnish low-income fathers. *Nursing Inquiry, 20*(2), 165–175.

Wakefield, S., & McMullan, C. (2005). Healing in places of decline: (re) imagining everyday landscapes in Hamilton, Ontario. *Health & Place*, *11*(4), 299–312.

Walsh, E. (1998). *Strengthening family resilience*. Guilford.

Wandel, M., & Roos, G. (2006). Age perceptions and physical activity among middle-aged in three occupational groups. *Social Science & Medicine, 62,* 3024–3034.

Wang, C., Burris, M., & Ping, Z. Y. (1997). Chinese village women as visual anthropologists: a participatory approach to reaching policy makers. *Social Science & Medicine*, *42*(10), 1391–1400.

Wang, C.C., Morrel-Samuels, S., Hutchison, P. M., Bell, L., & Pestronk, R. M. (2004) Flint Photovoice: Community building among youths, adults, and policymakers. *American journal of public health, 94*(6), 911–913.

Wang, Y., Hunt, K., Nazareth, I., Freemantle, N., & Petersen, I. (2013). Do men consult less than women? An analysis of routinely collected UK general practice data. *BMJ open*, *3*(8).

Wardle, J., & Griffith, J. (2001). Socioeconomic status and weight control practices in British adults. *Journal of epidemiology and community health, 55,* 185–190.

Watson, C. (2001). Well Man Clinics in In N. Davidson & T. Lloyd (Eds.), *Promoting Men's Health: A Guide for Practitioners* (pp 165–179). Bailliere Tindall

Watson, D., Clark, L. A., & Carey, G. (1988). Positive and negative affectivity and their relation to anxiety and depressive disorders. *Journal of abnormal psychology*, *97*(3), 346.

Watt, R. G., Venturelli, R., & Daly, B. (2019). Understanding and tackling oral health inequalities in vulnerable adult populations: from the margins to the mainstream. *British dental journal*, *227*(1), 49.

Weber, R. P. (1990). *Basic content analysis*. Sage.

Weekes-Bernard, D. (2017). *Poverty and ethnicity in the labour market.* Joseph Rowntree Foundation.

Weick, K. E. (2002). Essai: real-time reflexivity: prods to reflection. *Organization Studies*, *23*(6), 893–898.

White, A. K. (2001). *Report on the scoping study on men's health*. Department of Health.

White, A .K. (2010). Introduction. In D. Conrad & A. K. White (Eds.), *Promoting Men's Mental Health* (pp. 1–6). Radcliffe.

White, A. K., & Banks, I. (2004). Help seeking in men and the problems of late diagnosis. In R. S. Kirby, C. C. Carson, M. G. Kirby & R. N. Farah (Eds.), *Men's Health* (pp. 505–514). (2nd ed.). Taylor & Francis.

White, A., McKee, M., de Sousa, B., de Visser, R., Hogston, R., Madsen, S. A., Makara, P., Richardson, L., Zatonski, W., & Raine, G. (2014). An examination of the association between premature mortality and life expectancy among men in Europe. *The European Journal of Public Health*, *24*(4), 673–679.

White, A., Seims, A., & Newton, R. (2016). The state of men's health in Leeds - a summary. Leeds City Council.

Williams, R., Robertson, S., & Hewison, A. (2009). Masculinity,'men's health'and policy: the contradictions in public health. Critical Public Health, 19(3), 475-488.

Wohl, A. S. (1984). *Endangered lives: Public health in Victorian Britain.* Cambridge University Press.

Wong, Y. J., & Rochlen, A. B. (2005). Demystifying men's emotional behavior: New directions and implications for counseling and research. *Psychology of Men & Masculinity*, *6*(1), 62.

World Health Organization. (1986). Ottawa Charter for health promotion. In *First international conference on health promotion*. WHO.

World Health Organization. (2014). Mental health: a state of well-being. Retrieved May 9, 2017 from http://www.who.int/features/factfiles/mental_health/en/

World health Organization. (2019). Health Impact Assessment: The determinants of health. Retrieved Jan 2, 2020 from https://www.who.int/hia/evidence/doh/en/

World Summit for Social Development, & United Nations. (1995). *World Summit for Social Development: The Copenhagen Declaration and Programme of Action*. United Nations.

Wright, C. Y., Darko, N., Standen, P., and Patel, T. G. (2010). Visual research methods using cameras to empower socially excluded black youth. *Sociology, 44*, 541–558.

Wright, N. (2002). *Homelessness: a primary care response*. Royal College of General Practitioners.

Wright, T. (2004). *The photography handbook*. Routledge.

Xia, N., & Li, H. (2018). Loneliness, social isolation, and cardiovascular health. *Antioxidants & redox signaling*, *28*(9), 837–851.

Young. A. M. W. (2010). Urban distress and the mental health of men. In D. Conrad & A. K. White Eds.), *Promoting Men's Mental Health* (pp. 39–56). Radcliffe.

Appendices

Appendix A: Information booklet

Who can take part?

White British men over the age of 18 who live within a low income area.

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This research is being supervised by Dr. Anna Madill and Dr Siobhan Hugh-Jones. The university ethics reference is 13-0036

If you wish to discuss the research or have any reservations about the conduct of the researcher, please contact Dr Anna Madill by emailing a.madill@leeds.ac.uk

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WANTED!

Your views on men's health

What now?

Take some time to think about whether you would like to take part and talk it through with anybody you would like to. Think of any questions you have for the researcher or anything you are not sure about. Once you have decided then contact the researcher to get involved.

Mike Jestico
tel: 07932 849924
e-mail: psmpj@leeds.ac.uk

Would you like to be involved in research aimed at improving men's health and well-being?

What is the aim of the study?

Men die on average 4 years younger than women in the UK and have less healthy years too. This doesn't have to be the case and you can make a difference.

The study aims to understand what men think and do about their own health and how this affects how healthy they are. What difference does this make to their lives?

When would I take part?

You can take some time to decide whether or not to take part. The research will last for a limited time, so the sooner the better but not until you are totally sure you wish to take part. You can choose which week you take your photos and the interview will be arranged at a time that suits you.

Why should I take part?

Men die on average 4 years younger than women in the UK and have less healthy years too. Lots of people have written about reasons why but few researchers have thought to ask how men live their lives and how do they 'do' health. With your help in this study we can help improve this situation and help men live longer and healthier lives. You might also enjoy it too.

What is involved?

If you decide to take part then this is what would happen:

You will be asked to complete a short consent form. You will then be loaned a digital camera, and asked to photograph your life for 7 days. The photos will be of what is around you or things you do that affect your health and feelings of well-being. If you take photographs of adults, you must try and gain their verbal consent first. The researcher will develop the photos with you on a portable printer.

An audio recorded interview will then be arranged in a place of your choosing when you will talk about the photos you have taken with the researcher (Mike Jestico). This will give you the opportunity to discuss any issues that came up during the process.

Will anybody know I am taking part?

Your personal details (age, name etc) will be anonymous. All of the data (photos and interview recordings) will only be looked at by the research team and your name will not be used (you will be given a false name instead). All of the data will be stored securely in locked filing cabinets or on secure University of Leeds computer systems. Any reports, presentations or publication of results will not name anybody taking part.

If you tell me something during the project, or take a picture of something, that makes me think that you are at risk of harm, or may harm someone else, then I will have to tell someone else. If this happens then I will talk to you about it first.

Is there a downside to taking part?

If you do decide to take part then we will be asking for some of your time, but it will be quick between beginning and end of the research. There is the possibility that during the interview we may talk about some things that you find difficult or upsetting, but you will never be forced to talk about anything you do not want to. If you do decide to take part you will always have the option of withdrawing at any time you want to. You will be rewarded with £20 in supermarket vouchers in exchange for the time you have spent on the research.

Appendix B: Participant consent form

Interview Consent Form

Study title: Men's health and well-being

The purpose of this form is to make sure that you are happy to take part in the research and that you know what is involved.

Please confirm each statement by putting your initials in the associated box.

I have read the participant information leaflet	
I have had the opportunity to ask questions and to discuss the study	
I have received satisfactory answers to all of my questions	
I have received enough information about the study	
I understand that I am free to withdraw from the study up to one month after the research interview without having to give a reason	
I understand that I am unable to photograph any children other than my own.	
I understand that personal details in photographs used in this study will be blurred to preserve anonymity	
I understand that I am free to end the research interview at any time and without having to give a reason	
I understand that I am free to choose not to answer a question without having to give a reason	
I agree to the interview being audio-recorded	
I grant permission for extracts from the interview to be used in reports of the research on the understanding that my anonymity will be maintained	
I agree to take part in this study	

Participant signature Date
Name of participant
Researcher signature Date
Name of researcher

Thank you for agreeing to take part in this study.

Appendix C: Instructions for taking photographs

Instructions for photos

The purpose of this research is to understand how you think about your own health and well-being and what you do that affects it. To help with this I would like you to take some photos over the course of a week that I will then print with you on a portable printer. We will then talk about the photos so I can understand why you took them and what they mean to you.

1. Please take photos of anything in your life that reflects your feelings of health and well-being in a positive or negative way.

2. If you take more than one photo of the same thing, choose which one you would like to talk about.

3. I am not going to guide you as to which things that might reflect your feelings of health and well-being. I would like you to choose your own.

4. Please don't take photos of children as I will not be able to print them or ask you about them. If you wish to talk about children, please take a photo of something that reminds you of them, such as a toy or clothing.

5. Please try to gain verbal consent from any adults before taking their photograph

6. If you take photos of anyone or a specific location that could be identified, these images will be pixelated before being used in research. This will ensure that anonymity is preserved for you and those around you.

If you have any questions, please ask me now. If you have any questions over the course of the week, please email me at psmpj@leeds.ac.uk or call or text me on 07932849924

Thanks,

Mike

Appendix D: Sample pages from interview transcripts

Alan: Yeah I've always had a good diet erm [right] and no I would probably say my diet is self-taught where we didn't have as much as that when I was younger and erm [right] I'd just say though erm, being rammed down my throat by the media, I've eaten a lot of- erm having a good diet [mmm] you know what I mean [yeah] that's I'd say, I've swallowed the err media hype [((laughs)) ok] of having a good diet you know what I mean. [right] **(44:17)**

Int: So do you, believe everything they tell you?

Alan: No.

Int: How do you pick and choose?

Alan: Erm what the media say?

Int: Yeah, [erm] and and other things you hear from other people.

Alan: Erm if I'm over hyped with it if I can tend to think there's some truth in it right if I really want to I will research, [right] yeah. [ok]

Int: So you just don't take anything at face value? You always have a look into it? ok, [yeah yeah] right.

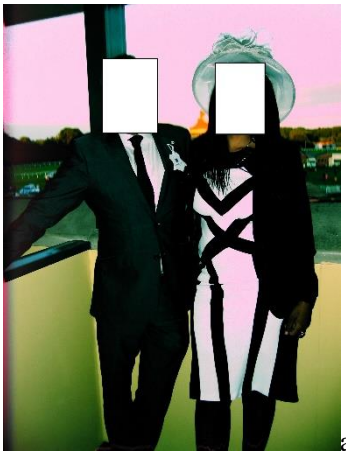
Alan: I don't always noI don't believe what they write in newspapers, and err I'm very cautious, [right] erm, but erm, media massive campaign on health last twenty years right [yeah] my doctors err, who, I tend to trust, you know a doctor and erm three or four times when I've spoke to different doctors erm, they've sort of said to me erm, don't stop your diet if you keep on your diet erm I think you've given yourself a good chance [mmm] of erm not getting alcohol damage, so that's why [yeah] I've sort of kept on that road really doctors advice.

Int: Right, great stuff, brilliant, ok.

Alan: We might have a few more pictures of it I think.

Int: Have we? Ok there's another one [yeah]. **(45:38)** (inaudible)

Alan: I don't know what's going on there [ok right] we'll give that one a miss ((laughs)) (pause) [inaudible]



ah my girlfriend [right] erm that's at, erm, that's at (name) races, [lovely] and erm my quality leisure time and I'd thought I'd spoil her and a bit of a present to me, I'd been working here, ten weeks and I thought oh yeah could do with a day out erm not had a day out for ages so erm, I booked a box, at (name) racecourse [oh, lovely] (pause) [ok, right, yeah] and erm, waitress service gorgeous food, and err, I'd worked the day so it were an evening meeting [mmm] and erm, so worked half seven till one and then set off picked her up and got to (name) at three, which I'd planned for you could go into our box at four, and, we ate at five and the first race was, was the first race twenty to six? [ok] the first race was maybe twenty to six and the last race was twenty to nine and erm, yeah just a nice day out to, get dressed well err get dressed up and erm, yeah get waited on hand and foot and erm [right], yeah, some pretty, rich nice people about, but erm no just a nice, treat for me really treat myself [mmm] I'd sort of like been working ten weeks and I thought oh yeah I wouldn't mind err a bit of a treat really so erm, yeah couple of hundred quid just had us a day out really [mmm] so it were, it were worth it I'd budget it in sort of like [yeah] sorted it out [circle round that amount] yeah ((laughs)). **(47:40)**

Int: So how, is it important to have these treats?

Alan: Yeah [yeah] yeah, erm (pause) I don't know how we're programmed mentally but you have to reward yourself right where erm, I like nice things and, err I'm used to having

nice things but the only way, I can, rewar- have these nice things is erm, to keep it tight keep it tight keep it tight keep it tight err, and you know and like I say I've just spent ten grand on me house right and, erm, I could have wasted that money, and it could have gone on and if somebody go what have you spent that on in the last two years and I go, I don't know, but if somebody says to me, what have you spent, your bits of money on last two years and I go well err, TV carpet lovely furniture bed, err interior design curtains ((chssh)) [right] something to show for it you know what I mean [yeah] erm, and so I we could have gone out every weekend into (northern town or northern town) and spent thirty or forty quid here right or, after, five weeks saving up, I can have a really nice, [mmm] two hundred quid day out going to (name) races well she won't ever forget that and I have a really nice time [mmm] erm so I'd rather keep it tight and then say, go to Monte Carlo for weekend, you know what I mean than erm, forty quid in (northern town) go to (northern town) have a Chinese spend fifty quid right I'd rather save five save five hundred quid and go to Marbella for the night [mmm] you know what I mean [mmm] I'd rather do that [right ,yeah] so [ok, no lovely] that were a that were a lovely day that [yeah] weather were good, nice people (pause) I got a bit of an urge that I think I think there are quite a few of that actually. [yeah, ok] **(49:39)**

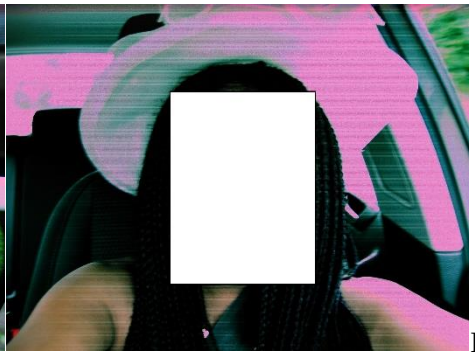
Int: Why is, is she, is she important to you? Is the relationship important to you? You don't have to talk about it if you don't want to you can not if you don't want to talk about it that's fine.

Alan: (pause) I'll I don't know [ok] I can't really I can't really answer it [ok] 'cause I don't know [right]

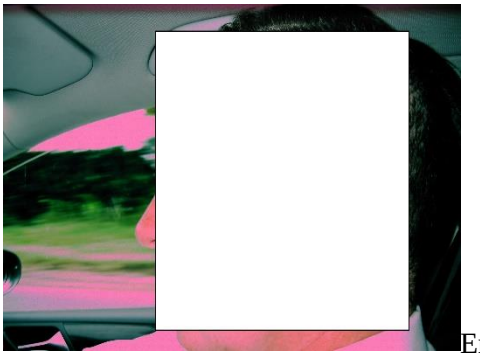
Int: Are you happy? Is that a good question?

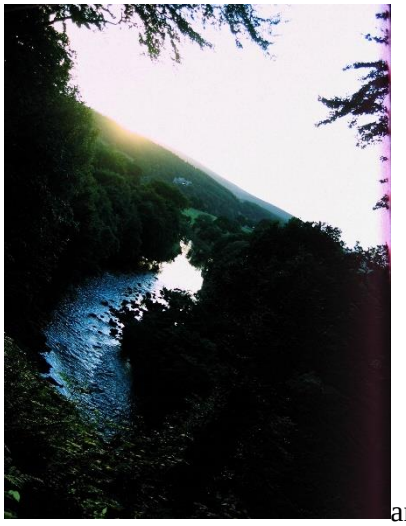
Alan: ((intake breath)) Yeah **(50.05)**

Int: Right we'll leave it there ok fine [right].

Alan:   Horses [yes] (name) races [yeah] don't know [ok] haven't a clue, might be my hand [yeah alright] (pause) her with her hat on [yeah], erm going back to that question there erm (pause) don't know I can't I can't answer any questions on that it's too complicated.

Int: ((laughs)), that's absolutely fine.

Alan:  Err me err, in the car [right] erm, and, that's sort of one of me pleasures it's a normal thing in life driving but erm, yeah where a lot of people will, erm, I don't really take it for granted 'cause a lot of people, it's a car and they just we need to get to A to B right but erm, with me not drinking, err I'd say don't mind spending ten pound on, going out for night [mmm], and, had a beautiful evening with my girlfriend the other week it were Saturday night and I says oh come on let's go for a drive, erm (northern location), went there really really nice [mmm] maybe eight o clockish half seven eight o clock (northern location) walked down to the (name) stepping stones and then and then there's this gorgeous view right I tried to take a picture of it but it it might



be further back [right], and erm, (northern location) it is and erm, could hear noises and thought what's that, so, carried on driving down the (name) valley and then sort of sneaked into this erm, wedding at this (northern location), never been there before and posh do, posh [yeah] marquees everything and sort of sneaked in there and then drive a bit further into, (pub name) at (northern village) [mmm] and then went to (northern village) [yeah] and so, did about hundred mile but, err fifteen quid in juice erm, that, was like, erm, having a weekend away it were a gorgeous night out and couldn't have done that with drink [no], 'cause would have been nicked or [yes] whatever right but again the car right, big asset fantastic [right] right because, went to four different amazing posh great venues all in the same night and err crammed it all in fantastic so car ((out breath)) it's great, great having me car, yeah I love it. **(52:49)**

Int: So is it just for pleasure?

Alan: The car [yeah] erm (pause) convenience pleasure lot of mental well-being because it's just like erm, yeah I couldn't do half the things err, I do [right] as in socially in my own personal social life erm without that where I can ring her up and say ah, oh be ready at twenty past five in the morning I'm off to- I need to go to a beach I want a beach, I want some water and, err peace and at twenty past five I'm on a beach in (northern town) at quarter to seven, yeah and then, great for a few hours then whilst all the err, rush are coming right err, half past nine I'm back in (northern town) at twelve [mmm], you know [yeah] so it really is great you know what I mean erm yeah so I love my car [great stuff]

(pause) this (northern location) I don't think it's, erm oh

 that's erm, a, Volkswagen campervan, [yes] with a surf board on top money box [((laughs))] right so, [yes] that's what I got brought back from erm, Newquay when I took my daughter surfing [yep] but erm yes that's my little money box that erm, put some, erm, bits of money in that and when it gets to say ten pound or whatever, goes into my bank account and err, might have some little treats for my daughter [mmm] she's been really ringing me up today Daddy can you buy me some makeup I went yeah see if we can, erm, yeah but I love my little err memento as it reminds me of a really nice holiday with my daughter [yeah], you know, [yes] so that every time I look at that, erm, I look at me-- I just remember the beach and the surfing and the, the deep the deep one that really really gives me a lot of erm, peace is erm, my daughter won't ever forget that holiday for the rest of her life [mmm] you know what I mean, [mmm] erm, and what's quite a nice thing that's come to light recently is erm, I think her Mum's on erm, me on job seekers I managed to take her on holiday for fifteen hundred quid a lot of money a lot of money yeah her Mum's on like fifty k a year and, she hasn't taken her away this six weeks holidays [mmm] I said I'm ashamed, I said, I know you were bad at money organisation but that is embarrassing, you can't take your daughter away and your on fifty grand a year, deary me, I'm glad I'm not with you [((laughs)) right] right. **(55:52)**

Int: So, do you have, there's a couple of questions for this one did she buy you that first of all or did you buy it?

Alan: Erm no I bought it but erm, she, I won't gonna buy it and then she convinced me to buy it ah that's great 'cause she was buying some mementos to bring home and she said oh

Daddy you could do with that as it goes with your interior and everything and get this and get this and erm, yeah I just bought it [yeah] when I were down there so yeah it's good it just I just have to look at it and it just reminds me of all the holiday [right] you know what I mean [yeah] and it says Newquay on it as well you know what I mean so I every time I look at it I just think ((blowing out breath)) and like when I went through rehab erm, you don't, they teach you you don't pat yourself on you back enough because erm its your journey and really there's a lot of selfish people in this world that don't give two fucks, about you [mmm yeah] or anybody right and so, err I look back on that and think ((breath out)) how did I do that how did I manage to get a grand and a half together to take her away but, that's my thing in live if you wanna, go to New York to see Beyoncé in concert and it's gonna cost you three grand to take your little girl you will do it [mmm] right if, erm, Lewis Hamilton, you know is up there now won't say fifty err, fifty million a year or whatever right [yeah] but he's not there right if his Dad had've thought ah no I can't be bothered but his Dad worked his bollocks off three jobs to put him where he is today right so, if you wanna do something you're the only obstacle that's stopping you doing it yeah [yeah] if you want a Ferrari if you want to buy a car for one hundred grand yeah you will get the money [mmm] to do it simple as that, [yeah] and erm, yeah yeah [ok] so every time I look at that I think ((out breath)) you did well there 'cause to me there is no such thing as erm, can't, there is won't right [yes] but there's not such thing If somebody puts a barrier in my way, erm, I'm a bit of a problem solver then I think well, right how can I get round this one yeah there's always a way to solve stuff [yeah]. **(58:20)**

Int: Do you have other things in your house that remind you of good times as well or is this, is this unique?

Alan: Erm (pause) no my furniture [ok] err also I look at everything and think that is mine [yeah] that is mine [right] and erm, you've got that err because you have stopped drinking every time I look at it right, that's mine because I stopped drinking right [yeah] and that's mine because I saved and saved and saved and saved and saved right and err ah no all my house once the doors locked that's my sanctuary and err everything in there's just like I

love it its brilliant [good] yeah and no one's allowed in my house [((laughs))] at all [((laughs)) ok] unless by appointment if anyone comes to my door, no get away [mmm] yeah [ok great]. **(59:15)**

Int Ok

Stan  That one's (name of town) market that's the place where wife got scratched when she were younger [right] I wanted to go see it cos I hadn't been out for that long and I just got me bus pass so I thought I'll take a trip out on the third at 8.15.

Int So why did you wanna go there

Stan Well wife got scratched when she were younger when she'd been drinking over there and we've never had the chance to go in back and it had been so long for her and I thought well I'm not doing owt so I'll get bus pass out and I'll go for a ride cos I haven't been out haven't been able to get out for a while so [yeah] I thought I'd go and take a picture of that

Int ok, so what does it mean to you that you'd been back there

Stan Well to see how many pubs were there as she said she got scratched from nearly all the pubs in (name of town) [laughs ok] ((laughs)) you know what I mean so I thought I'd see how many there actually were and [right] and I had no money on me I only had me pass which got broken and that

Int Right so you didn't go for a drink

Stan No no no just had a spot of tea from me flask of tea which I brought, [ok brill] which way did it go

Int Press that one yeah, that one there that one up there in the middle of that one

Stan 

That's of (name of town) [yeah] same place a bit further on for me tea break [right ok] er,

Int Why does it keep doing that, come this way then right

Stan 

That's down at (name of place) we went there me and wife went there first time it were open and it cost quite a lot of money to take me son when me son were doing pole-axing at the school [ok] so we're she never got up to go upstairs she were scared of heights so I thought I'd go down and have a look

 and this is another picture which was on the top floor [yeah]

 and down the corridor which she couldn't look down because she was scared of heights [yeah]

 same as that one [ok]

 taxis, there weren't any taxis on the river when we first went [right] they're the taxis looking down from the top

Int They are the boats

Stan Where the boats are theyre the boat taxis on the river on the river itself

Int Ah right I've never seen those right ok

Stan  that's the elephant which she would have loved to gone and see but it were on the middle floor but it was still a bit too high for the wife [yeah]

Stan  That were at (place) I were working on the top there cleaning [alright] when they were building them [mmm] they finished them off and we had to go in and clean em out and make sure they were spic and span for when the people who were buying em were coming round [right ok]

Stan  Which one were that, that ones walking over the bridge which wasn't there when we were there for the sea cadets that's why I took that one **3.15**

Int Were you part of the sea cadets

Stan Yeah I joined the sea cadets for about two three month

Int Ok when was that

Stan er 72

Int Oh ok going back

Stan  That's where I went fishing and about 4th bollard out [yeah] the bollards there its nice and clear and I got 3 or 4 fish there the first time I went same time further down the canal I was there from 8 while 1 and I caught nothing went there and caught went there between 1 and 2 and caught one straight away

Int Right do you fish now

Stan Yes I still go fishing

Int Right so how often do you go

Stan Er, not as much as I used to as I were just looking after the wife like with her being poorly [right[and er I've started going back as I've just got me bus pass and so I've been able to get out as it's a lot of money is 4 pound [yeah yeah]

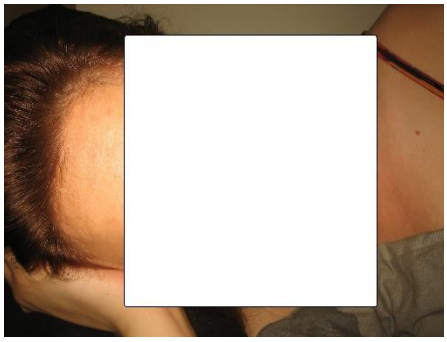
Int So where do your cooking skills come from?

Will I'd say it was from when I was younger when I was about 12 my mum worked in London my dad had his own business so I'd come home and have 3 hours where I'd have to do my homework cook for myself and just basically sort of look after myself yeah.

Int Yeah so taught you to be independent?

Will Yeah I used to cook for me and my brother he's older than me but I've always sort of because I was always a fussy eater when I was younger I was never the biggest fan of my mum's cooking and then I started learning how to do it so it was like oh so I know I don't like it like that so I'll do and then it sort of developed into a bit of a passion my mum would come home like here you are mum try this she was like oh bloody hell so yeah I do really enjoy cooking when I've got access to decent utensils and food yeah.

Int Okay cool good good stuff.

