THE LAY HEALTH BELIEFS OF GLASWEGIAN MEN

KENNETH MULLEN

Thesis submitted for the degree of Doctor of Philosophy

Department of Social
and Economic Research
University of Glasgow

DECLARATION

I declare this thesis and the research upon which it is based to be my own work and testify that it has not been accepted in any previous application for a degree, that all verbatim extracts have been distinguished by quotation marks, and that all sources of information have been specifically acknowledged.

Signed .....

Date 17th July, 1992.

SUMMARY

This thesis presents a qualitative interview study of lay health beliefs. It reports the analysis, by means of grounded theory and analytic induction of interviews with 70 Glaswegian men in mid-life. Although it is a general study of lay health beliefs, particular attention is paid to attitudes towards smoking and drinking, as tobacco and alcohol related disease feature prominently in the health statistics of the city. Issues of class and religion are also considered at length as these factors are strong elements in the cultural background of Glaswegians.

The early chapters detail the reasons for the choice of grounded theory and analytic induction as the most appropriate means of analysis, and give a detailed review of the relevant research literature. The findings from the literature are shown to be fragmented but various important issues are identified in lay thinking, in particular the dichotomy of control and release in people's ideas about health.

The main findings of the thesis are presented in parts two and three. Part two outlines the central features of lay health beliefs in the three areas of general health, ideas about tobacco use, and ideas about alcohol. The central ideas of control and release also found expression in my respondents' accounts, and these issues are analysed in terms of their thinking about

stress and the nature of relaxation. A great deal of ambivalence was discovered in their ideas about the use of tobacco and alcohol for these purposes. The similarities between lay and professional models of health are highlighted and discussed.

Part three takes the analysis of the dichotomy further by considering the overarching themes of work, marital status, and moral and religious issues. It is shown that although class and religion are important influences on health beliefs they can only be fully understood if analysed in their components, in the case of class by an analysis of occupation and general elements of lifestyle including marital status, and for religion in the wider sense of general moral concerns with regard to health.

As the conclusion points out, the method of analysis allowed for a more important issue to emerge from the interview data: this was the centrality of the dichotomy of control and release in the overall structure of the lay health beliefs of male Glaswegians. Although such a dichotomy has been presented in other work, the current thesis demonstrates the difficulty Glasgwegian men had in balancing both sides of the dichotomy and thus in maximising their chances of good health. These problems are traced to the heart of Scottish culture and society.

In memory of my mother Christina Mullen,

To my father Henry Mullen,

And for Sandrine and our son Sean.

CONTENTS

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CHAPTER 1

INTRODUCTION

People's ideas about health and illness are known to vary across cultures and over time. The meaning of health and illness for the Zande tribesmen studied by Evans-Pritchard is different from that of Hellman's (1978) inner-city London patients. Again, restricting ourselves to our own culture, it is well-known that ideas about health and illness underwent a radical change with the rise and dominance of the bio-medical viewpoint round the turn of the nineteenth century (Currer and Stacey 1986). However, although much is known about ideas of health and illness and their variation there are still large gaps in our knowledge. The literature shows a bias towards focussing on the negative pole of illness rather than on positive aspects of health, and a leaning towards the bio-medical viewpoint rather than concentration on the lay perspective. Where the lay or folk perspective has been considered this has largely been via the work of anthropologists looking at other cultures or focussing on specific minority groups within the dominant culture. This work has thus tended to be problem based, designed to answer questions of interest to the medical profession.

Again, empirical research in this field has often restricted itself to focussing on one social class (Blaxter 1983, Calnan and Johnson 1985, Pill and Stott

1982), or has been carried out specifically on women (Blaxter 1983, Calnan and Johnson 1985, Pill and Stott, 1982). Apart from the work of Williams (1981; 1990) differences between religious groups have been ignored. The concerns of such research have also varied. Blaxter's study (1983) considered causes of disease, not generalised illness. Pill and Stott (1982) researched the aetiology of illness and responsibility for health, whilst Calnan and Johnson (1985) looked at concepts of health and vulnerability to disease.

This thesis presents an analysis of the lay health accounts of male Glaswegians in mid-life. It reports the findings from an interview study carried out in 1987 and 1988 on the health beliefs of a group of seventy men aged between thirty and fifty. As such it aims to make a contribution towards rectifying some of the imbalances in the literature on lay health beliefs; specifically by its focus on male health beliefs and by looking at lay beliefs across social class and religious groups.

THE RESEARCH CONTEXT

Glasgow is often portrayed as a working-class city with a deep religious divide. Strong social class divisions in attitude are presented in Glasgow novels, plays, and poetry, both past (Grieve M, Aitken, W.R. 1985; Gifford 1985) and present (Kelman 1987, Gray 1981, Hind 1968); and religious bigotry is a common theme (as could be seen in McDougall's 1979 B.B.C. television play: 'Just

another Saturday'). The salience of alcohol to the culture of the city is a frequent topic, which has often dark associations. Commenting in The Dour Drinkers of Glasgow, Macdiarmid states:

> 'The majority of Glasgow pubs are for connoisseurs of the morose, for those who relish the element of degradation in all boozing and do not wish to have it eliminated by the introduction of music, modernistic fitments, arty effects, or other devices whatsoever. It is the old story of those who prefer hard-centre chocolates to soft, storm to sunshine, sour to sweet.' (1968:96).

And again Hind (1968) describes drinking in Glasgow as follows:

> 'There is always a cold deliberation in the Glasgow man's drunkenness as if the drink which makes the head spin and the stomach heave still leaves in them the sober certainty of the bitterness of life and the inexorable passage of time. So when they became gay at New Year it is always in a gauche left-handed sort of way which soon degenerates into viciousness and violence and a kind of bitter sentimentality.' (1968:44).

But these themes of fiction have also a grounding in fact. The class divide is clearly presented in

Glasser's (1987) autobiography: Growing up in the Gorbals. The other major aspect of cultural diversity in Glasgow relates to the religious divide between Protestant and Catholic to be found in the city. This divide has its roots in the 19th century migration streams from Ireland (Handley, 1943) and the highlands and in the earlier history of the West of Scotland. That such a divide persists can be seen from the work of Bruce (1985) and Walker and Gallacher (1991) on Protestant/ Catholic rivalry.

Alcohol and tobacco related disease is also high. Scottish mortality rates for coronary heart disease are 540 per 1,000 for men aged over forty, the highest rate for countries with developed economies. In second place is Finland followed by England and Wales (HMSO 1989). However, not only is Scotland's place highest in the world's ranking, but Glasgow's position within Scotland is particularly poor:

> 'For Glasgow City mortalities are considerably higher for each of these major causes of death (all cancer, heart disease, stroke) and for lung cancer mortality in men under the age of 65 years is a disconcerting 54% above the average for Scotland.' (Greater Glasgow Health Board 1989)

Knowledge of these aspects of the culture of Glasgow helped focus my research.

BACKGROUND TO THE STUDY

My previous experience in research had been in the fields of alcohol problems (Blaxter, Mullen and Dyer 1982) and social disadvantage (Illsley and Mullen 1991; Mullen 1986). I had also carried out a secondary analysis on religious differences in attitudes towards alcohol use (Mullen, Blaxter, and Dyer 1986). Such work led to my interest in explanations of the health differences found between social groups, and in particular how lay health beliefs might influence such differences. How were people's ideas about health formed? and how did ideas relate to social context and hence to health differences? This research background had also made me sensitive to the underlying social dimensions in the culture of Glasgow, dimensions which I knew were related to health. Further, I had conducted a study using the ethnographic interview method (Mullen 1985a; 1985b; Mullen 1987) and was aware of its strengths in revealing the depth of meaning in people's ideas. For these reasons I, therefore, decided to carry out a qualitative interview study of lay health beliefs in Glasgow.

THE RESEARCH QUESTIONS

These twin influences, of the research context and my previous research background, led me to ask particular research questions when I came to look at the lay health

beliefs of male Glaswegians. Some questions were related to the specific health problems of the people of the city. I believed it important to consider those health beliefs related to diseases contributing to high mortality rates in the U.K. in general and the West of Scotland in particular. This concern led to questions related to respondents' general ideas about health and health related behaviours, to their ideas about tobacco and alcohol use. First, what were the main features of their conceptualizations of health. Second, how did social context relate to alcohol and tobacco use. And third, how did they view their health related behaviours as influencing their health.

As a secondary theme I wished to consider questions related to social class and religion. As the salience of a social class and a religious divide in the culture of Glasgow clearly persists to the present day it was important to consider both these themes in the research. First, I wished to see if differences were to be found between social groups in their thinking about health issues. Second, I wished to see how respondents themselves thought how social class and religion influenced their health. Third, I wished to see how the various components of social class and religion could be seen in their ideas.

ORGANIZATION OF THE THESIS

The next chapter begins the serious consideration of

these issues with a review of the previous literature in the field. The qualitative literature on lay health beliefs is discussed under three headings: general health beliefs, beliefs about tobacco use, and attitudes towards alcohol use. Differences between social groups are then considered; with attention being paid to gender, social class and religious variations in beliefs. The final part of this chapter shows how the review of the relevant literature led to a refining of the research topic by identifying the key areas to be covered in the interviews. Various recurrent themes were identified in the literature, for example ideas of control of and responsibility for health, and taking account of these sharpened the focus of the research study.

Chapter 3 begins with a discussion of qualitative methodology. The interpretive tradition in sociology is contrasted with the positivist tradition. Distinctions are also drawn between the qualitative sociologists' notion of accounts and the positivist's conceptualization of attitudes. This chapter also includes a discussion of the sampling frame, questionnaire and schedule construction, and the style of ethnographic interviewing. The pilot study is discussed in terms of its implications for the revision of the interview schedule of the main study. The importance of the analysis of the pilot in the construction of initial coding frames for the main study

is also highlighted. The chapter concludes with a discussion of the method of the main study, the different screening sweeps and their response rates, and the characteristics of the main study sample.

The next seven chapters deal with the presentation of data and its analysis. This section is divided into two parts reflecting the initial problem areas which I wished to tackle. The first considers the research questions by health topic. It analyses general aspects of concepts of health, tobacco use, and alcohol use; and addresses itself to problems which come up under each of these separate headings. The second part, considers aspects of class and religion in relation to lay health accounts. As such it reconsiders issues which have been uncovered in the earlier chapters and looks across general ideas of health and health related behaviours, looking for unifying themes in the data.

Chapter 4 discusses respondents' general beliefs about health. Among the topics considered are negative definitions of health (health as lack of illness, health as characterised by infrequent visits to the doctor), ideas about the relationship between health and activity (it is shown how health was seen by respondents to be associated with levels of physical and mental activity or passivity) and ideas about diet. It also investigates whether such beliefs vary between social class and religious groups.

Chapter 5, the first on tobacco use, outlines the

reasons why people smoke and the perceived effects of smoking. It considers the links between smoking, relaxation, and stress, and the concept of addiction with regard to tobacco use. The importance of `natural breaks' (holidays, periods of sickness) for giving up smoking is highlighted. It also considers social class and religious differences between respondents.

Chapter 6 considers respondents' views on the changing social attitudes towards smoking and smokers. The chapter discusses smoking and youth, and the effects on smokers of advertising and taxation. It also shows the importance of round sharing in the social culture of smokers; how respondents were aware of such pressures to smoke and how they developed techniques to minimise such pressures and smoke at their own pace. Although use of such techniques was possible particularly in the work setting, they were seen to become in-operative in the context of the public house.

Chapter 7 turns to a consideration of alcohol use. The chapter discusses aspects of moderate and problem drinking and analyses respondents' stated reasons for drinking. It covers such topics as: alcohol and relaxation, and alcohol and sociability. It also includes a discussion of alcoholics, alcoholism and addiction, those groups seen to be particularly at risk, and changing perceptions of youth and women drinking. The concept of ambivalence is pervasive in the literature on attitudes towards alcohol use, and the

chapter draws out the complexity of interviewees' ideas of ambivalence. Ambivalence was found in interviewees' beliefs about women drinking, drunkenness, and the nature of personality change produced by the consumption of alcohol. Lack of ambivalence was, however, also discovered, particularly with regard to conceptualizations of alcoholism.

The next three chapters of the thesis consider aspects of social class and religion in the accounts of respondents. Chapter 8 looks at the occupational, and Chapter 9, the lifestyle elements of social class. Recent work on lay health beliefs has mainly viewed social class as a proxy for wider aspects of lifestyle and paid less attention to its occupational component. Chapter 7 shows that not only were respondents very aware of the influence their jobs had on their health but that they also took action to redress the balance, either by compensating for such effects or controlling their work environment to minimise their influence. Respondents' degree of commitment to their work also had a direct bearing on their coping styles. Although traditional occupational class measures were found to obscure much of how occupation influences health, unskilled and semi-skilled workers did suffer the greatest limitations in coping with the health effects of work.

Chapter 9 looks at various dimensions of marital status; being single was associated with freedom and

individual choice while being married brought constraints and responsibility. A moderate degree of restraint was seen to be beneficial for health. In general being married was found to be more protective for health than being single. Health damaging behaviours were minimised. The presence of children in a marriage was also believed to be beneficial for the psychological health of respondents. Marriage, then, was viewed as having protective functions which enhanced respondents' coping capacities.

Chapter 10 turns to a consideration of the religious and moral elements in the lay accounts of respondents. The chapter analyses the relationship between control and responsibility for health. Activist and fatalist dimensions were found in their thinking. However, activist thinking was seen to have three strands: personal activism, social activism, and religious activism. Further, fatalistic thinking was not about passive submission but rather the belief that control lay outwith the person in the realm of the social, natural or supernatural worlds. These findings demonstrate the subtle ways in which people relate to issues of control and responsibility in the health realm - a subtlety which is not fully brought out either in the theoretical or empirical work of social scientists researching in the health field.

The final chapter concludes by drawing together the common themes which have appeared in the course of the

analysis and brings out their health implications. It shows how health beliefs and behaviours are influenced by the social contexts of work, family, and leisure. It has been shown that the influence of social class and religion are complex issues that involve secondary links, for example occupation in the terms of class, and moral ideas in terms of religion. However, the method of analysis allowed for a more important theme to emerge from the interview data: this was the centrality of the dichotomy of control and release in the overall structure of the lay health beliefs of male Glaswegians. The current thesis demonstrates the difficulty Glaswegian men had in balancing both sides of the dichotomy and thus in maximising their chances of good health.

CHAPTER 2

LITERATURE REVIEW

INTRODUCTION

This thesis presents an in-depth analysis of the lay health beliefs of male Glaswegians in mid-life. Its focus is on how their ideas about health and illness are formed by the social context of their everyday lives. As stated in the introduction, because of the high incidence of tobacco and alcohol related disease in the West of Scotland (World Health Organisation 1989) particular attention is paid to respondents' accounts of smoking and drinking practices. The importance of both class and religion to the culture of Glasgow is reflected in the sample and will form secondary themes in the analysis.

These concerns overlap those of health education. The health education literature has also targeted areas which need specific attention. In Scotland these are coronary heart disease, cancer and the health related behaviours of alcohol and tobacco use (Scottish Office 1991). Much has been written about the need to adopt a healthy lifestyle approach if the nation's health is to be improved (Scottish Office 1991; Scottish Health Service Planning Council 1988); but before such an approach can be implemented it is important to know what the public's health beliefs are. Few studies have been carried out at a national level which have looked at

general health beliefs. A rare exception, but only for England and Wales, was Cox, Blaxter, and Buckle's, Health and Lifestyle Survey (1987). Rather more, of a survey nature, has been done on attitudes towards alcohol and tobacco use (Wilson 1980; Goddard and Ikin 1988; Dight 1976; Marsh and Matheson 1983) but again most have been conducted in England and Wales.

The review of the literature which follows is therefore designed to cover both these and the subsidiary themes. It begins with a review of studies of lay health beliefs, and, since the thesis reports the findings of a qualitative study, pays particular attention to those which used a qualitative methodology. Issues of gender, class and religion are then considered as is the relevant literature on alcohol and tobacco use. It concludes by drawing out the implications of this diverse literature for my own study.

QUALITATIVE STUDIES OF LAY HEALTH BELIEFS

The first point to be made is that the qualitative study of lay health beliefs (also included are those studies which have used an open-ended questionnaire approach) has not been given the same priority or attention as certain selected work in the health field, for example epidemiological work on disease, or studies of health professionals. Indeed it is only in the past 15 years that such studies have been carried out. For this reason studies are proportionately few in number and as

a consequence often have very different concerns and focus.

Concepts of Health

One of the most influential studies in this field was conducted in France by Herzlich (1973) on a group of 80 middle class subjects, 68 of whom lived in Paris the rest in Normandy. Herzlich analysed the meanings given by her subjects to health and illness in their accounts. Three dimensions were identified with regard to health and three to illness. The first of these she labelled `health in a vacuum': here health was defined by the absence of illness. The second `reserve of health' was about the person's capacity to maintain good health. This included ideas of physical strength, constitution and temperament, and natural resistance to illness. The third was health as 'equilibrium'. This was a positive rather than a negative definition of health and included feelings of relaxation, well-being and having socially satisfying relationships.

Her subjects also responded to illness in one of three ways. First, illness could be seen as an `occupation' where respondents spent their time attempting to fight and control their illness. Second, illness could be seen as a `destroyer'; here illness was viewed in a totally negative light and subjects could often respond by denial, refusing to accept or acknowledge the problem. Third illness could be seen as

a `liberator'; illness in its capacity to free people from their everyday responsibilities.

These conceptualisations were also related to both the stage and type of illness. `Illness as destroyer' occurred at the beginning, and `illness as occupation' at the end of an illness. Herzlich saw `illness as a liberator' as a response to benign, short and painless conditions.

This early French study by Herzlich has exerted a strong influence on British research on lay health beliefs (Williams 1981; Blaxter 1990; Calnan 1987). Williams (1981, 1983) in a qualitative study of 70 elderly Aberdonians uncovered two of the major dimensions of health described by Herzlich: `illness as a destroyer' and illness as `an occupation'. However Williams went further, and analysed the complex logical links which held between them. He saw each of these conceptualisations as a system of logical premises and consequences. He described how these were related to each other, and how they were reflected in respondents' statements about health and how they coped with illness. For example, he broke down Herzlich's category of 'illness as a destroyer' into three premises: one, if I am active, then I am not ill, two, if I am myself, then I am active, and three I have something to offer if, and only if, I am active. Williams then went on to draw out the logical consequences which followed if a person believed themselves to be ill, for example: that they

were not themselves and that they did not have something to offer. By such analysis he demonstrated the complexity of the logical threads running through lay health accounts.

Blaxter (1990) analysed open-ended responses from a national study of health and lifestyle. Ten categories of health were derived from people's own comments. These were: (1) negative answers, (2) health as not ill (3) health as a reserve (4) health as absence of disease/ health despite disease (5) health as behaviour, health as a 'healthy life' (6) health as physical fitness (7) health as energy, vitality (8) health as social relationships (9) health as function, and (10) health as psycho-social well-being. It can be noted that one of these conceptualizations of health, health as a reserve, bore a close relationship to that of Herzlich. We can also see that although (1) (2) and (3) are negative concepts of health and were found to be predominant, people also volunteered positive concepts of health. Often work on lay concepts has been criticised (RUHBC 1989) for uncovering largely negative concepts of health.

Blaxter argues that these ten concepts of health are a mixture of the bio-medical and the holistic. She also points to the strong distinction made by people between health as physical fitness and health as psychological fitness. There was also overlap between health concepts: for example both health as energy and

health as social relationships overlapped with the idea of health as function.

Causes of Illness

Studies of lay health beliefs have not only looked at general concepts of health but have also considered causation. Chrisman (1977) identified four theories of causality which could be found in people from different cultures. First invasion, by germs, cancer or something the person had eaten; second degeneration, being run-down; third mechanical causes, such as blockage of blood vessels and fourth, imbalance, for example not maintaining a proper diet or being out of harmony with the social environment.

Another, this time Scottish study by Blaxter (1983) looked at the health beliefs and attitudes of 46 middle-aged women. The women were all chosen from the working-class and from the same geographical area so that they were representative of the same sub-culture. A content analysis was carried out on the interview material to uncover the structure of their ideas about the causation of illness. Every mention of cause was recorded and categories of cause, derived from the interviewees talk, were ranked by frequency.

Infection was the most important category when the frequent mention of childhood diseases was included. Measles, mumps, whooping cough and chickenpox were seen as inevitable in the past, and with the possible

exception of whooping cough, not too troublesome now. Respondents used the terms germs and viruses when discussing infectious diseases. The term virus was seen to be the cause primarily of colds, influenza and throat complaints. Respondents felt they had some degree of control over germs but not viruses. Germs were also seen to penetrate certain organs of the body, particularly the stomach, the womb, the bladder and the kidneys. The idea that animals or humans were `carriers' of disease but were not themselves affected was also common. And infections were also associated with the environment because particular environments were seen to be conducive to the breeding of germs.

The second most `popular' category of cause, after infection, was heredity or family susceptibility. This category was given much more weight by respondents than medical science might give it, and was applied to a very wide category of disease. Blaxter states that the liking for hereditary or familial `weakness' as an explanation could easily be explained as a liking for continuity, of a firm long-term family identity. In some ways this might have made up for a lack of material prosperity. The emphasis on `family failings' was also seen by Blaxter as a way of expressing the inevitability of disease and a protection against the idea that illness might strike randomly. Again, the women in the sample were reluctant to place the `blame' for illness on their own behaviour or the failures of their bodies,

and so although the idea of illnesses running in families was a source of worry, it could also be comforting as individual responsibility was removed.

Stress and strain were the next most popular categories of cause. The women were very conscious of a mind/body link and they favoured ideas of `mind over matter' and psychological explanations of cause for blood pressure, bronchitis, stomach pain and ulcers. Stress was especially blamed for headaches and migraine and stress and overwork were commonly mentioned as the cause of heart disease. Causes of lesser importance were the results of trauma or of surgery; both appeared to be thought of as assaults upon the body.

So far we have looked at causes outwith the individual's control. Blaxter found there were only a small number of instances where women were willing to admit that disease was entirely self-inflicted:

> `Rushing around "might be the cause of blood pressure", several women described the cause of diabetes as overfondness for sugar, and a few said that not eating properly ("rushed meals, no vegetables") might result in stomach ulcers. Cold and chills were sometimes ascribed to foolish behaviour, not keeping babies warm enough, or not dressing sufficiently well against winter weather. Also, overweight was suggested by a few women as the cause of high blood pressure or heart attacks (but not many, for a

> high proportion were overweight themselves) and smoking was occasionally mentioned as a cause of bronchitis (but rarely, for almost all the women smoked)'. (Blaxter 1983:65).

Finally, although Blaxter was not surprised to find that cancer and tuberculosis were two of the diseases most frequently mentioned in her transcripts, they were spoken of without a discussion of cause. To name these diseases directly was also a taboo and instead the women used a wide variety of synonyms.

More recently Blaxter, in conjunction with Cox and Buckle (1987), in a study on health and lifestyle carried out on 9,000 people, found that one of the most common causes given for a wide variety of diseases was stress and worry. The influence of poor diet and eating habits was also highly ranked.

Pill and Stott (1982; 1985) also looked at working class mothers this time living in a suburban housing estate. These women, 41 in number, 30-35 years of age (slightly younger than those in Blaxter's research), had children and were primarily working. The major focus of the study was on the correlation between individual's views on the aetiology of illness and their ideas about individual responsibility for health.

The majority of women were seen to subscribe to the belief that germs were the main cause of illness. This was seen to be an 'amoral' theory, in that no-one had to feel responsible for the onset of illness. However,

Pill and Stott also noted that some respondents were prepared to consider that the individual might play some part in becoming sick and that such respondents held a different concept of resistance to illness. They saw people falling ill because they had become vulnerable as a result of their own actions and were more likely to view health as a dynamic relationship between the individual and their environment and therefore susceptible to a variety of influences, some of which were under individual control. These respondents tended to have had more formal education, to be buying their own homes, and to be working at the time of the interview when compared with the rest of the group.

Lay and Professional Models

Another main focus of this work, in addition to a concern with concepts of health and causality, has been on the relationship between lay and professional explanation of health and illness. Researchers have noted that although people often talk in the prevailing biomedical idiom their ideas go beyond issues with which medicine deals. Blaxter (1983) showed that even though her respondents used biomedical terms the logical framework of their ideas departed from that used in medicine. Cornwell (1984) also discussed the degree to which her subjects had become 'medicalized'. She made a distinction between 'public' and 'private' accounts of health and illness; public accounts being lay

interpretations of expert opinion while the private accounts were constructed from personal experience and were more complex and multi-causal in their structure.

Throughout his work Helman (1978; 1981; 1984; 1986) has shown how both lay and biomedical models influence each other. In a classic paper (Helman 1978) he analyses the ideas about colds and fevers held by patients in a London practice. He shows how their ideas rested on a fourfold classification of `hot', `cold', `wet' and `dry'. The terms hot and cold were not, however, related to medical ideas of body temperature, but to the experience of the patient. If the patient felt hot the illness would be called a fever and then classed as wet or dry depending on whether the symptoms included discharge from the nose and diarrhoea, or dry skin and non-productive cough. If the patient felt cold then this would be seen to be a cold or chill and classed as wet or dry again depending on the symptoms.