Will  That was now my ex-girlfriend who was good but mostly bad she was quite a lot of trouble she had a few problems of her own with like depression and sort of anger issues which I took the brunt of mostly I was with her for about 8 or 9 months and it just got to the point where she was sort of interfering with my own life so much that I couldn't really get on with what I had to do like you know I feel bad saying it like I'd have to look after her a lot more than we'd sort of spend time together as friends or as a couple and it took me a few months to realise how much of an impact it had on my work that I was just I literally did no artwork during the time that we were together at all and then I came to that realisation and even though she was having the problems that she was that I had to break up with her for myself and because it had been you know nearly a year and I had to

sort of start thinking about myself as well so ever since we broke up I've done so much it sounds bad but you know you have to be selfish to

Int You do sometimes.

Will Sometimes yeah.

Int So why don't you talk about the good stuff that was going on as well?

Will Like she was my first girlfriend that I'd kind of lived together sort of thing which it's nice waking up next to someone it's nice having someone that cares about you but it's also annoying having someone that cares about you and stuff like that so you know at that age it's hard balancing spending too much time together and getting on each other's nerves and stuff like that.

Int Yeah so in the end the bad outweighed the good and?

Will Yeah but I mean I still look back at it and take all the good things from it which is what you should do so.

Int Yes absolutely so are you seeing anybody now?

Will Not at the moment no it was fairly recently.

Int Ok but it was going on at that time, not knowing what the future was going to bring?

Will Yeah it was kind of I knew well before we got together I knew that I didn't want a girlfriend because it would get in the way of my work and then I sort of you know wool over the eyes sort of got this girl around all the time and then it took me a while to realise shit I was completely right yeah.

Int Ok so is it easier to talk about her now she's not here would you be able to talk like this if you were still going out?

Will No I would have done and she sort of knew that as well so kind of knowing that was a bit confusing to me why she'd sort of want to be with someone that didn't want a girlfriend in the first place but you know it did happen for quite a while and we were happy for quite a while so you know it was good and it was bad and there was a lot of I say I went through a lot you know got a lot of grief a lot of it's almost psychological torture but it kind of made me stronger it's made me realise what I should and shouldn't put up with with other girls and

things like that so you know it's all a learning curve really I'm not sort of curled up and depressed about it so it's like when I tell people oh God you sound really happy about that I don't mean to like in a mean way but it's really had a positive impact on my life but I'm not sure it has on hers so I'm kind of trying not to be overly smug or anything. **24.23**

Int Are you still in contact with her?

Will Yeah I still speak to her occasionally.

Int Ok and you see her in the same places that you go?

Will Yeah I mean she doesn't go there as much as she used to but that's not because of me I'd say our groups don't sort of cross over as much as they used to but that's always going to happen to a certain extent isn't it people hang out with each other for reasons and it's you know it's not that we're not friends but it's not like she's one of my best friends oh yeah what are you doing tomorrow let's sort of hang out if I saw her I'd have a chat with her and her mates but we probably wouldn't ring each other up to go out for a drink so you know I kind of feel I've lost a couple of friends through it but I mean I'm still friends with her but we don't speak the way we used to, but that's not the end of the world in my eyes so life goes on.

Int It does yes and you know that you're doing more work so that's you know like you said it's a positive thing.

Will Yeah and I've had people saying you know it's for the best and can see the difference and all that so yeah.

Int Brilliant yeah we might switch it back on again.

Will  Yeah so I did start drinking a bit after we broke up because my uncle so he had lung cancer and found out that he took a turn for the worst as well so I was kind of you know I wasn't in the best of spirits I sort of found myself you know

I'd be going to London and thought oh I'll get three cans for the train and the next thing you realise everywhere I go I'm getting a can of beer or something and just sort of drowning my sorrows almost but.

Int How did you realise that was going on?

Will It was the trains because I realised every train I got on I'd find myself walking down looking for the bar and after about 2 or 3 weeks of getting 4 or 5 trains and I realised I'd done I on every train I was like shit, this is actually a bit of a problem so I thought I'd acknowledge that and obviously acknowledging it makes it easier to tackle almost.

Int Definitely well it's interesting that you realised that something was happening [yeah] and did you change did your behaviour change?

Will Yeah um recently took a while and it did get a bit worse after like certain things happened

so yeah after my uncle did pass away so because he got cremated I've had this horse shoe all my life which I've always thought has given me good luck so I wanted to put it in his coffin with him when he got cremated you know for his sort of afterlife but because of the materials in it I wasn't allowed to so I thought that I'd take a picture of it and have it you know even though I've still got it as an item at my house in Birmingham I thought you know I was thinking about maybe getting a tattoo of it not as a sign of respect but just like a memory sort of thing but just thought I'd photograph it to let it sink in almost.

Int Right ok so you've got other tattoos [yeah] oh we're not going to see another one down there as well so why have you got tattoos?

Will Well it started out because being an art student just having an interest in that sort of rebellious sub-culture and my mum saying well if you get a tattoo then you're going to get kicked out of

the house so I went and got one when I was 17 and she actually turned out liking it the majority of my tattoos are either related to my art or to my history of my medical condition I've had a really nice upbringing I'm from a middle-class loving family but I was a very troubled teenager my uncle used to be a football hooligan which I always used to have that sort of nostalgia attached to me and I used to have a shaved head and I used to get into fights and I used to get arrested and I was really genuinely miserable until I was about 21 22 then I realised, I was like what have I been doing my whole life no one wants to be friends with this guy thinks he's hard as nails and is going to flip out at any moment and then I got a lot more into my art and my studies and I really found that as like a way out because I literally I went to private school and I was always you know the misfit, the one who's looked at as being stupid because I didn't perform as well as everyone else because I didn't like school I didn't relate to learning and then came to about Year 9 realised I could draw so that was something that I could do but I wasn't into and then I got kicked out of school in Year 10 and went to college to do my GCSEs and I ended up getting an A in art so I was like hang on, this is something that I can actually do I used it as an excuse not as a career path, it was like right, I'll go to college I'll see where that gets me then you know I went to college and did the absolute bare minimum for 2 years absolutely scraped by but had a pretty solid portfolio so I arranged four interviews at uni it was like Liverpool Manchester Bristol and Leeds and I had my first interview at Manchester and I had an unconditional offer then I have my second interview at Leeds and I had an unconditional offer so it was like well if this is what it's going to be like I'm not going to finish college I'm not going to go to these other things I'm going to take them up on this offer and I dropped out of college and started decorating earned a bit of money to come to uni and then all hell broke loose when I had my own space because I was still in that sort of really negative state of mind when I got here and I used to drink way too much and get into way too much trouble and then I sort of mid-way through second year got really quite ill and I was pretty much bed-ridden I was bed-ridden for the whole year but I still did my uni work so I still managed to complete the year and then I had so much time to sort of reflect on everything I was just like what the Jesus have I been up to these last 20 years

you know I started growing my hair started wearing different clothes just changed my whole view of life sort of changed my view of my parents my old friends my old people who I didn't class as friends and sometimes like when I was younger I'd have seen a bad thing as being something even worse and that would have made me worse but sort of with age you see the bad things and I take the good out of them so I almost see stuff like that as being a blessing so being ill has almost sort of saved my life in a certain way and I do really appreciate that, some people are like oh yeah you're really unlucky you know how can you do this I see it as having one up on people who haven't had that sort of experience so yeah it's a good thing really.

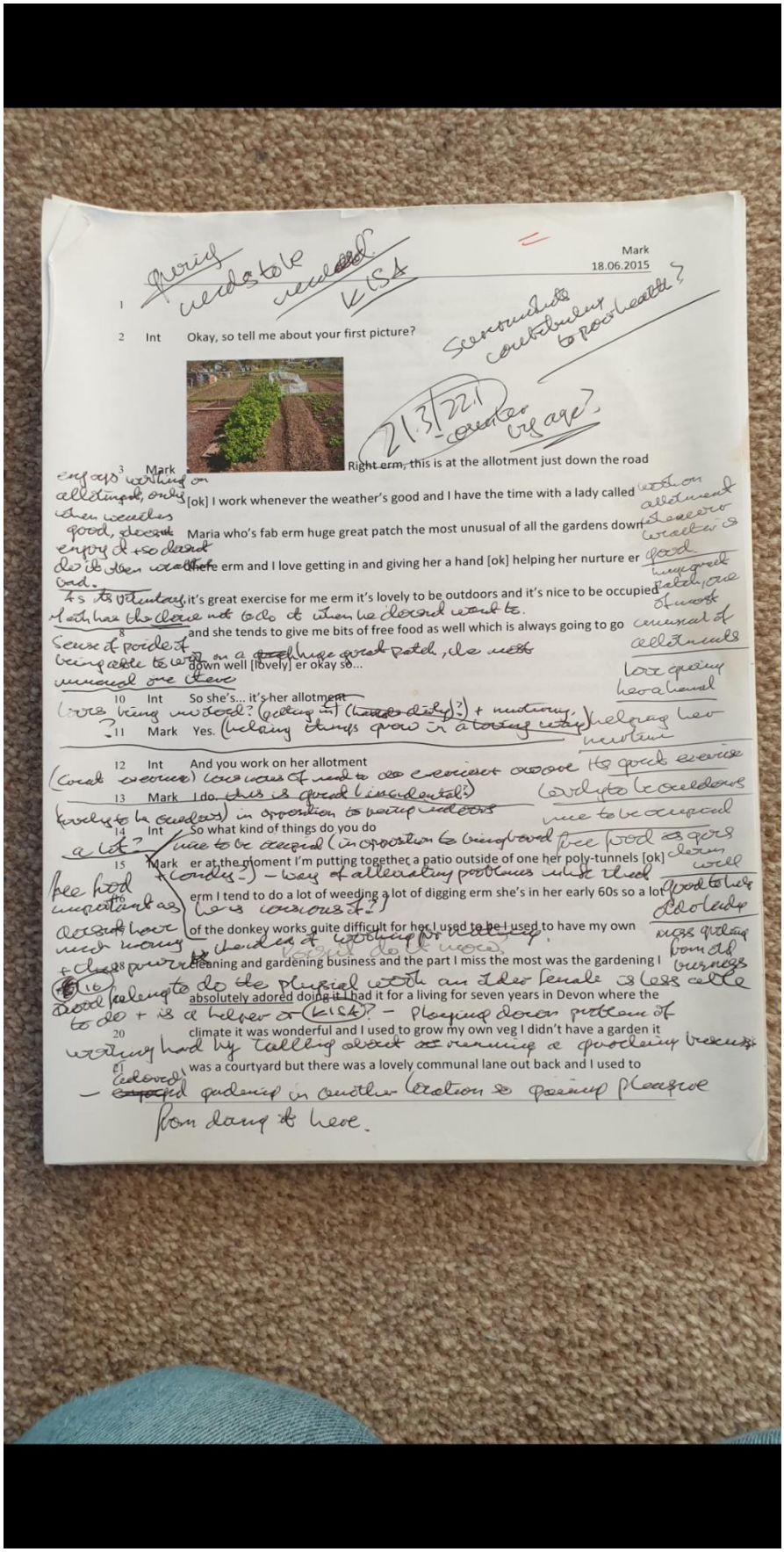
32.34

Int So how did if affect your last year at uni?

Will It affected it in a really good way because I came into the last year now having been engaged with the subjects that I'm studying and now being able to move about and to socialise and to do what I wanted to do it just really motivated me to try my hardest I was like well I've come from absolutely nothing to being told I should never go to college to being the best student on the course so I just really went to town on my final piece and I ended up getting, I got 75 and 75 for my final pieces which was quite a good 1sts but I mean I've always I mean yeah it stems from school I've always struggled with writing and reading so unfortunately I got 49 in my dissertation so I was one mark off a first in my final piece but it's still the best a 2:1's still the best grade I've ever got really I mean I got an A at art GCSE but as a whole I'm really happy with how I've done I don't think it could have gone much better considering everything that happened so I'm the first person in the family to graduate which is of great surprise to most but yeah.

Int Well done.

Appendix E: Evidence of coding and theme generation



Mark
18.06.2015

Int Okay, so tell me about your first picture?

Mark Right erm, this is at the allotment just down the road

[ok] I work whenever the weather's good and I have the time with a lady called Maria who's fab erm huge great patch the most unusual of all the gardens down there erm and I love getting in and giving her a hand [ok] helping her nurture er it's great exercise for me erm it's lovely to be outdoors and it's nice to be occupied and she tends to give me bits of free food as well which is always going to go down well [lovely] er okay so...

Int So she's... it's her allotment

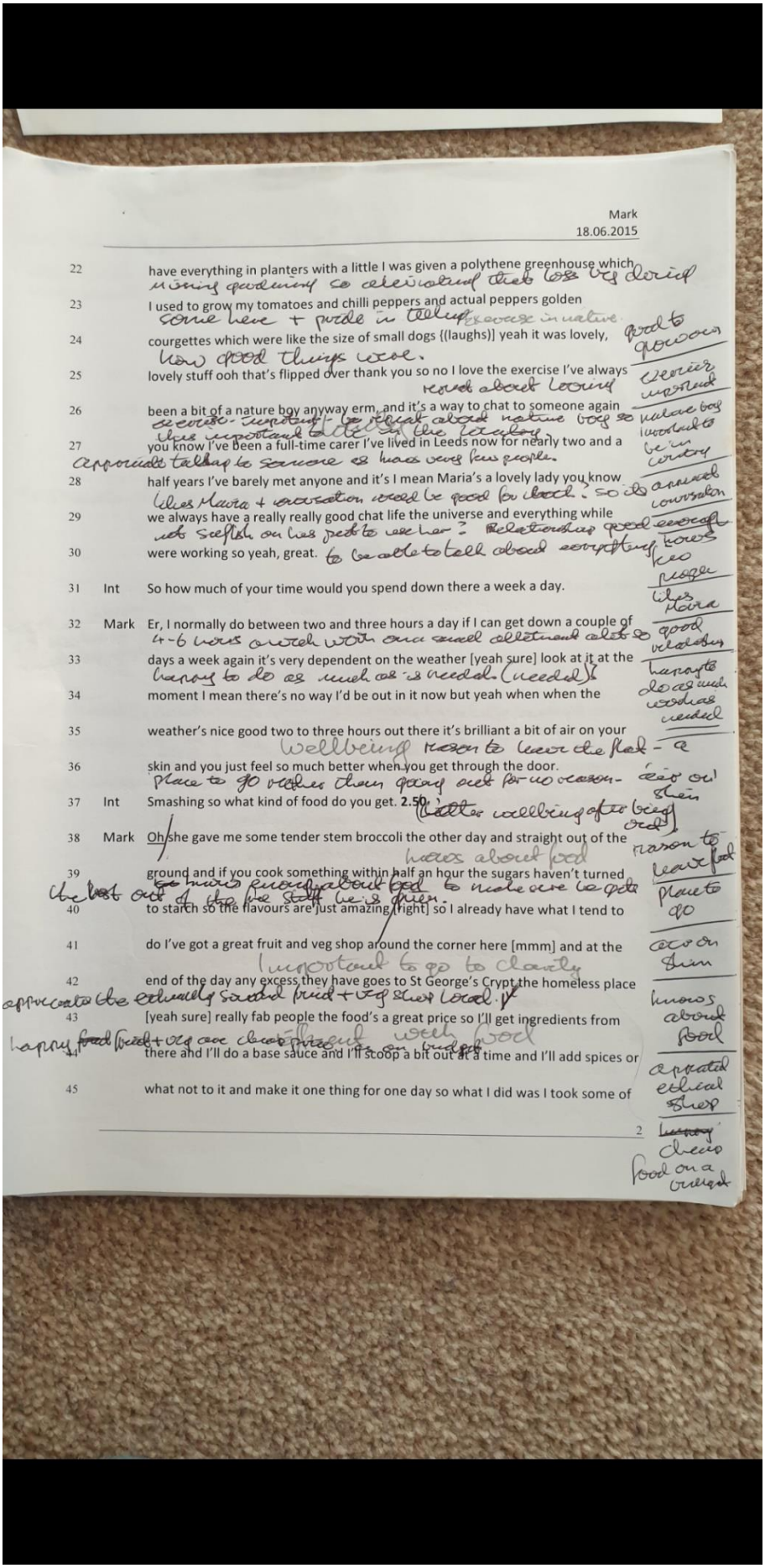
Mark Yes.

Int And you work on her allotment

Mark I do.

Int So what kind of things do you do

Mark er at the moment I'm putting together a patio outside of one her poly-tunnels [ok] erm I tend to do a lot of weeding a lot of digging erm she's in her early 60s so a lot of the donkey works quite difficult for her I used to be I used to have my own cleaning and gardening business and the part I miss the most was the gardening I absolutely adored doing it I had it for a living for seven years in Devon where the climate it was wonderful and I used to grow my own veg I didn't have a garden it was a courtyard but there was a lovely communal lane out back and I used to



Mark
18.06.2015

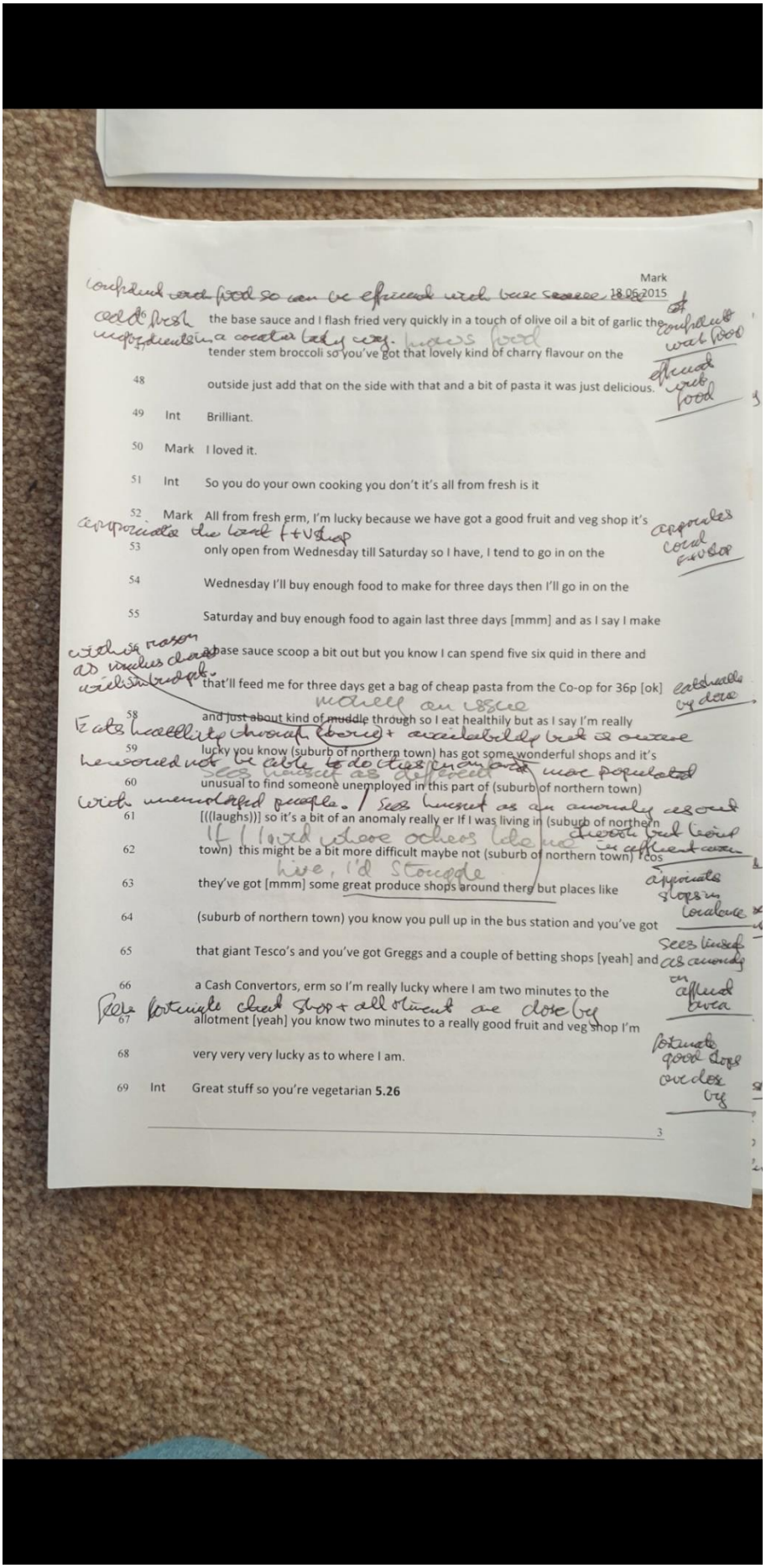
have everything in planters with a little I was given a polythene greenhouse which
I used to grow my tomatoes and chilli peppers and actual peppers golden
courgettes which were like the size of small dogs {(laughs)] yeah it was lovely,
lovely stuff ooh that's flipped over thank you so no I love the exercise I've always
been a bit of a nature boy anyway erm, and it's a way to chat to someone again
you know I've been a full-time carer I've lived in Leeds now for nearly two and a
half years I've barely met anyone and it's I mean Maria's a lovely lady you know
we always have a really really good chat life the universe and everything while
were working so yeah, great.

Int So how much of your time would you spend down there a week a day.

Mark Er, I normally do between two and three hours a day if I can get down a couple of
days a week again it's very dependent on the weather [yeah sure] look at it at the
moment I mean there's no way I'd be out in it now but yeah when when the
weather's nice good two to three hours out there it's brilliant a bit of air on your
skin and you just feel so much better when you get through the door.

Int Smashing so what kind of food do you get. **2.50**

Mark Oh she gave me some tender stem broccoli the other day and straight out of the
ground and if you cook something within half an hour the sugars haven't turned
to starch so the flavours are just amazing [right] so I already have what I tend to
do I've got a great fruit and veg shop around the corner here [mmm] and at the
end of the day any excess they have goes to St George's Crypt the homeless place
[yeah sure] really fab people the food's a great price so I'll get ingredients from
there and I'll do a base sauce and I'll scoop a bit out at a time and I'll add spices or
what not to it and make it one thing for one day so what I did was I took some of



Mark 18.06.2015

the base sauce and I flash fried very quickly in a touch of olive oil a bit of garlic the tender stem broccoli so you've got that lovely kind of charry flavour on the outside just add that on the side with that and a bit of pasta it was just delicious.

Int Brilliant.

Mark I loved it.

Int So you do your own cooking you don't it's all from fresh is it

Mark All from fresh erm, I'm lucky because we have got a good fruit and veg shop it's only open from Wednesday till Saturday so I have, I tend to go in on the Wednesday I'll buy enough food to make for three days then I'll go in on the Saturday and buy enough food to again last three days [mmm] and as I say I make a base sauce scoop a bit out but you know I can spend five six quid in there and that'll feed me for three days get a bag of cheap pasta from the Co-op for 36p [ok] and just about kind of muddle through so I eat healthily but as I say I'm really lucky you know (suburb of northern town) has got some wonderful shops and it's unusual to find someone unemployed in this part of (suburb of northern town) [((laughs))] so it's a bit of an anomaly really er If I was living in (suburb of northern town) this might be a bit more difficult maybe not (suburb of northern town) I cos they've got [mmm] some great produce shops around there but places like (suburb of northern town) you know you pull up in the bus station and you've got that giant Tesco's and you've got Greggs and a couple of betting shops [yeah] and a Cash Convertors, erm so I'm really lucky where I am two minutes to the allotment [yeah] you know two minutes to a really good fruit and veg shop I'm very very very lucky as to where I am.

Int Great stuff so you're vegetarian **5.26**

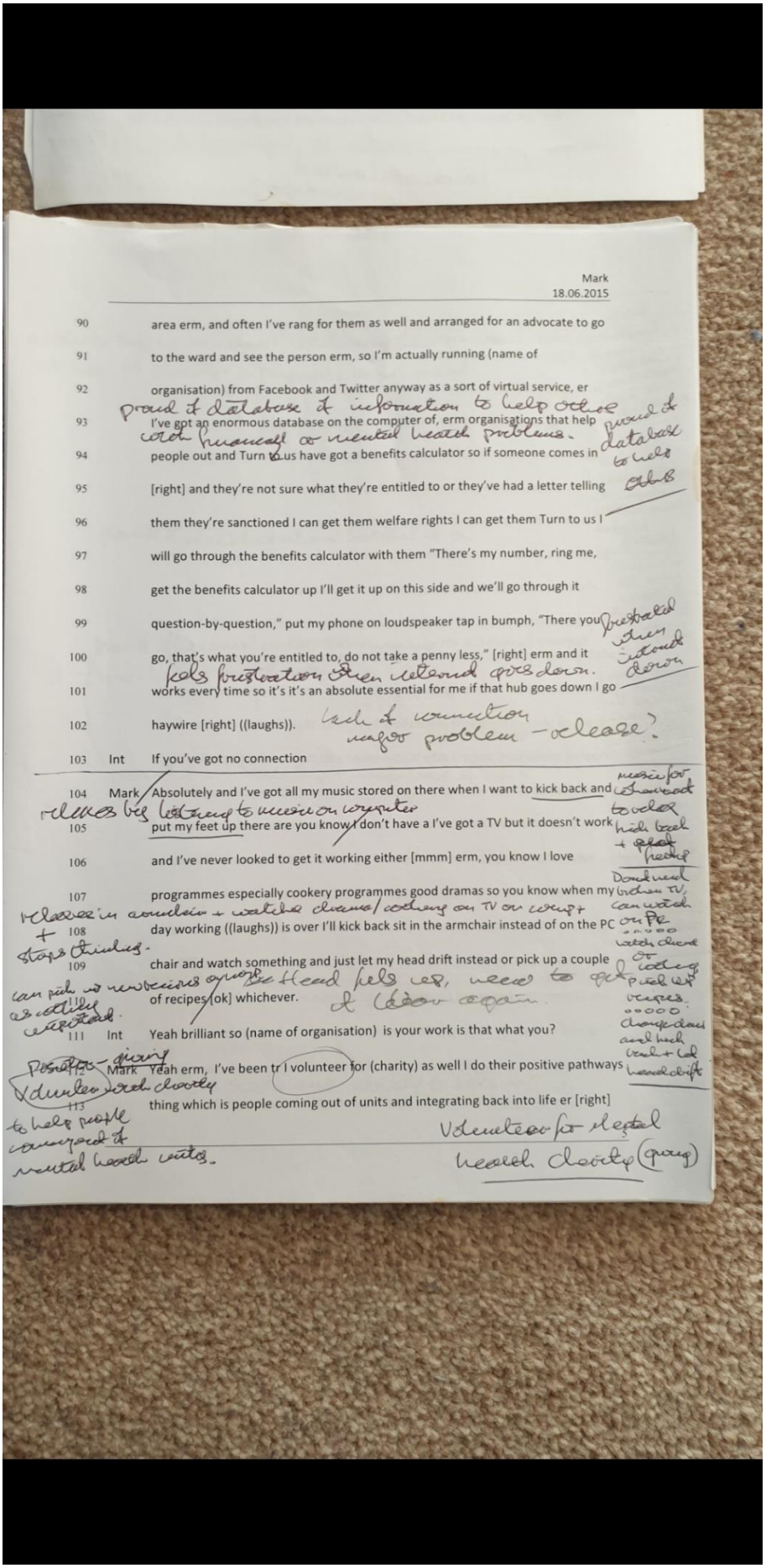
Mark I am and again that saves you a bundle and if I wasn't do you know what right next to the fruit and veg shop great butcher and he'll do you tiny amounts as well and he'll again because he's a local independent butcher he'll talk you through how to cook it [right] and he knows that people's budgets vary and he'll work with that [ok] as well he's great.

Int Good stuff that's really good okay I'm out of questions on that one.

Mark Okay erm is it that one?

Int Across was that the next one? **6.01**

Mark That's my computer [right] ((laughs))) that's my social area my workbench my entertainment system er the living room has become a corridor to get to the kitchen {((laughs))] or the bathroom I pretty much live in the bedroom [mmm] er, it was the most convenient place to set up the computer and erm, Facebook Twitter erm, for my social area LinkIn for my work area the initiative I'm trying to get off the ground via the heads of (charity in northern town) on Facebook we're having a meeting so they might be doing something with Hope [ok] and had I not had that wouldn't have happened [sure] again social isolation erm if I ever feel down, some people would say it's self-indulgent I help a lot of people on Facebook a lot of people come up on chat er lots of people who've had work capability assessments or sanctions or they've had somebody that's been admitted to a mental health unit "Can you get you know what do I do?" you know and I'll find them an independent mental health advocate in the



Mark
18.06.2015

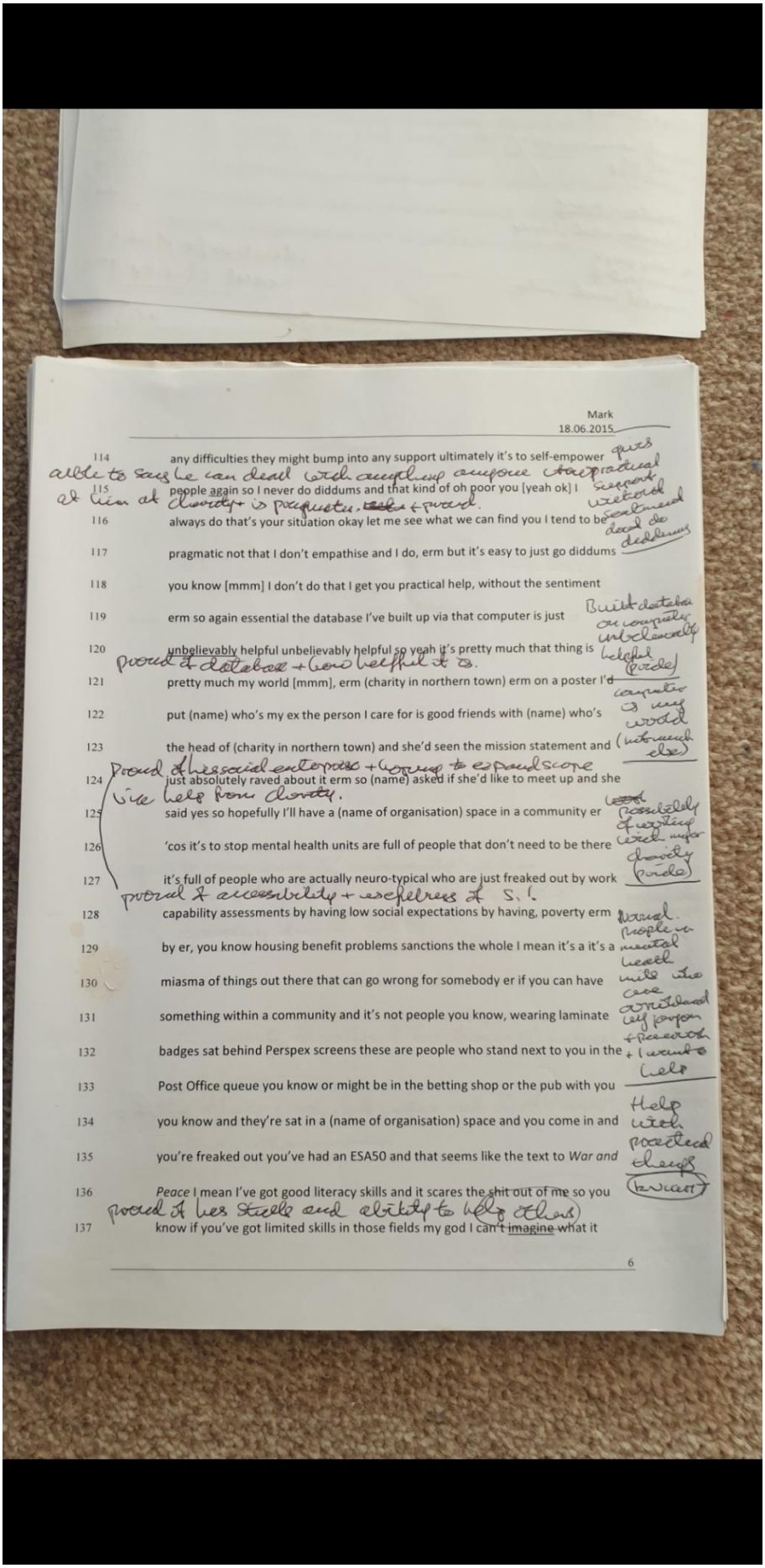
area erm, and often I've rang for them as well and arranged for an advocate to go to the ward and see the person erm, so I'm actually running (name of organisation) from Facebook and Twitter anyway as a sort of virtual service, er I've got an enormous database on the computer of, erm organisations that help people out and Turn to us have got a benefits calculator so if someone comes in [right] and they're not sure what they're entitled to or they've had a letter telling them they're sanctioned I can get them welfare rights I can get them Turn to us I will go through the benefits calculator with them "There's my number, ring me, get the benefits calculator up I'll get it up on this side and we'll go through it question-by-question," put my phone on loudspeaker tap in bumph, "There you go, that's what you're entitled to, do not take a penny less," [right] erm and it works every time so it's it's an absolute essential for me if that hub goes down I go haywire [right] ((laughs)).

Int If you've got no connection

Mark Absolutely and I've got all my music stored on there when I want to kick back and put my feet up there are you know I don't have a I've got a TV but it doesn't work and I've never looked to get it working either [mmm] erm, you know I love programmes especially cookery programmes good dramas so you know when my day working ((laughs)) is over I'll kick back sit in the armchair instead of on the PC chair and watch something and just let my head drift instead or pick up a couple of recipes [ok] whichever.

Int Yeah brilliant so (name of organisation) is your work is that what you?

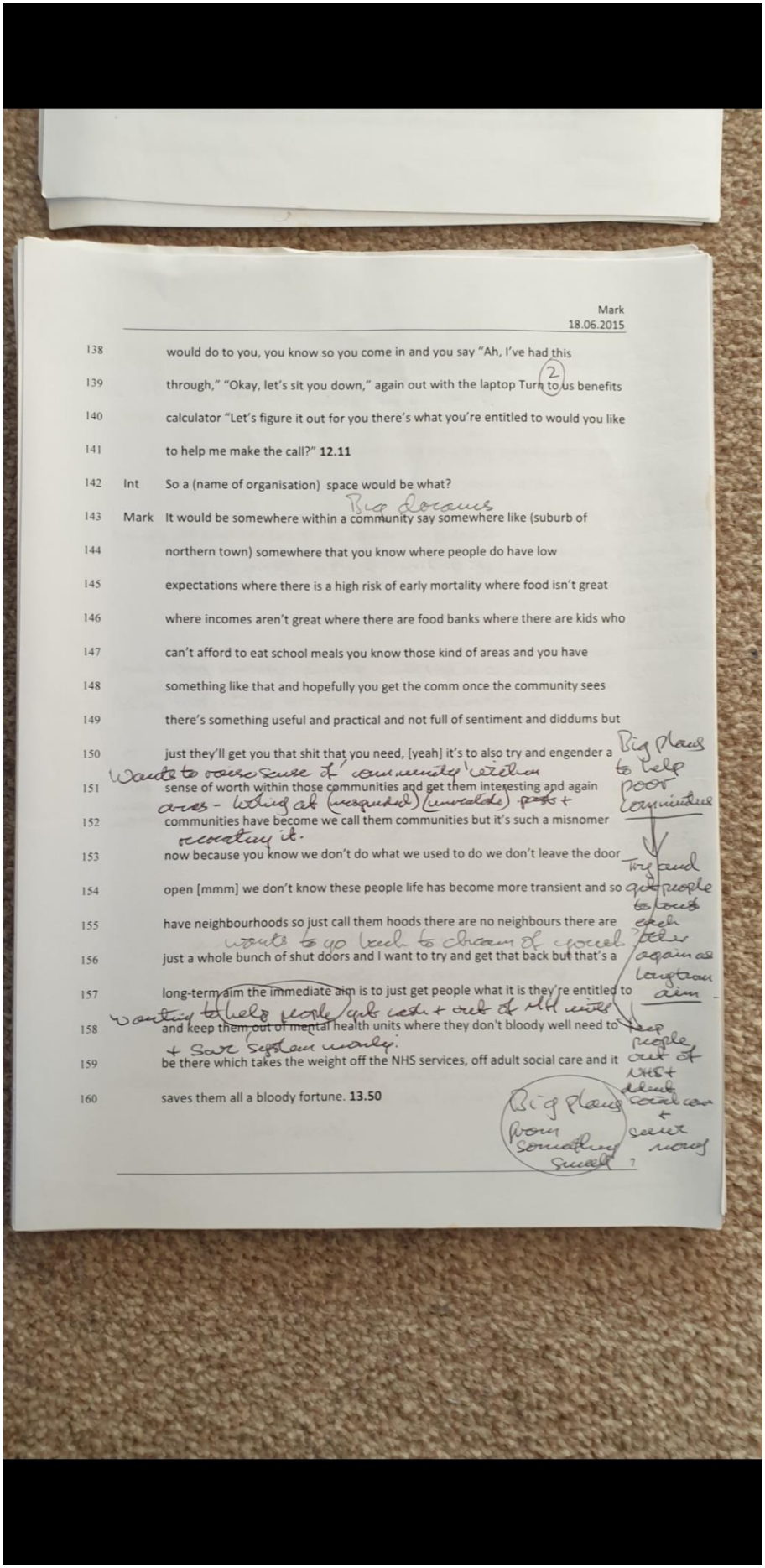
Mark Yeah erm, I've been tr I volunteer for (charity) as well I do their positive pathways thing which is people coming out of units and integrating back into life er [right]



Mark
18.06.2015

any difficulties they might bump into any support ultimately it's to self-empower people again so I never do diddums and that kind of oh poor you [yeah ok] I always do that's your situation okay let me see what we can find you I tend to be pragmatic not that I don't empathise and I do, erm but it's easy to just go diddums you know [mmm] I don't do that I get you practical help, without the sentiment erm so again essential the database I've built up via that computer is just unbelievably helpful unbelievably helpful so yeah it's pretty much that thing is pretty much my world [mmm], erm (charity in northern town) erm on a poster I'd put (name) who's my ex the person I care for is good friends with (name) who's the head of (charity in northern town) and she'd seen the mission statement and just absolutely raved about it erm so (name) asked if she'd like to meet up and she said yes so hopefully I'll have a (name of organisation) space in a community er 'cos it's to stop mental health units are full of people that don't need to be there it's full of people who are actually neuro-typical who are just freaked out by work capability assessments by having low social expectations by having, poverty erm by er, you know housing benefit problems sanctions the whole I mean it's a it's a miasma of things out there that can go wrong for somebody er if you can have something within a community and it's not people you know, wearing laminate badges sat behind Perspex screens these are people who stand next to you in the Post Office queue you know or might be in the betting shop or the pub with you you know and they're sat in a (name of organisation) space and you come in and you're freaked out you've had an ESA50 and that seems like the text to *War and Peace* I mean I've got good literacy skills and it scares the shit out of me so you know if you've got limited skills in those fields my god I can't imagine what it

6

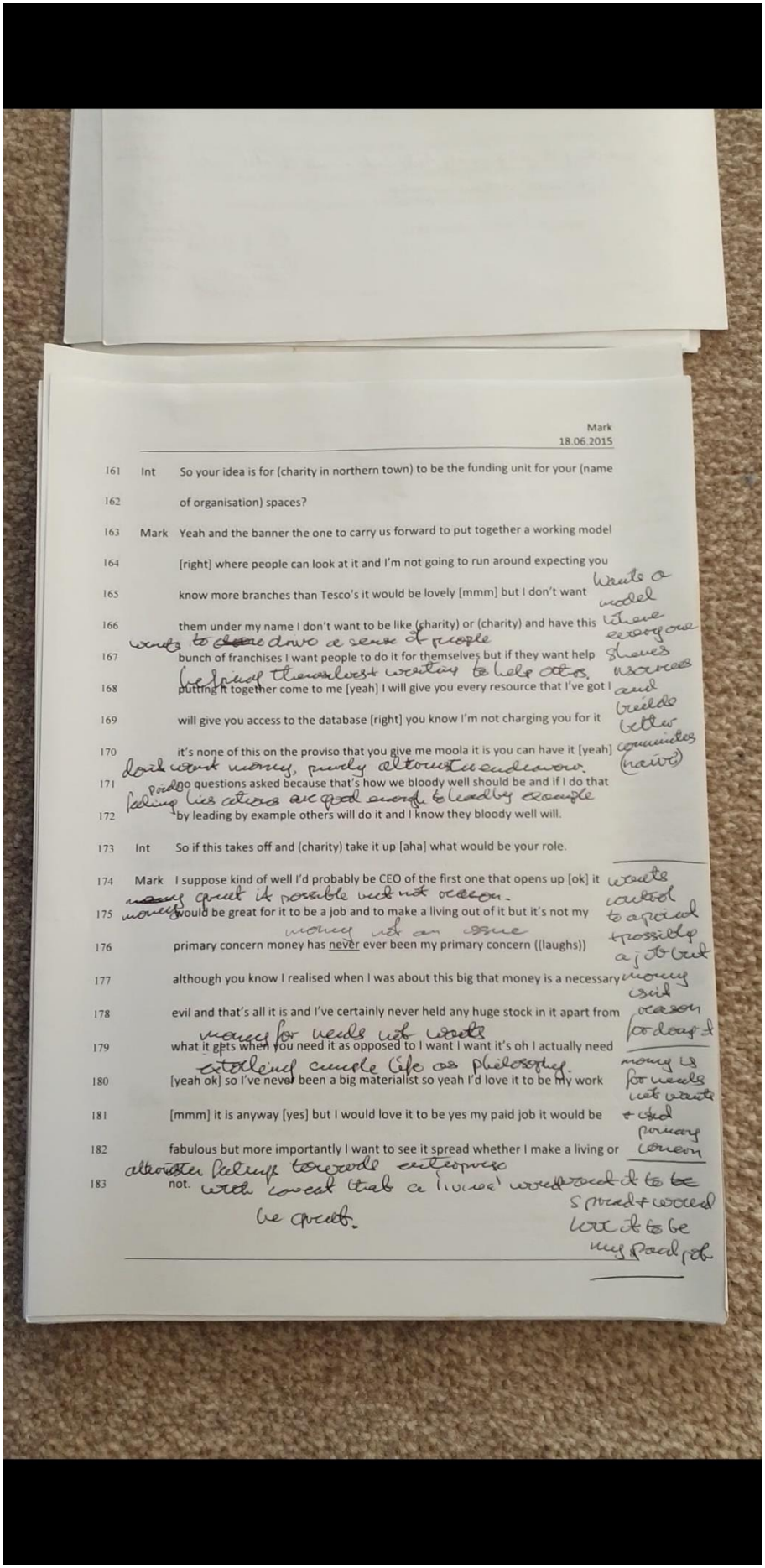


Mark
18.06.2015

would do to you, you know so you come in and you say "Ah, I've had this through," "Okay, let's sit you down," again out with the laptop Turn to us benefits calculator "Let's figure it out for you there's what you're entitled to would you like to help me make the call?" **12.11**

Int So a (name of organisation) space would be what?

Mark It would be somewhere within a community say somewhere like (suburb of northern town) somewhere that you know where people do have low expectations where there is a high risk of early mortality where food isn't great where incomes aren't great where there are food banks where there are kids who can't afford to eat school meals you know those kind of areas and you have something like that and hopefully you get the comm once the community sees there's something useful and practical and not full of sentiment and diddums but just they'll get you that shit that you need, [yeah] it's to also try and engender a sense of worth within those communities and get them interesting and again communities have become we call them communities but it's such a misnomer now because you know we don't do what we used to do we don't leave the door open [mmm] we don't know these people life has become more transient and so have neighbourhoods so just call them hoods there are no neighbours there are just a whole bunch of shut doors and I want to try and get that back but that's a long-term aim the immediate aim is to just get people what it is they're entitled to and keep them out of mental health units where they don't bloody well need to be there which takes the weight off the NHS services, off adult social care and it saves them all a bloody fortune. **13.50**



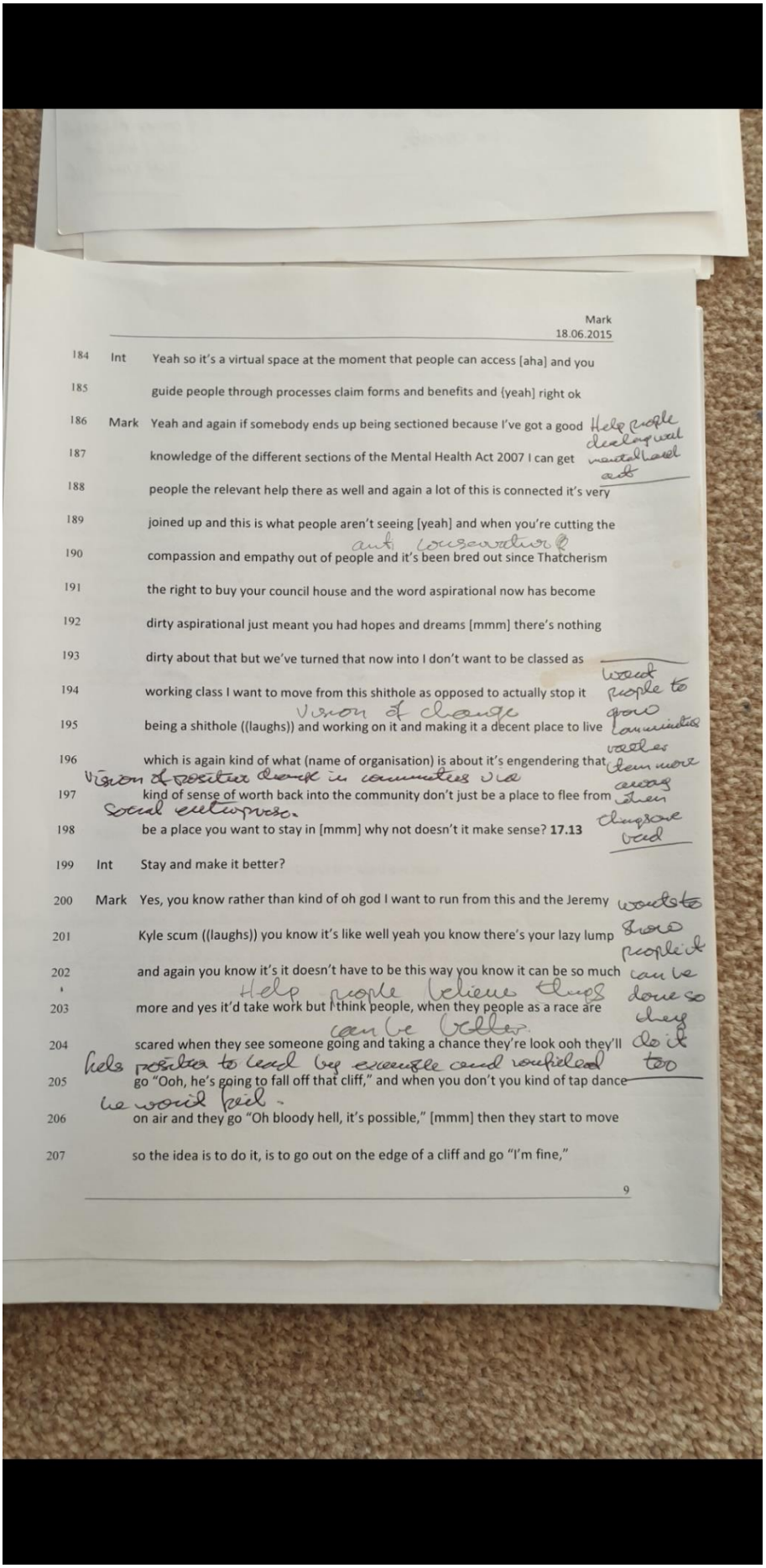
Mark
18.06.2015

Int So your idea is for (charity in northern town) to be the funding unit for your (name of organisation) spaces?

Mark Yeah and the banner the one to carry us forward to put together a working model [right] where people can look at it and I'm not going to run around expecting you know more branches than Tesco's it would be lovely [mmm] but I don't want them under my name I don't want to be like (charity) or (charity) and have this bunch of franchises I want people to do it for themselves but if they want help putting it together come to me [yeah] I will give you every resource that I've got I will give you access to the database [right] you know I'm not charging you for it it's none of this on the proviso that you give me moola it is you can have it [yeah] no questions asked because that's how we bloody well should be and if I do that by leading by example others will do it and I know they bloody well will.

Int So if this takes off and (charity) take it up [aha] what would be your role.

Mark I suppose kind of well I'd probably be CEO of the first one that opens up [ok] it would be great for it to be a job and to make a living out of it but it's not my primary concern money has never ever been my primary concern ((laughs)) although you know I realised when I was about this big that money is a necessary evil and that's all it is and I've certainly never held any huge stock in it apart from what it gets when you need it as opposed to I want I want it's oh I actually need [yeah ok] so I've never been a big materialist so yeah I'd love it to be my work [mmm] it is anyway [yes] but I would love it to be yes my paid job it would be fabulous but more importantly I want to see it spread whether I make a living or not.



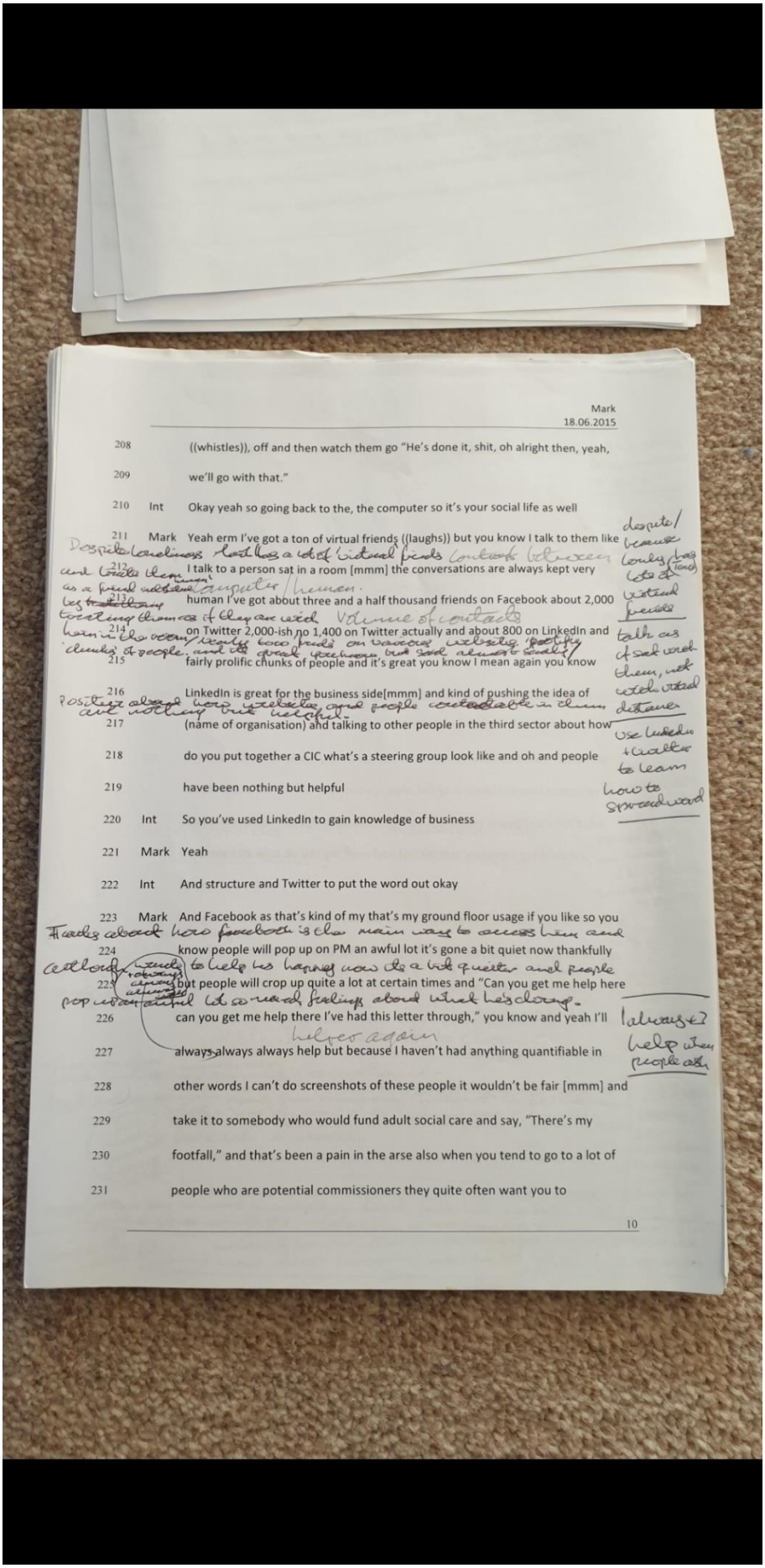
Mark
18.06.2015

Int Yeah so it's a virtual space at the moment that people can access [aha] and you guide people through processes claim forms and benefits and {yeah] right ok

Mark Yeah and again if somebody ends up being sectioned because I've got a good knowledge of the different sections of the Mental Health Act 2007 I can get people the relevant help there as well and again a lot of this is connected it's very joined up and this is what people aren't seeing [yeah] and when you're cutting the compassion and empathy out of people and it's been bred out since Thatcherism the right to buy your council house and the word aspirational now has become dirty aspirational just meant you had hopes and dreams [mmm] there's nothing dirty about that but we've turned that now into I don't want to be classed as working class I want to move from this shithole as opposed to actually stop it being a shithole ((laughs)) and working on it and making it a decent place to live which is again kind of what (name of organisation) is about it's engendering that kind of sense of worth back into the community don't just be a place to flee from be a place you want to stay in [mmm] why not doesn't it make sense? **17.13**

Int Stay and make it better?