Patients explained colds and chills in terms of the penetration of the individual by the environment via damp, rain and cold winds. The individual was; however, seen to be responsible for having a cold, for example if he didn't protect himself adequately. Colds and chills were also not seen to be the doctor's responsibility to treat. Fevers, however, were viewed more seriously and were a matter for the doctor. The causal agents were seen to be `germs', `bugs' or `viruses', although again they were not defined by patients in any strict

biomedical sense. Germs and viruses were, however transmitted by people; the cause was social rather than environmental and the individual was thus not seen to be responsible for their illness.

Blaxter (1983, 1987), Cox, Blaxter, Buckle et al (1987), Cornwell (1984) and Helman (1986) have also noted intergenerational differences in lay conceptions of health and illness. Older people attached more significance to ideas about moral fibre compared with the young generation who gave germs, viruses and social stress greater importance. Pill and Stott's (1982) study reflects the same preoccupations of the younger age groups. Various theories have been given to explain these variations; Helman discusses the discovery of antibiotics and the establishment of the NHS, while both Blaxter and Cornwell talk of the effect of poverty in forming the attitudes of the older generation. Changes in professional practice over time may also leave their impact. Both Blaxter (1983) and Helman (1986) see the indiscriminate prescription of antibiotics for a wide range of conditions as adding to the confusion of patients in their ideas about health and illness.

Genesis of Lay Health Beliefs

Writers have also attempted to get beyond the debate about the relationship between lay and medical ideas about health and illness to investigate what aspects of the larger social world form these concepts. Those

writing about lay and professional ideas have themselves discussed this problem. Often lay ideas are seen as 'folk ideas' of 'folk theories' of health and illness. Helman (1984) looks to a bed-rock of 'folk wisdom' which he sees as continuing to be deeply grounded in our everyday understanding of the world. However, he also traces some of these ideas, for example aspects of humoural theory remaining in lay health beliefs, to their more respected historical forebears, the medical system set forth by Galen. Currer and Stacey (1986) have also postulated that some aspects of lay thinking may come from earlier formulations of biomedicine itself.

Writers have looked to the underlying mechanisms of capitalism to explain recurrent themes in lay health beliefs. Foucault focussed his attention on the turn of the 19th century which marked not only a particular stage in the development of capitalism, but also saw a parallel development of the new medical 'gaze', dissection of the body, and the final triumph of the biomedical approach. Kelman (1975) has linked the occurrence of functionalist ideas in lay health beliefs to the demands of the capitalist mode of production: the imperatives of the readiness to work and a stress on activism.

Crawford (1984), believes lay accounts can be explained by the contradictions of capitalism as they are experienced in the bodies and minds of individual

human beings. Health , like illness, is a concept grounded in the experiences and concerns of everyday life. His article discusses the opposition between two key themes in the accounts of his respondents; health as self-control and health as a release. Health as self-control was typified by ideas including self-discipline, self-denial, and will power. He shows how this rhetoric works with respect to the changing standards about smoking, diet and exercise which make the person feel unhealthy by the mere violation of one or more of these new taboos of the failure to do something active for ones health. In order to track down these notions of self-control Crawford discusses the role of the media in health promotion, disillusionment with the medical services, and the commercialisation of health and fitness.

He shows how self-control, self-discipline, self-denial and will-power are concepts that are fundamental to the Western system of values:

> 'It should not be surprising that "health", a concept that gives expression to our culture's notions of somatic, psychic, and social well-being, would provide the perfect metaphor for values that so fundamentally structure our social and cultural life.' (Crawford 1984:77).

But today there is a revival of concern for health promotion; how is this to be accounted for? The primary

arena for the disciplinary ethic has been work, and economic crisis has increased the priority given to discipline and control. As Crawford states:

> 'The cultural reaction to hard times can take many forms. I am suggesting here that one of them is a hardening of bodies' (Crawford 1984:79).

However logically entailed by this discourse of self-control is its opposite the discourse of release: pleasure seeking rather than ascetic self-denial, satisfaction of desire rather than repression of desire. In the release mode, the most important ingredient for health is the psychological capacity for 'not worrying'. Crawford states that although some respondents held to only one metaphor, many held both. A fetishism of self-control was common with people experiencing difficulty in finding release:

> 'Numerous psychological and physical therapies - Reichian, gestalt and several now called holistic - are largely aimed at helping the individual (of course, almost always middle class) achieve release from these embodied controls.' (Crawford 1984:89)

There has also been a public discourse of the importance for release in attaining health.

Release can be seen as a means by which societal

tensions can be managed. Crawford sees this ethos as being tied into the sphere of consumption. Control relates to production and discipline, while release relates to consumption and pleasure.

Although these contradictions in structure lead to conflict in experience, Crawford shows how the new health and fitness consciousness tries to combine these oppositions; how it tries to resolve the contradictions, for example by providing bars in health clubs. Crawford, therefore, sees health beliefs as being a reflection of the imperatives of capitalist society, that contemporary capitalism and perhaps all industrialized societies must now promote both mandates: that of control and release.

In sum, the qualitative literature on lay health beliefs has looked at the general structure of lay ideas, the causes of illness, their relation to biomedical thinking, and their genesis. I will now turn to what they tell us about issues of gender, class and religion.

GENDER, SOCIAL CLASS AND RELIGION

Gender

Again qualitative work has primarily addressed women's health beliefs (Blaxter 1983; Calnan and Johnson 1985; Pill and Stott 1982; Locker 1981; Crawford 1984). The typical reasoning for this bias can be seen in the work

of Locker (1981). Interested in aspects of symptom definition outwith a professional medical context he decided to look at the definition of illness in the context of the family. Ruling out participant observation and choosing in-depth interviewing as his method he decided to interview just women:

> 'I decided to use women as informants and interviewed the mother of the family since I assumed that she would be closely acquainted with the problems I wished to discuss and would be more likely than any other individual to be willing to spend time talking about them.' (Locker 1981:18)

In a footnote he adds:

> 'There is research evidence which suggests that women are the main source of care for the sick within the family.' (Locker 1981:24)

I do not wish to suggest that this is not the case, merely to show that such assumptions have tended to limit the amount of research which has been carried out on male health beliefs.

Calnan and Johnson (1985) also restricted their focus to the attitudes of women:

> 'First because they were used in earlier research, thus were available for purposes of comparison and, secondly, because they tend to be the lay carers in the family and bear the major responsibility for the families health' (Calnan and Johnson 1985: 57)

Similarly Blaxter and Paterson's (1982) study on generational effects on health attitudes and behaviours focussed on the women (grandmothers, mothers, and daughters) as the source of transmission of lay health beliefs within families.

Another reason which has often been given for the lack of focus on men has been the assumption that men are less likely to discuss ideas about health. Stacey (1988:148) pointed out that Crawford and Cornwell both had trouble in getting men to talk about health. This may also help to explain the bias (for example Williams 1981) of using predominantly women's accounts even in research which has interviewed both men and women.

But what do those qualitative studies which have looked at both men and women's concepts of health tell us about gender differences? Often the issue is not discussed as a major topic and thus the similarities between their thinking is implied. Some findings, however, are given in the literature. Blaxter (Blaxter 1987; Cox, Blaxter and Buckle 1987:131) analysing open-ended questionnaire data stated that men were more likely than women to give exercise as a source of

health; and the notion of health as positive fitness was found more often among men. Health as energy and vitality was associated by men with work. Cornwell (1984) has also related such differences to the sexual divisions of labour which operate both inside and outside the home:

> 'For the men, therefore, the important question was whether or not they felt able to continue to go to work, and as long as they were able to, they did what they called "working it off". At home, however, they had no qualms about expecting their wives to be sympathetic whilst they " gave in" to even fairly mild symptoms.' (Cornwell 1984:139)

And again Blaxter (1990) has shown that women were more likely to define health by participation in social relationships.

Social Class

Turning from gender differences in lay health accounts, have we any evidence to support the hypothesis that lay beliefs may differ between the social classes? One problem we face is that most studies, for example the work of Blaxter (1983), and Pill and Stott (1982, 1985), have all looked at the beliefs of working class respondents (although Pill and Stott did look at differences by housing tenure and education). These

studies (Blaxter 1983; Pill and Stott 1982; Calnan and Johnson 1985) show similarity in working class ideas (Stainton Rogers 1991); respondents demonstrate stoicism and low expectations while at the same time deny individual responsibility and culpability.

But are such ideas limited to the thinking of people from working class backgrounds? The picture is complex. Certain ideas have been found to be held in common by different social and cultural groups as can be witnessed by the parallel findings of Williams from British and Herzlich from French respondents. However, Currer and Stacey (1986:14) have, by contrast, emphasised the differences between these studies. They believe the concept of 'health as a balance' as 'a state of equilibrium' is much stronger in France than in Scotland. Pollock (1984) also uncovered the three concepts of illness used by Herzlich in her Nottingham study. However, as Currer and Stacey (1986:24) point out, the concept of health as an occupation was most dominant. They relate this to differences in the strength of the Protestant work ethic: strong in Scotland and England but weaker in France.

One piece of research which did consider the health beliefs of different social classes in the same study was that of Calnan and Johnson (1985). They interviewed 54 women from social classes I and II and 38 women from social classes IV and V. Their study looked at two areas: concepts of health and perceptions of

vulnerability to disease. These two topics were chosen because of the many hypotheses put forward by researchers, linking them to health behaviours.

In terms of concepts of health, their findings were that no social class differences in ideas were evident although the upper classes gave a greater number of responses to questions. But this finding may be linked to the greater linguistic fluency of middle class respondents. However, they did discover some sign of social class differences when concepts of health were defined in the abstract.

With regard to the questions covering respondents' perceptions of vulnerability to illness they found that the term itself was problematic, incorporating a wide range of beliefs and feelings. On closer analysis, however, they did find slight differences between classes. Professional women tended to feel more vulnerable to disease than their working-class counterparts. Although hereditary explanations of vulnerability were used by both classes, professional women tended to emphasise previous or present experience of signs and symptoms while working class women often mentioned behavioural explanations. Both in terms of concepts of health and perceptions of vulnerability to disease, therefore, Calnan and Johnson found small differences between the classes studied.

The results from Calnan and Johnson's study may seem inconclusive though this may easily be accounted

for by the fact that they lapsed into a sort of numeric analysis rather than pursuing the necessary rigour demanded by the qualitative method. Another piece of research by d'Houtaud and Field (1984) also took a numeric approach to the analysis of qualitative data but this time with a much larger sample. Four thousand subjects from Lorraine in the north-east of France, who were undergoing a health examination, were asked to respond to an open-ended question on what health meant for them. Their replies were analysed and 10 definitions of health were discovered.

Managerial and professional groups mainly endorsed the first four of these definitions, which were (1) a hedonistic way of life (characterised by having no restraints, getting benefit from life, not thinking about illness, and seeing the doctor as little as possible), (2) equilibrium (of body, mind, and family), (3) reference to the body (that it should be good, or one shouldn't feel it) and (4) vitality (that a person could face problems, be optimistic, and not be afraid of the future).

This last definition of health, vitality, was also shared by other non-manual workers who also held three other definitions: (5) psychological well-being (joy of living, happiness), (6) hygiene (which included notions of regularity, sobriety, avoidance of excess, and exercise), and (7) health by its own value (that health was the greatest of riches).

The categories of psychological well-being and hygiene were also shared by manual workers, who in turn also held three final definitions of health: (8) prevention (having regular medical examinations, to live as long as possible), (9) physical attributes (to be in good form to be able to work), and (10) defining health negatively (not being ill).

D'Houtaud and Field's general findings were that manual workers tended to define health in terms of services, and in ways that tended to stress the collective and social aspects of health. Non-manual workers by contrast focussed on enjoyment and emphasised individual and personal aspects. As we ascend the social scale concern shifts from absence of sickness, psychological well-being, to a hedonistic way of life.

The study of Blaxter, Cox and Buckle (1987) on health and lifestyle also considered social class differences and was based on a large sample. They found that the notion of health as positive fitness was found more among the better educated and that the higher classes felt they had more control over their health than those in the lower. However, in recent work Blaxter (1990) is more cautious when drawing conclusions. Although in her earlier study with Paterson (Blaxter and Paterson 1982) she had found the concept of 'health as not ill' to be associated with the poorer groups, in the larger study (Blaxter 1990) this category was also found to be prevalent among the upper

income bracket. So differences between the social classes in terms of lay health beliefs do exist, although they may be hard to uncover in small-scale qualitative research.

Religion and Moral Issues

There has been a recent tendency for medical sociology to ignore the possible influence that religion may have on health. For example, religion as a social variable is now no longer routinely collected in large scale social surveys dealing with health or mortality. As Vaux stated with reference to America:

> 'The U.S. Public Health Service, in its extensive and comprehensive analysis of health in its etiological and epidemiological dimensions, has chosen to systematically ignore the variable religion'(Vaux 1976:524).

Such an attitude has been justified by recourse to arguments about the secularisation of society and in particular to the decline in the membership of the traditional churches.

As recent reviews of the field (Levin and Vanderpool 1987; Levin and Schiller 1987; Jarvis and Northcott 1987; Vaux 1984; Mullen 1990a) have shown, however, the question as to whether and how religion effects health is an important one. Quantitative studies which have looked at mortality have tended to

concentrate on deaths from a specific cause. One which by contrast looked across disease categories was that of Comstock and Partridge (1972). Comstock and Partridge's work analysed deaths from selected causes on a Washington County Census population in Maryland, U.S.A. As most of the population were Protestant they did not consider denominational differences but were primarily concerned with variations by church attendance.

The authors found tuberculosis death rates to be correlated with low church attendance. Maternal church attendance was associated with lowered neonatal mortality. They also found a relationship between church attendance and arteriosclerotic heart disease. As they said:

> 'Even after allowing for the effects of smoking, socio-economic status and water hardness, the risk (of arteriosclerotic heart disease) for the frequent church attenders was only 60 per cent of that for men who attended infrequently.' (Comstock and Partridge 1972:669)

Death rates from emphysema, cirrhosis and suicide were also appreciably higher among infrequent church attenders.

Most studies, however, have not looked at either mortality from various causes or all cause mortality, but have instead looked at mortality related to specific diseases. In particular those deaths produced by

cardio-vascular problems (Friedlander, Kark, and Stein, 1986; Snyder, Goldbourt, Medalie et al. 1978; Friedlander, Kark, Kaufmann et al. 1985; Comstock and Partridge 1972; Wynder et al. 1959; Rouse, Armstrong and Beilin 1981) and cancers (Gardner and Lyon 1982; Wynder et al. 1959; Seidman 1966).

These studies on deaths caused by heart disease and cancer have often reached the same conclusions, namely that the lowered death rates from these diseases are the result of the particular proscriptive behavioural injunctions of the religious groups involved. Although contraceptive, moral, and dietary practices have been mentioned, most writers have highlighted the lowered tobacco and alcohol consumption by these religious groups. As Lyon et al. stated:

> 'The favourable cardio-vascular mortality in Utah is primarily due to the more favourable experience for IHD enjoyed by the Mormon portion of the population and is partly explained by lower consumption of cigarettes.' (Lyon et al. 1978:365)

If we leave aside mortality and health related behaviours and turn our attention to morbidity we find that little has been written about physical morbidity independently of work related to heart disease and cancer. Numerous studies have however been carried out on psychological morbidity (Roberts 1965; Spencer 1975;

Murphy and Vega 1982; Hadaway 1978; Wilson 1969). Two major hypotheses are prominent in this research literature: first, that intense religiosity is a symptom-complex indicative of psychiatric disorder and second, that religion is a resource for the psychological well-being of the individual.

All the above studies have used a quantitative methodology; qualitative studies in the field are rare. One exception has been the work of Williams (1990). In his research he looked not only at official religion, as indicated by Church affiliation, but also considered what has been called 'invisible' or 'customary' religion, which in the case of his elderly respondents from Aberdeen took the form of generalised world conceptions which nevertheless drew on the themes of historical Protestantism. He found that religion both in its affiliated and customary form increased the coping repertoire of respondents when they were dealing with irreducible illness and dying. And in fact these forms of religious belief based on faith gave respondents the greatest range in abilities to cope. By contrast, those based on self-image, which approved of being healthy, active, determined and hard-working, were seen to be inflexible ideals when respondents were faced with chronic illness and the possibility of approaching death.

An important and related concept which has received more attention from sociologists is that of moral

concerns in health. As stated in Changing the Public Health:

> 'Perhaps the most recurrent theme of all emerging from the study of lay concepts is that of health and illness as moral constructs. Responsibility, blame, guilt, hypochondria and stoicism are just a few of the morally evaluative terms used by respondents when considering these matters.' (RUHBC 1989:43-44)

And as Blaxter (1990) states:

> 'It has also been noted that in the modern world, health still has a moral dimension. Ill-health and moral wrongdoing can be connected, as much among industrialized and urban populations as among primitive societies: one has a duty to be healthy, and unhealthyness implies an element of failure. Health can be seen in terms of will-power, self-discipline and self-control.' (Blaxter 1990:14).

Cornwell (Stainton Rogers 1991:79) also believes there are differences between 'public' and 'private' accounts in their moral components. In public accounts her respondents were less likely to accept blame for illness. However, Currer and Stacey (1986:15) have stated that the moral tone of concepts is often greatest

where access to medical facilities is limited. But when access to medical facilities is open moral injunctions tend to refer to the medical professionals, and Britain is viewed as open by comparison to the U.S.

HEALTH RELATED BEHAVIOURS

Qualitative Studies Of Alcohol Use

In all the qualitative literature on lay health beliefs discussion of the health related behaviours of alcohol and tobacco use tends to be minimal. Yet alcohol and tobacco use are central features of the social life of men and have a direct influence on their health. If we wish to discover what has been written about this topic of a qualitative nature we have to turn to the literature on either alcohol or tobacco use. Each topic has to be treated individually, as although both can be considered potentially addictive behaviours, and although there have been calls to research both together (Sobell, Sobell, Kozlowski, Toneatto 1990), in general research has been conducted in hermetically sealed compartments.

The amount of research which has been carried out on attitudes towards alcohol use and abuse is vast (see Crawford 1987). A lot of the work is also inter-disciplinary in nature covering the fields of sociology, social psychology and anthropology. Robinson (1976) acknowledging the difficulty of reviewing all the

literature on the topic classified the specifically sociological literature, although some of these studies could also be seen as coming within the tradition of social anthropology. He grouped studies into three main types: the societal-cultural, the aetiological-pathological, and the ethnographic-processual.

Societal - cultural studies are concerned with very broad questions about `the place of alcohol in society' and with postulating hypotheses about a whole culture of society. Aetiological-pathological studies focus directly on the question `why do some people use alcohol in a way which they, or other people, consider harmful'? And what are the causes of pathological drinking? Ethnographic-processual studies have been on both drinking and alcoholism but have focussed: `on particular drinking places, on particular groups of drinkers or alcoholics and on particular helping agencies'.

Stivers (1976) in his review on culture and alcoholism grouped studies by whether they focussed on alienation and anomie (or rather their alcohol research equivalents lack of control and strain), were cross-cultural studies of drinking, considered cultural attitudes towards alcohol and drinking, or focussed on modern culture and alcoholism.

The concerns of the present thesis come largely within Stivers' category of investigations into cultural attitudes towards alcohol and drinking; although the

work relates to Robinson's ethnographic-processual category the primary concern is with normal rather than problem groups of the population. It should be noted that it is mainly literature from an anthropological background which has been concerned with normal as opposed to pathological drinking (Douglas 1987). Although this literature has tended to look at the culture of a whole group rather than at the ideas of specific sub-groups its conclusions are important.

Pittman (1967) produced a four category typology of drinking cultures: abstinent, ambivalent, permissive and over-permissive. The drinking of most Western societies were typified by ambivalent attitudes. Pittman describes America in the following terms:

> 'The American cultural attitudes towards drinking are far from being uniform and "social ambivalence" is re-inforced by the conflict between drinking and abstinent sentiments co-existing in many communities.' (Pittman 1967:8).

Little work has been done of a qualitative nature specifically on Scottish drinking culture. Most has been of the form of social epidemiology (Plant and Plant 1986; Pattison 1983). However, Plant and Plant (1986) have stated that Scotland has been regarded as having a highly ambivalent culture in relation to the use and misuse of alcohol. And survey data from Dight (1976) found that subjects tended to agree both with 'pro' and

'anti' drinking statements, showing that positive and negative attitudes towards drinking coexisted within the same person. A greater degree of ambivalence was discovered among men.

More anthropological work has been conducted on Irish rather than Scottish drinking beliefs and practices (O'Connor 1978; O'Carroll 1979; Bales 1962), and this literature informs the present study as a high proportion of the Catholics in my sample were likely to have been the descendants of Irish migrants. Bales (1962), in one of the major works in the field on the drinking practices of the native Irish, contrasted the drinking of the Irish with that of the Jews. For Bales the Irish are involved in 'convivial drinking' as opposed to the 'ritual drinking' of the Jews. For the Irish drinking was seen to express solidarity with certain groups in the social system. These groups could be friends, kinship groups, those of age, from town or country. To abstain from drinking was thus seen as undermining such solidarity. Bales also discussed 'utilitarian drinking' on the part of the Irish: the use of intoxication to gain personal advantage over another group or person.

However, though Bales did not relate Irish drinking to ritual drinking, O'Carroll (1979) has hypothesised a close link between Catholic culture and drinking behaviour. Irish Catholic drinking practices and problems were seen to relate to a relatively tolerant

normative religious structure which initiates a routinised cycle of rebellion (abusive drinking) and reinstatement (confession, forgiveness and reincorporation into group life) that is easily transferable from religious to secular domains.

Pittman (1962:155) has also pointed out the difficulty of extrapolating attitudes of the Irish in Ireland to the situation of the migrant. O'Connor's first impressions of the historical experience of the Irish and the English was that their ideas about the use of alcohol were similar, although she maintains (O'Connor 1978:148) that the religiously orientated temperance movement in Ireland was one of the key factors in instilling ambivalent attitudes in the present day Irish. She found higher degrees of abstainers among Irish youth than among the English. The Irish viewed drinking as a problematic area, while considering it to be a social act. O'Connor also found the heaviest drinking to occur among the Anglo-Irish. She suggested that the Anglo-Irish drank heavily because they were placed in a dual and ambiguous situation.

We can thus see common themes in the literature on Scottish and Irish drinking: the social nature of drinking and its integration into all aspects of life, and coupled with this the deeply ambivalent culture surrounding drinking practices. In Glasgow a mix both of Scots and the descendants of Irish migrants is found; and the detrimental influences of migration on health

may present the descendants of the Irish with extra problems. The west coast of Scotland has also a strong history of temperance (Mullen 1989) and again this may be expected to increase the strength of an ambivalent culture surrounding the meaning of alcohol use.

Qualitative Studies Of Tobacco Use

There has been no work on the cultural meaning and place of tobacco use of the type discussed above on alcohol. There have been no British anthropological studies and Stimson (S.S.R.C. 1982) in a review of the addiction field found: 'no distinctly sociological work on tobacco use'. Studies have been of a non-qualitative nature often involving a multi-disciplinary approach which has been characterised as 'sociological epidemiology' (S.S.R.C. 1982). This research on tobacco use has mainly focussed on reasons for starting, why continued and why abandoned. Indeed there has been a strong concern with the link between attitudes and behaviour. This has led to recent studies concentrating on the efficacy of specific behavioural models, for example that of Fishbein and Ajen, to predict discontinuation of the smoking habit (Marsh and Matheson 1983). Although to date cultural belief systems have been ignored, they have increasingly been seen as an important areas for future research (Merriman 1978). The importance of monitoring changes in the ideas of sub-groups of the population has also been recognised.

An exception to the above style of research, however, has been the work of Graham (1984; 1987) who looked at the influence of social context in the smoking patterns of women. She found that smoking was a way of coping with caring for children when mothers were also suffering from economic deprivation. She thus highlighted the paradoxical nature of smoking for these women, as it promoted their sense of well-being while undermining their physical health.

CONCLUSION

We have seen that the literature on lay health beliefs is limited in terms of the numbers of studies which have been carried out. Studies have also tended to have different concerns making comparability difficult. However, common themes have emerged. Studies have focussed on the structure of health concepts, notions of causality, the relationship between lay and biomedical ideas, and to a lesser extent the genesis of such beliefs. We have seen how lay health beliefs have their own complex logic; a logic which derives from and has influence upon a person's everyday social context. Lay health beliefs have also been shown to have a strong moral dimension.

Lay health beliefs have similarities to, but depart from biomedical ideas. This has led researchers to hypothesize the possible link between the two, or to look beyond the strictly biomedical (to the underlying

features of capitalism or to the persistence of aspects of 'folk culture') to explain continuity in lay accounts.

However, although work on lay health beliefs has made great advances in the fifteen years since qualitative studies have been consistently produced, there is still dispute and uncertainty as to how much variation exists between social groups. Findings on social class differences have tended to be suggestive rather than definitive; and work on male health beliefs is rare. Again, although the moral tone of much lay accounts of health has been noted this has scarcely been developed at any great length and rarely related to religious themes.

In this literature, although the specific health related behaviours of alcohol and tobacco use have been touched upon, it is rare for writers, with the exception of Graham (1984, 1987), to give them centre stage. This need not be surprising if we consider the predominant bias towards women's health beliefs. Again although there is a voluminous literature on both alcohol and tobacco use, this is both compartmentalised, takes the form of social survey research and cannot tell us much about the influence of social context on such behaviours. This fact has been recognised as calls continue to be made (RUHBC 1989) for more work of a qualitative nature to fully elucidate the complex links between health beliefs and behaviours.