Mark Yes, you know rather than kind of oh god I want to run from this and the Jeremy Kyle scum ((laughs)) you know it's like well yeah you know there's your lazy lump and again you know it's it doesn't have to be this way you know it can be so much more and yes it'd take work but I think people, when they people as a race are scared when they see someone going and taking a chance they're look ooh they'll go "Ooh, he's going to fall off that cliff," and when you don't you kind of tap dance on air and they go "Oh bloody hell, it's possible," [mmm] then they start to move so the idea is to do it, is to go out on the edge of a cliff and go "I'm fine,"



208 ((whistles)), off and then watch them go "He's done it, shit, oh alright then, yeah,

209 we'll go with that."

210 Int Okay yeah so going back to the, the computer so it's your social life as well

211 Mark Yeah erm I've got a ton of virtual friends ((laughs)) but you know I talk to them like

212 I talk to a person sat in a room [mmm] the conversations are always kept very

213 human I've got about three and a half thousand friends on Facebook about 2,000

214 on Twitter 2,000-ish no 1,400 on Twitter actually and about 800 on LinkedIn and

215 fairly prolific chunks of people and it's great you know I mean again you know

216 LinkedIn is great for the business side[mmm] and kind of pushing the idea of

217 (name of organisation) and talking to other people in the third sector about how

218 do you put together a CIC what's a steering group look like and oh and people

219 have been nothing but helpful

220 Int So you've used LinkedIn to gain knowledge of business

221 Mark Yeah

222 Int And structure and Twitter to put the word out okay

223 Mark And Facebook as that's kind of my that's my ground floor usage if you like so you

224 know people will pop up on PM an awful lot it's gone a bit quiet now thankfully

225 but people will crop up quite a lot at certain times and "Can you get me help here

226 can you get me help there I've had this letter through," you know and yeah I'll

227 always always always help but because I haven't had anything quantifiable in

228 other words I can't do screenshots of these people it wouldn't be fair [mmm] and

229 take it to somebody who would fund adult social care and say, "There's my

230 footfall," and that's been a pain in the arse also when you tend to go to a lot of

231 people who are potential commissioners they quite often want you to

Dave
Date: 8.5.13

Dave: That's the first picture.

Picture of meds and dietary supplement

Open about his mental health.

Int: Okay. What's in the first picture?

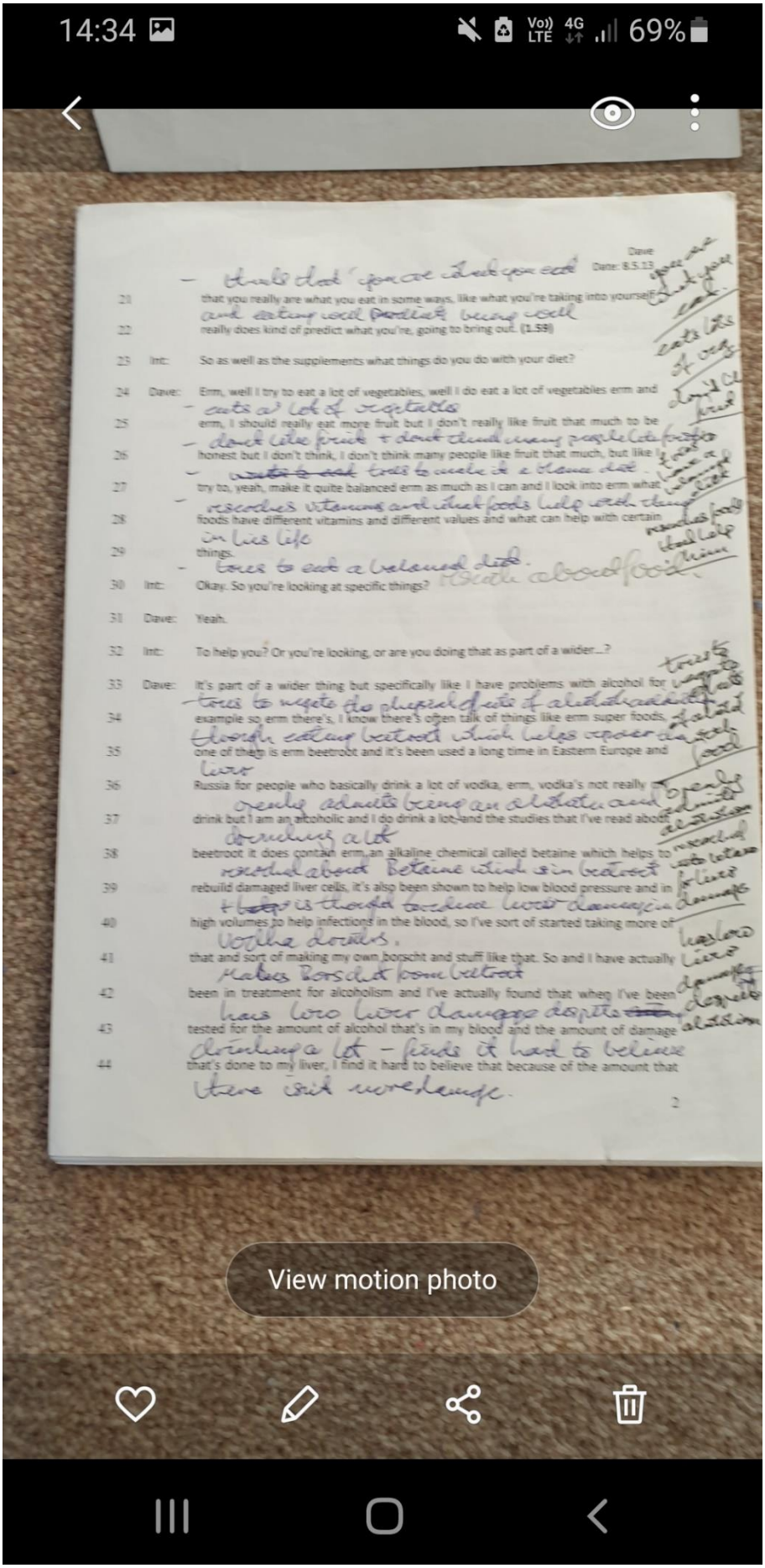
Dave: The first picture is a picture of my meds and some dietary supplements that I take. Um, so I um take a mood stabiliser and antidepressant and I also chosen to take some multivitamins. And it's not in the photo there but I do also take some omega-3 as well because I find that quite helpful.

Int: Yeah, okay so erm (pause) Do you want to tell me more about any of those? Sort of describe, tell me why you've chosen to take that picture?

Dave: Well I'm diagnosed with mental health difficulties for a few years and prescribed these drugs by, doctors [yep] and that's why I take them. But also I've heard that through erm having a good diet and having erm good nutrition you can help yourself have erm good mental health, so I've kind of looked into that and erm, found it useful. **(1.09)**

Int: Ok, so how, what things help you? Do do do you feel any different having a good diet?

Dave: Yeah, like with the omega-3 I think it does definitely help with concentration and erm I think with having a good immune system, having vitamins really does help you feel better erm and when you're not worrying about those things it's just something less off your mind to worry about erm and I know it just sort of seems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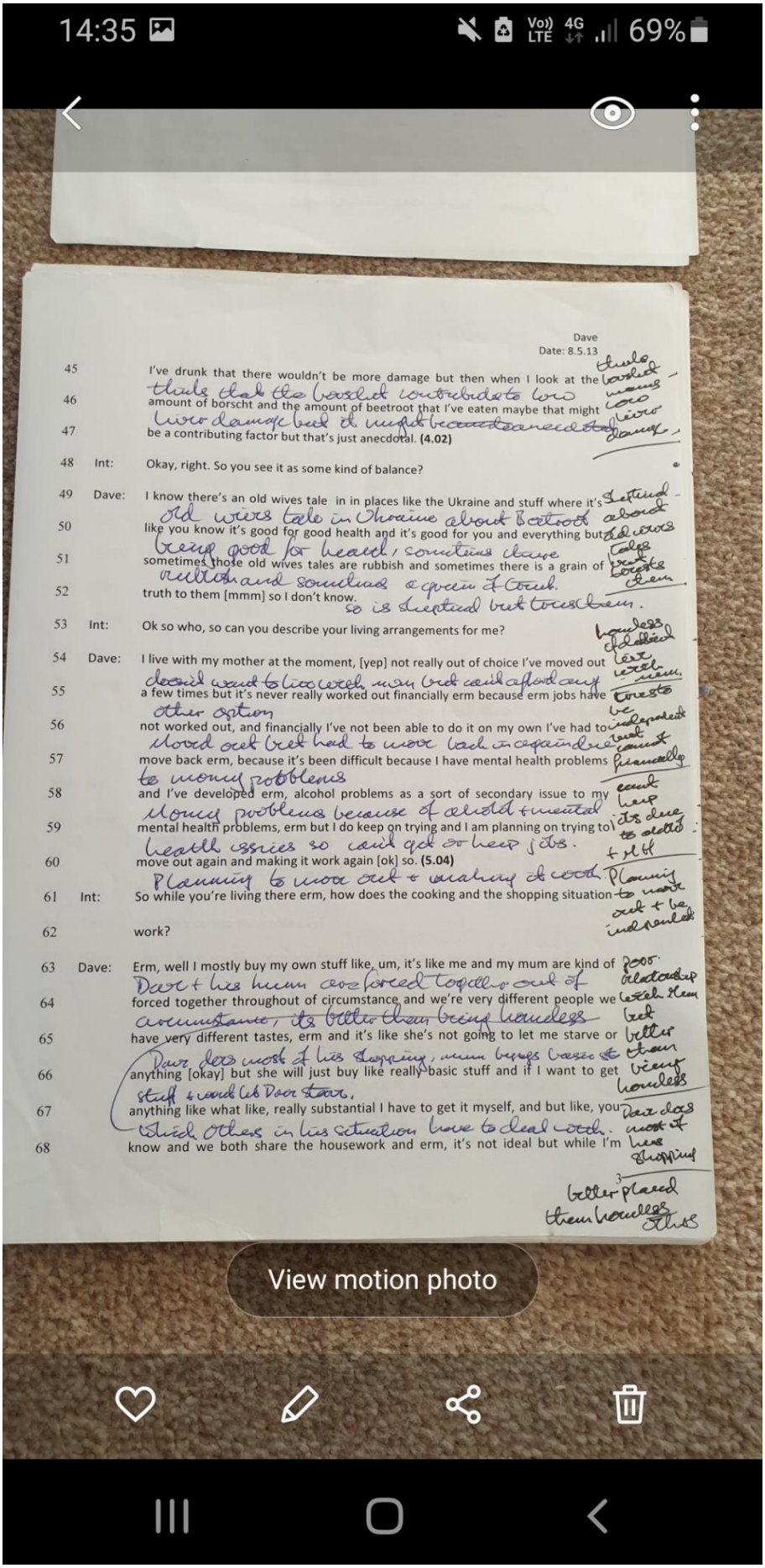
69%
Dave
Date: 8.5.13
that you really are what you eat in some ways, like what you're taking into yourself
really does kind of predict what you're, going to bring out. (1.59)
Int: So as well as the supplements what things do you do with your diet?
Dave: Erm, well I try to eat a lot of vegetables, well I do eat a lot of vegetables erm and
erm, I should really eat more fruit but I don't really like fruit that much to be
honest but I don't think, I don't think many people like fruit that much, but like I
try to, yeah, make it quite balanced erm as much as I can and I look into erm what
foods have different vitamins and different values and what can help with certain
things.
Int: Okay. So you're looking at specific things?
Dave: Yeah.
Int: To help you? Or you're looking, or are you doing that as part of a wider...?
Dave: It's part of a wider thing but specifically like I have problems with alcohol for
example so erm there's, I know there's often talk of things like erm super foods,
one of them is erm beetroot and it's been used a long time in Eastern Europe and
Russia for people who basically drink a lot of vodka, erm, vodka's not really my
drink but I am an alcoholic and I do drink a lot and the studies that I've read about
beetroot it does contain erm, an alkaline chemical called betaine which helps to
rebuild damaged liver cells, it's also been shown to help low blood pressure and in
high volumes to help infections in the blood, so I've sort of started taking more of
that and sort of making my own borscht and stuff like that. So and I have actually
been in treatment for alcoholism and I've actually found that when I've been
tested for the amount of alcohol that's in my blood and the amount of damage
that's done to my liver, I find it hard to believe that because of the amount that
View motion photo



Dave
Date: 8.5.13

45 I've drunk that there wouldn't be more damage but then when I look at the
46 amount of borscht and the amount of beetroot that I've eaten maybe that might
47 be a contributing factor but that's just anecdotal. **(4.02)**

48 Int: Okay, right. So you see it as some kind of balance?

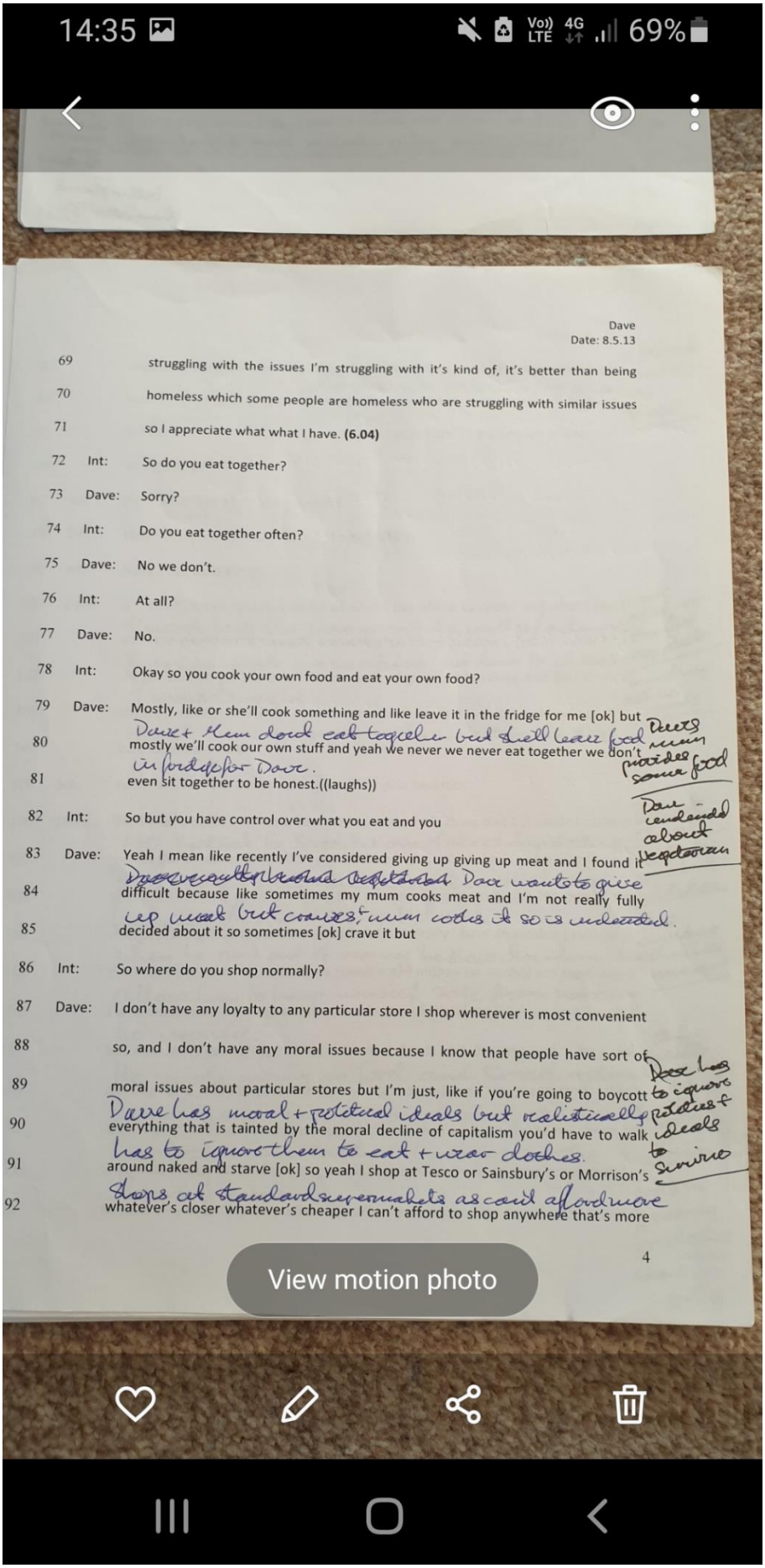
49 Dave: I know there's an old wives tale in in places like the Ukraine and stuff where it's
50 like you know it's good for good health and it's good for you and everything but
51 sometimes those old wives tales are rubbish and sometimes there is a grain of
52 truth to them [mmm] so I don't know.

53 Int: Ok so who, so can you describe your living arrangements for me?

54 Dave: I live with my mother at the moment, [yep] not really out of choice I've moved out
55 a few times but it's never really worked out financially erm because erm jobs have
56 not worked out, and financially I've not been able to do it on my own I've had to
57 move back erm, because it's been difficult because I have mental health problems
58 and I've developed erm, alcohol problems as a sort of secondary issue to my
59 mental health problems, erm but I do keep on trying and I am planning on trying to
60 move out again and making it work again [ok] so. **(5.04)**

61 Int: So while you're living there erm, how does the cooking and the shopping situation
62 work?

63 Dave: Erm, well I mostly buy my own stuff like, um, it's like me and my mum are kind of
64 forced together throughout of circumstance and we're very different people we
65 have very different tastes, erm and it's like she's not going to let me starve or
66 anything [okay] but she will just buy like really basic stuff and if I want to get
67 anything like what like, really substantial I have to get it myself, and but like, you
68 know and we both share the housework and erm, it's not ideal but while I'm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Dave
Date: 8.5.13
struggling with the issues I'm struggling with it's kind of, it's better than being
homeless which some people are homeless who are struggling with similar issues
so I appreciate what what I have. (6.04)
Int: So do you eat together?
Dave: Sorry?
Int: Do you eat together often?
Dave: No we don't.
Int: At all?
Dave: No.
Int: Okay so you cook your own food and eat your own food?
Dave: Mostly, like or she'll cook something and like leave it in the fridge for me [ok] but
mostly we'll cook our own stuff and yeah we never we never eat together we don't
even sit together to be honest.((laughs))
Int: So but you have control over what you eat and you
Dave: Yeah I mean like recently I've considered giving up giving up meat and I found it
difficult because like sometimes my mum cooks meat and I'm not really fully
decided about it so sometimes [ok] crave it but
Int: So where do you shop normally?
Dave: I don't have any loyalty to any particular store I shop wherever is most convenient
so, and I don't have any moral issues because I know that people have sort of
moral issues about particular stores but I'm just, like if you're going to boycott
everything that is tainted by the moral decline of capitalism you'd have to walk
around naked and starve [ok] so yeah I shop at Tesco or Sainsbury's or Morrison's
whatever's closer whatever's cheaper I can't afford to shop anywhere that's more
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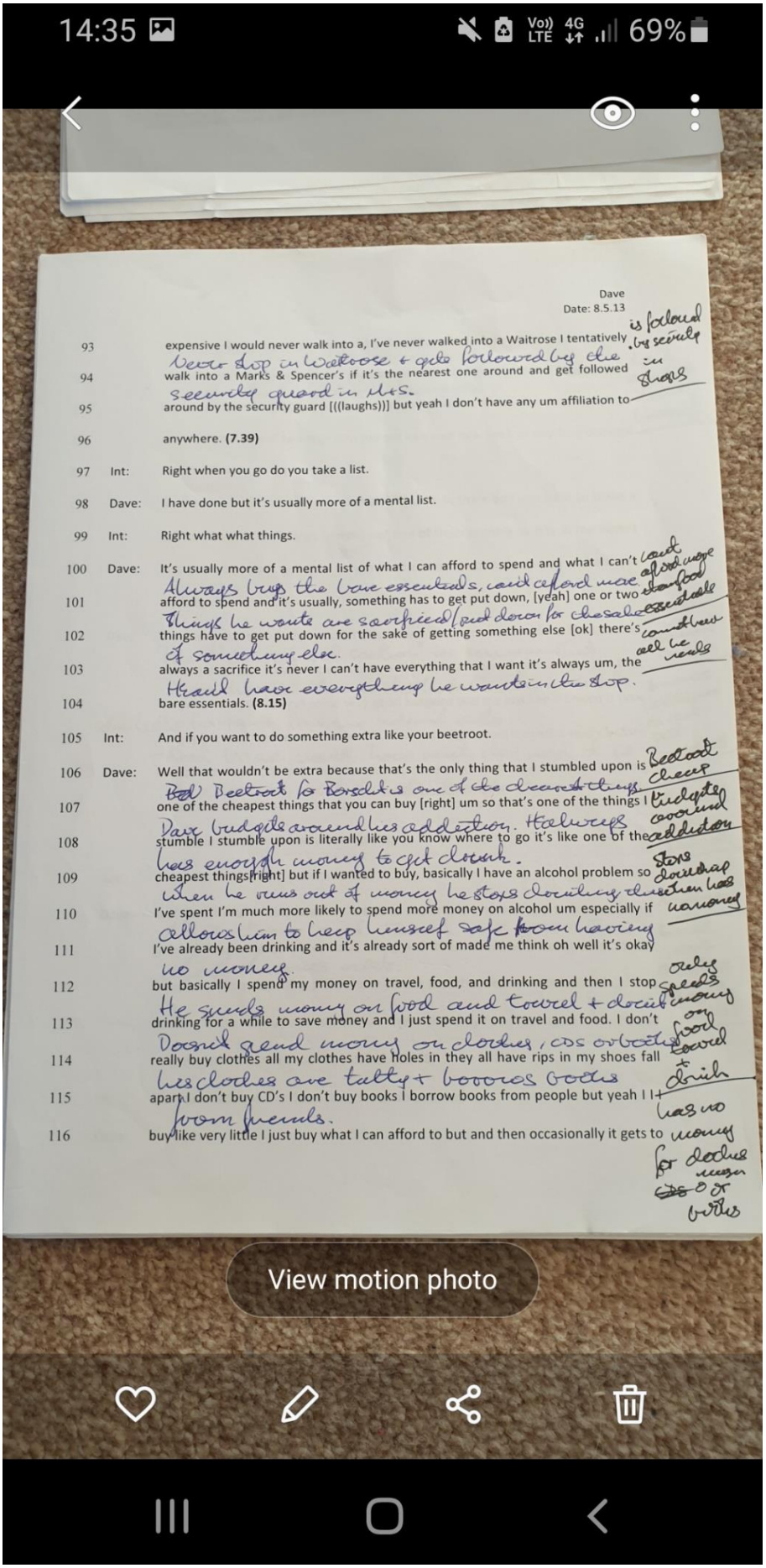
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Dave
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expensive I would never walk into a, I've never walked into a Waitrose I tentatively walk into a Marks & Spencer's if it's the nearest one around and get followed around by the security guard [((laughs))] but yeah I don't have any um affiliation to anywhere. (7.39)
Int: Right when you go do you take a list.
Dave: I have done but it's usually more of a mental list.
Int: Right what what things.
Dave: It's usually more of a mental list of what I can afford to spend and what I can't afford to spend and it's usually, something has to get put down, [yeah] one or two things have to get put down for the sake of getting something else [ok] there's always a sacrifice it's never I can't have everything that I want it's always um, the bare essentials. (8.15)
Int: And if you want to do something extra like your beetroot.
Dave: Well that wouldn't be extra because that's the only thing that I stumbled upon is one of the cheapest things that you can buy [right] um so that's one of the things I stumble I stumble upon is literally like you know where to go it's like one of the cheapest things[right] but if I wanted to buy, basically I have an alcohol problem so I've spent I'm much more likely to spend more money on alcohol um especially if I've already been drinking and it's already sort of made me think oh well it's okay but basically I spend my money on travel, food, and drinking and then I stop drinking for a while to save money and I just spend it on travel and food. I don't really buy clothes all my clothes have holes in they all have rips in my shoes fall apart I don't buy CD's I don't buy books I borrow books from people but yeah I I buy like very little I just buy what I can afford to but and then occasionally it gets to
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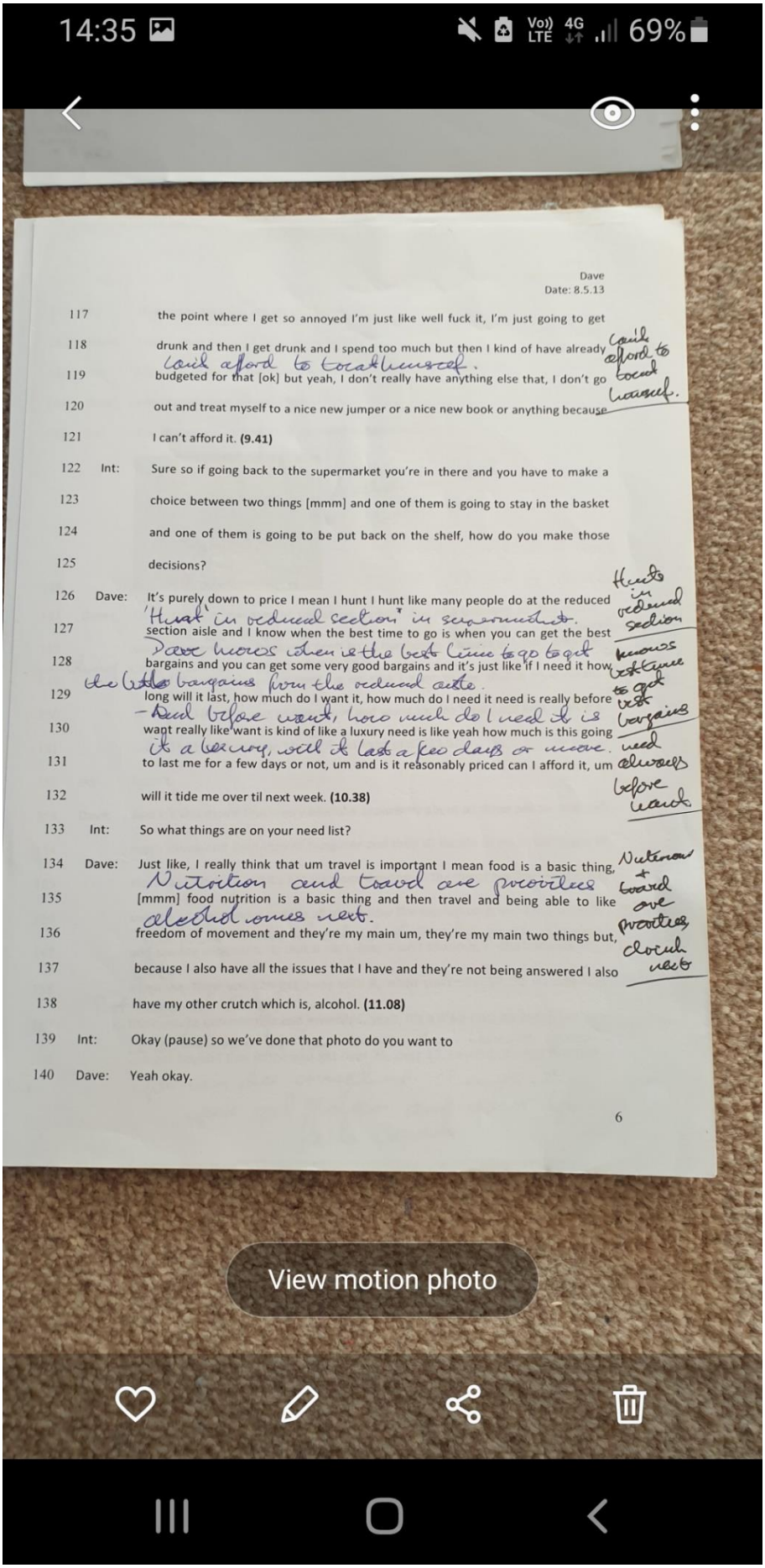
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Dave
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the point where I get so annoyed I'm just like well fuck it, I'm just going to get
drunk and then I get drunk and I spend too much but then I kind of have already
budgeted for that [ok] but yeah, I don't really have anything else that, I don't go
out and treat myself to a nice new jumper or a nice new book or anything because
I can't afford it. (9.41)
Int: Sure so if going back to the supermarket you're in there and you have to make a
choice between two things [mmm] and one of them is going to stay in the basket
and one of them is going to be put back on the shelf, how do you make those
decisions?
Dave: It's purely down to price I mean I hunt I hunt like many people do at the reduced
section aisle and I know when the best time to go is when you can get the best
bargains and you can get some very good bargains and it's just like if I need it how
long will it last, how much do I want it, how much do I need it need is really before
want really like want is kind of like a luxury need is like yeah how much is this going
to last me for a few days or not, um and is it reasonably priced can I afford it, um
will it tide me over til next week. (10.38)
Int: So what things are on your need list?
Dave: Just like, I really think that um travel is important I mean food is a basic thing,
[mmm] food nutrition is a basic thing and then travel and being able to like
freedom of movement and they're my main um, they're my main two things but,
because I also have all the issues that I have and they're not being answered I also
have my other crutch which is, alcohol. (11.08)
Int: Okay (pause) so we've done that photo do you want to
Dave: Yeah okay.
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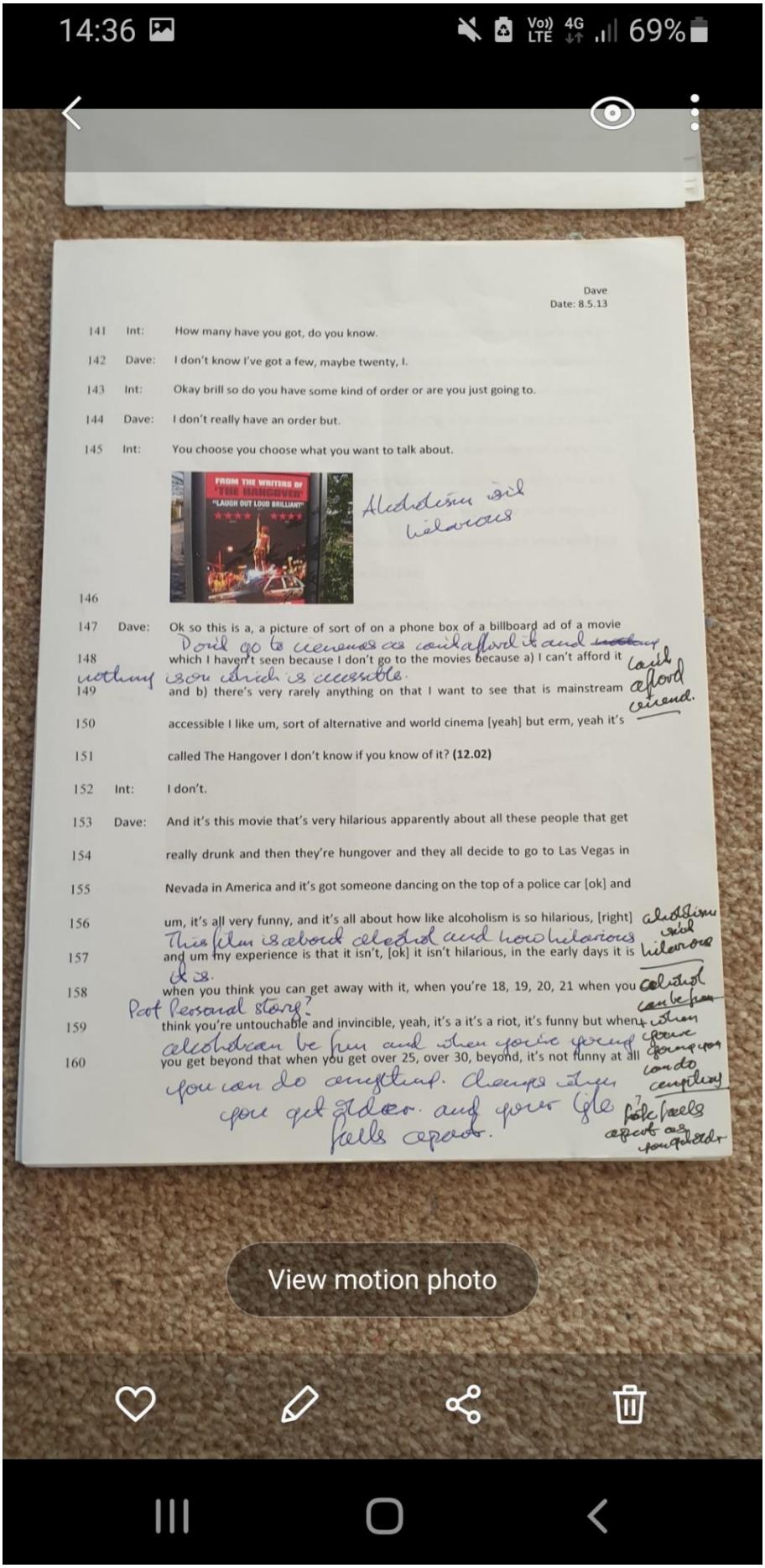
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Dave
Date: 8.5.13
141 Int: How many have you got, do you know.
142 Dave: I don't know I've got a few, maybe twenty, I.
143 Int: Okay brill so do you have some kind of order or are you just going to.
144 Dave: I don't really have an order but.
145 Int: You choose you choose what you want to talk about.
FROM THE WRITERS OF 'THE HANGOVER'
"LAUGH OUT LOUD BRILLIANT"
Alcoholism and hilarious
146
147 Dave: Ok so this is a, a picture of sort of on a phone box of a billboard ad of a movie
148 which I haven't seen because I don't go to the movies because a) I can't afford it
149 and b) there's very rarely anything on that I want to see that is mainstream
150 accessible I like um, sort of alternative and world cinema [yeah] but erm, yeah it's
151 called The Hangover I don't know if you know of it? (12.02)
152 Int: I don't.
153 Dave: And it's this movie that's very hilarious apparently about all these people that get
154 really drunk and then they're hungover and they all decide to go to Las Vegas in
155 Nevada in America and it's got someone dancing on the top of a police car [ok] and
156 um, it's all very funny, and it's all about how like alcoholism is so hilarious, [right]
157 and um my experience is that it isn't, [ok] it isn't hilarious, in the early days it is
158 when you think you can get away with it, when you're 18, 19, 20, 21 when you
159 think you're untouchable and invincible, yeah, it's a it's a riot, it's funny but when
160 you get beyond that when you get over 25, over 30, beyond, it's not funny at all
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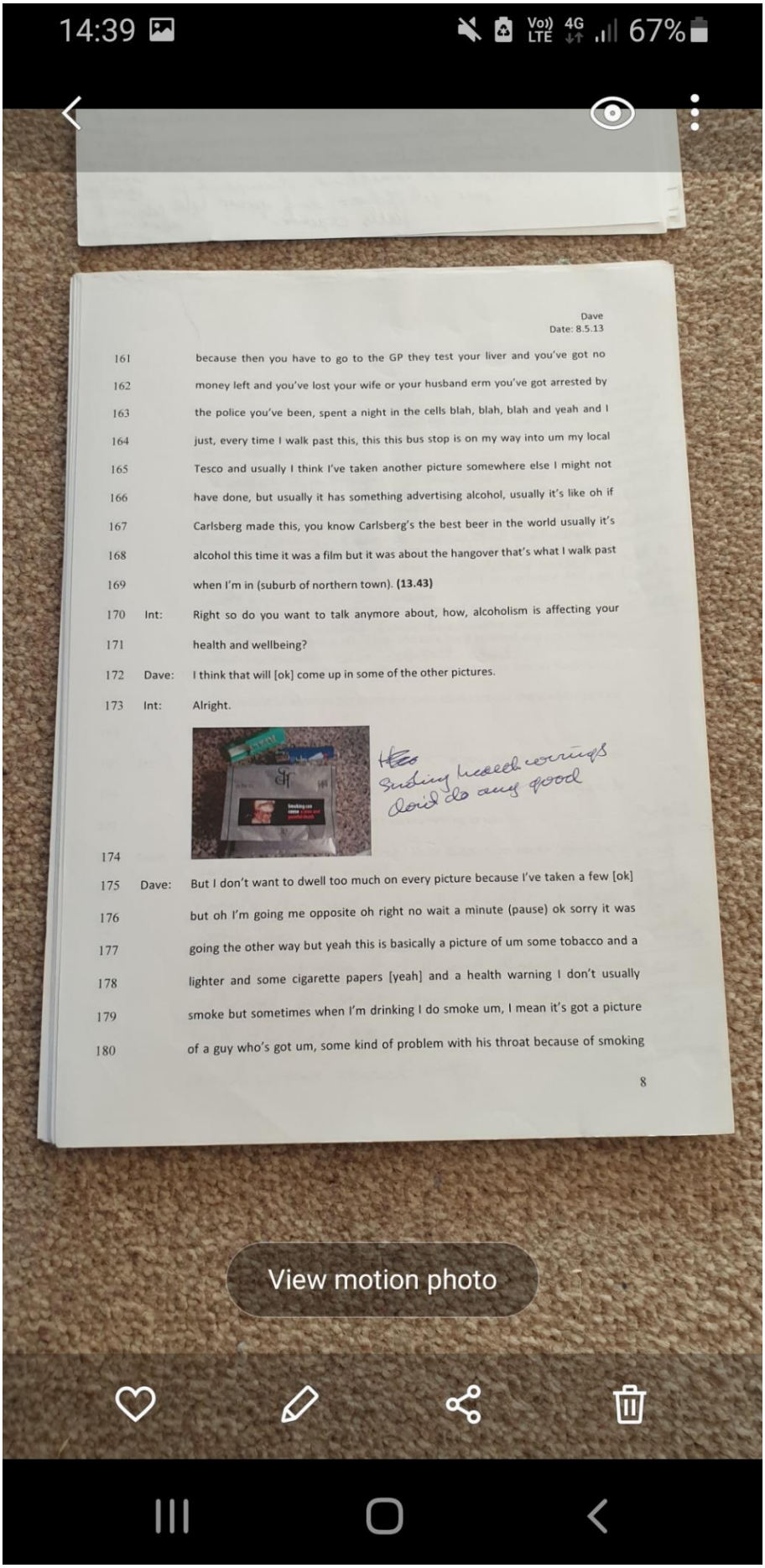
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Dave
Date: 8.5.13
161 because then you have to go to the GP they test your liver and you've got no
162 money left and you've lost your wife or your husband erm you've got arrested by
163 the police you've been, spent a night in the cells blah, blah, blah and yeah and I
164 just, every time I walk past this, this this bus stop is on my way into um my local
165 Tesco and usually I think I've taken another picture somewhere else I might not
166 have done, but usually it has something advertising alcohol, usually it's like oh if
167 Carlsberg made this, you know Carlsberg's the best beer in the world usually it's
168 alcohol this time it was a film but it was about the hangover that's what I walk past
169 when I'm in (suburb of northern town). (13.43)
170 Int: Right so do you want to talk anymore about, how, alcoholism is affecting your
171 health and wellbeing?
172 Dave: I think that will [ok] come up in some of the other pictures.
173 Int: Alright.
174
175 Dave: But I don't want to dwell too much on every picture because I've taken a few [ok]
176 but oh I'm going me opposite oh right no wait a minute (pause) ok sorry it was
177 going the other way but yeah this is basically a picture of um some tobacco and a
178 lighter and some cigarette papers [yeah] and a health warning I don't usually
179 smoke but sometimes when I'm drinking I do smoke um, I mean it's got a picture
180 of a guy who's got um, some kind of problem with his throat because of smoking
8
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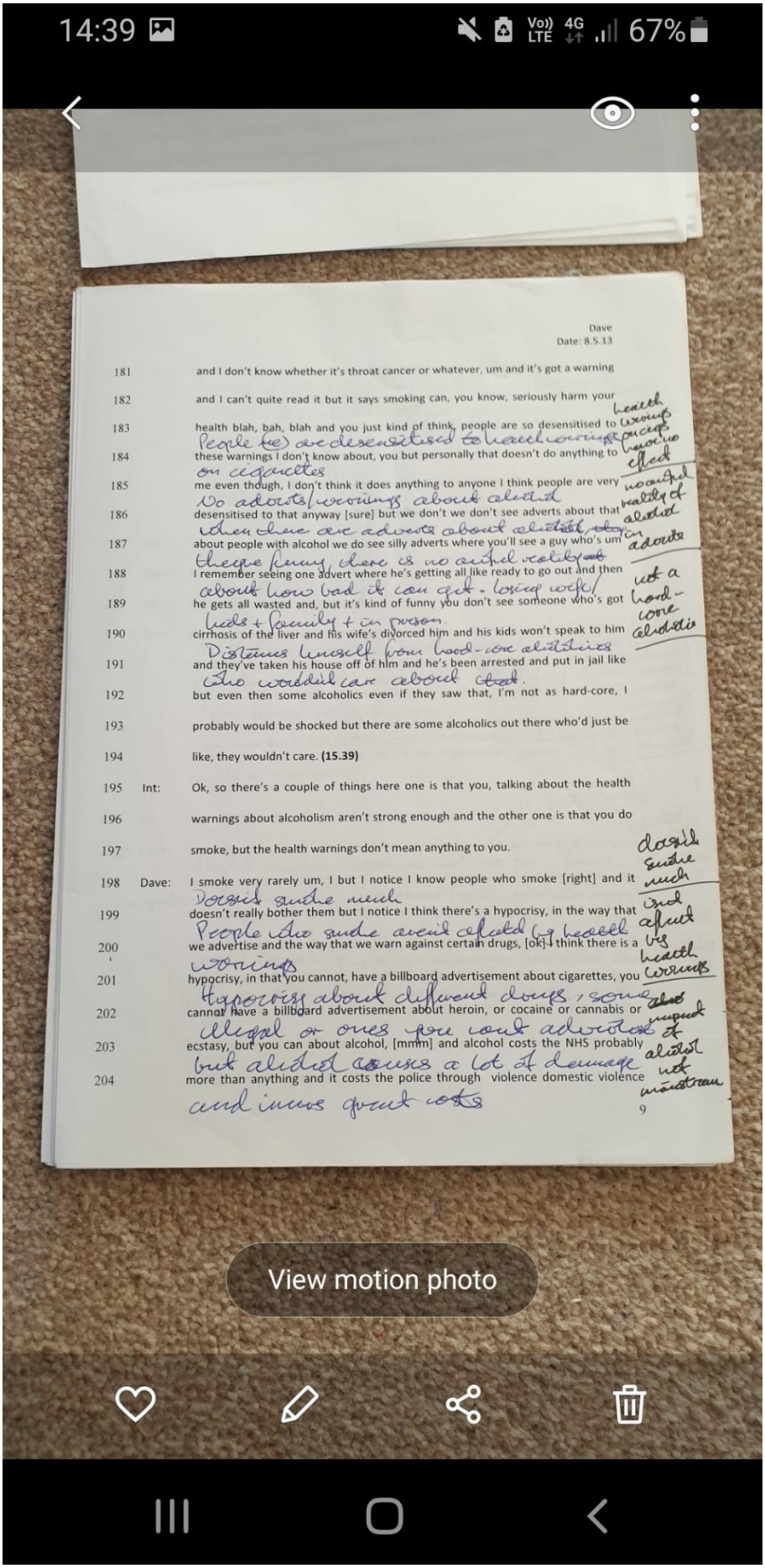


Dave
Date: 8.5.13

and I don't know whether it's throat cancer or whatever, um and it's got a warning

and I can't quite read it but it says smoking can, you know, seriously harm your

health blah, bah, blah and you just kind of think, people are so desensitised to

these warnings I don't know about, you but personally that doesn't do anything to

me even though, I don't think it does anything to anyone I think people are very

desensitised to that anyway [sure] but we don't we don't see adverts about that

about people with alcohol we do see silly adverts where you'll see a guy who's um

I remember seeing one advert where he's getting all like ready to go out and then

he gets all wasted and, but it's kind of funny you don't see someone who's got

cirrhosis of the liver and his wife's divorced him and his kids won't speak to him

and they've taken his house off of him and he's been arrested and put in jail like

but even then some alcoholics even if they saw that, I'm not as hard-core, I

probably would be shocked but there are some alcoholics out there who'd just be

like, they wouldn't care. **(15.39)**

Int: Ok, so there's a couple of things here one is that you, talking about the health

warnings about alcoholism aren't strong enough and the other one is that you do

smoke, but the health warnings don't mean anything to you.

Dave: I smoke very rarely um, I but I notice I know people who smoke [right] and it

doesn't really bother them but I notice I think there's a hypocrisy, in the way that

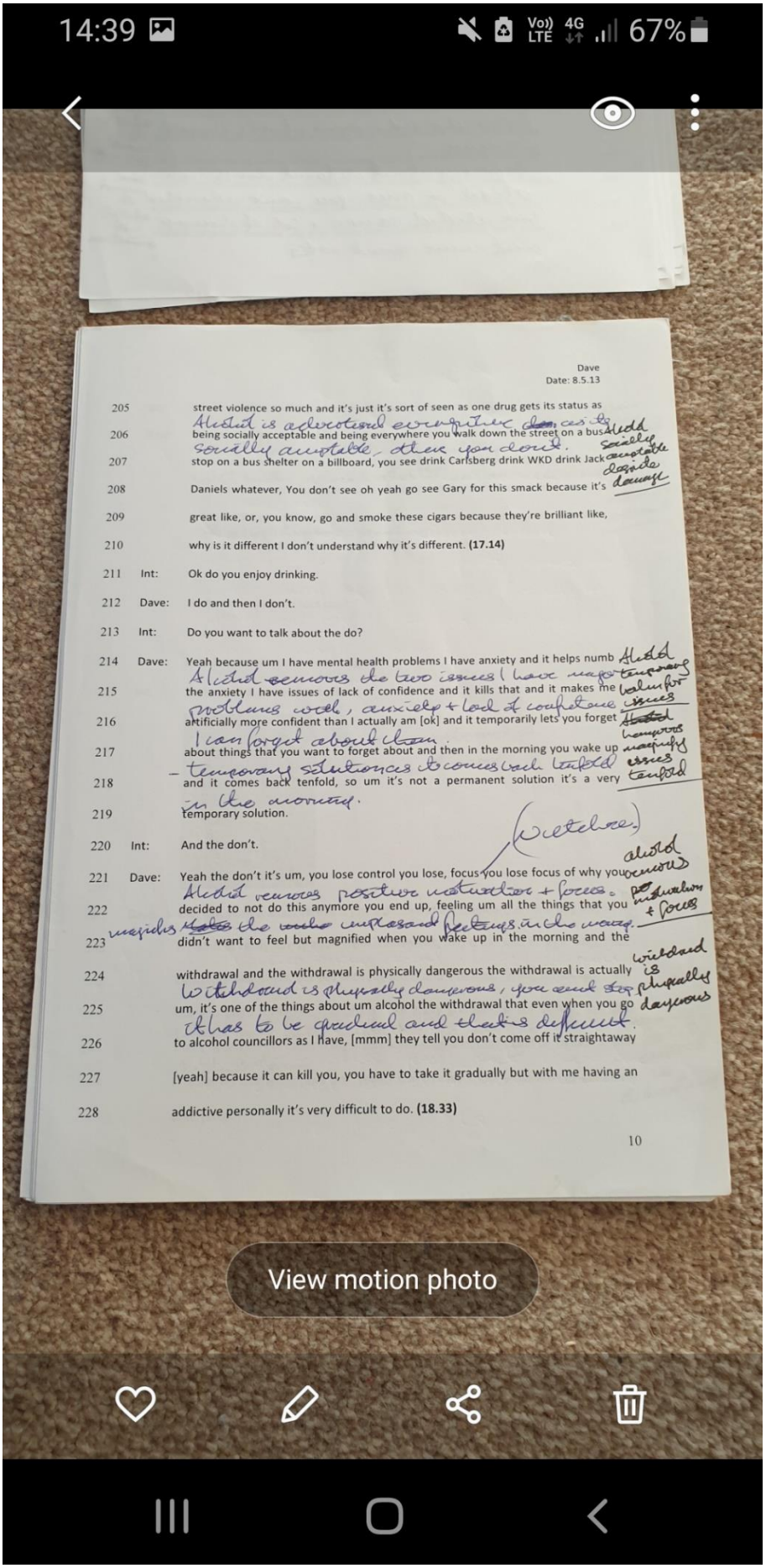
we advertise and the way that we warn against certain drugs, [ok] I think there is a

hypocrisy, in that you cannot, have a billboard advertisement about cigarettes, you