CHAPTER 3

METHOD AND SAMPLE

INTRODUCTION

The data for this study was collected using a qualitative interview method. I decided to use such a methodology because it could address the complexity of how the social context of individuals' lives would influence their health beliefs. I had previously undertaken a qualitative interview study and was thus aware of its advantages over the quantitative approach for the individual researcher working on their own (Mullen 1985a; 1985b; 1987a).

This chapter describes the method which was used to carry out the research. It presents the aims and focus of the study and discusses theoretical issues which have been raised in connection with the use of the qualitative interview method and their implications for the present research. It then outlines the practical difficulties which I encountered during my fieldwork and how these were addressed and overcome.

AIM AND FOCUS OF THE STUDY

This thesis analyses the lay health accounts of male Glaswegians in mid-life; and, as stated in the introduction their ideas of smoking and drinking are given a high salience. The interviews covered three themes: general attitudes towards health, attitudes

about smoking, and ideas about drinking. The major topics for investigation within each of these areas were developed from the review of the literature. The health section investigated respondents' general attitudes towards health, the good and bad effects of lifestyle, ideas about stress, and their perceived relationship between psychological and physical health; the section on smoking considered the degree of dependence on tobacco, stopping and starting smoking, public policy towards smoking, and the health effects of smoking; and the section on drinking covered ideas about drinking, drunkenness, alcoholism, and social policy towards alcohol use.

Although the main topics for research were developed from the previous literature, the aim was to cover these issues in greater depth than could be done by means of a standardised questionnaire. The aim was also to investigate themes which linked all three topics, to be able to discover unified styles of attitudinal approaches across areas: for example, ideas about control over, and responsibility for, health related behaviours. The purpose was to uncover how an individuals' way of life moulded their perceptions, and the way in which they made sense of the world.

A Study of Men's Beliefs

The thesis only studies men's beliefs; women were not included in the research design for various reasons. As

has been shown in the literature review, at the time of field work research on lay health beliefs had mainly been carried out on women. Researchers also thought that any work on men would encounter difficulties in getting them to speak openly about their ideas about health. Part of the reason for carrying out the present study was to both redress the research bias and test the assumption about the inarticulacy of men on matters of health..

Other reasons were of a practical nature and related to the feasibility of carrying out research on both men and women. A major focus was on social class and religion, to have interviewed both men and women, and to have made gender differences a topic for research would have necessitated carrying out a greater number of interviews. This would have posed problems both for the feasibility of carrying out such a number of interviews singlehandedly and in the qualitative analysis of such an amount of data. It is also known that women's ideas about tobacco and alcohol use are different from those of men; this would have posed difficulties in the preparation of the interview schedule and also for comparing the beliefs of men and women at the end of the period of study.

THE INTERVIEW METHOD: THEORETICAL ISSUES

Interpretive Methodology

The thesis is a work of qualitative sociology and it is therefore important to be clear about certain differences between the positivist and interpretive traditions within sociology and social psychology in their conceptualisation of attitudes (Schwartz and Jacobs 1979, Benson and Hughes 1983).

Thurstone, quoted in Summers (1977), defined attitudes as:

> `the sum total of a man's inclinations and feelings, prejudices and bias, preconceived notions, ideas, fears, threats and convictions about any specific topic'. (Summers 1977: 2).

For the positivist, such attitudes are deep within the individual's mind and can not be measured directly. We can, however, get a hint of these underlying attitudes from the opinions a person has about a topic. Attitudes are therefore measured indirectly utilizing opinions. In the course of an interview it is the respondent's opinions which are elicited by structured questioning and these opinions are measured and act as indicators of the underlying attitudes which the person may hold. For the positivist the underlying reality, the facts, are hidden. These are measured indirectly and measuring instruments (for example questionnaires) need to be

clearly structured and formalised in order to obtain as true a rendering of reality as possible.

For the qualitative sociologist however, utilizing an interpretive framework, the aim is not to get the respondent to proffer rigid opinions which can be measured and then taken to be indicators of deeper hidden attitudes, the aim is to have the respondent express their feelings about a topic as fully as possible. The person is encouraged to give as many ideas on the topic as possible until s/he has exhausted what s/he has to say on the issue. Such statements are taken as accounts, given by the respondent to the interviewer about a specific topic (Schwartz and Jacobs 1979; Cicourel 1964; Scott and Lyman 1968). An account is any manner in which a respondent: `describes, analyses, questions, criticizes, believes, doubts, idealizes, or schematizes' a subject (Bittner 1973: 115). And such accounts are tied to the social settings which occasion them, in this case the interview. Similar accounts may be given by other members of society, some accounts by everyone, others primarily by certain social or cultural groups. Accounts may be true or false, on the level of common-sense or scientific knowledge, or may reflect stereo-types. What is important is to obtain as full a range of accounts on a particular issue as possible. Accounts are not indicators of attitudes which are somehow hidden deep within the person. Rather, each account maps out the

common stock of knowledge held by individuals in society on a particular topic (Schutz and Luckmann 1974:109). It is with such accounts that this thesis is concerned.

The Status of Interview Data

However there are problems; sociologists using qualitative methods have also argued about the status of interview data. They have taken different positions on the nature of interview data, how it relates to reality, and its adequacy. Silverman (1985) has discussed the central division between data obtained in natural and artificially occurring settings. Silverman shows how there has been a tendency in qualitative sociology to believe that data collected in a naturally occurring setting, for example via participant observation or through the recording by video or tape recorder, of naturally occurring interaction or talk is somehow more pure than that collected by the process of interview, even though the interview was of a semi-structured form. Data from a natural setting is seen to be more reliable and valid and closer to a factual representation of social reality. The criticism of interview data has been that it is a poor proxy for the real social reality. As Benson and Hughes (1983: 82) state:

> `The descriptions it generates, though they may be rational and scientific according to the cannons of scientific investigation presents a distorted or at least inadequate depiction of the description social actors use in the course of their daily lives` (Benson and Hughes 1983:82).

The historical trend in qualitative sociology has also been a move away from the collection of data in an artificial context to the collection of data in natural settings. Part of this criticism of data collected in formal interview settings resulted from an attack on the methods of quantitative interviewing; strong objections to the quantitative interview method resulted in new approaches being taken by sociologists. Two directions were taken by sociologists who accepted these criticisms. First, some stressed the importance of participant observation rather than the interview method. Second, the focus on talk was still seen as important but the recording of talk by the formal interview method was rejected. As the present study is concerned with the nature of talk the second development will be considered.

The second direction can be witnessed in the historical development of ethnomethodology where the move was to consider naturally occurring talk rather than conversation collected in the formal interview (see Sacks 1966). As ethnomethodology developed into the work of conversational analysis (CA) there was an

increased emphasis on the recording of naturally occurring talk and a deepening distrust of data obtained by the interview method. Indeed the development of such work has also moved in the direction of a narrowing focus on the form of conversational data, for example turn taking, rather than on a concern with content. However, as Silverman shows the obsession with collecting naturally occurring data may hide a lapse back into positivistic styles of thought with its concerns for objectively detailing social facts. This concern with the `facts and nothing but the facts' gives a spurious sense of objectivity, as the work of conversation analysis still involves decisions on the part of the analyst as to when to classify data in a particular way. Hammersley and Atkinson (1983) have also pointed out this positivistic trap, the idea that best kind of data are `"untouched by human hands" neutral, unbiased and representative', here naturalists are seen to be inheritors of the positivist programme.

Linked to this difference of opinion about natural versus artificial settings is the question as to how far the interview context and the interviewer's questions influence and form the replies of respondents. Again sociologists have taken different stances on this question, it has often been framed as an internal/external problem. Does interview data tell us anything about the wider social reality beyond the limited context of the interviews? For some

ethnomethodologists one cannot infer anything of the wider social reality from such data but the data itself is limited and mutually constructed by the interviewer and his respondent - that `talk is constitutive of the settings in which it takes place' (Benson and Hughes 1983).

But how closely is interview data linked to the social interaction between interviewer and respondent? When Garfinkel (1967) talks of biographical details seemingly uncovered by the interview he maintains that there is no such thing as a biography for all purposes but that biographical details were `worked up' as a practical accomplishment during the interview. Other writers have discussed the problem of the interviewer and respondent creating the recorded belief <u>in situ</u>: that the respondents may never have thought about, or have no opinions on, a particular topic but that in reply to the prompts of the interviewer and the social pressure to respond they give an opinion on the topic at that particular point in time.

These ideas about the nature of the interview have at their extreme a tendency to move away from a focus on the content of interview data to a consideration of its form. As Benson and Hughes state when discussing the work of Sacks:

> `instead of treating such talk as being other than itself, it should be taken as an object for description and analysis' (Benson and Hughes 1983:155).

Other sociologists, while still believing that interview data does not inform us about social behaviour outwith the interview context, have a greater concern with the meaning of such data, with content rather than form. From the perspective of phenomonology, language is a repository of cultural stocks of knowledge of the social world (Schutz and Luckmann 1974), and it is these stocks of knowledge which the ethnographic interview seeks to uncover. However, interactionism saw a problem in the degree of intersubjective depth needed so that mutual understanding could be achieved. Problems of openness and concealment were discussed and there was the notion of breaking through barriers to reach the underlying reality or truth. Accounts were often seen to be false accounts and the focus shifted to accounting practices.

But how justified is this concern with truth and falsity? One can, rather, view the interview as displaying different levels of reality. Manning (1967), and Brenner (1978) for example, talk in terms of multiple realities. And Askham (1981) talks of the layers of meaning which are recognisable in interview data, believing not that some answers are less true than others but that all may be true within a particular

context of meaning (Askham 1981:86). Cornwell (1984) also discussed layers of meaning in her distinction between public and private accounts.

So different layers of meaning may be displayed in the interview, but how do these relate to the wider social reality? These points touch on the thorny question of the relationship between people's beliefs and their behaviours. In the current research the primary concern is to give an account of people's beliefs. The study is not of behaviour but of people's perceptions of behaviour. Following Bhasker (1979) and Silverman (1985) I believe the correct position to take is that of being consistently realist:

> `This means that interview data display cultural realities which are neither biased nor accurate, but simply "real". Interview data from this point of view, are not "one side of the picture" to be balanced by observations of what respondents actually do or to be compared to what their role partners say. Instead, realism implies that such data reproduce and rearticulate cultural particulars grounded in given patterns of social organisation'. (Silverman 1985:157)

Other problems closely related to the status of ethnographic interview data are the issues of validity and reliability; and various solutions have been given to these problems for interviews which are part of

survey research. These mainly relate to processes of standardization both of aspects of the interview setting and also of the interview schedule. Once again such techniques can be seen to lead back to concerns of positivistic research: a concern to correctly measure the social world. In qualitative interviews problems of validity and reliability can be handled in a different fashion. Validity does not rest with a narrowing and standardization of responses but with the assurance that the range of possible topics in the cultural stock of knowledge is covered and that these are also covered in great depth. The researcher should display 'the cognitive universe' in respondents' thought (Silverman 1985:173). From the point of view of interpretive sociology the main way to ensure validity and reliability is to maintain rigour both in the data collection and analysis, but particularly in the analysis of data.

The Ethnographic Interview and Triangulation

The data for the present study was collected using one research method, that of the ethnographic interview. The use of only one research method in qualitative research has been criticised (Denzin 1970; Becker and Geer 1970). Researchers often recommend the method of triangulation where different qualitative methods, for example participant observation and in-depth interviewing, are seen to complement each other in

uncovering the reality of the topic being researched. The assumption behind triangulation is that any one method is not seen to be adequate to fully grasp the reality of the subject being researched. However, do the results from different methods neatly build on one another to produce a more complete picture? I would argue that each method discovers its own reality about the topic and that although each reality can inform the others and may be complementary they are not additive.

Again triangulation is often presented as a defence against criticisms levelled at qualitative methods. Here the strengths of triangulation are given that one method can be used to check and show the validity of ideas being generated by the other method. Triangulation is presented as a check on validity and reliability. However, if each qualitative method discovers its own social reality the use of triangulation for establishing validity and reliability is weakened.

These concerns are to be found in the use of quantitative methodologies and I would suggest that some of their justification in the qualitative field is the result of defensiveness on the part of qualitative sociologists rather than that there is a fundamental problem of only using one qualitative method for a piece of research. The ethnographic interview methods then is sufficient in itself for uncovering one type of social reality. I will now turn from a discussion of

theoretical issues to a consideration of their practical consequences for the study.

THE INTERVIEW SCHEDULE, SAMPLING FRAME AND SCREENING QUESTIONNAIRE

The Interview Schedule

The main themes and topics which I wished to explore, and how they resulted from my previous research have been detailed in the introduction. The review of the literature also made me aware of the more specific issues in the field. From this dual background, of my own previous research and my reading of the research literature, I constructed the interview schedule. Although, as will be seen below, the schedule was modified as a result of the pilot study, I will here outline the major features of its final form as used in the main study. Its full form is given in the appendix.

The interview schedule had five substantive sections: on respondents' attitudes towards health, their views of tobacco and alcohol use and their beliefs about the influence of social class and religion on these ideas. In each of these sections general topics were approached by direct questioning and a series of prompts was then used to explore the respondents' thinking on these issues. As not all of my respondents would drink or smoke, supplementary questions were included for non-drinkers and non-smokers covering the same, or similar topics: for example legislation, cure,

and the dangers to health with regard to various behaviours.

Topics covered in the health section were the respondents' health status, their concepts of health, lifestyle and life satisfaction, ideas about improving and maintaining health and the impact of stresss and how this was handled. Questions on tobacco use covered consumption, starting, maintenance and giving up smoking, their attitude towards health policy against smoking, and respondents' ideas about the relationship of smoking to health and passive smoking. The section on alcohol use again looked at consumption, problem drinking, the effects of alcohol, its social uses, and their ideas about drunkenness and social problems.

Although in the typed schedule questions and prompts are presented in sections, in interview the issues related to each section were not treated in a hermetically sealed fashion. For example if in the flow of conversation a respondent introduced tobacco use when being asked about health then this issue would be explored in this context. In the ethnographic interview method (Schwartz and Jacobs 1979) a strict order of questioning is not followed, thus if a respondent starts to spontaneously talk about one of the topics which occur later in the interview schedule then that topic will be investigated at that time. This technique allows for a more natural, relaxed flow to the interview conversation with the result that more in-depth answers

are obtained. This method allows issues to be probed, to be explored in depth, until the respondent's answers and elaborations on a topic are fully exhausted. This process can also be followed across interviews. As an area is explored in one interview a respondents may suggest new ideas on a topic, these can then be explored with other respondents in later interviews.

Again all interviews were tape recorded. The replies from respondents during the interviews could have been written down in a notebook but meaning can easily be distorted by such a method, even when a form of shorthand is used. Another equally important reason for not using the notebook method is that the flow of the interview is continually being interrupted. Using a tape recorder overcomes these difficulties, making for an easy flow of the conversation with the minimum distortion of meaning. The presence of the tape recorder did not, however, inhibit respondents.

Sampling Frame, and Screening Questionnaire

As I was adopting a qualitative methodology I needed to both design an interview schedule which would give sufficient flexibility to enable me to cover the topics of the study in depth and to construct a suitable sampling frame which would enable me to select respondents for inclusion in the research who would be fully representative of their religious denomination and social class positions.

The means by which I collected my sample has been called by Glaser and Strauss (1970), theoretical sampling:

> `The initial decisions for theoretical collection of data are based only on a general sociological perspective and on a general subject or problem area'. (Glaser and Strauss 1970:105).

In my case I was going to consider social class and religious differences in beliefs between respondents. I therefore needed a sample of respondents which spanned these categories.

I constructed a sampling frame incorporating two social class categories (manual and non-manual workers) and three religious categories (Protestant, Catholic and non-religious). Respondents were needed who would fill all 6 combinations of these categories.

Various possibilities were considered with regard to the sampling frame. As a representative sample of respondents from Protestant and Catholic denominations above and below the social class IIInm/IIIm divide was required, and, as a high correlation is found to exist between Catholic adherence and Irish descent, I began by geographically plotting first generation immigrants to Glasgow. The sampling frame based on such maps was quickly rejected, however, as it would have introduced

the confounding influence of ethnicity into the study. The catchment areas and numbers of pupils of Glasgow's religious schools as well as the geographical locations of Roman Catholic Churches and the size of their congregations was also plotted. Although such exercises could have provided a potential sampling frame, statistical calculations demonstrated the extensive door knocking exercises which would be needed to obtain adequate quotas of respondents in my age, social class and religious denomination categories.

Because of such problems, I decided to use a list of names for which various details of potential respondents were already known: a list being used in connection with the MRC Hearing Research Unit's study: A Cross-Sectional Study of Hearing Impairment, organised from the Royal Infirmary in Glasgow by Dr S Gatehouse and Dr A C Davis.

For their study the researchers, Dr Gatehouse and Dr Davis had obtained a list of names and addresses from Glasgow District Council and had already sent out a screening questionnaire to gain extra details on potential respondents: age, gender, SEG, previous medical consultations, and reported disability or impairment with regard to hearing. Initial postal contact had been made with 10,000 people in stratified enumeration districts (ED's) in an approximate 6 mile radius of Glasgow's Royal Infirmary (see Document `Cross-Sectional Study of Hearing Impairment). The

precise postal code sectors are given in map no.1 in the appendix. As they were only going to research a certain proportion of this sample (those individuals with some form of hearing impairment) they offered me access to the other names on their list.

They agreed to draw off names in batches from their computerised list. These were names of people who did not have any hearing problems and were therefore not to be included in the MRC Hearing Unit's study. The names were selected so as to obtain equal quotas in the following categories. All were male, in two age bands (30-39, and 40-49), and above and below a dividing line between social class III non-manual and social class III manual.

I also decided to use a screening questionnaire. The aim of this screening questionnaire was to obtain face data, which would allow me to select specific respondents for my study, particularly those within the correct religious denominational groups (a factor that had not been screened for by the MRC Hearing Unit), and some background information on the respondents' health, tobacco and alcohol use. The inclusion of a few Lickert-style attitude questions on general health, smoking and drinking would also allow me to compare my own sample with those of large-scale questionnaire studies in the field.

THE PILOT STUDY

Between September and November 1986 a pilot study was carried out. It aimed to ascertain the feasibility of interviewing men about their ideas about health, and to test the schedule content, the screening method and the suitability of using the MRC Institute of Hearing's list as a sampling frame. Ninety-nine names were drawn off the computerised list, screening questionnaires were sent out, and twenty respondents were interviewed.

The main finding from the pilot was that male respondents were willing to discuss their health at length provided they were given enough time to consider their ideas and were questioned in depth on certain issues.

However, I decided to modify the interview schedule. One section relating to the causality of illness was dropped in favour of an expanded coverage of lay health beliefs; this allowed respondents greater scope in exploring their ideas. Again although I knew the social class and religious affiliation of my respondents, the issues of social class and religion and their influence on health, alcohol and tobacco use, had not been addressed directly in the body of the interviews. Although it was the case that respondents had spoken spontaneously about the influence of work on health and alcohol consumption, and also, and more frequently, about the effects of unemployment, these topics had not been initiated directly. And the

influence of religion had not been discussed. I therefore decided to include two extra sections at the end of the interview designed to explore respondents' perceived importance of both class and religion on their attitudes towards health, and in particular, alcohol and tobacco consumption. The pilot also alerted me to potential, mainly technical, problems with the research method. Difficulties with high numbers of call backs increased my use of the telephone as a means of arranging interview appointments. A follow-up questionnaire which was used in the pilot to get more information on health beliefs was dropped in favour of a supplementary form filled out at the time of interview which asked for more face sheet information, for example family size and housing conditions. The amended schedule and information sheet can be seen in the appendix.

Whenever possible respondents were interviewed on their own. Either spouses, or relatives left the main room or the respondent and myself moved to another room in the house. On the occasions when spouses did remain in the main room, in general because of the impracticality of going anywhere else, I did not feel that my respondents were significantly modifying their views. On the rare occasions when spouses did comment this often had the affect of causing the respondent to clarify their views rather than to change their opinions. For example when I asked one respondents what

they would do if someone started smoking in a non-smoking area, the interview went as follows:

> (husband): If I was, it would depend.
> (wife): I think you would, I think.
> (husband): If there was a lot of people there, I think, and nobody said anything, em, I think I would be inclined to approach them and just tell them that it is a non-smoking area and to move out, move out of it...If there was nobody else there I would be less inclined, and he wasn't too close, or she wasn't too close to me, yes it wouldn't bother me. (R652).

In sum, the pilot demonstrated the feasibility of interviewing men about their ideas of health, and allowed me to fine-tune the screening questionnaire and schedule content. It also demonstrated the acceptability of using the MRC Hearing Unit's list as a sampling frame.

THE MAIN STUDY

The fieldwork for the main study was carried out between January 1987 and January 1988. Interviewing was done in three sweeps with names being drawn off the computerised list in three batches in the appropriate quotas. The first interview sweep was brief, resulted in three

completed interviews, and was used as a final check on the interview schedule. The second and third sweeps enabled a balance to be maintained in the social class and religious grouping of my respondents. To recapitulate, the method of selection was as follows. First a screening questionnaire was sent out to potential respondents to ascertain face data, simple information on health, smoking and drinking, and, more importantly, to obtain information on their religious affiliation. On the basis of this information respondents were chosen to fill up my sample quotas.

In all, 352 screening questionnaires were sent out, of which 183 were returned completed, giving a response rate of 52 per cent. Of these 183 returns, 70 were eventually interviewed (with only four people refusing to take part in the study). Potential respondents were then contacted by telephone and the time for an interview arranged. These respondents were randomly chosen within each social class and religion category to obtain an adequate quota sample. The interviews were tape recorded and lasted from one to two hours, and were conducted either in the respondent's own home or in my office. Issues covered in the interviews included the respondent's health status, smoking and drinking behaviour, and their general attitudes towards health, tobacco and alcohol use. At the conclusion of each interview further household information was entered onto the supplementary sheet (see appendix). Information

from the screening questionnaire and the supplementary sheet was coded and mounted on a NORSK computer and all interviews were transcribed.

METHOD OF ANALYSIS

The aim of the analysis was to 'establish the cognitive universe or cosmology' (Silverman 1985:173) in respondents' thought about health. The process of analysis is the means by which the sense of pattern in respondents' thought is uncovered (see Wuthnow 1984 on Douglas). Granted that this is the aim, which methods did I employ?

The two theoretical approaches which have guided my analysis have been grounded theory (Glaser and Strauss 1967; Glaser 1978; Strauss 1987) and analytic induction (Lindesmith 1968; Cressey 1973; Znaniecki 1934). Although most qualitative researchers have not gone into much detail about their actual means of analysis, the work on grounded theory and analytical induction has been more explicit. There is also much overlap between the ideas of grounded theory and that of analytic induction, although the latter was formulated at an earlier date. Hammersley (1990:604) maintains that the two approaches are: `attempts to apply the hypothetico - deductive method to ethnography'.

Analytic induction is a method by which the qualitative researcher or ethnographer tries to formulate generalisations that hold across all his data,

and is based on the attempt to discover negative evidence for any generalisation he proposes.

> `This procedure of examining cases, redefining the phenomenon, and reformulating the hypothesis is continued until a universal relationship is established, each negative case calling for a redefinition or reformulation' (Denzin 1970:195).

In the analytic inductive method hypotheses are generated from particular cases and are refined by the search for deviant cases. In induction the sense of movement is from the particular to the general.

The early researchers who both formulated and used this method were Lindesmith (1968) in his study of addiction and Cressey (1973) on embezzlement. This pioneering work demonstrated its strength when used in connection with interview data. At the same time Znaniecki (1934) also produced an exhaustive theoretical formulation of this approach. Later generations of sociologists and ethnographers (Denzin 1970; Mitchell 1983; Bloor 1978; Dingwall and Murray 1983) have also born witness to its strengths.

A fundamental approach of grounded theory is for the researcher to be sensitive to his data without having too many pre-determined ideas about the topic under study. The aim is to systematically generate theoretical categories from the research material; and, in a complementary way to constantly check the fit of

these theoretical ideas to the data (Glaser 1978:4). This element of grounded theory is the same as that of analytic induction. In grounded theory there is a dialectical process in which one continuously moves between the data and theoretical ideas. Strauss (1987:23) details the various research procedures of grounded theory; and these methods, of analytic coding, the use of theoretical memos, and theoretical sorting, were all used in the present study.

Glaser and Strauss also discuss the various phases through which the research process must pass - moving from the descriptive to the theoretic - and how this is reflected in the increasing complexity and theoretical strength of the coding schemes which are generated from the data. The structure of the thesis reflects this process, with the earlier chapters being primarily descriptive in nature and the later chapters being more analytic, deepening the argument. The earlier phases of research are more 'open' while the major task of the later phases of research is to achieve integration between the central theoretical ideas.

The final goal of both grounded theory and analytic induction, however, is the same; and this goal can be distinguished from research using statistical methods:

> `The claim...is not to representativeness but to faultless logic'. (Silverman 1985:14).

Central importance is laid on the power of the

theoretical model to account for initially negative instances. The distinction between the logic of qualitative and quantitative approaches has been detailed by Williams (1981) and Mitchell (1983). Again both approaches rely on theoretical sampling rather than statistical sampling models (Denzin 1970).

The Use of the Computer in Qualitative Analysis

For part of the data analysis of the data the qualitative computer package Ethnograph was used (Seidel 1988). This involved getting the interview transcripts in a form which could be read by the package. Once this had been accomplished, a transcription was printed out for each respondent and this was coded. Descriptive or analytical codes could then be attached to specific sections of the text utilizing the computer. Once coding had been carried out the data files of all, or a subset of, respondents could be interrogated for common themes and the appropriate sections of the transcripts printed out. Fuller details of the technicalities of this procedure can be found in Fielding and Lee (1991) and Pfaffenberger (1988).

In practice Ethnograph was extremely useful in the early stages of analysis which involved the production of descriptive material. However, it proved to be inflexible in the more analytical stages of analysis where extensive recoding would have been necessary. Although Ethnograph allows for recoding at any stage, in

practice it was found easier to keep track of the increasing complexity of codes, sub-codes and families of codes by means of paper copies of the interview transcripts and index cards. Ethnograph also tended to restrict the way in which data could be retrieved and viewed and thus inhibited the process of creativity which is needed at later stages of analysis.

Another problem with Ethnograph is the fact that it selects coded text across a range of respondents; for example it easily prints out all instances of codes for a group of respondents. But it takes horizontal slices across respondents' transcripts rather than taking a vertical view, where a topic is considered in the whole context of the respondent's accounts. By continually presenting horizontal strata there is a tendency to lose sight of the logical threads in the thinking of respondents.

The use of the computer also tends to inhibit the use of diagrams and the construction of charts and sketches which enable the researcher to see how key analytic concepts may link together or how one idea may follow another. Such forms of visual representation of data have been recommended by various researchers (Miles and Huberman 1984; Becker 1986; Strauss 1987) as a means of progressing from a purely descriptive presentation of qualitative material to the development of an analytical focus.

Again although not a quantitative work, number is

used in the analysis; but it is aimed to give the reader an idea as to how common certain types of ideas were among particular groups of respondents. It is used in a descriptive rather than in a rigourous statistical fashion (see Silverman 1985; and Williams 1990).

CHARACTERISTICS OF MAIN STUDY RESPONDENTS

In terms of health 55 of my respondents said their health, at the time of receiving their questionnaire, was good. Eleven said their health was average, and 4 said their health was not good. Nineteen respondents suffered from a long-standing illness. Of this 19, 9 said their illness limited their activities. In the fortnight before they received the questionnaire, 13 respondents said their activities had been curtailed because of illness or injury.

Sixty-two of my respondents described themselves as Christian, 8 described themselves as having no religion. Thirty-six described themselves as coming from Protestant denominations, 25 described themselves as Catholic. In terms of frequency of attendance; 9 attended church more than once a week, 18 once a week, 5 once a month, and 30 less frequently.

Forty-seven respondents said yes to the question; have you ever smoked a cigarette, cigar, or pipe? Although only 29 smoked at the time of receiving the questionnaire. Of those who had ever smoked cigarettes; 12 had smoked up to 5 packets of cigarettes per week, 17

yhad smoked over 5 packets of cigarettes per week. Six respondents smoked 5 or less cigars per week, 3 smoked more than 5 cigars per week. Four respondents smoked 3 ounces or less tobacco per week. Two smoked over 3 ounces of tobacco per week.

Only 2 respondents said they had never drank alcohol. Fifty-eight of my respondents drank at the time of receiving the questionnaire. Of those who had ever drank, at the time of their drinking, 12 said they hardly drank at all, 18 described themselves as drinking a little, 22 as drinking a moderate amount, 11 as drinking a lot, and 5 as drinking heavily.

In terms of age; 30 were between the ages of 30 and 35, 16 between 36 and 40, 14 between the ages of 41 and 45, and 10 between the ages of 46 and 50. Fifty-six had been born in Glasgow; 11 elsewhere in Scotland. Fifty eight had been living in Glasgow for over twenty years.

Eleven of my respondents were single, 57 were married, 1 was divorced, and 1 co-habiting. Three of my respondents were unemployed and looking for work, 1 was unemployed and not looking for work, 3 were permanently sick and disabled, and 63 were employed. In terms of house ownership; 6 respondents owned their house outright, 48 had a mortgage, 15 rented, and 1 had a tied house. Of those who rented, 12 rented from the local authority/council, 3 from a housing association, and 1 from their employer. Thirty-five respondents were from non-manual occupations and 35 from manual occupations.

CHAPTER 4

ACCOUNTS OF HEALTH

INTRODUCTION

As has been shown in Chapter 2, in the review of the field, the qualitative literature which has considered lay concepts of health is limited. The concerns of such research have also varied. Pill and Stott's (1982) research and Blaxter's study (1983) considered causes of disease. Pill and Stott (1982) also researched responsibility for health. Calnan and Johnson's work (1985) looked at concepts of health and vulnerability to disease. Whilst Locker (1981) considered symptoms of illness. As can be seen, therefore, a lot of this work did not restrict itself to, or was often not primarily concerned with positive conceptualisations of health. In the current study the focus was exclusively on the meaning of health.

This chapter presents a general overview of the ways in which my respondents conceptualised health. What did they mean when they considered themselves or other people to be healthy? Closely related to this question are the following: what factors were seen to be associated with health? and how was health maintained and how could it be lost?

In the interviews respondents were asked to describe their ideas about health at length. For example they were asked about, what made them feel healthy, what they did or would like to do to improve

their health, and the health of their family and of other people.

The procedure which was followed was to break down lay concepts of health into their various components or factors; to uncover these categories relating to health by detailed coding and analysis of textual data - a process similar to that used by Crawford (1984), Blaxter (1990) and D'Houtaud and Field (1984). As D'Houtaud and Field (1984) state the aim is to arrive at the 'thematic groupings' in respondents' conceptualisations of health.

Interviewees presented various components or 'thematic groupings' related to the concept of health. From a close analysis of transcripts eight major components were identified: these I have called, health as lack of illness, health and physical appearance, health as physical activity, health as correct mental attitude, health as general fitness, health and environment, health and diet, and health related behaviours.

LAY CONCEPTS OF HEALTH

Health as Lack of Illness

Numerous respondents stated that a person could be gauged healthy if they were not susceptible to illness or had not attended hospitals or visited doctors. Indeed this was their main response when asked to describe a healthy person:

> R124: 'Their outlook on life, lack of hospital treatment, just a moderate drinker. Maybe only smokes at weekends that sort of thing. Hasn't had any complaints for as long as I can remember anyway.'

In this quotation the respondent is giving a mixture of why a person is justified in being seen as healthy and also evidence of being healthy, or rather not-ill. Another said of his wife:

> R209: 'She has never had any problems with herself, she has never had any problems at all.'

They also judged themselves to be healthy by the same criteria. A large proportion of respondents gave such negative conceptualizations of health. This finding corroborates other studies in the field; Herzlich (1973) spoke of such negative answers as `health in a vacuum'. And Blaxter (1990) found three negative categories in use among her respondents `negative answers', `health as not ill' and `health as absence of disease/health despite disease'.

My respondents' negative answers covered the same range as Blaxter's. Health as lack of illness was also discussed in reference to not approaching the medical services of either the G.P. or the hospital.

Health and Physical Appearance

Respondents also conceptualised health in terms of

physical appearance, although I had difficulty in getting interviewees to describe what they meant by this in detail. People often merely said:

> R550: 'He just looks healthy.'

A few pointers can, however, be ascertained by the following quotation:

> R170: 'He is always tidy and looks after himself.'

Again this quotation includes both how health can be recognised and also how it may be attained.

This health theme included ideas about dress, seen by some respondents as an extension of physical appearance, and complexion was also mentioned by interviewees.

The idea of health being related to physical appearance is surprisingly rare in the literature on lay health beliefs. Although Blaxter (1990:25) does briefly mention it, it is categorized under the concept of fitness and is discussed exclusively in relation to women. Women were seen to think of fitness in terms of physical appearance, men to relate fitness to sports. As can be seen from above,however, men often spoke of physical appearance when they wished to describe someone who was healthy.

Health as Physical Activity

When analysing the data I was constantly aware of the strong association between health and activity. Other writers have noted the importance of the concept of activity. Blaxter in the Health and Lifestyle Survey (1987) has mentioned the fact that in terms of their attitudes towards health, respondents could be categorised as either 'active' or 'passive'. Where people having active views of health were seen to encourage self-responsibility, while those with passive views believed health to be outwith a person's control.

Herzlich (1973) and Williams (1981) have also brought out the close relationship between ideas related to activity and those of health. As Calnan (1987:112) states: 'keeping fit and being active are key elements in lay definitions of health'.

My own respondents link of health to activity came through clearly when respondents were asked to describe a person they believed to be healthy. Such people were often seen to be healthy because they were very active. A healthy person was someone who was athletic and took part in a lot of sports. As one respondent said:

> R505: 'partly because they're athletic, it was partly the sort of lifestyle I would associate with being healthy, I think that's one of exercise.'

And as another indicated:

> R509: 'he's very athletic. That's basically what springs to mind right away.

In these quotations the activity of being involved inn sports demonstrates and is an indication that a person is healthy.

Interviewees also spoke about their own involvement in sport in a similar fashion and believed their own health would improve if they could be involved in more sports. For example respondents wished to play more tennis and golf. Also if their chosen sport came to a halt they looked around for alternatives. As one respondent stated:

> R250: 'I trained at football but my team disbanded so I am just waiting to go into the badminton club again.'

Here, their own involvement in health activities was seen to increase their stock of health.

Activity was not just mentioned with regard to formal sports however. Rather it could be brought out in the interviews in a general way. As one respondent said:

> R506: 'Ah feel healthiest when ah've got a full diary an' plenty to do and plenty to keep me occupied, really ah think maybe, well that would be my view of health.'

Walking was often mentioned in this connection:

> R523: 'I do a lot of walking into the town, I do a lot of walking you know. I don't jump in buses or in a taxi or trains, I usually walk into town or back home again. I maybe do two or three miles you know.'

Respondents also saw involvement with their family as affording an opportunity for getting exercise. Having children was seen to keep people active both in the home, where they had to keep their children occupied and amused, and outside the home, where they often took them to games. As one said:

> R503: 'Ah try to do it on a reasonably regular basis, em for the sake of the boys, the boys love swimming, so we go swimming. That's about the only sort of outdoor, physical sort of exercise that ah do at the moment.'

The link, then, between health and activity has two strands. First, people who took part in sports or were attending work demonstrated that they were healthy; it was taken as a sign of health. Second, physical activity, via sport or work, was seen to build a person's health, or stock of health, to make people healthy.

Finally physical activity was mentioned in relation to combating illness. Respondents expressed themselves

by such terms as 'working off a cold' and 'fighting an illness'.

Not to be concerned with such physical activity was seen to be potentially detrimental to health. The importance of activity for health was then expressed in a negative fashion:

> R158: 'They can let themselves go, and in that respect it would be their own fault...by not participating in any activities. Take the car instead of walking and things like that...'

The concepts of activity was often directly related to the sphere of work. Attendance at work was generally used by respondents as a proxy indicator for a person's health. As one respondent stated:

> R362: 'Well I would judge a person's health by how they attend their work.'

Others said that people were healthy due to the fact that they were always at their work. But why was work taken to be an indicator of health? One common type of statement which helped clarify this issue was that a person needed to be healthy in order to work. Work was seen to provide a challenge, and it was only a healthy person who could respond to this challenge.

Of course, different work situations presented different challenges, many indeed health threatening. For example, a manual worker, a welder (R249) said that

people needed to be fit to work, as they were exposed to unhealthy fumes in their work situation.

Another related issue was that respondents would often work through periods of ill-health. As one supervisor and fork-lift driver said a healthy person was: 'somebody that is working all their days, maybe have the 'flu but still go to work.' (R469). This was not taken to mean that a person was unhealthy while at work, rather respondents tended to make fine distinctions within the concept of health; distinctions between health and fitness, or between general health and health problems. In all cases differentiation was made between the underlying health of a person and temporary health problems which the person suffered. Indeed the fact that a person could continue to work while suffering a temporary illness was further proof of the person's underlying health (see Blaxter's distinction between health state and health status).

Respondents from the manual occupations in particular stressed working through illness as a criteria for a healthy person. For the non-manual groups health was mentioned in relation to diminishing efficiency at work: not between doing or not doing the job, but doing the job more or less efficiently, working on a 'higher level'.

Many researchers have uncovered the lay idea of health being viewed in terms of physical activity (Blaxter 1990; Cox, Blaxter and Buckle 1987; Stacey

1988; Calnan and Johnson 1985; Williams 1981). And writers have often linked this concern with activity directly to work via the Protestant work ethic or by extension to the underlying values of present day capitalism (Kelman 1975; Crawford 1984). It has thus often been seen to be a feature of male rather than female health beliefs. Cornwell (1984) and Blaxter (1990) note the focus on activity and work as a male concern. Blaxter (1990) maintains that by contrast women stress the quality of social relationships as an indicator of health. And Cornwell (1984) states that women's concepts of health are more concerned with the home.

However some researchers have uncovered ideas of activity in women's health concepts (Calnan and Johnson 1985; Williams 1981). Calnan and Johnson's female respondents also spoke about physical capability and the need for exercise.

Distinctions have also been found within the relationship between activity and work. It has been pointed out (Cox, Blaxter, Buckle 1987: 131) that certain groups (farmers, agricultural workers, and own account manual workers) regard work as being favourable to health. A focus on physical attributes, to be able to work, was found by D'Houtaud and Field (1984) to be stressed by manual workers. Again Stacey has linked this to the immediate material circumstances of people in the lower social classes. The stress on positive

fitness, however, was more related to the better educated (Cox, Blaxter and Buckle 1987). And Cornwell (1984: 146) has linked activity among her lower social class respondents with 'a cheerful stoicism'. Such distinctions will be analysed in chapter 10 of the thesis.

Health as Correct Mental Attitude

Not all references to activity and health, however, were about physical activity, a great many related to mental attitude and health. This was often described in similar terms to physical health. As one respondent stated:

> R521: 'I suppose mentally fit as well. No mental problems, just not looking at the physical aspects, the other side as well.'

Having the wrong mental attitude was often seen to open a person up to increased susceptibility to illness. As one respondent stated:

> R504: 'Also talking about ehm, mental attitudes to health, obviously if one is depressed then your health suffers.'

And another expressed the idea in the following fashion:

> R503: 'Ah believe you know that a lot of ailments could be mentally brought on you know in as much as people tend to sort of think of their own ailments.'

Positive thinking and mental activity were seen to counteract such tendencies. As one respondent said:

> R506: 'I'm a great believer in really getting out...and pulling yourself out of it. I've always enjoyed good health so you always feel that, well, they could do something to avoid being ill, but I've always been sort of positive and had good health.'

Other interviewees spoke of the need to 'perk yourself up' if you were at a 'low ebb'.

Other writers in the field (D'Houtaud 1976; Blaxter 1983, Calnan and Johnson 1985) have stressed that fact that health is closely connected with mental attitude in lay health beliefs. D'Houtaud (1976) states that professionals and non-manual workers associated optimism with health. Blaxter and Paterson (1982) and Blaxter (1983) showed that their women respondents stressed the mind/body link and favoured `mind over matter maxims'. Worry was thus seem to be one cause of disease. This was a finding of women from social classes IV and V. Calnan and Johnson (1985) also found that their

respondents believed that those who were likely to get breast cancer were `nervous people'.

The relationship between hypochondria and illness was also a concern of respondents, hypochondria was used in its normal sense of people who complained of illness but were not ill, however, respondents generally believed that if this was indulged in for any length of time the person might become genuinely ill. As one respondent stated:

> R523: 'As I said earlier, a lot of it is in the mind...he's a complete moaner you know and I feel as if he probably feels these pains because he tells himself he's got them you know...there are probably a lot of people like that...and I suppose I think they will bring it on themselves if they think about it long enough...because I think an awful lot of it to me is boredom, if you activate your mind a lot, if you don't give yourself time to think about these things you will be O.K.'

Again the antidote for such a slide into illness was to keep the mind active.

But of course mental attitude was also affected by elements of the social situation in which the person found themselves. Some (R218) stressed the importance of their children in keeping them optimistic about the future, and environmental factors, which will be

discussed below, were also seen as important.

Currer and Stacey (1986) believe that there might be cultural differences in the expression of the perceived link in lay thought between mental state and health. They describe the French as more open in expressing the importance of an upset to equilibrium as a reason to consult a doctor, that they were more likely to consult for psychosomatic reasons. The Scots on the other hand, stress the inappropriateness of adopting the sick role on the grounds of 'weakness'. Williams suggests that this has to do with the 'disease-centred conception of illness, and the fear of hypochondria which goes with it' (1986:202).

Health as General Fitness

Closely allied to ideas about activity and health, be it mental or physical, were respondents' notions of fitness. To be healthy was to be fit. Fitness was often seen to be related to a person not being susceptible to illness. As one respondent said:

> R234: 'she never takes any colds or anything...she never seems to catch it you know. She is pretty healthy and fit.'

Here we have a negative definition of fitness. D'Houtand and Field (1984) and Blaxter (1990) have suggested that notions of positive fitness are more associated with non-manual workers and the better

educated.

Fitness was also associated with the subjective feelings of health that taking part in physical activity could produce:

> R115: 'Well when I had my knee operation and I was trying to get back to the football I joined the olympic health studio. When I started going there I felt fitter.'

Fitness then, was expressed as a global term, a term which incorporated within itself some of the other components of health - it carried the connotation of activity or the ability to be active.

Among my respondents the concept of health as general fitness, in keeping with the findings of Blaxter (1990) includes physical and mental components. This idea is also close to Herzlich's concept of `health as a reserve'; here health is viewed as a certain capacity to overcome adversity.

Health and Environment

Respondents discussed environment when they spoke of health. They separated environments into those which were healthy and those which were unhealthy. Environments referred to were their places of living or work. As one respondent said:

> R362: 'I think a lot of illness is self-inflicted through the style of life of the occupation or the environment...people in, who are working in industries where there are a lot of fumes, em, dangerous chemicals, things like this.'

And another:

> R250: 'In certain cases. Not so much in that I don't actually work in tools any more. I am away from dust particles. I work in a clean environment but I still go down to these areas. You go down to these areas and you can see the dirt.'

Respondents commented on the effects of both indoor and outdoor work although the healthiness of occupations depended on the nature of the work. They described the dangers of pollutants at work, the stressful effects of noise, and also the dangers associated with sedentary occupations.

With regard to the home environment respondents spoke of differences between residential area and living conditions. One respondent had moved from one part of the city to another:

R133: 'I stayed in Castlemilk before and it is even worse out there you know. You should go in the taxi with me for a day and see some of the people, you know.'

KM: 'So how would you describe the differences between Castlemilk and here in terms of health?'

R133: 'Night and day really. There is no noise.'

And another said:

R111: 'Well I think physical illness is linked to your mental attitude to a great deal. I think it is also people's illnesses are conditioned by their own environment - well I tend to think in terms of depressive illnesses and people feeling run down. I know this can contribute to your physical being... I think that if there is certain things lacking in people's life it can make them run down.'

And again:

KM: 'Are there things about your life now that you would say have a good effect on your health?'

R306: 'I suppose the environment I live in. I have a back and front garden and a reasonably contented family. I suppose these things contribute to it.'

KM: 'In what way do you think they contribute?'

R306: 'Well it helps to make you feel more

> settled, this is going back to a sort of mental attitude. If you have that sort of attitude I think you can help yourself.'

Such a relationship between health and environment has rarely been commented on in research on lay health beliefs. Where it has been mentioned, findings have been ambiguous. Stacey (1988: 148) states that manual workers were aware of the health denying attributes of the environment. However, Cox and his colleagues found (1987), by contrast, that workers in hazardous environments did not see this as affecting health.

Health Related Behaviours: Diet, Smoking and Drinking

The following three themes are about health related behaviours. First, respondents spoke of health in term of diet. To have good health was to eat well, eating badly could bring on ill-health. A healthy diet included brown or wholemeal bread, fruit and vegetables. An unhealthy diet was one which contained too many fried foods, or too many chips and greasy foods. As one respondent said:

> R115: 'Watching what I eat. I usually stop eating crisps and chocolate and ginger and things like that.'

Respondents not only spoke about the content of diet but were also aware of ideas of balance within a

diet and the quantities of food which should be eaten.

Respondents were also aware of their own weight at the time of interview and took action to remedy the situation if they were overweight. As one said:

> R541: 'I probably feel the healthiest when I shed some weight. I generally carry a stone more than I should, when I drop that I probably feel at my best.'

However, obsessiveness with regard to diet was also seen to be bad:

> R419: 'I used to know a guy, and he used to eat home made soup and then he stopped eating so much, and he had cancer. I think that is a disease that you can worry yourself into getting. You can worry yourself into a cancer state. Worry is self-inflicted.'

Health was often closely linked in respondents' minds with certain behaviours, in particular smoking and drinking. This was often given in the context of a person being responsible for their health. As one respondent stated when asked if it was ever people's fault if they became ill:

> R541: 'Yes I suppose so sometimes. If you are a smoker I would imagine you could become ill yes.'

In terms of drink health was more related to excessive

drinking:

> KM: 'Are there any things at the moment that you think have a bad affect on your health at all?'
> R550: 'When I am on the booze I drink a wee bit heavier than I should.'

Both these lay concepts of health can be subsumed under health as health behaviours and have been discussed by Blaxter (1990) and Murcott (1983) in these terms.

SOCIAL CLASS AND RELIGIOUS DIFFERENCES

Above I have outlined the eight components of the concept of health which appeared in the interviews. However, not all respondents mentioned all eight components during an interview. Were there systematic differences between respondents in their recognition of the saliency of the various components? Even if respondents mentioned the same health components, were there any differences in their presentation? I will first consider social class and then turn to religious differences.

Both health as physical activity and health as correct mental attitude were mentioned by all respondents from both social class groupings. These were indeed the most commonly referred to components of health. Health and its close relationship to diet was also mentioned by most respondents although there was a slight bias towards the non-manual groups who mentioned

diet more frequently. Health and environment was also mentioned frequently and again in almost equal proportions between manual and non-manual groups. Health and its relationship to physical appearance was mentioned far less often although it was mentioned by both respondents above and below the manual non-manual divide.

The health behaviours of smoking and drinking were discussed by both groups but manual workers were more likely to specifically mention their importance. This can be seen to relate to increased consumption among respondents from manual occupations. Lack of illness was not so popular as physical activity but it was cited equally by both manual and non-manual groups. And finally the concept of fitness although commonly expressed by both manual and non-manual groups was a slightly more popular option in the non-manual category.

Turning to religious differences; both health as physical activity and health as correct mental attitude were again mentioned by all respondents from all religious groupings. The relationship between health and diet was mentioned by most respondents, although Protestants mentioned diet more frequently than Catholics. The relationship between health and environment was also frequently discussed although less by respondents who stated they were non-religious.

Health and physical appearance was mentioned far less often by respondents, and least by Protestants.

Drinking, smoking and health was discussed by respondents from all religious groupings although most often by those professing no religion. Again it can be surmised that this response was related to the smoking and drinking behaviour of such respondents.

Lack of illness was mentioned by respondents from all religious groupings but particularly by Protestants. And finally fitness was discussed by respondents from all religious groups but least often by the non-religious.

In general then, we can see that the eight components of health are endorsed by respondents spanning all social class and religious categories. However, I have also shown that different groups placed different emphases on some of the health components.

Respondents were also asked to give their own ideas about the influences of social class and religion on health attitudes. In general most respondents did not think that their own social class or religion affected their attitudes towards health. There was a greater tendency, however, for them to believe that it would affect others' attitudes.

The few comments in which respondents directly spoke of class and religion can be categorised as follows.

Respondents when asked about class spoke of the importance of money and resources for producing a healthy life. Further up the social scale, not only did

people have more resources for maintaining health but they were also seen to be more aware of what influenced their health. Respondents spoke of the importance of education in moulding attitudes towards health, and education increased the higher up the social scale one went.

Further down the social scale, escapism was given as a reason for heavy drinking and smoking in the working class. Some respondents believed there was a greater acceptance of smoking and drinking amongst the working class. And heavy drinking and smoking in the working class was often linked to specific residential areas.

A couple of respondents pointed out the restraining effects of a mortgage which cut back on the money available for drink.

Religion was not often seen to affect health beliefs. It was however, seen to affect health practices, not only smoking and drinking but also contraception. Respondents own ideas about religion were often seen to influence their own smoking and drinking.

Though religion was not often seen to influence health directly respondents often spoke of it having a general protective function. However, religion could also be seen to have negative implications. As one respondent stated:

> R132: 'it seems that people who have strong religious convictions tend to blame the weaknesses in people who drink too much or don't look after themselves. I think part of the responsibility lies with the individual but I think the consensus of people should be channelled through government'.

The general feeling then was that social class and religion were not seen to be all that important in directly influencing respondents attitudes towards health. However although they infrequently mentioned social class or religion specifically respondents often spoke of related ideas, in particular social background. One of the major components of social background was family environment. Respondents stressed 'upbringing' and highlighted the importance of the early years of life for forming attitudes. Interviewees either felt similar to their parents or had reacted in some way against their parents' background. A popular phrase in interviews was that they were 'going along the same road' as their parents. Others, if not hostile to their parents, often believed that their parents background had been deprived in certain ways and that they wished better for their own children. Respondents spoke of how extremes in parental up-bringing could lead to excessive smoking and drinking among the children.

Respondents did not just speak of their family environment in a limited way however but also brought in

references to their wider social background touching on aspects which related to social class and religion in a general sense.

Some of my respondents had also moved from the social class of their birth and their comments on the differences between classes were of interest.