cannot have a billboard advertisement about heroin, or cocaine or cannabis or

ecstasy, but you can about alcohol, [mmm] and alcohol costs the NHS probably

more than anything and it costs the police through violence domestic violence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Dave
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205 street violence so much and it's just it's sort of seen as one drug gets its status as
206 being socially acceptable and being everywhere you walk down the street on a bus
207 stop on a bus shelter on a billboard, you see drink Carlsberg drink WKD drink Jack
208 Daniels whatever, You don't see oh yeah go see Gary for this smack because it's
209 great like, or, you know, go and smoke these cigars because they're brilliant like,
210 why is it different I don't understand why it's different. (17.14)
211 Int: Ok do you enjoy drinking.
212 Dave: I do and then I don't.
213 Int: Do you want to talk about the do?
214 Dave: Yeah because um I have mental health problems I have anxiety and it helps numb
215 the anxiety I have issues of lack of confidence and it kills that and it makes me
216 artificially more confident than I actually am [ok] and it temporarily lets you forget
217 about things that you want to forget about and then in the morning you wake up
218 and it comes back tenfold, so um it's not a permanent solution it's a very
219 temporary solution.
220 Int: And the don't.
221 Dave: Yeah the don't it's um, you lose control you lose, focus you lose focus of why you
222 decided to not do this anymore you end up, feeling um all the things that you
223 didn't want to feel but magnified when you wake up in the morning and the
224 withdrawal and the withdrawal is physically dangerous the withdrawal is actually
225 um, it's one of the things about um alcohol the withdrawal that even when you go
226 to alcohol councillors as I have, [mmm] they tell you don't come off it straightaway
227 [yeah] because it can kill you, you have to take it gradually but with me having an
228 addictive personally it's very difficult to do. (18.33)
10
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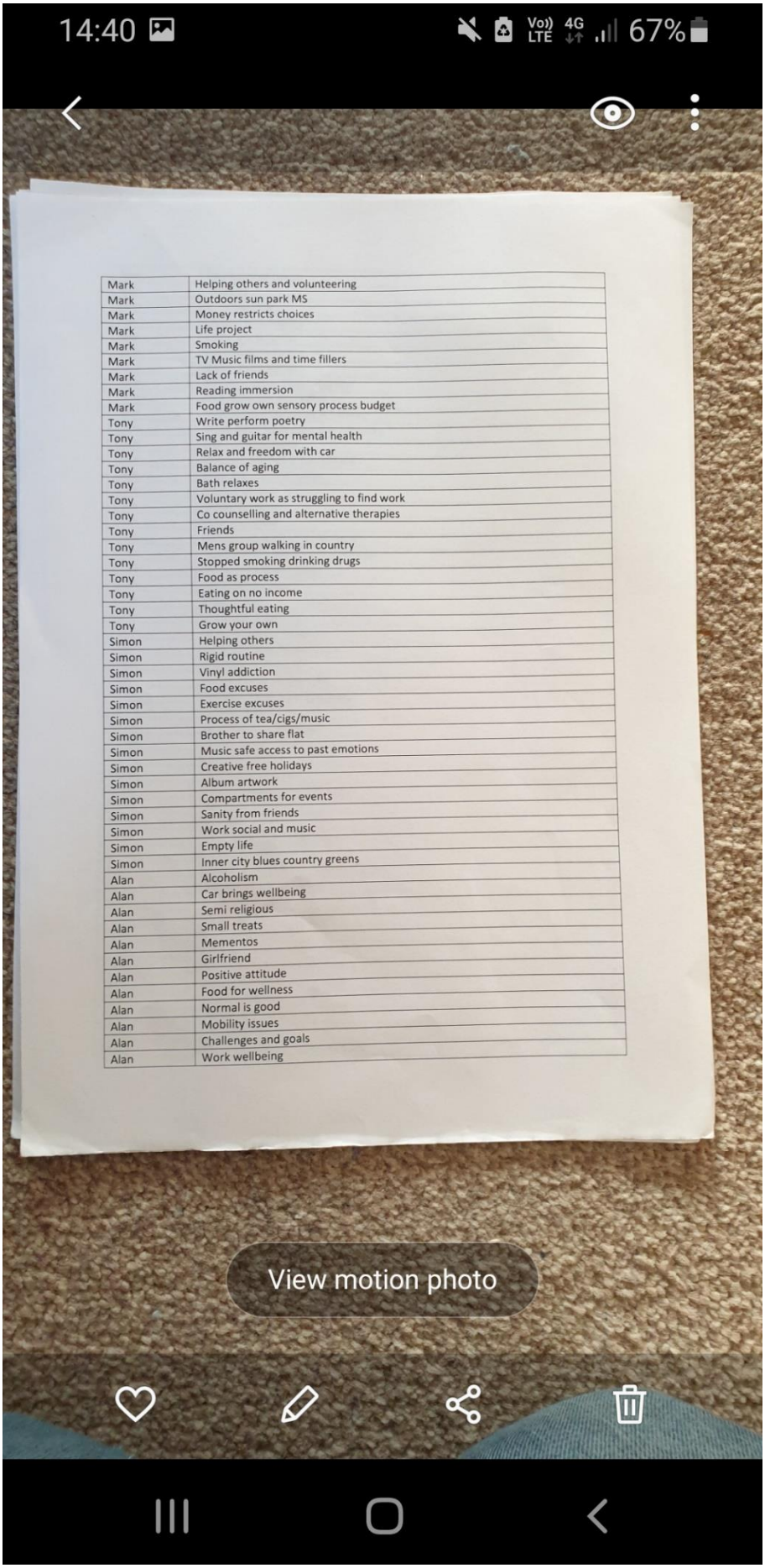
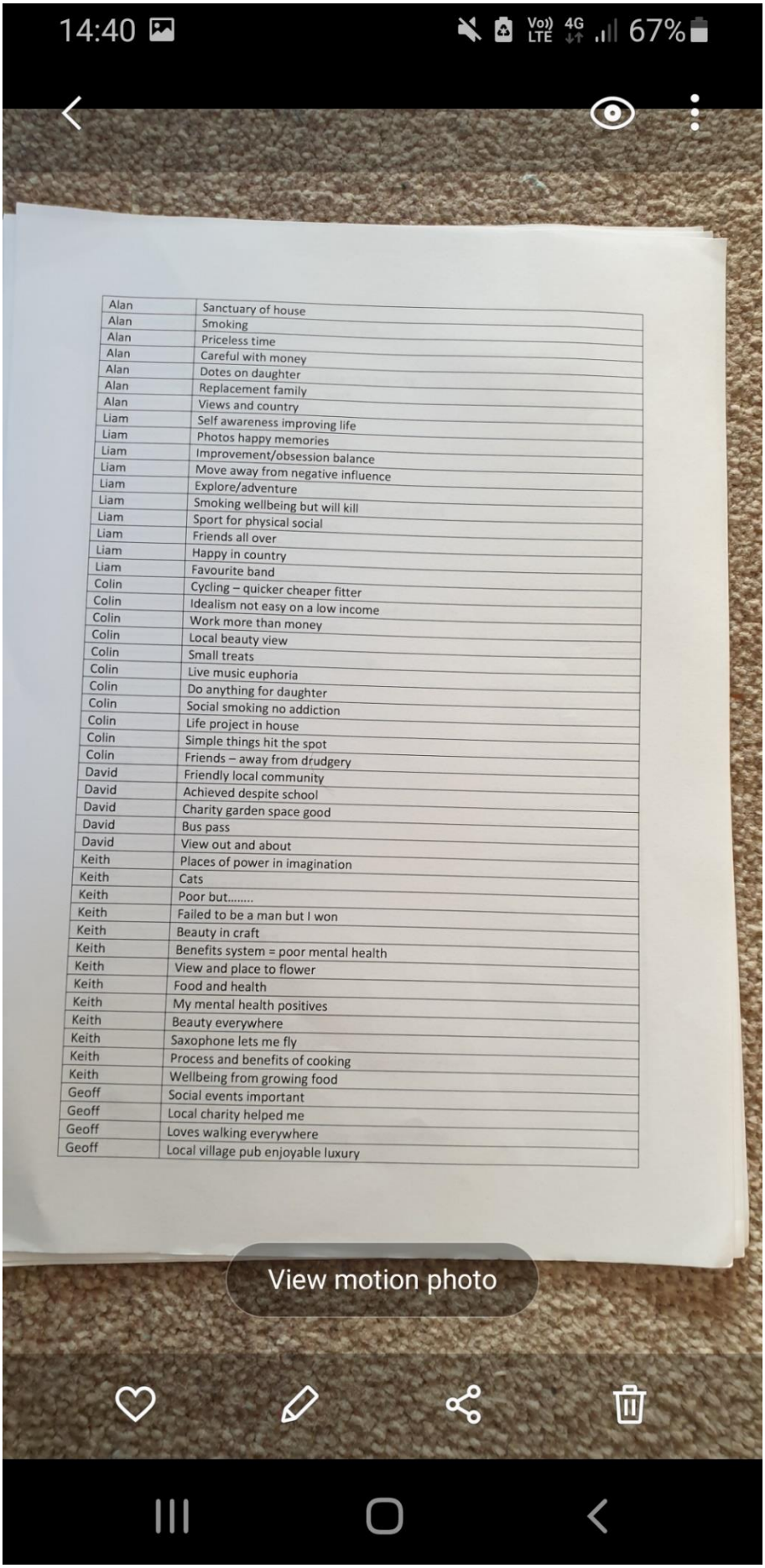
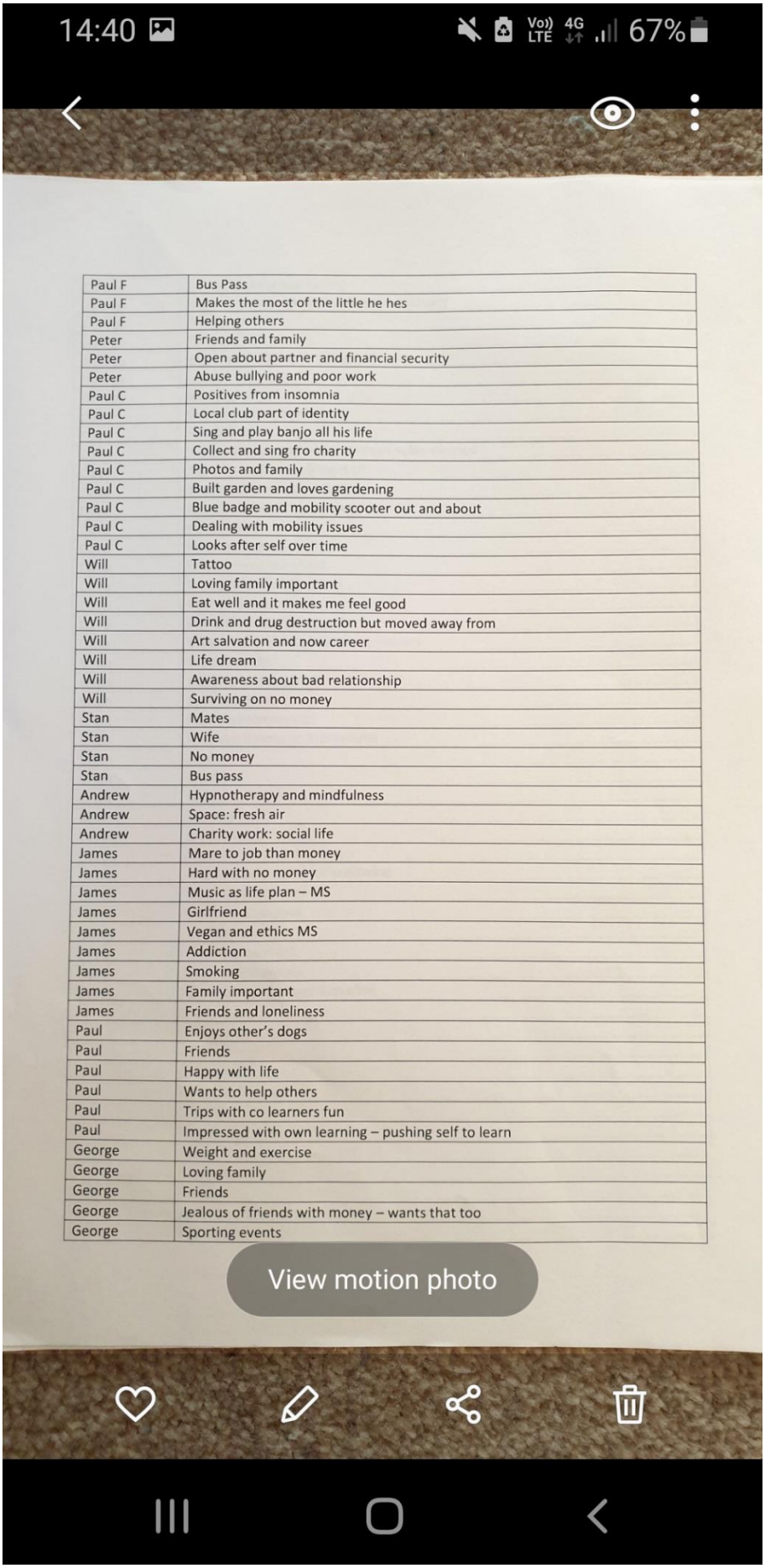


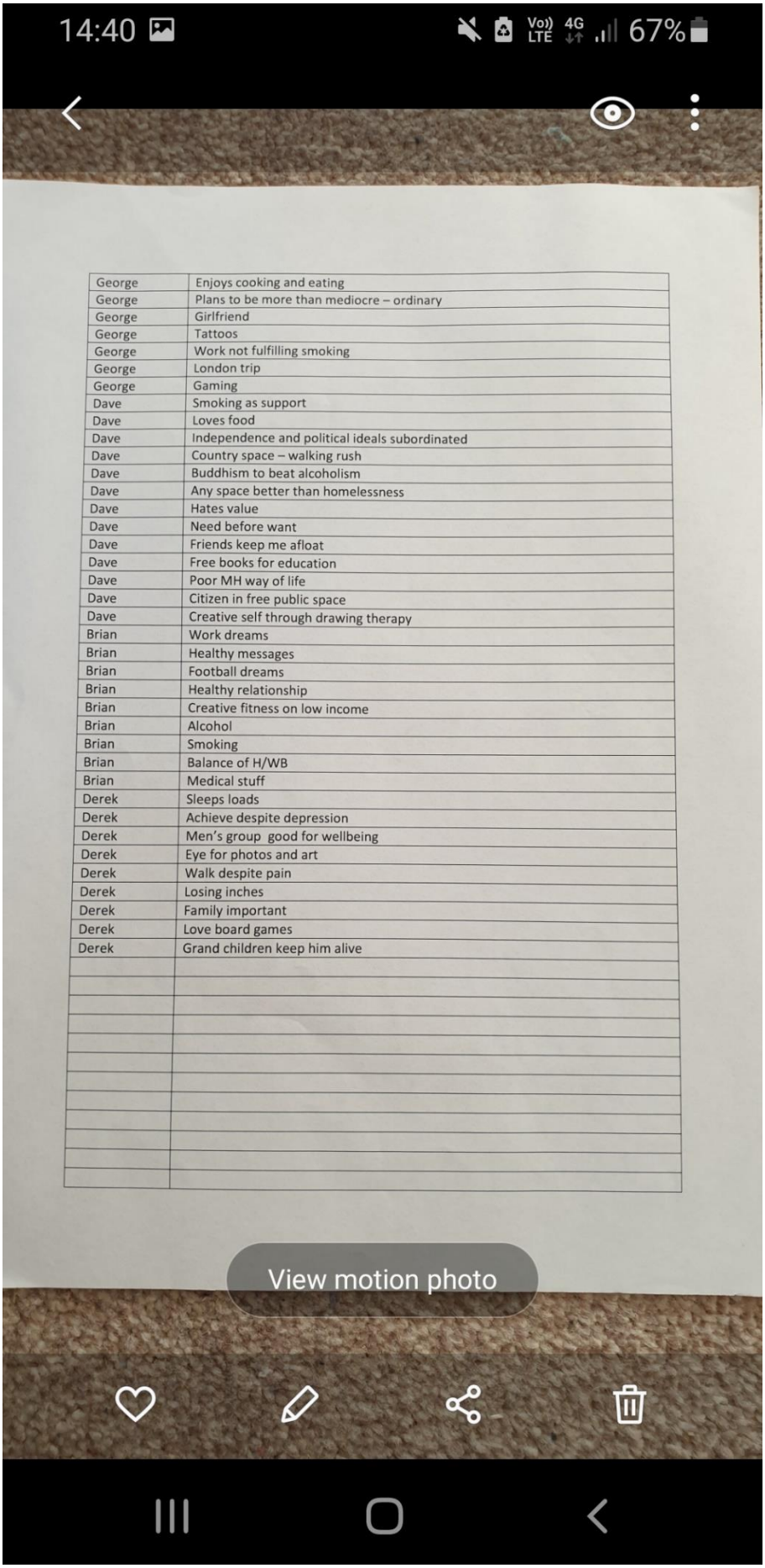
Mark	Helping others and volunteering
Mark	Outdoors sun park MS
Mark	Money restricts choices
Mark	Life project
Mark	Smoking
Mark	TV Music films and time fillers
Mark	Lack of friends
Mark	Reading immersion
Mark	Food grow own sensory process budget
Tony	Write perform poetry
Tony	Sing and guitar for mental health
Tony	Relax and freedom with car
Tony	Balance of aging
Tony	Bath relaxes
Tony	Voluntary work as struggling to find work
Tony	Co counselling and alternative therapies
Tony	Friends
Tony	Mens group walking in country
Tony	Stopped smoking drinking drugs
Tony	Food as process
Tony	Eating on no income
Tony	Thoughtful eating
Tony	Grow your own
Simon	Helping others
Simon	Rigid routine
Simon	Vinyl addiction
Simon	Food excuses
Simon	Exercise excuses
Simon	Process of tea/cigs/music
Simon	Brother to share flat
Simon	Music safe access to past emotions
Simon	Creative free holidays
Simon	Album artwork
Simon	Compartments for events
Simon	Sanity from friends
Simon	Work social and music
Simon	Empty life
Simon	Inner city blues country greens
Alan	Alcoholism
Alan	Car brings wellbeing
Alan	Semi religious
Alan	Small treats
Alan	Mementos
Alan	Girlfriend
Alan	Positive attitude
Alan	Food for wellness
Alan	Normal is good
Alan	Mobility issues
Alan	Challenges and goals
Alan	Work wellbeing



Alan	Sanctuary of house
Alan	Smoking
Alan	Priceless time
Alan	Careful with money
Alan	Dotes on daughter
Alan	Replacement family
Alan	Views and country
Liam	Self awareness improving life
Liam	Photos happy memories
Liam	Improvement/obsession balance
Liam	Move away from negative influence
Liam	Explore/adventure
Liam	Smoking wellbeing but will kill
Liam	Sport for physical social
Liam	Friends all over
Liam	Happy in country
Liam	Favourite band
Colin	Cycling – quicker cheaper fitter
Colin	Idealism not easy on a low income
Colin	Work more than money
Colin	Local beauty view
Colin	Small treats
Colin	Live music euphoria
Colin	Do anything for daughter
Colin	Social smoking no addiction
Colin	Life project in house
Colin	Simple things hit the spot
Colin	Friends – away from drudgery
David	Friendly local community
David	Achieved despite school
David	Charity garden space good
David	Bus pass
David	View out and about
Keith	Places of power in imagination
Keith	Cats
Keith	Poor but.....
Keith	Failed to be a man but I won
Keith	Beauty in craft
Keith	Benefits system = poor mental health
Keith	View and place to flower
Keith	Food and health
Keith	My mental health positives
Keith	Beauty everywhere
Keith	Saxophone lets me fly
Keith	Process and benefits of cooking
Keith	Wellbeing from growing food
Geoff	Social events important
Geoff	Local charity helped me
Geoff	Loves walking everywhere
Geoff	Local village pub enjoyable luxury



Paul F	Bus Pass
Paul F	Makes the most of the little he hes
Paul F	Helping others
Peter	Friends and family
Peter	Open about partner and financial security
Peter	Abuse bullying and poor work
Paul C	Positives from insomnia
Paul C	Local club part of identity
Paul C	Sing and play banjo all his life
Paul C	Collect and sing fro charity
Paul C	Photos and family
Paul C	Built garden and loves gardening
Paul C	Blue badge and mobility scooter out and about
Paul C	Dealing with mobility issues
Paul C	Looks after self over time
Will	Tattoo
Will	Loving family important
Will	Eat well and it makes me feel good
Will	Drink and drug destruction but moved away from
Will	Art salvation and now career
Will	Life dream
Will	Awareness about bad relationship
Will	Surviving on no money
Stan	Mates
Stan	Wife
Stan	No money
Stan	Bus pass
Andrew	Hypnotherapy and mindfulness
Andrew	Space: fresh air
Andrew	Charity work: social life
James	Mare to job than money
James	Hard with no money
James	Music as life plan – MS
James	Girlfriend
James	Vegan and ethics MS
James	Addiction
James	Smoking
James	Family important
James	Friends and loneliness
Paul	Enjoys other's dogs
Paul	Friends
Paul	Happy with life
Paul	Wants to help others
Paul	Trips with co learners fun
Paul	Impressed with own learning – pushing self to learn
George	Weight and exercise
George	Loving family
George	Friends
George	Jealous of friends with money – wants that too
George	Sporting events



George	Enjoys cooking and eating
George	Plans to be more than mediocre – ordinary
George	Girlfriend
George	Tattoos
George	Work not fulfilling smoking
George	London trip
George	Gaming
Dave	Smoking as support
Dave	Loves food
Dave	Independence and political ideals subordinated
Dave	Country space – walking rush
Dave	Buddhism to beat alcoholism
Dave	Any space better than homelessness
Dave	Hates value
Dave	Need before want
Dave	Friends keep me afloat
Dave	Free books for education
Dave	Poor MH way of life
Dave	Citizen in free public space
Dave	Creative self through drawing therapy
Brian	Work dreams
Brian	Healthy messages
Brian	Football dreams
Brian	Healthy relationship
Brian	Creative fitness on low income
Brian	Alcohol
Brian	Smoking
Brian	Balance of H/WB
Brian	Medical stuff
Derek	Sleeps loads
Derek	Achieve despite depression
Derek	Men's group good for wellbeing
Derek	Eye for photos and art
Derek	Walk despite pain
Derek	Losing inches
Derek	Family important
Derek	Love board games
Derek	Grand children keep him alive

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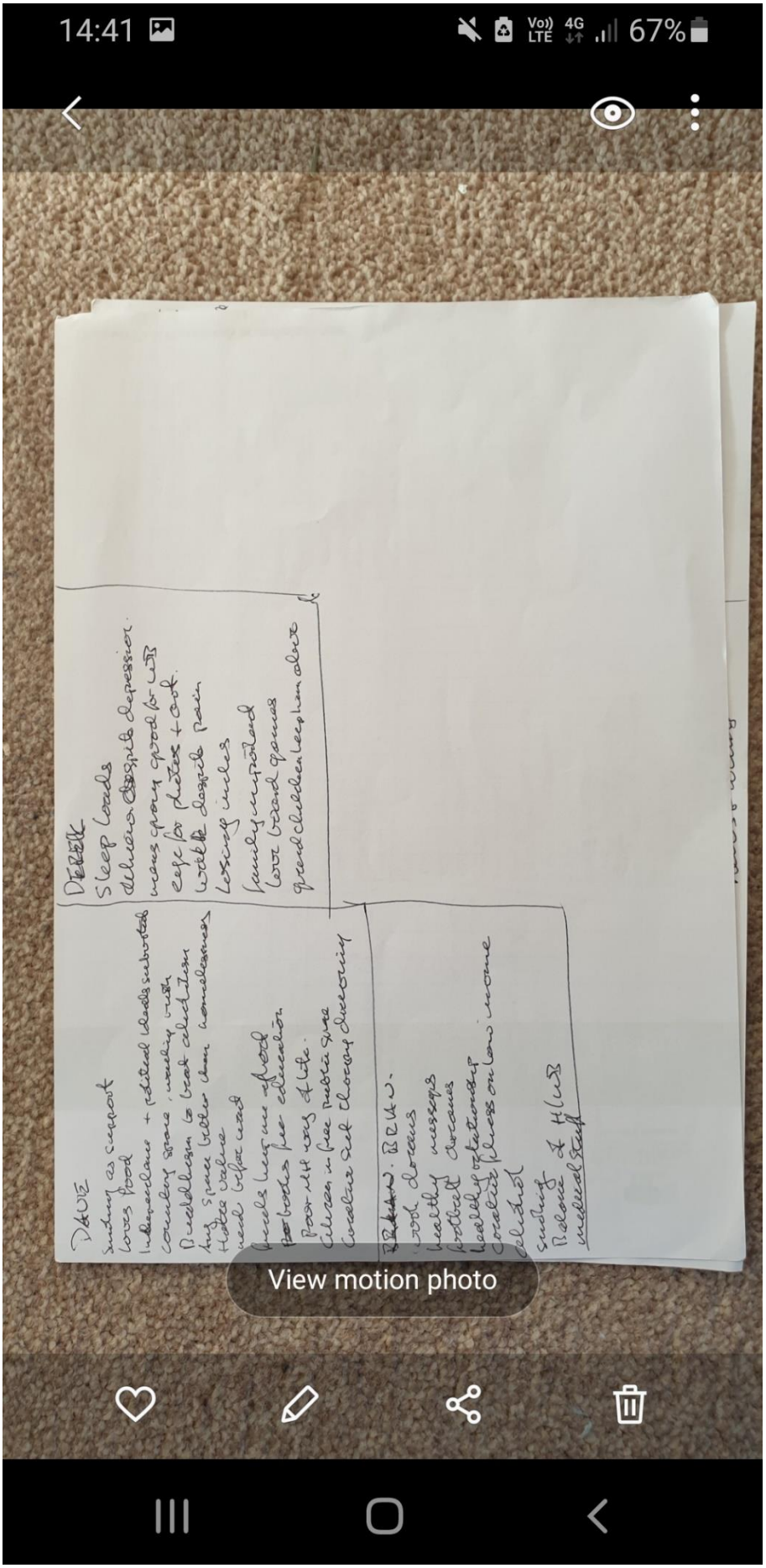
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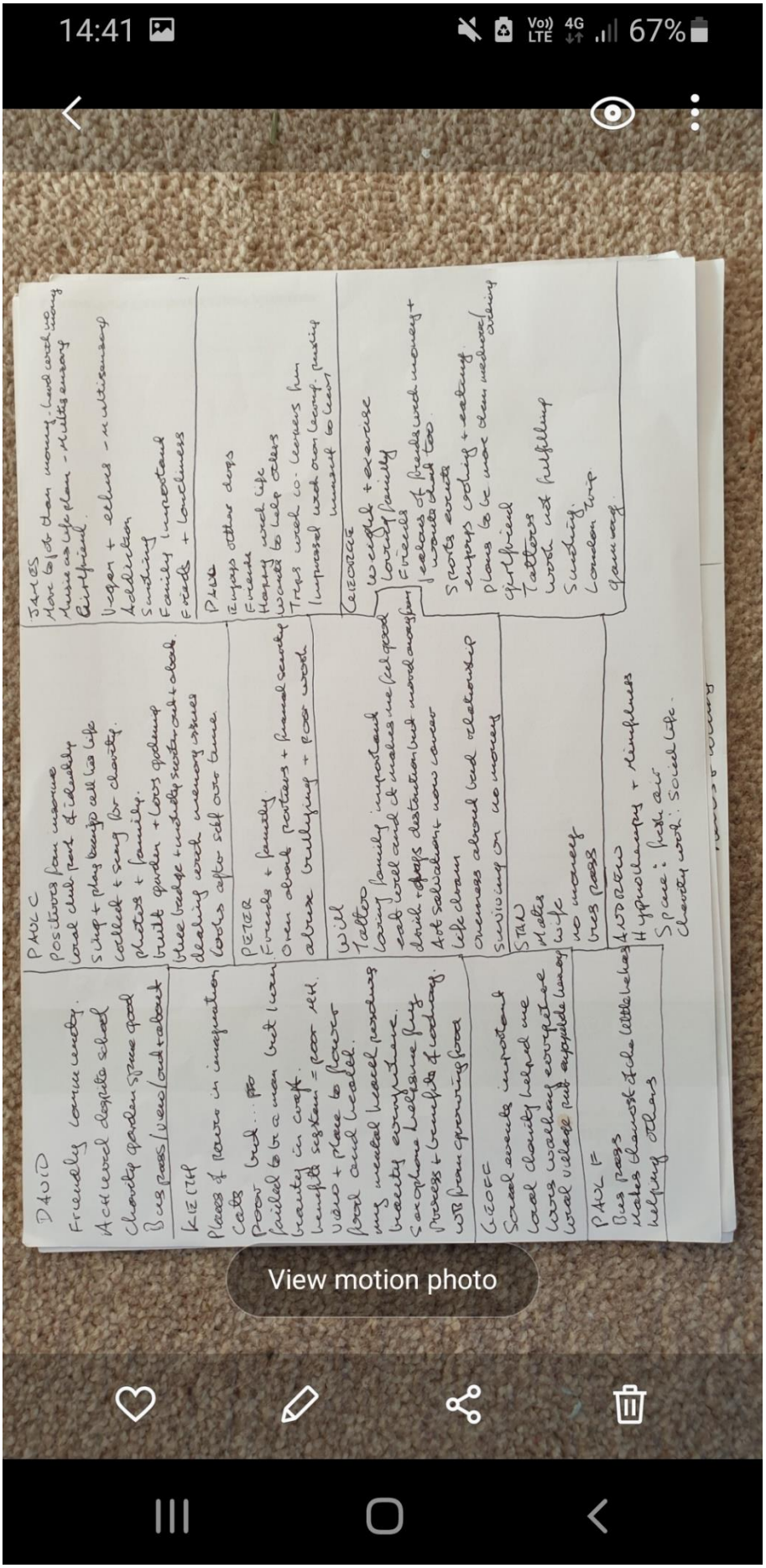
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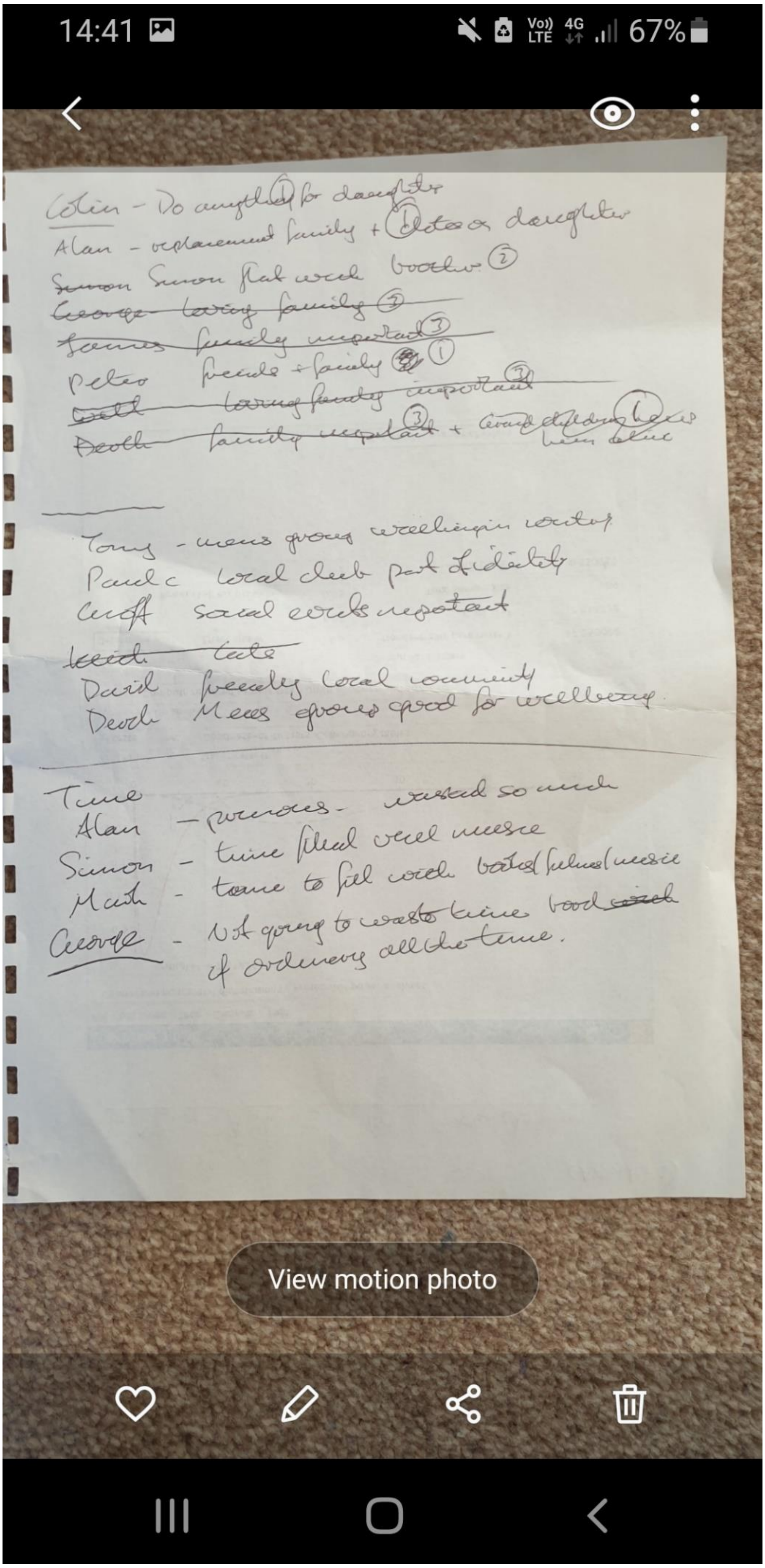
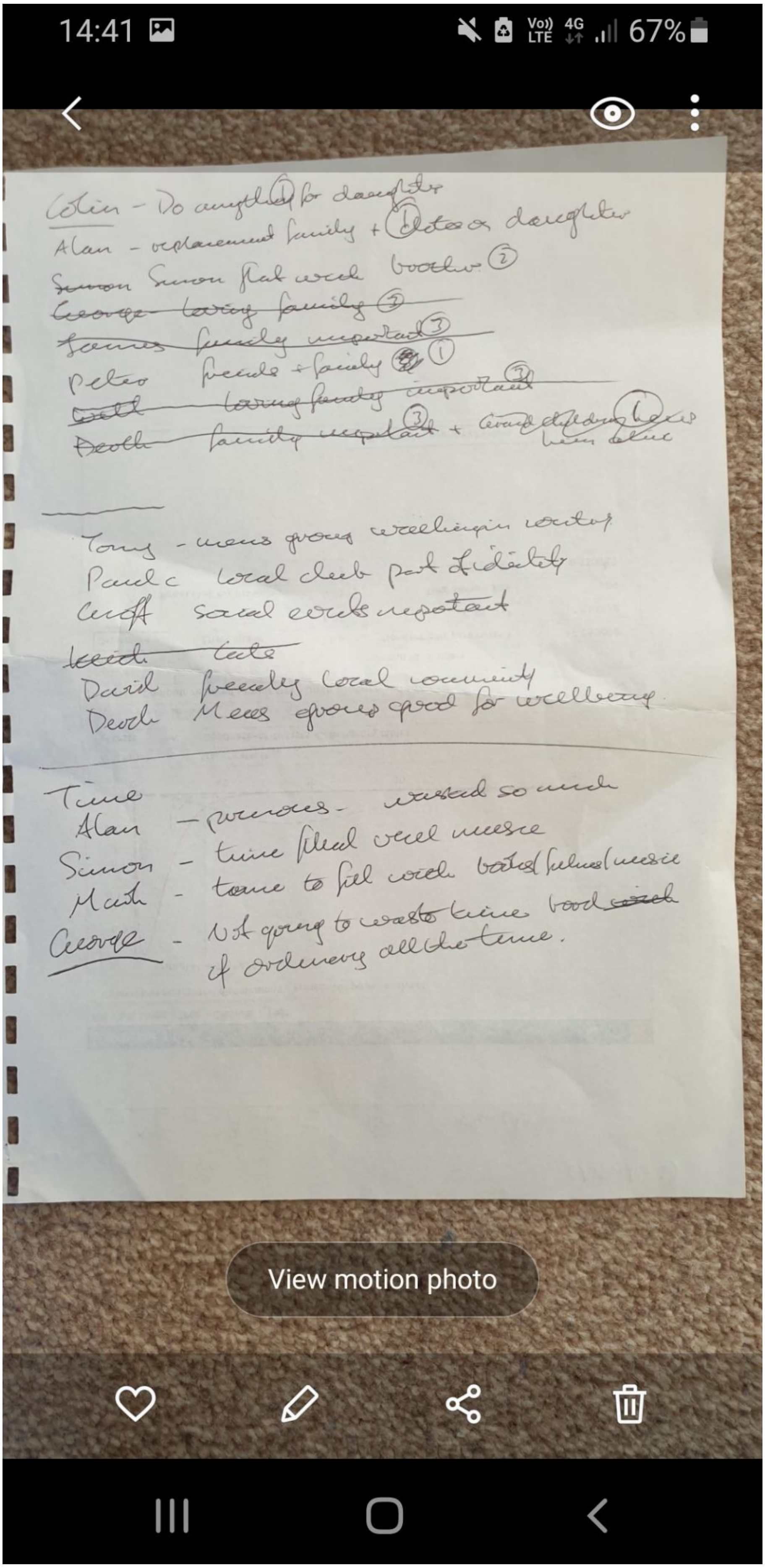