In summary respondents concepts of health can be broken down into eight components: health as physical activity, health as correct mental attitude, health and diet, health and environment, health and physical appearance, health behaviours, health as lack of illness and health as general fitness. Such components were inter-related and underlying respondents' ideas about health was a notion of balance - that health could be gained or lost and that health behaviours (physical exercise, diet, and smoking and drinking) or social environment were important in this context.

The eight components of health were endorsed by respondents from all social class and religious groupings. Also, although respondents thought their own social class or religion had little influence on their own health beliefs they could influence the beliefs of others. The early upbringing of respondents however, their family background and circumstances, was seen to be particularly important for developing their later attitudes towards health.

LAY THEORIES OF HEALTH AND ILLNESS

As we have seen respondents thinking about health can be conceptualized in terms of eight components: health as physical activity, health as correct mental attitude, health and diet, health and environment, health and physical appearance, health behaviours, health as a lack of illness, and health as general fitness. These components should not of course be viewed in isolation but, were often related to each other. Some components are about physical others mental attributes of health. Some relate to the person, others to the wider social environment. Components are also of different types, some being functional definitions of health, others indicators of health.

These components of health were also often presented in the interviews in a dynamic inter-relationship. This can be most clearly understood if we consider the component of fitness. Here a number of attributes helped define fitness. Fitness could be gained or lost and it was seen as being in a dynamic tension with other health attributes. If a person did not take part in physical activities, if his diet was poor, if he was mentally depressed, then the person was seen to loose fitness. If on the other hand the person improved his diet, became both mentally and physically more active, changed his job or house then the person's fitness could improve. Respondents then did not see these components of health as existing in isolation but

as relating to each other, with a change in one potentially causing a change in another.

Ideas of moderate drinking and smoking were linked into other aspects of a respondent's conceptualisation of health:

> R124: 'Their outlook on life, lack of hospital treatment, just a moderate drinker. Maybe only smokes at weekends, that sort of thing. Hasn't had any complaints for as long as I can remember.'

This respondent brings together mental attitude, lack of illness, lack of use of medical services, moderation in the health related behaviours of smoking and drinking.

Not only did conceptualisations of health often appear together, but specific links were made between them by respondents. Respondents volunteered lay theories of illness causation:

> R306: 'There are circumstances which would tend to make folk ill. Taking the world's problems and things like that, er, I suppose there are some people who are caught in what you would call the poverty trap. No matter what they do, it is like climbing a muddy slope, you never get any further. Quite often a depression type thing could lead to many other illnesses.'

Here one respondent links aspects of the

environment to mental state and then onto physical illness. And below we have another example of a respondent bringing together various ideas connected with health (environment, employment, sporting activity, personal resources) to produce a lay theory of the links between lifestyle and health:

> R758: 'I would think stability...I have a regular job to do, that is a big thing, in that you have something that you are doing. Firstly you have regular employment, you have something to do. You also have money which allows you to do things that you can't otherwise do, and live in the best part, a lifestyle that you you want to live. If you want to go to the Sports Centre and play squash then I have got the cash which I can then say I can go and do it.'

CONCLUSION

Respondents presented eight themes when they spoke of health, and, although negative definitions of health were common, positive ideas were also given. Like Blaxter (1990), respondents made a distinction between ideas relating to the physical and to the psychological.

Similar to the work of Blaxter (1990) and Calnan (1987) the idea of health as equilibrium was not spontaneously presented by respondents when asked about the meaning of health for them. However as will be shown in later chapters of this thesis the idea of

balance was found to be a strong underlying principle to the way in which they thought about health and health related behaviours. Apart from the lack of mention of ideas related to equilibrium respondents also did not mention Blaxter's concept of psycho-social well-being; this was a concept which in the health and lifestyle study was endorsed predominantly by women.

A major finding is the stress respondents put on the effect that the environment could have on health. This has rarely been discussed by other writers in the field; and it has been shown that physical appearance as an indicator of health was also a concern of men and not just of women (Blaxter 1990).

The most striking feature of these accounts, however, was the stress respondents put on the relationship between activity and health. This feature of lay health accounts has often been related to the Protestant work ethic and its later transformation into the central value system of capitalism. However, writers have often associated it predominantly with manual workers (D'Houtaud and Field 1984), But in my study it was a feature of the thinking of people from both sides of the manual/ non-manual occupational divide.

The two major findings from the chapter, however, are first, the distinctions to be found within health themes. Definitions of health can also be looked at in various ways. Some definitions answer the question of

what health is, others more on how one can recognise health (a sign of health rather than health itself), and others how health can be gained. The two studies of Blaxter (1983) and Pill and Stott (1982) have been on illness causation rather than directly on health maintenance. Most research has looked at causes of illness not so much as causes of health. Second, like the finding of Blaxter (1990) there is a great deal of overlap between concepts. However, when concepts appear together more can be said about them than mentioned by Blaxter. When this occurs they demonstrate lay theories of health and illness causality. For example the two dimensions of what health is and how to maintain health although logically distinct were found to be closely related in respondents' thought. Taking part in sports was taken as a sign of a healthy person but was also seen as a way of maintaining health.

CHAPTER 5

ACCOUNTS OF TOBACCO USE I: HEALTH HAZARDS AND DISSONANT SMOKING

INTRODUCTION

In the last chapter on lay health beliefs we saw the close association in respondents' thought between the maintenance of health and the specific health related behaviours of alcohol and tobacco use. The next three chapters explore these connections by first considering respondents' ideas on smoking. The general features of respondents' accounts of the relationship between smoking and health are considered; then the complexity and ambivalence of their ideas is highlighted before moving into a discussion of those elements involved in stopping and starting tobacco use.

THE HEALTH HAZARDS OF SMOKING

The most noticeable feature which emerged from the interviews was the general acceptance by respondents of the health hazards of smoking. This was true for both smokers and non-smokers. The following excerpts are taken from interviews with non-smokers.

> KM : 'Do you think there is a connection between smoking and ill health?'
>
> R506 : 'Yes'
>
> KM : 'And what sort of connection?'

R506 : 'I think all things, I imagine all the chest complaints, I think nearly everything... asthma, cancer, I mean I'm not a medical man but ... I couldn't see any reason why it wouldn't.'

And from another interview with a non-smoker:

KM : 'Does it damage the health?'

R514 : 'Lung cancer for example, heart attacks, you know.'

And again:

R758 : 'Well lung cancer is the most obvious. I suppose there must be blood disorders that must come from smoking as well. General ill health from the smoke affecting other parts of organs in the body. Lung cancer is certainly the obvious one.'

Smokers were also however well aware of the health hazards caused by smoking. As one respondent who smoked six packets of cigarettes per week stated:

R763 : 'I think general things like cardio-vascular problems, chest problems are the main ones I can see.'

And another excerpt taken from an interview with a smoker:

KM : 'And what sort of connection do you think there is, what health problems do you think it causes?'

R515 : 'Well as I wis saying earlier on there lung cancer an' a lot o' maybe heart attacks, that's the main two major things in it is heart attacks an' lung cancer.'

As can be seen from the above quotations the types of health problems mentioned by respondents were respiratory disease, cardio-vascular diseases and cancer, although more general health difficulties were also cited. These findings corroborate other research which has universally shown that the general public, both smokers and non-smokers, increasingly realise that smoking can damage health (Merriman 1978, Marsh and Matheson 1983).

A large number of respondents also believed the health of non-smokers could be affected by the smoking of others. Again these ideas were expressed by both non-smokers and smokers. As one non-smoker expressed it:

R506 : 'I think that most definitely if your breathing in tobacco (smoke) your smoking second hand, you're not getting the tar I think it's the smoker that actually gets the tar, but even the actual smoke, the nicotine it must, they say it affects, brings out some sort of cancers.'

And a smoker stated:

> R515 : 'Oh aye, automatically, 'cos if I'm smoking 'an' somebody's standin' next to me that disnay smoke an' ah'm damagin' their health because they're inhaling the smoke an' although they're no getting so much as whit ah'm smoking because I'm inhalin' it but when ah'm inhalin' it the smoke an' that they're breathin' it in, its automatically they have to breath it in if they're standing next to me.'

In general however respondents were less convinced of the effects of passive smoking and often qualified their statements by saying that health effects would depend on the amount of tobacco smoke inhaled. As a respondent who smoked one cigar per month said:

> R652 : 'I'd think their health could be affected if there's a lot of smoke in the area. I think so.'

And another respondent, who smoked 7 packets of cigarettes per week, when asked if people's health was affected if they lived or worked in a smoky environment, said:

> R625 : 'Yes I think it is. Depending on the degree of pollution if you like. I think it must have some affect.'

Respondents were divided about the comparative health effects of cigarette, cigar, and pipe smoking. Some saw little difference. One respondent who smoked six packets of cigarettes per week stated:

> R609 : 'I don't view them any differently for the like of what it is doing to your lungs.'

And a non-smoker said:

> R784 : 'I don't think so. I think I react to the three the same way. I think I was also sick on a cigar. I think I regard all of them the same. I don't think anything like that can help your health at all.'

Most respondents however believed that pipe and cigar smoking were less damaging to health than cigarettes.
As one respondent said:

> R504 :' Well the cigar smoker is em, you've found a good one here, the cigarette smoker eh tends to be off ill more often than the non-cigarette smoker or the cigar smoker em I think that's the main thing I would notice, they tend to be off more.'

The cigar smokers in my sample conceded that smoking was injurious to health but saw this purely in terms of the dangers of cigarette smoking. One of the respondents

classed themselves as a non-smoker since he only smoked the occasional cigar.

The reasons given for the reduced damage caused by cigar and pipe smoking was seen to be related to the extent to which tobacco smoke was inhaled. As one cigarette smoking respondent said:

> R682 : 'My father and my grandfather both smoked pipes. They did not really inhale and I would regard them as different as regarding health. I think the nicotine still gets through to them but not so much.'

Although there was this general acceptance of the health hazards of smoking by smokers themselves, there was also evidence of a subtle denial of such dangers in the interviews.

Qualifications

Occasionally during the interviews health affects were accepted but they were expressed by reference to qualifiers, by such terms as 'I suppose' for example. One respondent who smoked six packets a day played down any possible health affect:

R609 : 'I know I should not be doing it you know. I have never ever said to myself I am going to stop smoking you know. I have just carried on, I don't really think it is that dangerous the amount that I am smoking. Obviously you might say to me that one cigarette a day is not really good for you. I don't think it is dangerous the amount that I am smoking anyway.'

Strict causal links were also denied, smoking was rather seen to 'irritate' or 'exacerbate' cancer, as in the quotation below:

R539 : 'It affects your health in every way you know. They say it causes cancer but if you have any problems with your health if you smoke well it is going to irritate that problem. I don't think it causes cancer. If the cancer is there smoking will not help.'

KM :' And why do you not think it causes cancer?'

R539 :' I'm not up on the medical you know but I just have a feeling that there is other factors causing cancer than cigarette smoking. It is bad for your health.'

KM : 'But you don't think it is the major cause?'

R539 :' No I don't think it is the major cause.'

And again:

> R667 :' I don't see any direct connection between smoking and cancer.'
>
> KM :' Can I ask you why you don't see any direct connection?'
>
> R667 : 'Well because it has'nt been proved. Probably I am refusing to see the connection because when I was a smoker people would point this connection out to me which I had to defend my position. I had to deny the connection.'
>
> KM : 'When your friends say it has been proved what sort of arguments do you tend to use?'
>
> R667 :' Well there is not direct relation between smoking cigarettes and contracting cancer. I know enough to know that cancer has dormant in most of us in some form or other. And something will set if off, and cigarette smoking may well be a cause along with a great many other things. My wifes' grandfather smoked Capstan full strength and lived to a ripe old age.'

Such comments utilized sophisticated arguments about the nature of cancer and the difficulties of the scientific proof of causality. Although such arguments were also voiced by non-smokers, here respondents tended to accept that there was a connection between smoking and cancer as can be seen from the next quotation:

> R784 : 'Basically lung problems I think, bronchial problems. Cancer, I think there is still an argument that there is no direct evidence between smoking and cancer. I think what circumstantial evidence there is available would certainly indicate that there is a connection between the two. I suppose basically the feeling is that anything that is inhaled is likely to cause damage to the lungs and lung related disease.'

Another common argument balanced the weight of scientific evidence against that of personal experience:

> R682 :' That is what is drummed into us in the papers. You see some folk that smoke like chimneys all their lives and they have never had an illness in their puff. There is folk who have been tee-total non smoking and they die at 25 of cancer or something. Obviously yes it is true that if you do smoke a lot you are more at risk.'

The health hazards of cigarette smoking were occasionally given the same priority as the health hazards from other sources. Also in terms of health problems smokers emphasised heart problems, or respiratory problems, rather than mentioning cancer directly. Such qualifications, however, were few although smokers did have a greater tendency than non-smokers to minimise the health importance of passive

smoking using the arguments mentioned above:

> KM : 'Compared with other non-smokers do you think if other non-smokers are working or living in a smoky environment that would be bad for their health?'
>
> R539 :' I suppose it can affect your health. It is the same as diesel fumes that must affect your health in some way.'

And as another smoker said when asked about passive smoking:

> R609 : 'That could depend on your work as well you know. If you are a welder in Govan shipyard you are drawing that amount of smoke in every minute of the day.'

Similar qualifications have been made by other researchers (see Spelman and Ley 1966; Eiser, Sutton and Wober 1979).

DISSONANT SMOKERS

Although such qualifications, both about the nature of the link between smoking and health, and also the degree of danger to health, were found, the predominant belief among respondents was that of a general acceptance of the health hazards of smoking, both on the part of smokers and non-smokers. This leads to a discussion of dissonant smokers: smokers who would like to give up

smoking if they could do so easily (McKennell and Thomas 1967; Chapanis and Chapanis 1964).

There was a high proportion of such smokers in my sample, and a general acceptance of the health education message was found among respondents. A lot of the ideas about dangers to health, were coming from various medical reports broadcast by the media; newspapers, radio, and television.

Dissonant smokers agreed with tougher measures to stop smoking. One respondent who smoked 7 packets per week said:

> R625 : 'If Maggie Thatcher banned cigarettes tomorrow it would not bother me too much.'

This same respondent thought cigarettes should be 'banned from a health point of view.' He also looked for non-smoking seats on trains and chose to sit in non-smoking seats aboard aeroplanes, actions typical of dissonant smokers. Another respondent (R763) who smoked 6 packets of cigarettes per week, described the health problems associated with smoking and the unpleasantness of being in a smoky environment, said in summing up that he: 'would certainly like to be a non-smoker.'

Respondents' dissonant attitudes were also brought out with regard to the price of cigarettes. Some were in favour of an increase in price as this might force them to cut down on their own smoking:

> R609 : 'I am the sort of person that if I am getting something reasonable I would probably indulge in it more you know. So I would keep the price up.'

Although this endorsement of tougher measures reinforces the ideas from other work that dissonant smokers may be more addicted to tobacco use and also smoke more (McKennell and Thomas 1967, Eiser 1982); some dissonant smokers were also infrequent smokers. One respondent who smoked one cigar per month stated:

> R652 : 'I don't like to be in an area where I've got to ehm, I've got to inhale somebody else's smoke while I'm sitting beside them and it smells horrible. You feel that em, they to a certain extent, I get the feeling, you know, that they could be giving you cancer through the smoke you're inhaling you know, from their cigarette.'

SMOKING AS SOCIAL DEVIANCE

The growing acceptance of the health hazards of smoking had also lead, on the part of smokers, to general feelings of unease about smoking in the presence of others. As one respondent expressed it:

> R522 :' I do think people feel more guilty about lighting up a cigarette and stuff like that. There are no-smoking areas now.'

And another:

> R509 : 'I felt embarrassed when I was with friends who didn't smoke. There was actually occasions when I wouldn't take a cigarette. I would wait 'til I was away out of their company then I would take a cigarette.'

A sense of increasing isolation was also felt by smokers. Cigarette smoking in Britain was seen to be on the decline, it is now no longer viewed as the norm. Or at least it has problematic aspects, almost as if smokers indulged in a deviant activity often restricted to the company of other smokers. As one respondent said:

> R521 : 'If you are a smoker you are a minority. It is very unusual for people to smoke now I find amongst my circle, I don't know many people that smoke. So it has become an anti-social habit. There is a lot of times I don't smoke because I would be the only one smoking and nowadays to smoke is a sign of weakness, a sign of ill-health.'

And again:

> R528 : 'Ah've got that, ah just get that feeling that ah'm just foulin' up their house, the air in their house.'

And one respondent stated:

> R609 : 'I am a smoker, I should be able to smoke when ever I want, but that is a ridiculous attitude. I should not really be polluting people, what gives me the right to blow smoke about. I have seen me ask if its O.K. to smoke you know. If they say do you mind not bothering. It is no problem. I would always give people the option you know, I would, not like to impose on them.'

Another described the steady decline of the number of smokers at work:

> R504 : 'At one time it was the norm I would think, oh about 90% of the staff overall, in this department smoked and in the last ten years, yes in the last ten years em the habitual smoker, the continuous smoker em now counts for three people that's all.'

These ideas of respondents reflect the current situation in Great Britain, where cigarette smoking among men has been on the decline since the 1960's (Godfrey 1986); for men aged between 35-49 it has dropped from an average weekly consumption of 87 cigarettes in 1960 to 56 cigarettes in 1984 (Department of Health and Social Security 1988:17). Similar shifts to these both in public opinion and consumption have

been documented in America (Markle and Troyer 1979, Nuehring and Markle 1974).

Such shifts in opinion had led smokers to restrict the context of their smoking:

> R522 :' In the evenings I smoke. I smoke more when I am with other people that smoke ... I think at work, I work with my hands a lot quite a lot, and I work with people. It is not convenient and it is not nice. I just made it a habit not to smoke when I am working.'

It could also lead people to stop smoking and often given as a reason:

> KM : 'When you stopped smoking, why did you stop smoking?'
>
> R667 : 'To improve my health, to make myself more socially acceptable, to prove that I could do it ... Just generally for society, to be acceptable. You have become the exception by smoking.'

If respondents felt guilty about smoking but continued to smoke this could then be interpreted, or justified, as smokers being selfish. As one respondent said:

> R536 :' I feel a bit selfish that way you know ... you should (not smoke) but you don't you know.'

And again:

> R515 : 'People who smoke don't think o' that they're sort o' a, they're sort of a selfish, they're no carin' as long as they're smoking they don't think about anybody else.'

Alongside moves towards compliance with the views of non-smokers, smokers also voiced attitudes of annoyance. As one smoker replied during his interview:

> R531 :' I sometimes get annoyed at work we have a smoke-free area for eating and a smoking area, you tend to find that in the smoke-free area there is nobody there and everybody that smokes have friends that don't smoke so they all sit in the smoking area if they want to have a chat you know.'

The above reactions show that smoking in Scotland is developing various aspects of a deviant activity. The main processes are that of stigmatization, social isolation, ostracism of individuals from normal roles and groups, and membership of a deviant sub-culture (see Becker 1963; Downes and Rock 1982; Clinard 1964). Indeed Neuhring, Markle and Troyer (1974; 1979) have detailed similar changes taking place in America to make smoking an illegitimate behaviour and to denigrate those who continue to smoke.

However, although smoking was generally seen to be

on the decrease in the age group of my sample it was thought of as a problem for the young and indeed to be on the increase in this age group.

To sum up I have shown how the health hazards of smoking were universally accepted both by smokers and non-smokers. The health hazards of passive smoking were also acknowledged although to a lesser degree among smokers. Cigarette smoking was however seen to be more dangerous than either cigar or pipe smoking. The health education message with regard to tobacco use was therefore clearly getting across, via the media, to my group of respondents. I then went on to show that although the health hazards of smoking were accepted in a general sense, such a message was often interpreted by smokers, or balanced against their everyday experience, in such a way as to reduce its implications.

Further I have also shown the high proportion of dissonant smokers in my sample; respondents who accepted the health hazards of smoking and said they wished to give up, but did not. The social pressure against smokers and smoking has also been shown to be high, reaching the point where it has taken on various aspects of a deviant activity - for example elements of avoidance and concealment. But respondents still smoked - why? This paradox between the documentation of changes in attitudes and the lack of corresponding changes in behaviour has puzzled other researchers (Merriman 1978; Marsh and Matheson 1983; Eiser 1982).

What were seen to be the positive benefits of smoking? In the next section the reasons which were given for smoking will be analysed.

REASONS FOR SMOKING: THE IMPORTANCE OF RELAXATION

Overwhelmingly respondents associated smoking with relaxation. The following are typical comments:

> R522 :' I think it helps me to relax.'

And:

> R521 : 'I don't know probably it is the er I don't know how true this is but to me it is relaxing.'

Non-smokers also associated smoking with relaxation in the following case as a comforter:

> R506 : 'It's just like a dummy tit or whatever once they use it it's just a comforter.'

And another non-smoker said:

> R644 : 'I think it is nerves, it calms them down. It becomes like a drug to them. It calms them.'

Other reasons for smoking were as follows. Some respondents stated that they smoked because it increased their concentration when at work. This was particularly mentioned by those who had to write reports as part of their work activities.

Another reason given for smoking was that it gave respondents a sense of satisfaction. One taxi driver, when things were going well at work, described smoking as follows:

> R133 : 'It is like a pat on the back to myself. If you have got a good hire over the radio or something like that.'

A common reply given by respondents as to why people smoked was that they smoked for 'something to do with their hands'. For example:

> R546 : 'I always like something in my hand you know. I needed something in my hand you know. My hands had to be doing something.'

Smoking was also associated with boredom, habit, as something to do:

> R527 : 'I would say it is actually boredom that makes me smoke you see I always have to have something in my hand, cigarettes is the easy thing for me to have in my hand, I am not a reader, I have never been a reader in my life you know.'

One of the major aspects of habit was that individuals often smoked without realising that they were smoking:

> R519 : 'Unconscious. Like where ah work it's like a long bar goin' straight through tae the kitchen, straight through to the ootside, the cellar. So the cigarettes are always lyin' on the bar. So if your walking by maybe there might be several cigarettes. ...It's in your mouth before yer up the first step you know?'

The above reasons have also been cited by other researchers (Eysenk 1980, Marsh and Matheson 1983, Ashton and Stepney 1982, Dunn 1973). But psychologists have given explanations of a particular kind. That smoking should have the possibility to both relax and increase concentration has been related to the complex 'biphasic' effect of smoking, giving the smoker the ability to 'top and tail the range of his emotional responses' (Marsh and Matheson 1983:87; Merriman 1978:42). Something to do with the hands has been spoken of as one of the 'sensory-motor rewards' of smoking (Merriman 1978:41), smoking when bored has again been seen as a means to normalise arousal (Ashton and Stepney 1982:100), while smoking due to habit has been related to the addictive properties of nicotine.

People smoked, then, for a variety of reasons, but relaxation was found to be the most important. Relaxa tion was also related to those other reasons respondents gave for smoking. Because of this I will concentrate my analysis in the first instance on the relation between smoking and relaxation, bringing in respondents' other

reasons for smoking where appropriate.

However, there were various aspects to the connection between relaxation and smoking. Interviewees spoke of relaxation from two standpoints. First, respondents said they smoked 'to relax', to relieve stress etc. And second, respondents said they smoked 'because they were relaxed', for example, at the weekends, on holiday, or after a meal.

The first aspect is recounted in the following quotation:

> R523 :' Or maybe obviously stress, any slight stress eh or upset you know eh say some of the kids get hurt or somethin' you were sitting I would have a cigarette.'

Another expressed relieving stress in the following manner:

> R546 : 'If I worry at all I smoke double the amount of cigarettes you know, after one or two I am all right'.

Some (e.g. R546) spoke of smoking in medical terms as a substitute for tablets. Or they said (R132) that it was 'the drug affect' which soothed.

Non-smokers (e.g. R146, R158) could see this need to relax as an indication that smokers were by nature nervous people, that they smoked 'for their nerves'. Smokers would also stigmatise other smokers in this

fashion although in such instances it was pipe or cigar smokers' characterisations of cigarette smokers. As one pipe smoker stated:

> R111 : 'I always found pipe smoking very relaxing, light up the pipe, the pipe went out, then it went out again, cleaning it. It was all conducive to calm. I always associate cigarette smoking, generally I see cigarette smoking as very neurotic. I am aware of people trying to calm themselves down, whereas pipe smoking to me has always been to me the sign of somebody who was calm.'

The idea that smoking is related to personality is not only a feature of lay thinking but is also to be found in the professional psychological literature. Eysenck (1960) and Smith (1970) link smoking to extroversion; others (McRae, Costa and Bosse 1978, Meares et al 1971) to anxiety and neuroticism.

SMOKING SITUATIONS

The ideas of the relationship between smoking and relaxation were closely connected to those situations, times and places in which respondents felt the need to be relaxed. Above I have shown how this could occur in the domestic situation. Others would smoke when under stress at work:

> R625 : 'I tend to find that when I am left on my own with some reports or something that I tend to smoke more than I should. If I am thinking hard and have a deadline to meet I think it would be stressful. That is when I think I smoke probably more.'

Respondents said they reached for a cigarette when they had to make an important phone-call, or were working on a complicated task. As one respondent stated:

> R124 : 'I did have the tendency to smoke in times of stress or any other reason like that, apart from just a habit, making that phonecall you don't want to make, and instances like that. I would always find myself coming off the phone with a cigarette in my hand which I didn't really want, er that sort of instance I found myself doing that an awful lot.'

Non-smokers also spoke of such situations:

> R132 : 'I am aware of people who can't make an important phone-call without first lighting up a cigarette.'

Another respondent (R652), who worked in a music band in the evenings said that after the excitement of an engagement a small cigar 'settled' him.

Thus people who smoked at work varied their smoking depending on their tasks or the timetabling of the work

situation. For example one respondent smoked more when on night shift because he was at work for a longer period of time, others smoked more when they were carrying out the most stressful aspects of their occupations. One respondent mentioned difficult and dirty tasks:

> R101 : 'It is maybe work where I am going to get my hands dirty. It is times like that I would have a cigarette.'

Another mentioned an increased in his smoking when the organisation of his work changed:

> KM : 'When did it start going up would you say?'
> R133 : 'Well that would be 1974. I remember times when I would be working on the machines I think it changed then, I would always have a cigarette going you know.'

One respondent, (R153) a bus driver, only smoked at work when he was sitting down in the cab, not at the bus terminus or between shifts.

Smoking to relax however need not occur in every stressful situation, and indeed some respondents spoke of gradations in stressful situations. One school teacher (R682) smoked if there was what he described as a mini-crisis' with the children at school but not at other times.

Although respondents smoked 'to relax' they also

said they smoked 'because they were relaxed': for example, at the weekends, on holiday, or after a meal. This aspect of the association is illustrated in the next quotation:

> R536 : 'Because your sitting, sitting in one place a' the time if you were movin' about ye wouldn't be doin' that, if you were playing tennis or somethin' like that ah don't suppose you'd be smokin' too much you know, relaxation maybe does it you know, 'cos yer ... yer relaxed ye know, ye canny ... yer no restless or anythin' like that so yer just smokin' all the time ye know.'

And another example this time during work:

> R608 : 'After I have done something (at work) I stand back and say that's fine, that's O.K. and then I will sit down and have a smoke. While I am having a smoke I am relaxing for 10 minutes.'

The male respondents of my study used cigarettes for similar reasons to the women in Graham's (1984; 1987) research, as a means to reduce stress and to demarcate short periods of relaxation from the normal routine. But male respondents gave examples from the work rather than from the home context.

As can be seen from the above quotation such periods of relaxation were often associated with

feelings of satisfaction. It can be asked, if a person was already feeling relaxed and satisfied what additional aspect was brought to the situation, if any, by smoking. Although respondents often said no more than they smoked in relaxing situations some said it helped to increase their sense of relaxation:

> R763 : 'I smoke very much in the relaxing situation. I really do find to sit down at night after a meal and watch television in a pleasant chair to be totally relaxed and have a cigarette. The cigarette seems to help me relax even further ... when I sit down and relax there is a lot of pleasure in having a cigarette and watching T.V. it seems to bring me down onto a different plane.'

One of the main times and places where respondents were relaxed and smoked were those during or after eating and drinking. This could be first thing in the morning at breakfast, during or after the main meals of the day, during tea and coffee breaks, or when out for a special meal or at the public house. As one interviewee stated:

> R550 : 'Yes always after meals, and as soon as I woke up in the morning I smoked, I would have a cigarette with my cup of tea in the morning. If I was in the pub I would smoke all the time.'

Respondents would smoke after drinking both alcoholic and non-alcoholic drinks. This partly counters some of the research findings which show high correlations between smoking and drinking alcohol and put this down to the disinhibiting effect of alcohol on smoking behaviour (Ashton and Stepney 1983:108). Some however only smoked when drinking alcohol or had a tendency to smoke more when drinking alcohol. This confirmed the results of the screening questionnaire that smoking was strongly associated with drinking alcohol. As one commented:

> R111 : 'I would have cigars on occasion. A cigar and a pint I always found relaxing.'
>
> KM : 'Why a cigar and a pint?'
>
> R111 : 'because the cigar tended to cut into the taste of the pint and take the edge off the pint. This was my feeling at the time, it is probably unsound.'
>
> KM : 'take the edge off the pint?'
>
> R111 : 'in other words it did not feel as intoxicating if I had a cigar with it.'

Myrsten and Andersson (1975) have also found positive support for this hypothesis.

And another stated:

> R133 : 'I smoke more at the pub'
>
> KM : 'when you say you smoke more at the pub, why do you think you smoke more at the pub?'

R133 : 'When you are sitting and drinking .... it is just the atmosphere. I just tend to smoke more you know.'

The main time and place then of drinking and smoking heavily was in the public house as the following two examples show:

R536 : 'If ah'm in a pub or somethin' like that ye smoke a lot more you know.'
KM :' why do you think that is?'
R536 :' Ah don't know, ah don't understand it, ah think maybe the tow of them go together, all the bad habits goin' in the one place i'n it.'

And:

R539 : 'During the week I smoked less and at the weekend out with the lads for a drink you tend to smoke more because nicotine and alcohol go together.'
KM :'When you say that nicotine and alcohol go together why do you say that?'
R539 : 'One encourages the other I think.'

In general the practice of sharing cigarettes between individuals in such a situation was given as the reason for heavy smoking. Respondents often said they wouldn't go into such social situations without having an adequate number of cigarettes in their possession. Feelings of embarrassment if they themselves ran out of

cigarettes, or annoyance at others who didn't have any cigarettes to share, were expressed in the course of interviews:

> R503 : 'Ah was never really without, possibly mainly because if ah've, if ah wis in social circles em it was always an embarrassment like if you kept pullin' out packets wi' just one cigarette, oh ah'm sorry ah've none left sort of thing you know, so ah suppose that that in itself had a sort o' part to play in it as well you know, although you do get certain blokes that that's all they seem to bring out is a packet wi' one or two in it, you know, sorry boys ah canny gie you a cigarette ah've only got two left an' ah'll need tae get some sort of thing you know, so ah suppose socially to be accepted as well you sort of tended to make sure you had enough cigarettes you know with you, eh to be involved in the company you know.'

In the case of the public house, therefore, there are strong social pressures for smoking.

In general then the social world structures those times and places in which smoking occurs. The following respondent illustrates the way in which reasons for smoking and occasions of smoking come to be linked:

> R134 : 'Yes I must admit it is a time clock thing. I always smoke a cigar going to work in the morning and I always smoke my pipe when I go into work. I smoke it at tea break. At home I smoke after my tea and then I will smoke with a cup of tea before going to bed.'

I have spoken of the relationship between smoking and relaxation. Smoking 'to relax' occurred more at work, during the days of the working week. Smoking 'because one is relaxed' occurred in the evenings, at the weekends, or when respondents were on holiday.

During the work period, however, there were also breaks where respondents would smoke, partly to wind down from the tasks of the day and partly because they were in a relaxing situation. Teachers for example often spoke of breaks taken in the staff-room in this way.

And again any one respondent could associate smoking and relaxation from both aspects. One respondent smoked a cigar when writing work reports: to produce the necessary relaxation and provide extra concentration. He also smoked when going home in the car, the time not only of relaxation but also the time of the commencement of 'non-work'. Here, smoking this cigar acted as a marker for a different qualitative use of time.

The way in which tobacco is consumed, be it via cigarette, cigar, or pipe, also had a bearing on

relaxation. One respondent had smoked a pipe before switching to cigars and saw differences between cigar and pipe smoking in terms of relaxation.

> R504 : 'Cigars are much more convenient, ehm a pipe tends to be much more leisurely. Eh, when I was smoking a pipe I attempted to smoke it during the course of the working day, again because I enjoyed it em, but I found then that I wasn't enjoying it because I would start my pipe up and then I would have to go and do something perhaps in a room where I couldn't smoke, so em, I would heave my pipe, em so like for a short smoke if you like then the cigar was perhaps the better option.'

Some interviewees described the ritual of pipe smoking:

> R505 : 'I think it was the whole, the whole thing as it were : from making sure it was clean, to packing it, to lighting it, to keeping it going, as well as the enjoyment of actually physically smoking it. It was the whole, it was the whole thing em, which was an enjoyment in itself.'

But others saw this as difficult to manage and not conducive to producing relaxation. There was a lack of associated mobility with pipe smoking. Pipe smoking could be relaxing but substantial periods of time were needed to enjoy it.

Cigars were seen to be more convenient than a pipe. However, like pipe smoking there was a tendency for cigar smoking to be seen as 'ceremonial' in nature compared with cigarette smoking. This had its effect in focussing cigar smoking to particular times, occasions, and situations: weddings, special meals in restaurants etc.

CONCLUSION

This chapter has shown that among respondents there was a general acceptance of the health hazards of smoking. It has also shown that there is strong public pressure against smoking. This current situation reflects a change from the past which held more liberal ideas with regard to tobacco use. The current situation has also meant that there was a high proportion of dissonant smokers in my sample.

But even though they were dissonant smokers they did not stop. In the chapter I have also shown the reasons as to why people smoked; that overwhelmingly the most important reason given was the connection between smoking and relaxation. In other words smoking was seen to have beneficial qualities, and qualities, for example in relation to reducing stress, which directly link into health. If smoking was bad for physical health it may serve a purpose in reducing mental tension.

What we have is a set of conflicting imperatives; to stop smoking because of its dangers to health, to

continue because of its pay-off in reduced stress. And beyond these personal reasons were generalised social pressures to stop. This had produced a highly ambivalent atmosphere for those who continued to smoke. This can be witnessed in the difficulties of dissonant smokers and also the fact that the activity of smoking had developed elements of a deviant activity. Aspects of guilt, restriction and concealment had been produced in the habits of smokers, along with the consolidation of smoking among smokers only, for example in smoking areas at work or in the public house. In the next chapter how people resolve such ambiguities and stop smoking will be considered.

CHAPTER 6

ACCOUNTS OF TOBACCO USE II: STOPPING AND STARTING

INTRODUCTION

The last chapter detailed the high proportion of my respondents who were dissonant smokers. This had led many of them to attempt to give up smoking. Others had smoked but no longer smoked at the time of interview. What factors were seen to be important in giving up smoking? This question can be considered from two aspects: first, why did people stop? and second, how did people stop?

STOPPING AND STARTING

Health and Finance

As has been found by other researchers (McKennell and Thomas 1967; Trahair 1967; Horn 1969) people generally stopped for reasons connected with their health or because of the cost of tobacco. And it was due to changes in their perception of these influences which could trigger a decision to stop smoking. Some respondents mentioned particular health campaigns. Other spoke of their own health being the decisive factor.

> KM: Why did you stop?
>
> R475: It was for my health really. I used to wake up in the morning and be sick and things like that and that is one of the reasons I gave

it up.

Tobacco related disease among close friends was also clearly a precipitating factor in coming to a decision:

> KM :And why do you think you managed to stop on that occasion where previously you had not?
> R448: Just pure willpower and determination that is all. I think one of my friends had cancer of the throat you know and I think that had an influencing factor on it.

Financial considerations were other strong influences in getting people to consider stopping smoking. Some respondents (R421) spoke of difficulties when they were made redundant while others gave the example of the government increasing prices as providing the incentive. As one respondent said:

> R439 : I cut down quite considerably over the year before. I was down to about 10 a day. I had been trying to cut down. Again not necessarily because of health. I found the price was going up too.

Natural Breaks

The current social pressures against smoking could act as a powerful incentive to reduce consumption but to stop often required something extra. It is important to consider not just why someone wished to give up smoking

but also how they gave up.

One of the key factors in giving up smoking was the occurrence of natural breaks in routine. Although I have shown how respondents often smoked when relaxed and relaxation was often mentioned in terms of holidays, how respondents viewed time when on holiday varied. For some, holidays were often seen as a break in the routine, a period of relaxation, and if they smoked when they were relaxed their cigarette smoking would increase. Respondents often mentioned smoking more cigars when on holiday. Holidays were a 'special occasion'.

However, just as smoking was not only associated with relaxation but also with routine, holidays could also act as a break in respondents' normal routine, and act as a break in habit. Interviewees often mentioned such a break as giving them the opportunity to stop smoking:

> R521: I have a deadline the first of the month, midnight or whatever, and if you are away from your normal places if you are on holiday for instance it is so much easier because you don't have the same routine, like coming in here in the morning or having a cup of coffee and a cigarette that's a habit more than anything else er well it is a break it is a change so you might as well not smoke it seems easier.

As the same respondent said, however, there were dangers of trying to give up at such a time, because of the artificiality of such a break, its non-routine nature:

> R521: I ...try and carry it on for another week until I crack up again... I think it is just a habit being in you know the same desk the same area er and one other person in the office smokes you know which makes it quite easy to have a cigarette.

Holiday time could act as a break to 'break their habit', although difficult to sustain.

Another 'natural break', mentioned in the context of giving up smoking, were periods of illness. Either respondents did not smoke when they were ill, they cut down, or managed to use such a period as the prelude to a serious attempt at giving up smoking. As one interviewee stated:

> R528: Well when ah'm in hospital ah can manage tae stop it but when ah come out ah just again.
> KM: Why do you think you manage to stop when you went into hospital?
> R528: Ah don't think about it when ah'm in hospital ah just didn'y bother.

Other respondents mentioned colds and flu:

R509: The reason ah stopped smokin' was eh, ah got a cold - ah got the 'flu one winter. It was a particularly heavy 'flu, a particularly heavy cold. So it lasted for about... ah would say about a week - about 5 days, 6 days. So in that time obviously ah couldn't smoke. Eh, ah do remember in that time ah was aying' eh: 'Ah can't wait 'til this all clears up so ah can have a cigarette.' When the 'flu, the cold an' the 'flu cleared up, the craving for the cigarette had gone, an' ah thought, ah just couldn't believe, because ah'd tried to stop before an' ah failed on a lot of occasions, so ah couldn't do it an' eh, when this 'flu had cleared up eh, ah just couldn't believe this, so an thought, Well what an ideal opportunity to stop.

And another said the following:

R763: I think it did get less as time went on. One time I did stop I had a terrible cold and there was no way I could face cigarettes, and I was really on my back for several days and that got me over the first two or three days having not had one for two or three days I struck out to avoid smoking.

KM: You said you could not face a cigarette when you had flu?

R763: I knew the way my chest was all tight I

knew if I had a cigarette I would start to cough. I knew if I had a cigarette it would start a coughing fit and this would be rather unpleasant.

But here, just as respondents spoke of the opportunities offered by breaks in routine to stop smoking there were also instances where breaks in routine led to a person re-starting smoking:

KM: You said you drifted back into smoking again. How did you drift back into smoking again?

R763: I am sure that it was at a meeting or a conference or somewhere and I accepted one cigarette thinking it would not lead to another, and it did. In a situation being away from home at that particular time I brought a packet of cigarettes and from there it built up to a level whereby it went back to what it was previously.

Goal Setting

Apart from natural breaks respondents often set themselves special tasks when they attempted to stop smoking:

R503: Yeah ah would say ah was a fairly average smoker all the way through if you know, ah never really sort of got heavy or light or anythin' like that ah just, a couple of times when ah, ah

> sort of played it if you like, thinkin' about stopppin' smokin' em, ah sort of cut maself down a wee bit but ah was only really kiddin maself on as well as everybody else sort of thing you know, but eh, when ah did stop smokin' ah mean, ah stopped just before christmas so if ah got through christmas and New Year not smokin' an bein' sociable em, then that was it you know, so ah succeeded in doin' it that way, an 'ah just cut maself off.

As can be seen from the above such goals set up by the respondent could be closely tied to special times and the social nature of the problem of breaking their habit were clearly recognised. Another respondent described the need for a special target day as follows:

> R625 - 'Well it is a significant birthday for me it is my fortieth. I feel it is a milestone in my life and I feel having tried to stop smoking previously I will set this day, and hopefully I will be able to look back and say I stopped on my fortieth birthday. I believe you should set a target. Build up a mental attitude to help yourself. I don't smoke in the house anymore, and as of next Monday I will not smoke in the office anymore. I will still have the odd cigarette in the golf club or rugby club or

> whatever. I am trying to make it a wee bit easier for myself.

And another respondent who stopped at lent clearly incorporated extra social pressures, this time from his children, in order to stop:

> R667: I have problems even now, if I think about it hard enough I would like a cigarette. It took a while for the feeling to wear off. How I engineered it was all my children got me to promise to give it up for lent, you see... and I have not smoked since. For the first few weeks it was very difficult I still had a craving for it.

The involvement of other family members, particularly children, in getting respondents to stick to their resolve, was common:

> R306: You just feel that you want one. This last time it was a bit easier. I think there was a no-smoking campaign at the beginning of the year. My older daughter had been on and on at me for years and the younger one had been doing it at school, so I told them to bahave and I would stop in my own time, and I did.

So far I have been considering respondents who gave up smoking abruptly. Many respondents, however, gave up gradually. They could do this by attempting to cut down

on the the quantity of tobacco which they smoked, or they could switch from smoking cigarettes to smoking roll-ups, cigars or pipes, all of which were seen to be less harmful than cigarettes. Some respondents had not given up tobacco use completely but still smoked cigars or pipes.

> KM : Have you always smoked a pipe?
>
> R307: No. At one time I smoked cigarettes. I smoked maybe 30 a day but I was conscious of the fact it <u>was</u> damaging my health. It was because I was getting sinus all the time and catarrah and everything else and I stopped smoking but I put a stone and a half in weight on and try as I might I just couldn't get that weight off and I went on the pipe and then I <u>hated</u> it to be perfectly honest with you. It took me 6 months to get the hang of it! I <u>detested</u> it but I was determined to stick to it because to my way of thinking it was the lesser of the 2 evils. It was, I wasn't inhaling it and the weight well, I lost about half a stone actually.

Another described moving via pipe smoking to becoming a non- smoker:

> R469: I smoked a pipe when I came off cigarettes.
>
> KM: And did it work?
>
> R469: I smoked a pipe and I smoked a couple of cigarettes a shift in the steal works. Then I

was just smoking the pipe and then I just took the pipe with nothing in it and then I just threw it away.

KM: And you did not continue smoking the pipe?

R469: No I did not need it.

KM: And the idea of smoking a pipe to give up cigarettes where did you hear that from?

R469: I think I heard that in the steel works. Just ease yourself off it don't stop smoking right away. Personally I have known people to stop it and a couple of weeks they are back on it again.

KM: Why do you think that is?

R469: I felt the benefit come off it easy like.

Other respondents however did not change to pipe or cigar smoking but found ways to directly cut down on their cigarette consumption:

R439: Yes my way of mind was to smoke to a clock. I worked out that if I had one every two hours I could keep to my 10 a day when I was cutting down. On a couple of times I found coming to the time for my cigarette I was halfway through the cigarette and I said what am I smoking this for I am not enjoying it. But you found that you were now developing a new habit by the clock. You were not smoking when you wanted to smoke but you were now smoking on the clock whether you enjoyed

> it or not. I think that possibly helped me when I did come to give it up. I was becoming aware that I had set up a clock instead of a normal habit.

Restarting

Although stopping smoking could be very difficult, going back to smoking could be very easy. Above I have mentioned the dangers of breaks in the routine: just as they could allow respondents the time and space to stop smoking they could also cause respondents to drop their guard and start. Those social situations in which respondents would have shared cigarettes with their friends and in which friends continued to offer cigarettes were particularly difficult to negotiate. Respondents were acutely aware of the dangers and had to take avoidance action. As one respondent described it:

> R439: The time when you normally have your problems is as soon as you have given up, the first few weeks and that, was when I did not miss them at all. I must admit now it is almost two years and I have more thoughts about smoking now than I had before. The initial success has gone by without any problem. Now I sometimes find in company, if somebody is lighting a cigarette, I would think to myself I would not mind a cigarette. and you have to kind of pull yourself up.

KM :How do you deal with that?

R439: I just kind of switch my mind away from it. Quite often visually, you see a person light a cigarette, or taking out a cigarette, it is the physical ritual, and I just turn away and think about something else instead (laughs).

SOCIAL POLICY AND THE PRIVATE SECTOR

I will now go on to consider respondents awareness of the wider social influences on tobacco consumption. Generally these break down into three main areas. The effects of tobacco company intervention, those of government policy, and particular private measures which have been taken due to concern over the effects of tobacco use.

Discussion of tobacco company intervention covered sponsorship and their use of the media. Some respondents believed that whether sponsorship was acceptable or not depended on the nature of the sport. For example snooker was often seen as an 'unhealthy sport'. In other words snooker players themselves often smoked. Other sports, for example football, were by contrast seen to be closely related to health. The sports organisations who received sponsorship were also seen to be in a compromised situation. Sport was an expensive business and respondents often believed were it not for the financial support of the tobacco companies some sports would collapse.

Another important issue related to tobacco company intervention, was the influence of such advertising. Some respondents did not mind advertising with regard to sports events because they did not believe that such advertising would have an influence on people to go out and buy cigarettes. This did not mean however that the same people underplayed the influence of television advertising. The style of advertising was seen to be important. Concern was voiced particularly about its influence on the young.

Finally another area which caused ambivalence in respondents' attitudes was the effect that any moves against the tobacco industry would have on levels of unemployment. The awareness of such possible effects was heightened due to the proximity of a cigarette manufacturing factory, W.D. and H.O. Wills, near to the homes of a proportion of interviewees. Its history of lay-offs was particularly clear in some respondents memories.

Discussion of government intervention covered the education of the young, campaigns on smoking, health warnings and taxation. One issue related to government intervention was again the influence of advertising. Health warnings carried out by the government were often seen to be ineffectual and not noticed by people who bought a packet of cigarettes. Various respondents were in favour of a change in the health statement carried on packets, often towards a more direct or a stronger

message. Other respondents were unclear whether they noticed the health warning or not. One respondent (R625) only noticed when they were absent, when he bought cigarettes in a duty free shop. There was a general feeling that the effect of the present health warnings on packets of cigarettes had worn off and that people no longer read them.

In contrast to respondents attitudes towards health warnings on cigarette packets they were often in favour of larger campaigns or health advertising which were seen to be more effective in changing the publics views. Newspaper advertising was thought to be influential (R652). People were also in favour of strong health warnings and style. One respondent (R784) thought such material should be as strong as the government's aids adverts. Others (R769) stressed the effectiveness of similar campaigns which had been mounted by ASH.

However not all respondents thought that such campaigns would have an automatic effect in the reduction of the number of people smoking. One aspect to this lay in the audience for such health campaigns. Respondents believed that they could be ineffective among those who already smoked heavily or had been smoking for any length of time. Such respondents thought they could be effective however in prevention and particularly if directed towards the young. The importance of campaigns being carried out in the schools was therefore stressed.

With regard to taxation and the effect of cost on consumption most respondents first highlighted the compromised position of the government in not really wanting to stop smoking but having to be seen to do something:

> R763: Well it brings in an awful lot of revenue and if they lose this revenue they have got to raise it elsewhere.

However whether increases in cost would deter people from smoking brought forth mixed responses from interviewees. Some believed it would only stop those who were contemplating giving up and that it would not stop heavier smokers or those they described as addicted. The nature of price increases was also seen to be important. Gradual increases were not believed to be as effective as sudden large increases.

And the views of dissonant smokers were also ambivalent. Partly they wished to see prices remain where they were to minimise financial cost to themselves and partly they wished to see a large price rise which might give them the incentive to stop smoking. One respondent, quoted earlier and bellow in an expanded form, expressed such ambivalence as follows:

> R609: Obviously I would like them cheaper cigarettes are a daily commodity to a smoker you know like a cup of tea. Obviously I would like them cheaper then again I am saying to myself if

> it is kept at that price... I am the sort of person that if I am getting something reasonable I would probably indulge in it more. So I would say keep the price up.

Again raising the cost of cigarettes was also seen in terms of stopping people from starting smoking as well as getting them to stop.

Another theme which crossed both government and private intervention was the introduction of bans both on the manufacture and consumption of tobacco products. Although respondents varied in the strength to which they were in favour of bans most wished to see an extension particularly in public and enclosed spaces. Such an extension was endorsed by both smokers and non-smokers and this again partly reflected the large proportion of dissonant smokers in my sample. Others wished to see extensions of non-smoking areas at work. However few wished to see a total ban and most were concerned with preserving a balance between extending control on smoking and preserving individual liberty. As one respondent stated when asked about bans:

> R758: No not a total ban. People have got to have the right to smoke as long as it does not interfere with other people.

In sum,as can be seen from the above there were some general issues which crossed government, tobacco company, and private business intervention. One related

to the effectiveness of different types and styles of advertising whether it be tobacco company sponsorship of sports events or aspects of a government health campaign. More direct forms of advertising were seen to get across to the public whilst respondents were less certain about indirect approaches be it via sponsorship or general health warnings on cigarette packets.

Respondents also saw variations in the audience for such messages. The young were seen as both the most vulnerable for being encouraged to start smoking and also as being the most important group at which to aim preventative material. Dissonant smokers were the next most 'at risk' group with long term 'hardened smokers' being the least likely to be swayed from their stable habit. The effectiveness of price increases was also seen to be dependent on the status of the smoker. It is interesting to note in this context that McKennell and Thomas (1967) suggested that anti-smoking campaigns should be directed towards 'consonant smokers' as 'dissonant smokers' already posses the desired attitudes but their behaviour is confounded by addiction. Consonant smokers were also found to be lighter smokers and thus more liable to change.

The compromised position of both the government and sporting organisations was also clearly as common factor. And one in which both groups were seen to be compromised because of financial considerations. Finally although an extension of bans was generally

approved there was a conflict between such an extension and ideas of personal freedom.

SOCIAL CLASS AND RELIGION

In the chapter on concepts of health I showed how the dangers to health from smoking were discussed by both manual and non-manual groups but that manual workers were more likely to specifically mention its importance. I related this to the greater consumption of tobacco by respondents from the manual occupations.

I will now turn to an analysis of all those instances in the interview transcripts where respondents mentioned a connection between social class and smoking. These are where a direct connection was mentioned and excludes those which come under the more general relationship between social class and health, which have been discussed in chapter four.