Colin – Do anything (1) for daughter
Alan – replacement family + (1) dotes on daughter
~~Simon~~ Simon flat week brother (2)
~~George loving family (2)~~
~~James family important (3)~~
Peter friends + family (1)
~~Keith loving family important (3)~~
~~Derek family important (3)~~ + grandchildren (1) have been close

Tony – mens group wellbeing [illegible]
Paul C local club part [illegible]
Geoff social events important
~~Keith late~~
David friendly local community
Derek Mens group good for wellbeing.

Time — wasted so much
Alan – precious –
Simon – time filled with music
Mark – time to fill with [illegible] music
George – Not going to waste time [illegible] of ordinary all the time.



Colin - Do anything for daughter ①

Alan - replacement family + ① doter on daughter

~~Simon~~ Simon flat with brother ②

~~George loving family ③~~

~~James family important ③~~

Peter friends + family ①

~~[illegible] loving family important ③~~

~~Death family important ③~~ + Grandchildren have been divine ①

Tony - mens group wellbeing [illegible]

Paul c local club part [illegible]

Cliff social circle important

~~Keith [illegible]~~

David friendly local community

Derek Mens groups good for wellbeing.

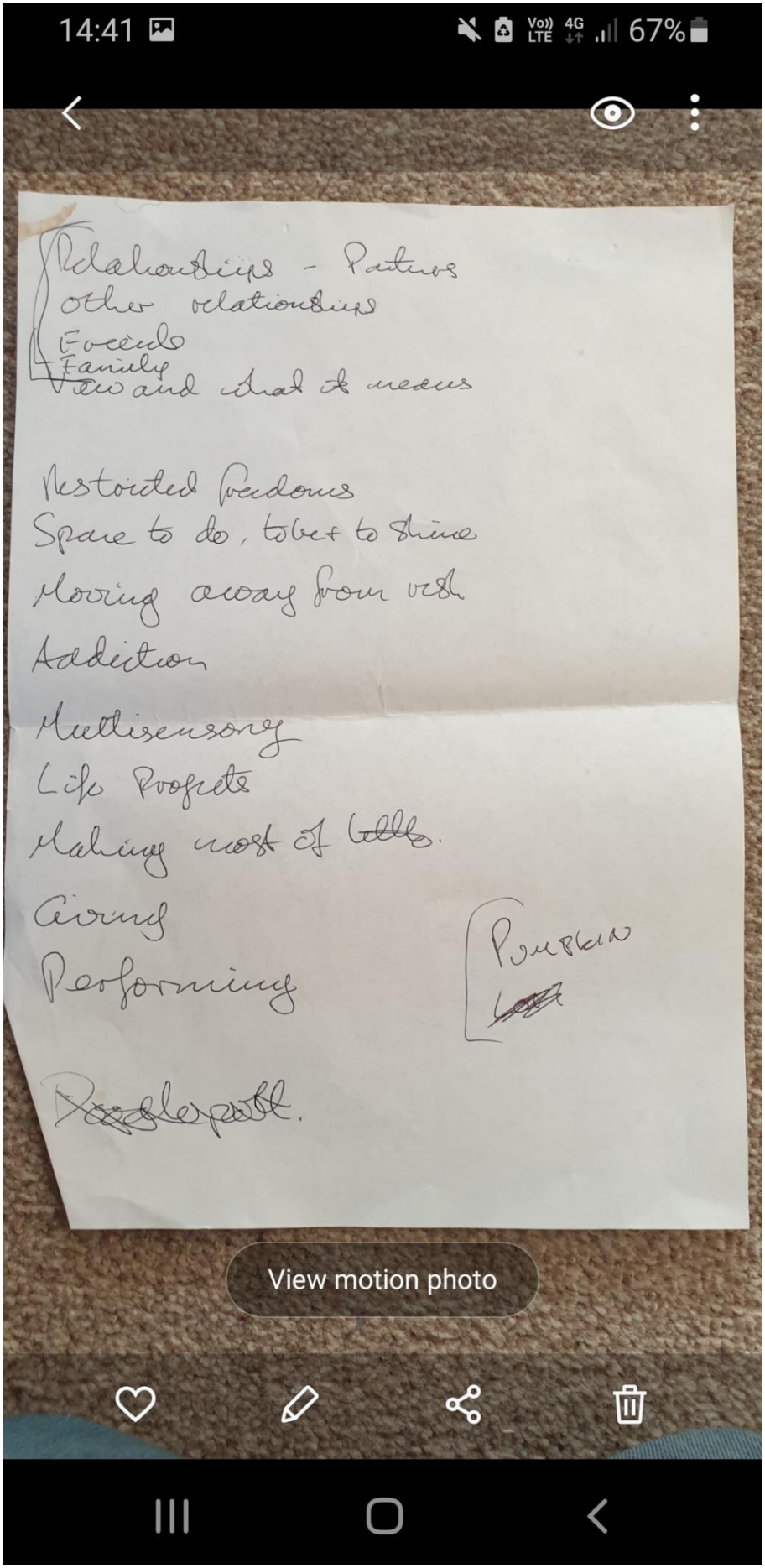
Time

Alan - precious - wasted so much

Simon - time filled with music

Mark - time to fill with [illegible] music

George - Not going to waste time [illegible] ~~[illegible]~~ of ordinary all the time.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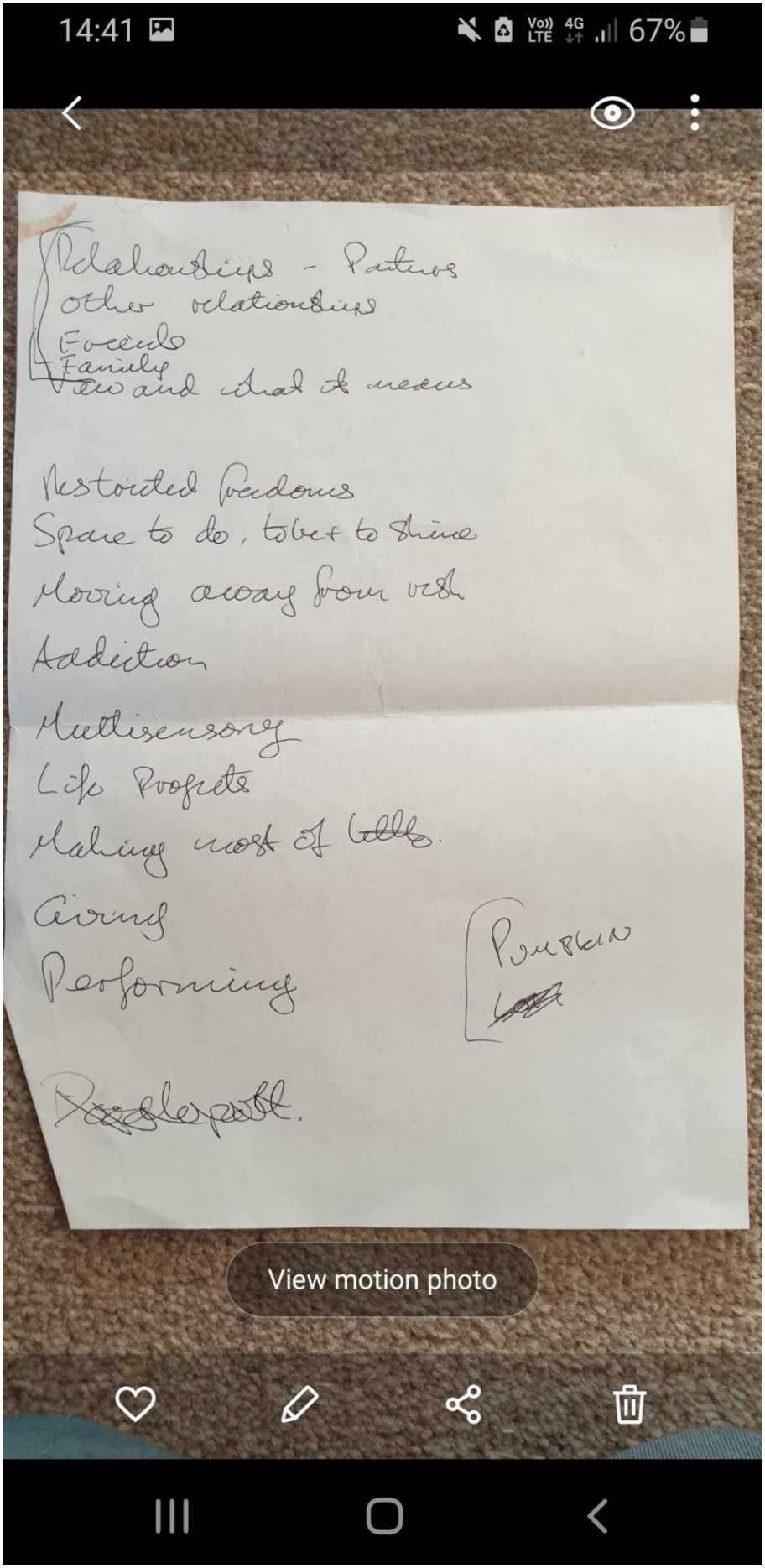
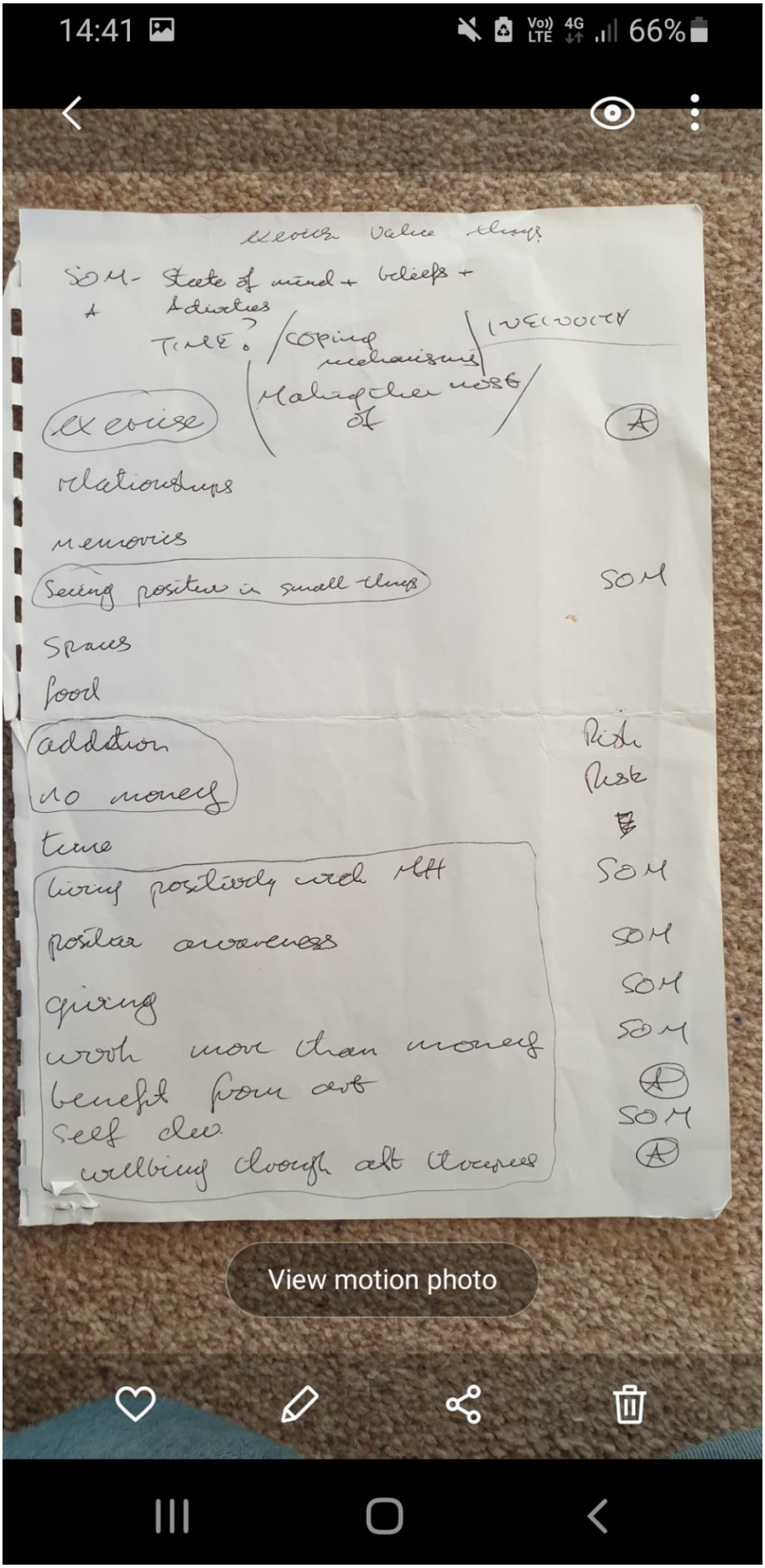
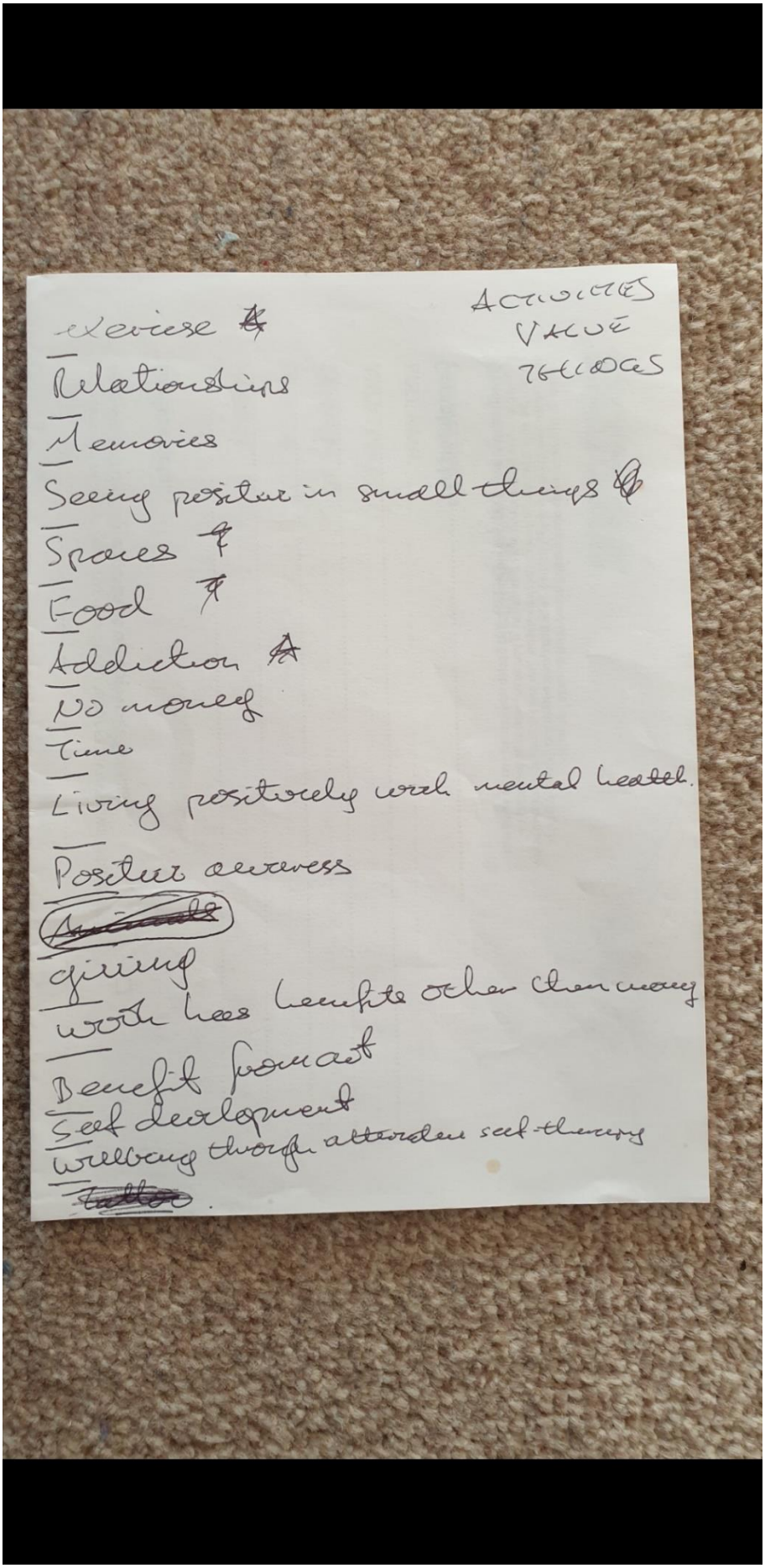
Relationships - Partner
other relationships
Friends
Family
Sex and what it means
Restricted freedoms
Space to do, to be + to shine
Moving away from risk
Addiction
Multisensory
Life Projects
Making most of [illegible].
Giving
Performing
Pumpkin
[illegible]
Doodlepath.
View motion photo


14:41
67%
Relationships - Partner
other relationships
Friends
Family
Sex and what it means
Restricted freedoms
Space to do, to be + to shine
Moving away from work
Addiction
Multisensory
Life Projects
Making most of [illegible].
Giving
Performing
Pumpkin
[illegible]
Doodlepath.
View motion photo

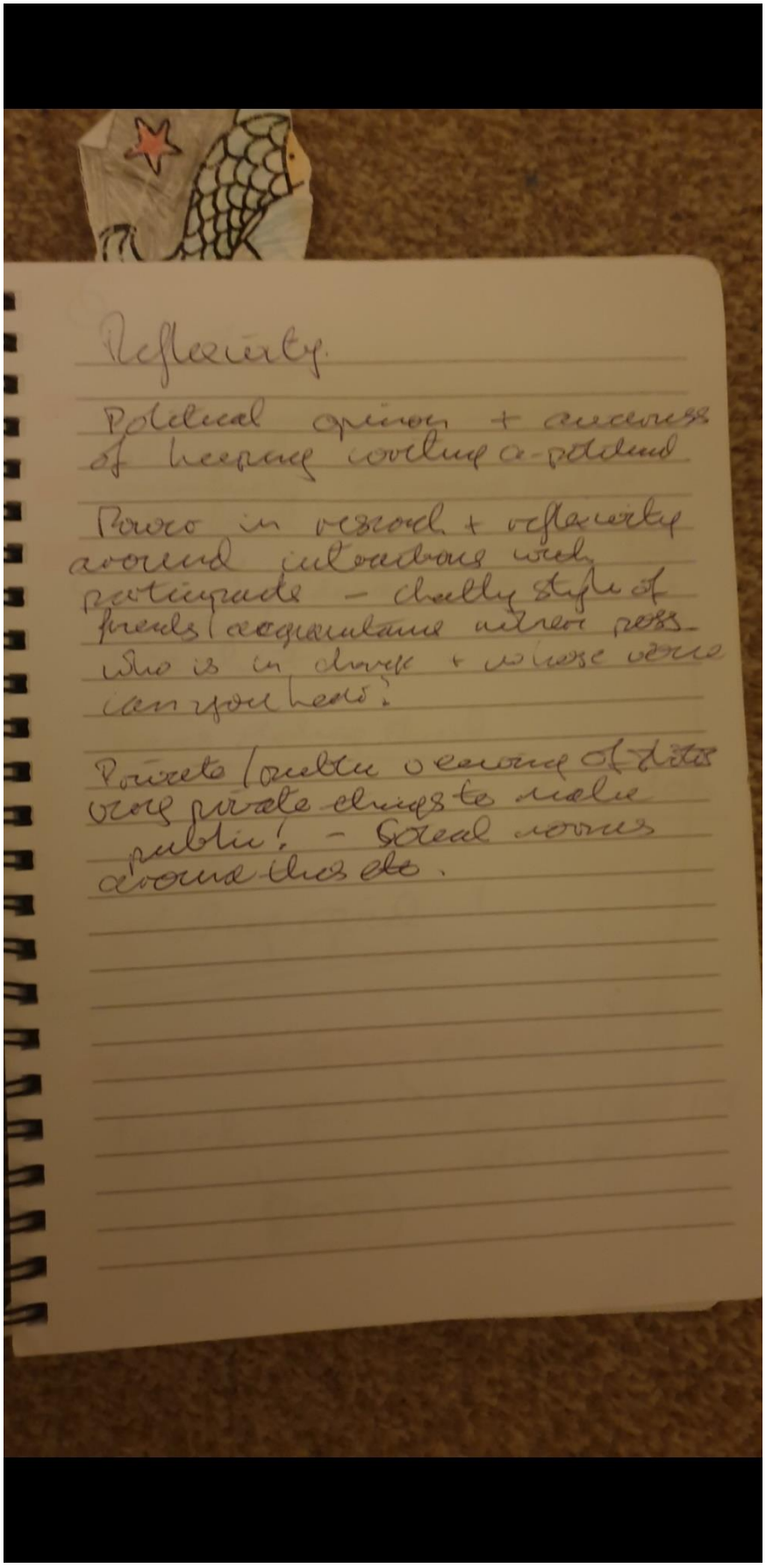

14:41
66%
Mental Value things
SOM- State of mind + beliefs +
+ Activities
TIME?
COPING mechanisms
INFLUENCE
Maladaptive ness
Exercise
A
relationships
memories
Seeing positive in small things
SOM
Sports
food
addiction
no money
Risk
Risk
time
living positively with MH
SOM
positive awareness
SOM
giving
SOM
work more than money
SOM
benefit from art
A
self dev
SOM
wellbeing through alt therapies
A
View motion photo