Such statements fell into two types: those which made a connection between smoking and early parental upbringing, and those which stated that smoking was worse in the lower social classes. In terms of parental up-bringing people were either seen to follow or go against their parents. An example of the former was:

> R134 : I tend to follow in my father's footsteps in a lot of things. My father was working class he enjoyed a pint now and again and enjoyed a smoke. I now have got quite a lot of the same habits and things like that.

And the later:

> R121: It is swings and roundabouts situation my dad never drank in the house, er, he did not drink in the house as often as I drink in the house, but he smoked so he set a bad example by smoking but not by drinking. Perhaps I am the opposite I would drink in the house but not smoke.

Most said that they followed their parents smoking patterns. None of the respondents who gave such responses were from the unskilled manual classes. Such views could also be reflected in the way they wished to bring up their own children (R234).

Those who believed the working class tended to smoke more gave various reasons for this view. Smoking was related to the need for escapism among the working class, the lifestyle of the group, and to their reduced expectations from life. The working class were also thought to be less aware of the health - effects of smoking. In this my respondents echoed the views of Merriman (1978) who attributed social class differences in smoking to differential responses to information on the health hazards of smoking. As he said: 'Members of higher social classes are more likely to have had an educational background which enables them to comprehend and respond to such probabalistic information'(p28).

All the above ideas however were endorsed by

respondents from both manual and non-manual groups.

Again in the chapter on concepts of health that the negative influences of smoking on health was discussed by respondents from all religious groupings, including those professing no religion. When I asked respondents directly if they thought that religion influenced their own or other people's views on smoking the majority of respondents did not think it had any effect. Some by way of contrast, however, did make an explicit connection. Again this was either in terms of their own smoking or that of others. The general form of the connection was to highlight the moral injunction of various religions not to smoke:

> R101: I think a religious background naturally look towards smoking and drinking, because of some religions that it is against your religion to smoke.

Not all respondents followed such rules however (either because they were not religious themselves or belonged to a religious group which did not hold such strong views) but were often just giving examples of what they thought the religious would do. Some were affiliated to such a religious group but chose to ignore such injunctions even though they may have been aware of their force:

> R317: It's the Presbyterian thing that you're accountable...yeah, the smoking was the same to a

> lesser degree (than drinking). You could smoke, but a lot of people in the congregation didn't like the smoking. You know, I mean outside on the pavement, they still looked at you "you're not a Christian" and that type of thing.

Again, although respondents mentioned such formal rules and injunctions they often stressed, as can be seen from above, that they were not as binding as those connected with alcohol use. Finally, all those mentioning an injunction were either from a Protestant background or if not from such a background their comments were about people from a religious group which formally had injunctions against smoking. By contrast one respondent, a Roman Catholic, put across his ideas on moderation:

> R313: The Roman Catholic Church does not advocate smoking or non - smoking, or drinking or non - drinking ?

Apart from mention of religious injunctions against smoking a few respondents went further in their explanations and gave more detailed reasons why religious people should not smoke. They said that Christians should not damage their bodies as they were God given. As one said:

> R921: Yes with regard to smoking I look at a situation where to smoke a good deal would be

> harmful to your body, and my Christian viewpoint of that is that by doing something that is harmful to the body which God has given to us then I don't feel as helpful.

However, such views need not influence respondent's health behaviours :

> R809: I think we have a duty to the body we are given although susceptable to pain and suffering and death is one which is God given, one which is marvellous and miraculous and beautiful in its abilities to conceive and understand and to operate. It is one that should be looked at, in fact it is the temple of the living God and what you do to your body you are fast diminishing many of the spiritual aspects of my religion by abusing the body that I own.So it is part of my beliefs although you would not think it from my smoking, that I know the gift of life, the gift of my body and the way I look after my body should all be positive.

All those respondents who gave such explanations were from a Protestant, largely evangelical background. They were also frequent attenders, going to church at least once a week.

The above findings were not, however, reflected in

the smoking status of my research sample where there was an equal bias against smoking among Protestant and Catholic respondents: 22 out of 36 Protestants (60%) and 15 out of 25 Catholics (60%) didn't smoke at the time of interviews. However only 4 out of 9 (40%) of the non - religious didn't smoke.

Finally respondents (R234) also mentioned the importance of the way you have been brought up rather than religion in having the major influence on people's attitudes towards smoking.

CONCLUSION

In the last two chapters I have discussed the relationship between smoking and relaxation, health and dissonant smoking, and looked at stopping and starting and the wider social influences on tobacco consumption. I have shown how even although the health hazards of smoking were generally accepted, and that there was a large proportion of dissonant smokers in my sample, respondents often continued to smoke, and that respondents often smoked for reasons connected to relaxation. The central influence of social factors, in the continuation of a smoking routine, its interruption, or its re-establishment, have also been analysed as have the wider social influences affecting tobacco consumption.

Chapter 5 looked at the reasons for smoking given by respondents and noted the importance of relaxation.

However the need for relaxation and periods of relaxation were structured by the social situations in which the individual moved. Different work and leisure patterns dictated both time of smoking and even whether respondents smoked tobacco in the form of a cigarette, cigar, or pipe. The public house was also shown to be a central social arena for smoking; and the importance of round-sharing in the smoking routine was also highlighted.

This chapter also focussed on the relationship between smoking and health, and the related issue of dissonant smoking. The dangers to health of smoking were accepted by most of my respondents although some had different interpretations of the level of danger involved. Respondents gave relatively sophisticated accounts of the difficulties of imputing direct causality. Others compared the findings of scientific research to their own direct experience of the results of smoking to their friends and relatives. In regard to the causes of cancer respondents also balanced the dangers in the environment, both from work and everyday exposure. Again, the current social climate against smoking had not only led to guilt and difficulties for smokers but was also reflected in the high proportion of dissonant smokers in my sample.

Chapter 6 analysed those situations in which respondents stopped and re-started smoking. When giving up tobacco use, the importance of breaks in respondents'

routine social world, also the incorporation of social pressure in the form of the involvement of family members, and the choice of 'special days' for stopping were highlighted. Specific techniques which used a gradual method to stop smoking were also considered.

In terms of reasons for stopping these were found to confirm other work in the field and be a combination of health and financial considerations. Focus on the wider social influences affecting tobacco consumption highlighted the ambivalence of respondents' attitudes about the effectiveness of advertising, both from the tobacco industry and government. Respondents also believed the government were heavily compromised in their stance against smoking by their reliance on tobacco revenues.

Both these chapters point to three key issues relating to tobacco use. First, is the general acceptance of the health education message that smoking is bad for health, and linked to this a general hardening of social attitudes against smoking. Second, we have seen that smoking is, however, used as a means of relaxation and that this is seen to have beneficial pay-offs for the individual smoker in terms of stress reduction and management. Third, linked to the first two points, is the general climate of ambivalence which surrounds smoking. This is seen in the attitudes of dissonant smokers and also in the characterisation of smoking as a deviant activity.

Research in the field of tobacco consumption often addresses itself to the relationship between attitudes and behaviour, showing that although attitudes may change, behaviour often remains remarkably constant. This has raised doubts as to whether it is still worth while to monitor changing attitudes (Merriman 1978), it has also led to a focus on the attitude/behaviour link and the development and testing of specific models which theorise their connection (Marsh and Matheson, 1983; Fishbein and Ajzen, 1975).

The present study shows that smoking is often viewed as having positive qualities and this can explain why knowledge of its health damaging properties is not enough on its own to stop a person smoking, but may rather increase ambivalent attitudes towards tobacco use. These findings complement Graham's (1984; 1987) research on women's smoking for men, on the perceived beneficial uses of tobacco.

Again all the components of increased public proscription against tobacco use, feelings of ambivalence, guilt and exclusion, lead to the conclusion that, smoking in Scotland is beginning to display aspects fo a deviant activity. It shows that similar changes are occurring in Britain as have been detailed in America (Nuehring and Markle 1974; Markle and Troyer 1979). I have been able to take the work of Nuehring , Markle and Troyer further, however, by detailing such shifts of opinion in lay health accounts and not merely

in large scale surveys and work on media pronouncements.

Finally in this chapter I turned my attention to the topics of the influence of social class and religion on smoking. The importance of the concept of upbringing when respondents were asked about these topics needs to be noted, as are the reasons respondents gave for perceived greater smoking among the working classes: reduced expectations of life and less awareness of health effects. When asked to discuss religion most references were to proscriptive rules against smoking although a few respondents went into greater detail to explain why Christians should not damage their bodies by smoking.

The next chapter turns to a consideration of respondents' accounts of alcohol use, and here I will return to the twin themes of relaxation and ambivalence.

CHAPTER 7

ACCOUNTS OF ALCOHOL USE AND ABUSE

INTRODUCTION

The concept of ambivalence, however, is pervasive in the literature on attitudes towards alcohol use (Dight 1976; Rix and Buyer 1976; Mulford and Miller 1960; Heather and Robertson 1985; Marlatt and Nathan 1978; Pittman and Snyder 1962). In a study of Scottish drinking habits , Dight (1976) found that subjects tended to agree both with 'pro' and 'anti ' drinking statements, showing that positive and negative attitudes towards drinking co-existed within the same person. A greater degree of ambivalence, however, was discovered among men. Similarly, in a comprehensive review of the alcohol literature, Marlatt and Nathan (1978) found that all national surveys and a large proportion of smaller scale studies documented conflict both within individuals and between groups about drinking. Such ambivalence was found in various topic areas: with regard to alcoholism, the beneficial and harmful effects of alcohol, and how to deal with alcohol problems.

One of the major attempts to state the idea of ambivalence in theoretical form is that provided by Pittman (1967). In his book Alcoholism, Pittman discusses the nature of the ambivalent cultures to be found in America and most other western nations. He describes such cultures as those in which there is 'a

conflict between co-existing value structures' (Pittman 1967:8). Pittman first describes the two opposing poles of the value structure, the pro-drinking and abstinent sentiments, to be found within American society. Pro-drinking groups view drinking as hospitable and sociable; abstinent groups view drinking as sinful and hedonistic. These extremes of value orientationare then seen to lead to conflict within the majority of drinkers within a society.

Pittman also discusses a different form of attitudinal ambivalence, one in which individuals hold different attitudes towards different aspects of alcohol use:

> 'Another type of ambivalence noted by Krauweel in the Netherlands is that some societies, such as the Dutch, accept drinking but reject the drinker who becomes alcoholic.' (Pittman 1967:8)

This type of ambivalence has been identified by other researchers (Stivers 1976; Dight 1976; Heather and Robertson 1985; Crawford 1987).

Attitudinal literature (Crawford 1987; Dight 1976) generally tends to concentrate on whether people are for or against drinking, drunkenness, and alcoholics, rather than asking people what drinking, drunkenness and alcoholism mean fro them. However, it is clear that a group of people could differ as to whether they endorsed drinking, but still be more or less in agreement that

alcohol is a particular substance which affects consciousness and behaviour in particular ways. The first such component of attitudes relates to individuals' endorsement, and judgement, as to whether drinking practices are good or bad. The second component of attitudes and beliefs relates to the content of the drinking practices, the 'what happens' when people drink.

It may be the case that much discussion of ambivalent cultures relates more to ambivalence over the approval or disapproval of drinking, drunkenness and alcoholism, rather than to inconsistency of attitudinal content with regard to the effects of alcohol consumption. Of course differences in such attitudinal content have been found; for example, differences between Protestant and Catholic cultures (Mulford and Miller 1960; Mullen, Blaxter and Dyer 1986; Skolnick 1958; Nusbaumer 1981; Schlegel and Sandborn 1979). However, it is still important to separate out judgemental statements from content statements of belief. And, of course, in general the two aspects may often be compounded in the same statement. For example, in the work of Pittman it is difficult to know if the two statements, 'drink makes people sociable' or 'drink makes people hedonistic', are two different beliefs about the affects of alcohol or, rather, approval and disapproval of the same effect of alcohol from the differing perspectives of the drinker and the abstainer.

The focus of most alcohol research has tended to be on ambivalence at the affective level of attitudes towards alcohol use: how individuals feel about use rather than the meanings they attribute to alcohol use.

In this chapter I will explore aspects of ambivalence and the complexity of statements made about alcohol. The chapter covers three major themes corresponding to the three major areas of questioning about alcohol use covered in the interviews: normal drinking, drunkenness, and alcoholism.

MODERATE DRINKING, ITS SOCIAL USES [1]

Among respondents there was a general approval of drinking. Even among those who hardly drank themselves there appeared to be no strong anti-drink feelings. Their pro-drink attitudes, however, were generally qualified: drinking was seen to be alright in moderation. In terms of what the respondents meant by moderation, it was clear that many had assimilated information from various health sources. As one respondent stated:

> R521: 'I have read that it is better to drink a few glasses of wine a week or have a couple of drinks a week than it is to have nothing to drink at all.'

Respondents either knew about the results of surveys by reading newspapers or magazines or through

watching television (for example R115, R132). The idea of moderation, however, had more general connotations, the central idea being that any behaviour carried out in moderation did not do any harm. A typical response came from one respondent when asked about whether he approved of drinking:

> R218: 'But again it does not matter it is like everything else, in moderation it is quite alright.'

Such general ideas of moderation in all things were often seen to stem from parental upbringing. Helman (1984) has also shown how ideas of balance and moderation are persistent features of folk health beliefs.

In moderation, alcohol was either seen to be beneficial to health, or, another common response, not too damaging. When asked how it was beneficial respondents generally gave the reply that it reduced stress; it helped people to relax and this had beneficial health effects. When questioned as to whether some drinks were healthier than others they often said that there were no difference between drinks, that alcohol was alcohol no matter in which form it was consumed. Some, however, believed that spirits were more damaging. As one respondent said:

> R506: 'Spirits, it's more pure alcohol ... at the end of the day you've got to drink a lot of beer to get to to do what maybe a couple of whiskies can do, or a couple of gins, so I would think spirits are more unhealthy than lagers.'

Others saw stout as having health giving properties, it could 'build people up' or 'keep them regular.'

In the concept of moderate drinking we see a link between such lay ideas of moderation in all things and medical policy linked to ideas of encouraging moderate alcohol consumption in the population. The close link between lay and medical ideas can also be seen in beliefs about the relative healthiness of different alcoholic drinks. The exact meaning of moderate drinking, however, was closely linked to respondents' reasons for drinking, and it is these which I will consider next.

Respondents gave numerous statements as to why people drank. These could however be grouped into the eight following categories: people drank, to relax, to be sociable, for the intoxicating effect, for the taste, through habit, to escape their problems, out of boredom, or because it was part of the male image. Of these, when asked about their own reasons for drinking, respondents overwhelmingly gave two of these reasons: they drank to be sociable, or to relax. As one stated:

R503: 'As I say ... in my group it's sociable you know, I don't think there's any other reason I drink you know.'

Social reasons for drinking were endorsed even among those who were faced with having to give up drink for medical reasons:

R528: 'As I say, it's just the company I go for. If I had to I'd just go on to orange juice.'

And by total abstainers:

R521: 'And the social reasons why the pub is there. It is a meeting place, that's why they drink.'

Respondents also said they drank to be relaxed. Alcohol was seen to allow people to unwind after a hard week. Alcohol led to a relaxation of pressure. Often the concepts of sociability and relaxation were closely linked. As one respondent, when asked why he drank, stated:

R103: 'I find it relaxing and sociable.'

The symbiotic link between sociability, relaxation, and alcohol use was constantly referred to in the interviewers.

What did alcohol contribute to this association? In general respondents saw alcohol as acting as 'a

social lubricant'. It made people 'more voluble', more 'friendly from a conversation point of view'. It was seen to be able to 'bring people out', to make people 'more outgoing'. As expressed in one interview:

> R503: 'People become friendly, happy go lucky, as I say they seem to sort of, their troubles and cares seem to disappear for that period of time.'

These effects were often seen to be brought about by alterations in an individual's character or personality. As one respondent put it:

> R503: 'They become less of a frontage, everybody seems to have their own frontage and it drops as alcohol affects them.'

And another explanation:

> R505: 'I suppose it may react within character, except what they do is rather more pronounced ... things tend to be heightened, the way people act.'

Such moderate changes in people's personality allowed them to become more relaxed, and to ease their tensions.

The relationship between alcohol, relaxation, and sociability, however, was also connected to specify times and places, to the routines of respondents. Drink could be consumed at home or in the public house, in connection with work or at leisure.

Drinking socially was seen to be linked to a person's occupation. Jobs developed certain drinking cultures. In some, drinking could be integrated into the structure of the occupation, for example the 'liquid lunches' of businessmen or sales representatives, in others it was part of the accepted routine connected with work. One respondent (R211), a parts delivery driver, expressed this by saying that lunchtime drinking was 'the done thing' to do. Workers from the building trade or engineers described lunchtime drinking, particularly at the end of the working week. The irregular working hours of some occupations also led to particular drinking patterns among those respondents who worked shifts or travelled away from home.

The reasons which respondents gave for drinking at such times also varied depending how alcohol related to their occupational subculture. Most, however, considered such drinking, although largely undertaken with work colleagues, to be a relaxation from work. One respondent (R221) described how such times got people out of the 'usual mundane routine of work'.

Although such drinking was common practice among some respondents others in my sample preferred to avoid such practices by either not drinking at lunch-time or returning directly home after work rather than stopping off at the public house. Such an alternative was seen to be less possible for those where alcohol was more integrated into the work culture, particularly those

working away from home.

Respondents also drank at home for reasons connected with work, as the following case demonstrates:

> R121: 'I don't know whether it is because I have had a wee bit more pressure in my job that I have started to get cans of lager, late at night when the children are in bed I will maybe sit back for half an hour and have a can of lager and then go to bed. Maybe it is a way of winding down or something.'

In general drink in the house was again associated with sociability and relaxation. As the occasions for sociability in the home were limited respondents who gave this reason for drinking often kept alcohol in the house but drank infrequently. Respondents would drink in the house when friends, neighbours, or family came round, but consumed little at other times. As one respondent stated, the public house was still seen to be the main arena for sociability:

> R221: 'I don't like to drink in the house'
> KM: 'And why don't you like to drink in the house?'
> R221: 'Well it is the pub, it is company, its the patter you know.'

Some respondents drank in the home when they organised a party, but in this situation drink would be brought in

for the special occasion. Respondents also drank at home, to relax during the evening, but the quantities consumed were limited.

With regard to drinking in the home and drinking in general, marriage and particularly young children in the home were clearly viewed as a moderating influence on the quantity of alcohol respondents consumed. They said they drank far more before they were married:

> R121: 'Most of my married friends don't drink heavily. The ones who are still single, friends who are my age group who are still single, they still drink quite heavily.'

The financial restraints of marriage were often mentioned as limiting the consumption of alcohol, as were difficulties in getting baby-sitters which stopped respondents going out with their wives for an evening. There were also constraints within the marriage, respondents might not drink in the presence of their young children. Marriage entailed a change in focus, away from the centrality of the public house to that of the home, and a shift from engagement with friends to that of their family.

To summarise, respondents were in favour of drinking in moderation, and saw people as drinking for relaxation or for social reasons. Alcohol was seen to produce changes in people's behaviour or personality which enhanced the social pleasures to be found in

drinking. Alcohol was seen to produce an easy sociability. Without alcohol, outwith the contexts in which it is obtained, in the work-a-day world, people often believed the social, more relaxed, sides of their natures were suppressed.

The connection between moderate drinking and sociability was so close in the minds of respondents that they often used the term 'the social drinker' to describe themselves:

> R541: 'I would have said that I am a social drinker really. I enjoy chatting in the pub and it is a way of meeting other colleagues and that.'

Others used the term 'a social drink':

> R550: 'A social drink is good I think. It is like anything else if you have too much of anything it does not do anybody any good no matter what it is. A social drink, aye, I think it is good for people.'

Another phrase which was often used to describe acceptable drinking in others was drinking which was carried out on a 'social scale'.

PROBLEM DRINKING AND ALCOHOLISM

Unacceptable drinking

So far I have been discussing respondents' views on moderate drinking. Often in the course of interviews

aspects of moderation were sharply contrasted with examples of non-moderate or non-acceptable drinking. A dichotomy was suggested where moderate drinking was social, relaxed, and where conversation was directed towards others, but problem drinking was anti-social, solitary, and conversation was not directed towards others. These distinctions also related to the social arenas of alcohol consumption; although there were cultures of drinking at work and styles of drinking within the family which were non-problematic and non-disruptive, imbalances in these social spheres were seen to lead directly to problem drinking. I will take a closer look at these distinctions by considering respondents' ideas towards drunkenness, problem drinking and alcoholism.

Just as most respondents were in favour of the 'moderate social drinker' most were against 'drunks'. Or to be more precise, they could not stand them if they were pestered by them. People could not stand drunks leaning over them, or being annoying, or aggressive. 'I cannae stand them' was a common reply. To be drunk was to stagger, to be unable to co-ordinate physical bodily movement.

Drunks were described as being 'out of control' or having 'lost control'. They were, 'not in control of their senses' or had 'lost control of their faculties'. Such loss of faculties often elicited pity from respondents. Perhaps more importantly, however, drunks

were seen to be unable to communicate appropriately. One respondent stated of his own periods of drunkenness:

> R506: 'I probably talk a lot, ... talk a lot of rubbish, and I feel a kind of false bonhomie.'

And from another respondent:

> R505: 'Somebody being drunk is somebody who cannot articulate properly ... maybe become confused, not know what they are talking about.'

Repetition was a common complaint:

> R509: 'Some people may repeat themselves when they've just already told you something.'

Loudness of speech was also cited as one of the annoying characteristics of drunkenness.

Although most respondents mentioned slurred speech, they also mentioned inappropriate speech. There is a definite boundary with regard to speech within which alcohol increases the possibility of sociable conversation but beyond this boundary sociable communication starts to break down.

The acceptability, credibility, and truthfulness of the content of a drunk person's speech was an important issue. Some were inclined to the belief that a drunk person told the truth. As one respondent stated:

> R124: 'Their responses can get dulled they can say things they don't mean to say. I don't know if there is any truth in the fact that drunks never lie.'

Others, as shown above, believed drunks 'talked a load of rubbish'. This issue was closely related to ideas of alcohol's influence on character and personality.

Although alcohol was, in moderation, seen to produce slight alterations in mood and character leading to greater informality and sociability, an intensification of such changes were viewed in a negative light, leading respondents to re-define the drinker as being drunk. Respondents were, however, divided as to whether they believed alcohol changed an individual's personality or merely emphasized what was already there. For example, one respondent stated:

> R506: 'If someone's a happy drunk, well then he's a nice person, but if someone's kind of a violent drunk, he's no' a nice person.'

This seemed to be a case of bringing out the person's latent character, while typical of the other type of response was:

> R531: 'Well, they have changed from the person you know, you can see a difference in them and you can detect a difference in their attitude.'

Another respondents spoke about changes in personality in this way:

> R506: 'A false confidence, I think they've got a false confidence, a false personality.'

Related to these issues of character change was the common idea that danger was inherent in drunkenness. This was expressed in interviews as general concern over a drunk person's disregard for their surroundings, about any latent aggression in drunk people, or worries about the unpredictability of drunk peoples' behaviour. As one respondent commented:

> R211: 'An aggressive drunk is dangerous because a drunk person is very unpredictable.'

The connection between drunkenness and violence was often mentioned in respondents' frequent dichotomous depiction of drunks as being either happy drunks or aggressive drunks. This was heard when respondents characterised drunken people as 'nutcases'. Others spoke of this in terms of degrees of drunkenness rather then categories of drunks. As one respondent said:

> R166: 'There is a difference between someone being drunk and being happy. You see some guys being happy and having a carry on and having a joke. When you see someone who is drunk, their words are all a slur and they are falling over the place, knocking things over, just totally no regard for anybody round them.'

Respondents therefore, gave two accounts of the effects of alcohol, it was either seen to change personality or bring out a person's latent character. And violence could be associated with both.

Earlier I said that respondents held ambivalent attitudes towards drunkenness, this was clearly brought out in their accounts of their management of drunks and their attitudes towards their own episodes of drunkenness.

Reaction to drunks varied depending on whether respondents were themselves drunk. If they were drinking and everyone in their company was drunk then this need not produce any problems. Everyone was then seen to be 'in the same boat'. Situations in which respondents encountered drunks who were not part of their company, but who were not causing a nuisance, were again accepted. If drunks were causing a nuisance, however, the main response from respondents was avoidance:

R503: 'I usually try and steer clear of them, avoid them like the plague if possible.'

And again:

R509: 'You tend to look down on that person, if you see a drunk person. It's got a, it's a kind of social stigma, I would say that drunkenness has.'

Respondents also made the distinction between occasional and habitual drunkenness. The occasional episode of drunkenness was generally accepted. Often respondents talked of particular celebrations in this context - weddings, engagements, sports club celebrations, and special nights out. Intoxication on a regular basis, however, elicited negative responses:

R125: 'Everybody gets drunk sometime or another. People who get drunk regularly are just a pest.'

Again, although most respondents had no objections to women drinking, general disapproval was expressed at the idea of seeing women drunk. Such responses were often linked to the idea of women's relationship to home and the family. A typical response was:

> R170: 'It does not look right to see women drinking to excess. It does not seem right to see a woman drunk in the street or anything like that.'

Adolescent or teenage drinking was something which many respondents spoke even more negatively about. In particular this related to under-age drinking and mainly to the style of drinking behaviour to be found among youth: drinking by groups in public spaces (parks, wastegrounds, around housing estates) or unsupervised drinking in bars, discotheques, and hotels.