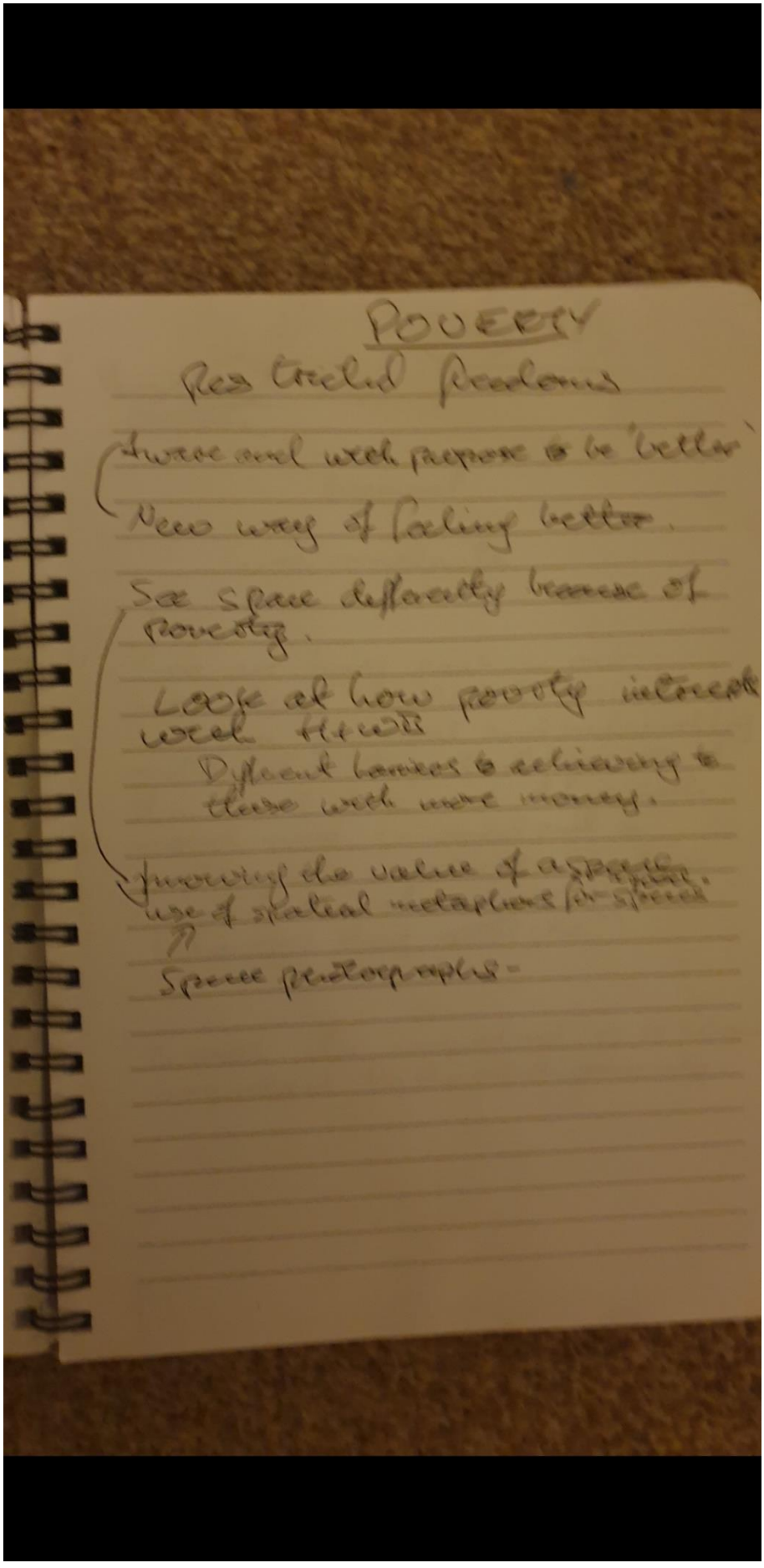


ACTIVITIES
VALUE
THINGS

exercise ✱
Relationships
Memories
Seeing positive in small things ✱
Spaces ✱
Food ✱
Addiction ✱
No money
Time
Living positively with mental health.
Positive awareness
~~Animals~~
giving
work has benefits other than money
Benefit from art
Self development
wellbeing through attended self-therapy
~~Tattoo~~.

Appendix F: Extracts from research diaries





POVERTY

Research Questions

Those and with people to be 'better'

Need ways of looking better.

See Space differently because of poverty.

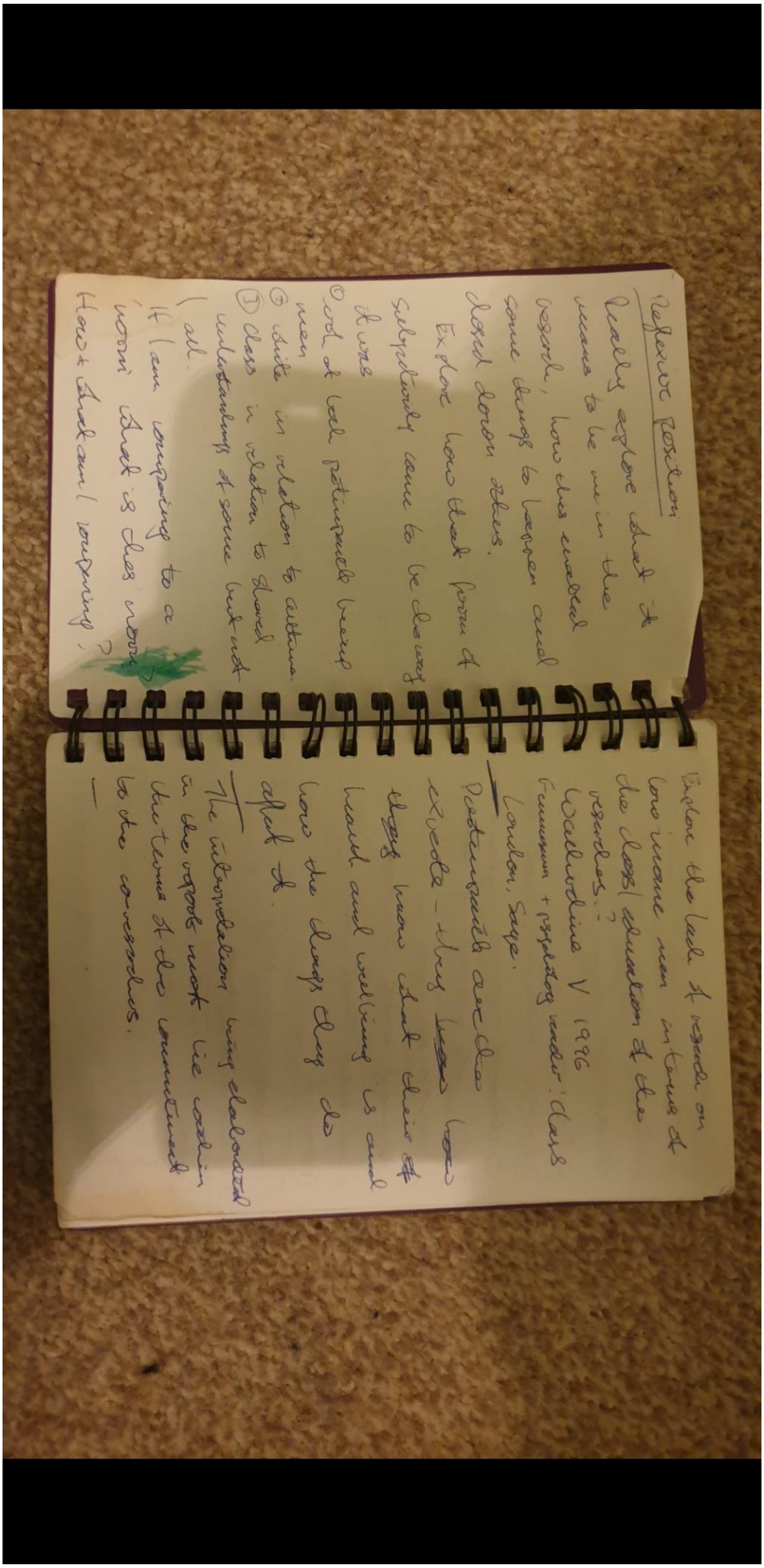
Look at how poverty interacts with these

Different barriers to achieving to those with more money.

Knowing the value of a space.

use of spatial metaphors for speech

Speech pictographs -



Reflexive Position

Really explore what it means to be me in the research, how this enabled some things to happen and closed down others.

Explore how that form of subjectivity came to be the way it was

(1) Not at both participants being men
(2) White in relation to culture.
(3) Class in relation to shared understandings of some but not all.

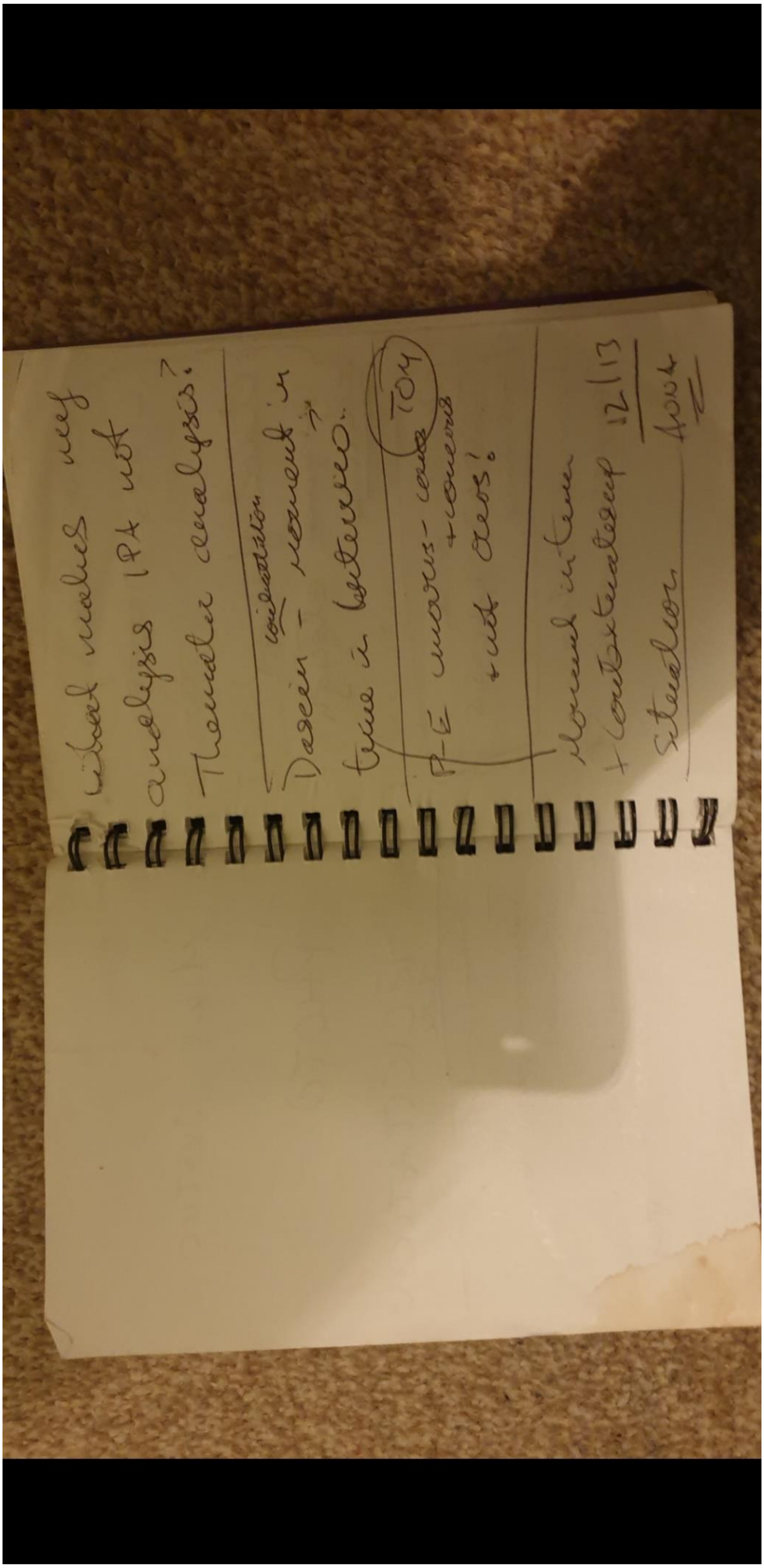
If I am comparing to a 'norm' what is this norm? How & what am I comparing?

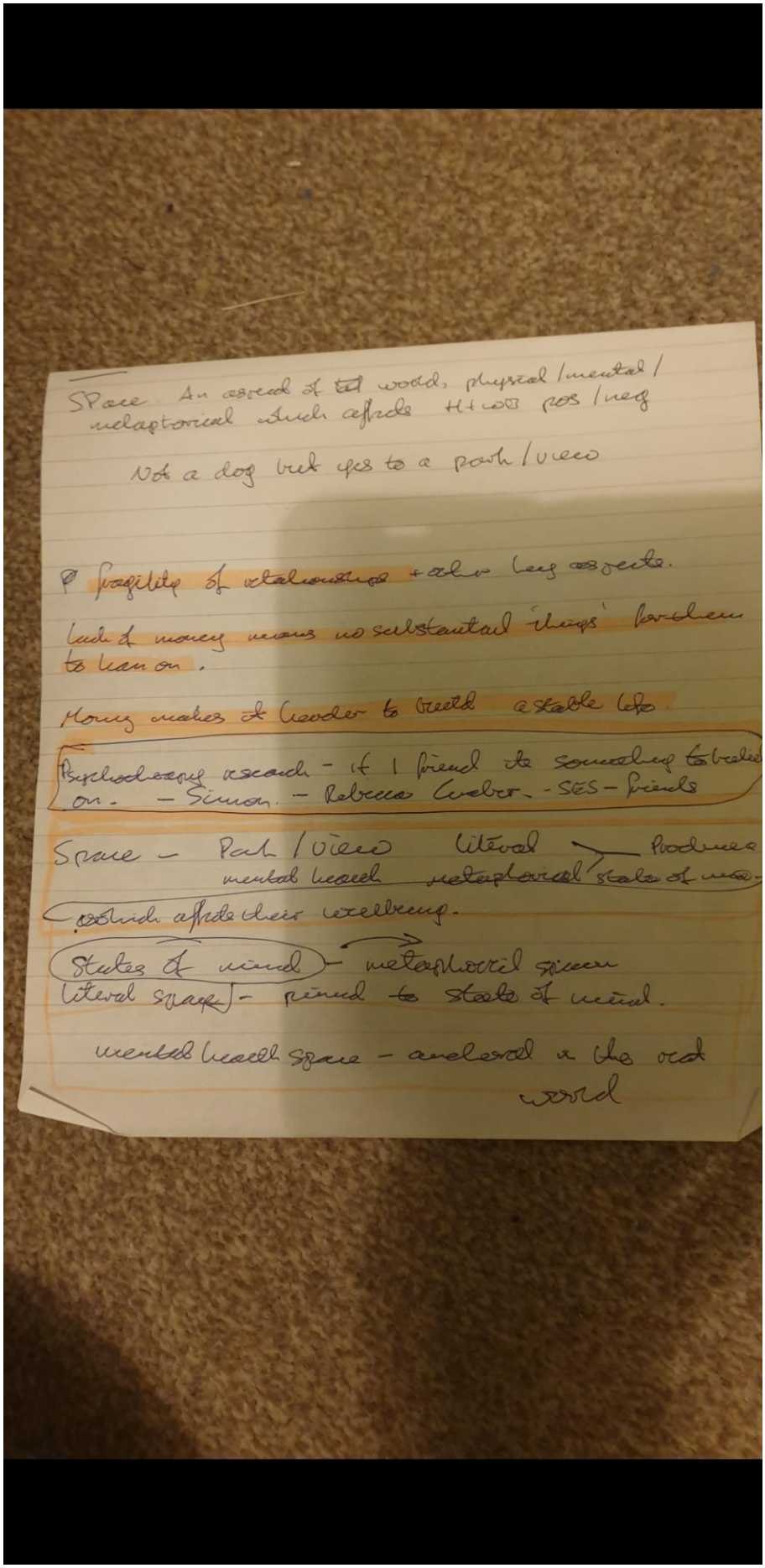
Explore the lack of research on low income men in terms of the class/education of the researchers.?

Walkerdine V 1996 Feminism + psychology reader: Class London, Sage.

Participants are the experts - they ~~know~~ know how they know what their health and wellbeing is and how the drugs they do affect it.

The interrelation being elaborated in the reports must lie within the terms of the commitment to the co-researchers.





Space An aspect of the world, physical / mental / metaphorical which affords +/- pos / neg

Not a dog but yes to a park / view

? fragility of relationships + other key objects.

Lack of money means no substantial 'things' to lean on.

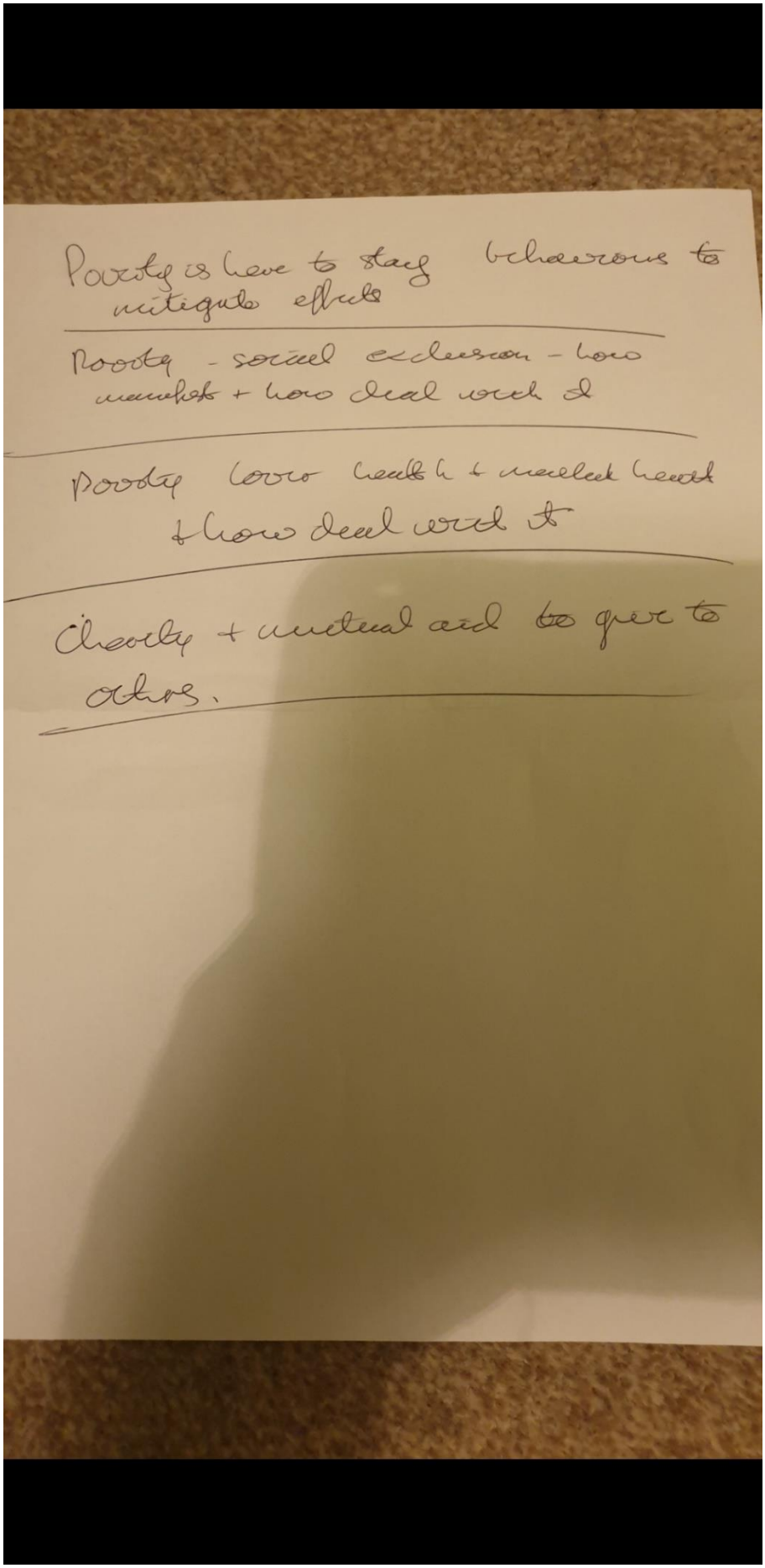
Money makes it easier to create stable life.

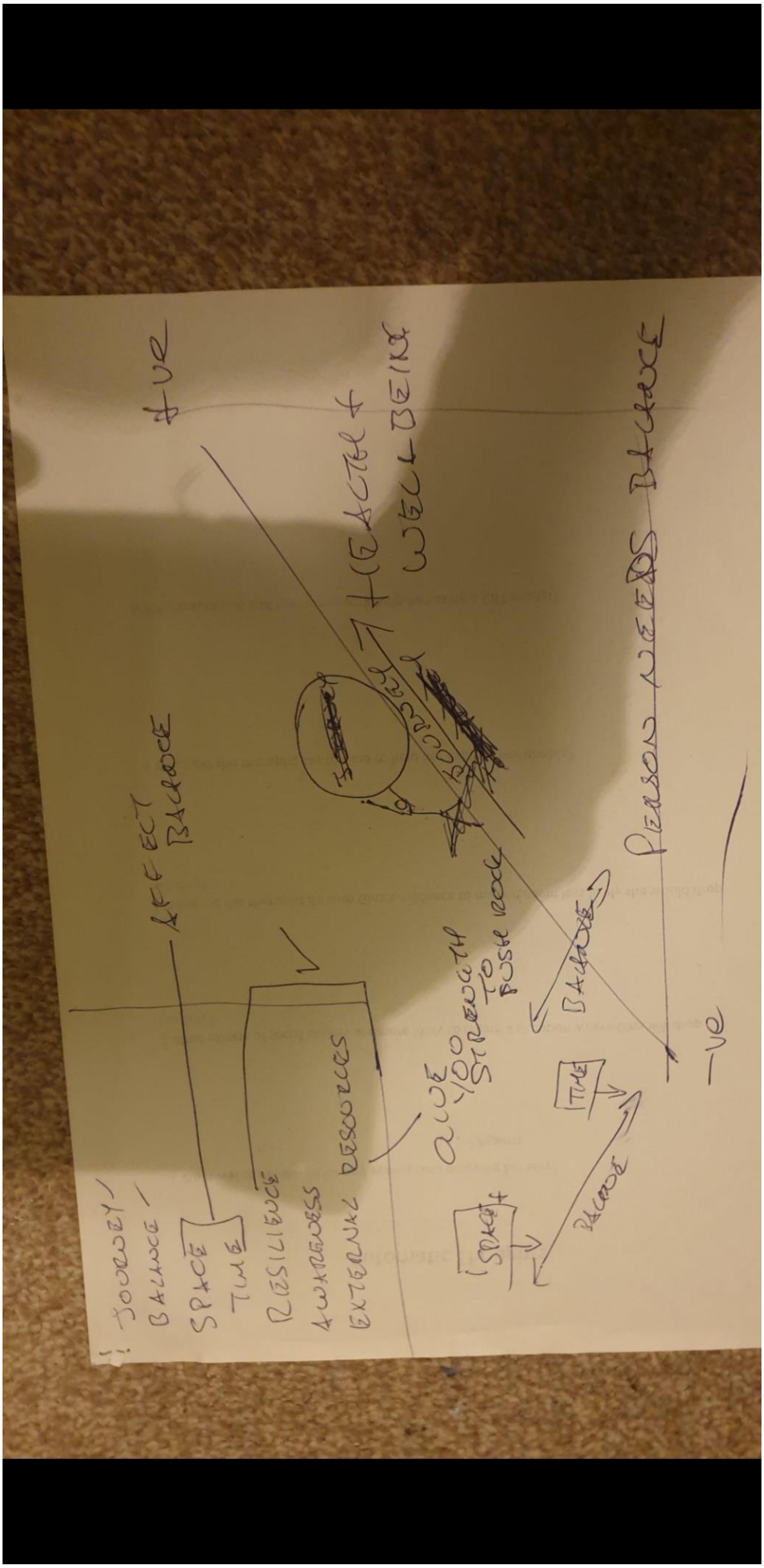
Psychodrama research - if I friend is something to lean on. - Simon - Rebecca Cuebas - SES - friends

Space - Park / view literal → produces mental health metaphorical states of mind which affects their wellbeing.

States of mind - metaphorical space
literal space - mind to state of mind.

mental health space - anchored in the real world


Poverty is how to stay
mitigate effects
Poverty - social exclusion - how
Poverty how health + mental health
& how deal with it
Charity + mutual aid to give to
others.


JOURNEY
BALANCE
SPACE
TIME
RESILIENCE
AWARENESS
EXTERNAL RESOURCES
AFFECT BALANCE
+VE
-VE
HEALTH &
WELL BEING
PERSON NEEDS BALANCE
STRENGTH TO PUSH ROCK
BALANCE