With regard to their own episodes of drunkenness, respondents often commented that they 'knew their limit,' and when this was reached would cease their alcohol intake and disengage from the situation. This often meant going home and going to bed.

Respondents descriptions of their own drunkenness often focused on the positive rather then the negative side of intoxication:

> R211: 'I don't get aggressive with drink, I tend to be the opposite, I get happy and I get tired and I come home to bed.'

Interviewees did occasionally mention the more negative aspects of their own behaviour but still in muted terms:

R218: 'My wife gives me a right telling off in the morning. She says I talk a bit louder, she seems to see a change in my character you know.'

Earlier the centrality of the social functions of drinking were discussed. Again, in terms of over-indulgence, when social drinking became problem drinking, social factors were mentioned in regard to changes in, and restraints on, their own drinking behaviour. For example, marriage and settling down were often seen to have reduced respondents' intake of alcohol. As one said:

R419: 'No I used to be a heavy drinker ... but my life is settled through meeting Ann (his wife).'

Responsibilities, and the economic cost of a family, mortgage, and car, were all seen as influencing drinking patterns. Changes in occupation for example, a move from being a self-employed business-man to being an employee in a larger firm, changing from a job which demanded stays away from home to one that did not, or a move to a job that required a clean driving license, were again seen to safeguard the individual from problem drinking. By contrast the lack of such restraints was seen to open the doors to problem drinking. The small business-man who kept irregular hours and always carried cash, the single man with no responsibilities, and the unemployed person who had too much time on his hands and nowhere to go apart from the public-house, were all seen

to be in danger.

Alcoholism

I will now turn to respondents' accounts of alcoholics and alcoholism. In the course of the interviews respondents characterised alcoholism in various ways. They discussed the styles of drinking behaviour related to alcoholism and the characteristics of alcoholics. They defined alcoholism by the problems which they associated with it, or the agencies by which it was treated.

The first definition was in terms of the characteristics of drinking behaviour associated with alcoholism. A person was seen to be an alcoholic if their drinking was addictive or showed signs of dependency. The most common feature mentioned by respondents in this regard was regularity of drinking. Alcoholics were seen to drink throughout the day, every day of the week, or whenever an opportunity presented itself. Although some respondents did mention quantity, regularity of drinking was far more important. A few respondents spoke of the type of the alcohol consumed, that alcoholics drank spirits rather than beer or lager, but again such responses were rare. Other ideas were linked to the idea of regularity of drinking: that alcoholics were unable to stop their drinking, that they were under a compulsion to drink, and that alcohol controlled them. Respondents thus often thought that

alcoholics should not be held responsible for their actions. Alcoholism was called an illness. Denial of alcohol problems was also believed to be an important feature of alcoholism and respondents thought that little by way of cure was possible until a person admitted to themselves the seriousness of their condition. Finally the extreme regularity and continuous nature of their drinking was seen to lead to their perceived solitary condition.

When asked to describe alcoholics and alcoholism respondents often described the personal characteristics of individuals rather than their drinking. Some believed that you could only be an alcoholic if you were over a certain age, the young could not be alcoholic. Others gave the stereo-type of the 'skid-row alcoholic': people who were to be found drinking outside public-houses in the street, of a disreputable appearance, and begging for money. Respondents could also view such people as being of lower than average intelligence. Many respondents, however, believed that all alcoholics displayed a need to escape from everyday life and that alcohol acted as a substitute for normal reality.

Two other factors were mentioned in regard to alcohol related difficulties. First was the total nature of the problems involved: that problems were seen to occur simultaneously in all areas of a person's life. Not only might the drinker be inefficient and disruptive at work but they might be involved in

arguments and difficulties at home. Second, was the aggravating influence of financial pressure on such problems. Alcoholics were seen to require increasing amounts of money to sustain their drinking, and to do this they would stop spending in other areas of their lives, in particular sacrificing the needs of their families.

Finally, another common way respondents defined alcoholics was in relation to the agencies which helped treat such problems. Respondents often said a person was an alcoholic because they attended AA, or because they had 'dryed out' or received medication at particular hospitals, for example Duke Street or Gartnavel.

The defining characteristics of alcoholism either related to the cause of alcohol problems (people having personal problems) or their results (financial difficulties, home and work problems). Indeed it was often difficult to clearly separate out cause and effect.

Again, I have presented the numerous ways in which respondents characterised alcoholics and alcoholism. An important feature of these responses is the close correspondence between these lay accounts and those of professionals who deal with or theorise such problems.

Above I have shown how people could be defined as alcoholics by the type of problems their drinking produced. Respondents were also asked, however, to

speak about drinking problems in general, not necessarily connected to alcoholism. Again respondents said that alcohol could produce problems in the two main areas of a person's life: in relation to their work or their family. People could be late at work, inefficient or drunk on the job, or lose their driving license, which could result in eventual dismissal. Drinking could also put strain on a marriage potentially leading to separation and divorce.

Finance was again highlighted as a key source of strain in such areas. As a person became more involved in drinking, it was believed that more money needed to be allocated to this activity. People would get into debt and have to borrow from finance companies and loan sharks. They would also cut down on spending in the home with the result that wives and children would want for essentials. For such reasons some respondents tended to believe it was more acceptable for a single person to drink heavily than a married man, because at the end of the day they would only be injuring themselves.

Alcohol was seen to produce major problems in the area of health. Although the most direct was to the drinker in the form of cirrhosis of the liver, there were other indirect health consequences. As in respondents attitudes towards drunkenness, violence was seen to be a key contributing factor. Injuries through domestic violence were discussed as were the

consequences of acts of aggression outwith the domestic context, including murder. In general, alcohol and crime were seen to be closely related.

Accidental injury was also seen as a problem. Drunk people could fall in their homes or accidentally start fires. They could also fall in the street or in front of cars. Respondents continually talked of the dangers of drunk driving, both to the driver and the public.

It should be noted that by no means all problems caused by alcohol abuse described by respondents relate to extreme cases of alcoholism. Research (Heather and Robertson 1985; Royal College of Psychiatrists 1986; Royal College of Physicians 1987) has also shown that domestic violence and traffic accidents may be caused by occasional as well as habitual episodes of over-indulgence. Respondents also discussed alcohol problems in particular ways: either in relation to their own experience, of family members or work colleagues who had such problems, or by reference to the wider social context.

Most respondents thought alcohol abuse was a serious problem in Britain regardless of the type of difficulty it was seen to produce. They were, however, divided as to whether problems were on the increase or the decline.

The causes for such problems were seen to originate either from the individual or the societal level. Some

gave as causes those areas of life where most problems were seen to occur. Unhappy marriages or unsatisfactory job environments could potentially lead a person to alcohol abuse. A common response to explain the scale of such problems was the negative influence of run down urban environments. People in such areas had little opportunity to improve their situation and thus drank as an escape. Another common reason given for alcohol abuse was the relatively low cost of alcohol. Advertising was frequently cited as an aggravating influence due to its pervasive nature which produced a generalised social pressure on people to drink.

When respondents turned to possible solutions to alcohol problems most cited Alcoholics Anonymous as the primary agency in the field. Respondents described their own experience of A.A. or that of relatives and work colleagues. Although A.A. was seen to be doing a vital job criticisms were voiced about some aspects of its approach and whether it was suitable for all types of people and all types of alcohol problem. In particular its confessional style came in for comment, as did its stress on total abstinence, and its own potentially 'addictive' effect - the fact that members had to regularly attend meetings.

Other agencies cited by respondents included de-toxification units, general hospital drying-out units, and Councils for Alcohol. The importance of the general practitioner as as central point for referral to such

agencies was also mentioned.

No matter what the treatment agency, however, respondents believed that the most important element of a solution to an individual's drink problems was their own wish to be cured. Without such a strong commitment treatment was unlikely to be effective. This idea is again a central theme of the medical literature on alcohol problems, and although some respondents stated they had picked up this concept from Alcoholics Anonymous others said they had come to this conclusion from their own experience of individuals with alcohol problems.

In addition to discussion of agencies for the treatment of alcohol problems, respondents stressed the importance of education, particularly for the young. Publicity campaigns which clearly pointed out the dangers of alcohol, similar to those on illegal drugs, were also recommended. It was believed that these would have their maximum effect on those who had not yet developed alcohol problems. Respondents were also often in favour of stronger controls on publicans with regard to under-age drinking, although the recent liberalization of licensing laws was seen to have had a favourable effect on drinking patterns. Finally a few respondents believed that there should be a greater encouragement of alcohol at work schemes.

SOCIAL CLASS AND RELIGIOUS DIFFERENCES

So far in this chapter I have outlined some of the respondents general ideas about alcohol use and abuse. I would now like to consider some of the ways in which social class and religion relate to these topics. First, was there any variation in beliefs or systematic differences between respondents from different religious and social class backgrounds? And second, since I asked respondents to give their own opinions of the affects of social class and religion on their beliefs about alcohol use, how did these opinions vary?

When analyzing the interview transcripts of those above and those below the manual/non-manual divide, the clearest difference between these two groups was that respondents from manual occupations mentioned the influence which social circumstances, and the urban environment, had on drinking. For example one respondent, a maintenance electric welder, when asked about the problem of alcoholism said:

> R419: 'I think the serious thing in Britain is lack of work. To my mind it is all back to the government. If there are people on the Broo give them a job. .. so what people are doing is going for a couple of pints.'

A general labourer also mentioned the fact that 'social pressure' led people to drink. He believed that people in some parts of the country drank more than in others:

R539: 'I think cities tend to be more. It always comes down to the stress factor.'

Although respondents from the non-manual group did mention social factors these were related to particular occupations: travelling salesmen, business people etc. Comments were related to individual types rather than being directed to general social forces.

Turning to differences between the religious groups it was apparent that although each group displayed a range of responses from the more to the less tolerant, the balance was different for each. Differing trends could also be noted between the groups.

The non-religious and the Catholic groups had similar beliefs although there was a greater tendency to condemn drunkenness among Catholics. Protestants tended to be more proscriptive in approach condemning the person more than the drink.

One way of conceptualizing these differences is to place these three groups on a continuum, from the non-religious, the least proscriptive, to the Catholics in the middle, to the Protestants, the most proscriptive.

For the church-attending Catholics, drunks were 'foolish' and it was seen as 'humiliating' for a person to have lost control through drink. The non-religious often said that drunks were okay, as long as they did not bother them. However a few also said they were 'daft', or that drunks were 'sad'.

Although both Protestant and Catholic respondents

condemned drunkenness there was a slight tendency for Protestant respondents to be more negative in their comments about the drunk individual; particularly with regard to being a nuisance and lacking will-power. As one regular attending Church of Scotland member said:

> R158: 'There is a distinction between a heavy drinker and an alcoholic. The alcoholic must be less strong willed. A strong willed person might know what they were leading themselves onto if they continued to drink excessively a lot of the time.'

And another respondent who attended church once a week replied:

> R306: 'I suppose there was a puritan attitude towards drink...the attitude drinking is bad for you and you don't drink...That type of attitude is in the mind from childhood. My father is tee total because of family circumstances, because his father at one time was a very heavy drinker. So I think this attitude has stuck with me to a certain extent.'

Catholic respondents tended to emphasize the damage to the body by way of contrast:

> R504: 'Well I don't see any sense in punishing your body...too much alcohol is bad for you, it obviously leads to dehydration.'

And again one respondent said the following when talking about youth drinking:

> R156: 'I don't think it is a good idea to start drinking too young...They have not fully developed and I would think they would really need to develop fully into adulthood before they start drinking on a regular basis. I think they could stand it better and it would give their body time to develop properly. Later on there would be less chance of them being alcoholics.'

I will now consider respondents' own ideas about the influence of social class and religion on attitudes towards alcohol use. A large proportion of interviewees believed that problems of drunkenness and alcoholism could be found at any level of society. The majority also believed that a person's own social class position had little affect on their attitudes towards alcohol.

Those that did believe social class to be important mentioned the following. A few believed that drink was more acceptable among the working classes, that it was part of working class culture. Reasons given for its importance were seen to be the lack of any other opportunities open to the working classes. A common style of response was given by one clerk of work in the study:

> R125: 'I think there are people who drink a lot because they don't see any hope in their situation.'

However not all comments were about working class drinking. Some respondents said that the middle classes tended to hide their drinking:

> R302: 'I think there is a danger that you tend rather sanctimoniously to say you know "we" meaning the middle classes are somehow or other insulated from all this, and of course the reality is that we are not, there is a tendency to try and disguise these problems amongst middle-class people whereas you know that they (the working class) are more open.'

Others mentioned how the pressures of life in the upper classes could lead to excessive drinking.

Although unemployment was seen as a factor leading people to drink because of despair, respondents also stated their belief that the unemployed were likely to drink less than those in work due to lack of money. The effect of unemployment on drinking came across in the interviews as a separate issue, related to, but not synonymous with, ideas of class.

When questioned about the influence of social class on attitudes towards alcohol respondents often answered by saying that they considered family background to be the most important influence in moulding their own

beliefs. As one respondent noted when asked about the influence class had on his beliefs:

> R158: 'No. I feel my family background has. But not my class background...everything in moderation really. All my family are anti-smoking, they disapproved of smoking but they did not disapprove of drinking. So I probably went along the same road.'

We have considered respondents' ideas about the influence of class upon alcohol consumption. What did they have to say about the influence of religion on attitudes towards alcohol use? For church attenders the concept of moderation was frequently expressed. Protestants were, again, more prohibitive in their attitudes towards the use of alcohol than Catholics. Catholics mentioned other faiths' proscription of alcohol but occasionally saw their own religious beliefs as not having a dramatic affect on their own attitudes. However although Protestants believed their religion to be proscriptive, they themselves did not always put these ideas into practice. One Church of Scotland member who attended once a week and was also involved in church activities stated:

> R306: 'In the last few years we have more an evangelical type of ministry within the Church, which tends to be rather puritan, "thou shalt not" drink, smoke or whatever. I think more so in the last few years. But so saying I am one of the rebels in the group...if I want a drink I will have a drink no matter what you say.'

Only two respondents, who no longer attended church, still thought that their present attitudes had been moulded by their earlier religious upbringings. For most of the non-religious (many of whom had been raised in either the Protestant or Catholic faiths) their religious backgrounds were seldom seen to affect their present attitudes towards alcohol use. They did however believe that people who were religious would probably be influenced by their religion in their attitudes towards alcohol. That some churches were against drink and that some encouraged moderation was frequently mentioned. Respondents also occasionally gave the example of priests who drank to put the counter idea that religion need not have a strong affect on a person's beliefs about alcohol use.

AMBIVALENT ATTITUDES

I have described respondents' beliefs about the use of alcohol and although concepts of ambivalence have been encountered these have not been discussed systematically. In this section I will draw together

the major themes regarding ambivalence as they appeared in my own study.

One aspect of ambivalence towards alcohol use revolves round the concept of moderate drinking. For nearly all respondents moderate drinking was acceptable but non-moderate drinking was not. The question also arises as to where the dividing line between moderate and non-moderate drinking should be placed. Different respondents gave different limits in answer to this question. Thus although nearly all respondents voiced the same affective feelings towards moderate and non-moderate drinking, their feelings about individuals who consumed certain quantities of alcohol were diverse depending on where they placed this limit. In other words, moderate drinking is a relative not an absolute concept.

Ambivalence was also apparent in peoples' attitudes towards drunkenness. Respondents said that if they were drunk in the company of others who were drunk, drunkenness could be condoned. However if they were sober they were less likely to accept drunken behaviour. It was less the case that they were totally against drunkenness but rather that they did not want to be disturbed by it. Again we can note the relational aspect in connection with attitudes towards alcohol use. The social contexts of the drinker and the non-drinker differ and so too will the attitudes of people depending on which context they are in at the time and whether

they are viewing others' behaviour across context boundaries.

The ambivalence in respondents' attitudes towards women also came through clearly in the course of the interviews. Although most respondents said that they did not object to women drinking and that women had as much right to drink as men, under the surface most respondents also voiced more traditional views about the dislike they had in seeing a drunk woman; when probed by further questioning this feeling was found to stem from their beliefs that a woman's place was still in the home and that their responsibilities should be first and foremost to thier families.

Respondents were also ambivalent about youth drinking. Respondents believed that youth should be educated how to drink but were often unsure as to how this could be accomplished. Problems were seen to be how to maintain control once young people had started to drink with their peer group in public houses. Education into drinking could be done in the home or through the schools (or by parents taking their children into hotels), but once they got into the public house then there was difficulty in seeing moderate drinking continue. Most accepted that young people drank, although not all were happy about it.

Nowhere however was the concept of ambivalence given clearer expression than when respondents described how alcohol affected behaviour. It would seem to be the

case that at times of sobriety certain aspects of an individual's personality cannot be displayed. Alcohol is needed for an easy sociability, typified by freer conversation, a relaxed manner, often accompanied by humour. It is as if in normal sober situations such a style of interaction is disallowed, curtailed. Although as was also shown, the consumption of alcohol is not entirely necessary, being part of 'an occasion where alcohol is consumed' may be sufficient.

Alcohol, therefore, allows for different behaviour and for a different presentation of the attributes of an individual' personality. However, different respondents varied as to what they thought occurred and also in their stance towards such changes. Three categories of response were uncovered:

1) Some believed that in everyday life the person was not as truthful, or in some respects, not the 'real person'. Alcohol allowed for this 'real person' to be viewed. Of course the 'real person' might, or might not, have been to the respondent's liking. If people were intrinsically good or bad these facts were suppressed when people were sober.

2) Others believed that the self of everyday life was the real or complete person, and alcohol only deprived the individual of self-control, allowing lower qualities to become manifest.

3) Between these views were respondents who believed that alcohol exaggerated personality traits, and

produced changes which could either be for the good or the bad. What existed in a muted form in everyday life could be brought out in a more extreme form after drinking.

Interviewees were ambivalent about the above issues but when asked about more extreme forms of alcohol intoxication respondents came closer in their views by condemning drunkenness and expressing statements of annoyance and disgust about drunks. They also produced similar statements as to the attributes of drunkenness.

Finally, there was a general agreement among respondents as to the central features of alcoholism, that of dependence, and the lack of control over drinking behaviour. Interestingly, however, what was seen to protect an individual from such loss of control were the steadying social attributes of family and employment.

What we seem to have with regard to ambivalence is that these respondents seem to be in agreement at the extremes in their ideas as to being a responsible sober citizen and in their attitudes towards alcoholics and alcoholism. It is in the middle range that people were seen to have conflicting views.

CONCLUSION

In this chapter I have analysed the accounts respondents gave of alcohol use. I have considered the distinctions between their ideas of moderate and problem drinking. Drinking in moderation is be central to sociability and

a key component in relaxation and the reduction of stress. We have seen how alcohol can both alter and reveal character and how this facet was of importance when concepts of drunkenness and problem drinking were analysed. In the discussion of alcoholism I showed how certain key concepts in lay accounts mirrored professional thinking in this area: in particular those ideas related to compulsion and the individual's deep desire for cure as an important pre-requisite for successful treatment.

Differences related to social class and religion were explored. Respondents from manual occupations mentioned the effect which the social environment could have on drinking, they spoke of the influence of general social forces rather than viewing alcohol problems as being individualised. In terms of religious differences we noted the proscriptiveness of those respondents who belonged to religious groups in comparison to those who were non-religious, and the stronger negative feelings voiced by Protestants compared to Catholics.

Finally, the complexity of interviewees ideas of ambivalence has been demonstrated. Ambivalence has been found in interviewees' beliefs about women drinking, drunkenness, and the nature of personality change produced by the consumption of alcohol. Lack of ambivalence has, however, also been discovered, particularly with regard to the conceptualizations of alcoholism. Ambivalence has been described as 'the co-

existence in one person of the emotional attitudes of love and hate towards the same object' (Sykes 1982). This chapter has attempted to show the complexity of such a relationship with regard to alcohol.

In the above three chapters respondents' attitudes to tobacco and alcohol use have been considered. The twin topics of relaxation and ambivalence have been discussed at length. Although these ideas are found in respondents' accounts they differed for alcohol and tobacco use. There is stronger public pressure against moderate tobacco use, and tobacco use was also seen to be damaging to the health of others, not just that of the smoker. Linked to this is the emergence of smoking as a deviant activity. By contrast moderate alcohol consumption was not viewed as a deviant activity but was on the contrary part of normal social life; deviant categorizations were only applied to problem drinkers and alcoholics. Ideas of ambivalence were thus different for he moderate smoker and the moderate drinker. For alcohol use, we see that the recent ideas of 'the new temperance movement' (Mullen 1988; Heath 1989) have not gained popular support among lay people.

How tobacco and alcohol are used for relaxation also varies: tobacco use is for short term relief of stress in the work and and home contexts while alcohol use tends to be bracketted outwith these times and situations. Crawford (1984) has discussed the ideas of control and release as being key metaphors in the way

people in a western capitalist societies view their health. He describes the twin imperatives of control and release and how both mandates have to be met if health is to be assured. What the current findings show is that for Scottish respondents, release is difficult to attain and tends to be found in the limited range of tobacco and alcohol use, behaviours which are in themselves health damaging. It has also demonstrated the degree of guilt and ambivalence which is associated with the release mode. People may be over-controlled in their behaviour leading in turn to increased levels of anxiety, but may then release such tensions in the health damaging behaviours of alcohol and tobacco use.

In part two of the thesis the general themes in lay health accounts were analysed, and, as part of this work, the preliminary results of the influence of social class and religion were presented. In part three, the analysis of social class and religion is deepened and expanded. Both social class and religion are defined in a broad way, reflecting my concern to cover all aspects of these topics in the present study. The social class section looks at the influence of occupation, class defined as occupational class, and the broader life-style components of the family and marital status. The chapter on religious elements also takes into account aspects of implicit religion (Bailey 1983, 1990; Davie 1990) and the wider topic of the moral components in respondents' thought.

NOTES

1. The following section has been previously published in slightly revised form (Mullen 1990b).

CHAPTER 8

HEALTH AND WORK CONTEXT

INTRODUCTION

In part two respondents' accounts of health and their attitudes towards tobacco and alcohol use were analysed sequentially. In the following chapters, the common themes which have emerged from this discussion will be related both to the social characteristics of respondents and to aspects of their social world. I will begin with an analysis of the relationship between work and health.

Research on the analysis of lay health beliefs has focussed on different topics. Consideration has been given to lay ideas about the causation of illness (Blaxter 1983; Pill and Stott 1982; Cornwell 1984), the relationship between lay and professional perspectives, responsibility for illness (Pill and Stott 1985), and the structure of respondents' beliefs (Williams 1981; Herzlich 1973). Recently, partly as a result of the catalyst of discussion in both the Black Report (Townsend, Davidson, Whitehead 1988) and the Health Divide (Whitehead 1987) of the persistence of social class inequalities in health, research has considered differences in lay health beliefs between social classes (Calnan and Johnson 1985; Cox, Blaxter, and Buckle 1987; Calnan 1987; D'Houtaud and Field 1984). Such work, however, rather than focussing on the occupational component of social class, has mainly viewed social

class as a proxy for wider aspects of lifestyle. Calnan and Johnson's work, for example, has attempted to produce a better understanding of the relationship between lifestyle and health beliefs. This tendency to neglect occupation can also be explained by previous work's focus on the health beliefs of women.

This chapter aims to rectify this bias by focussing on social class differences in lay health beliefs, this time concentrating on male respondents' perception of health in the work context. In the discussion of the influence work had on their health it became clear that not only were respondents aware of potential health hazards in their work, but that they also adopted coping strategies to counteract such dangers. Most of these strategies of adaptation were presented as compensatory practices, inexplicitly invoking some image of equilibrium with regard to health.

There is of course a corresponding researchers' concept of equilibrium, which is discussed to a limited extent in the literature on work and health (Neff 1981; Landy and Trumbo 1980). Kahn (1981), in a comprehensive review of this literature, argued that if a person's orientation towards their work did not match the characteristics of their job, this could result in the production of stress and strain over a period of time. In turn he hypothesised that if such stresses occurred, workers may develop coping strategies and methods of adaptation, or alter their approach to work, in order to

minimise the harmful effects of their jobs. He also hypothesised that the relationship between levels of strain and certain job characteristics, for example occupational responsibility and job complexity, followed a U-shaped curve, with minimal strain being experienced by workers whose jobs had neither too little nor too much of these attributes. The mean was the most desirable position.

Ideas about the importance of the mid-point in relation to health, and the occasional attempts by workers to secure this optimum level for health reasons, are also found in Warr's: Work, Unemployment, and Mental Health (1987). In this book he presents a vitamin model as a metaphor to describe the relationship between features of the work environment and mental health. At low levels of intake vitamin deficiency gives rise to ill-health but after the attainment of certain levels increased vitamin intake provides no added benefit and in many cases can be detrimental to health. Warr hypothesised the same relationship between the environmental features of work and the mental health of the worker. Warr, like Kahn, demonstrated that workers need not be passive with regard to the effects of the environmental features of their occupations but may attempt to influence their situation. He quotes Roy's (1960) study of American factory workers, where employees informally increased the variety of their work by incorporating ritual non-work activities into their

daily routine. These workers were thus able to reduce stress in an occupation with low levels of intrinsic variety.

In the research literature the concept of equilibrium has been discussed with reference to psychological rather than physical health. In the analysis which follows I will present Glaswegian accounts of compensatory and other practices in regard to both mental and physical health, and I will discuss their relation to the researchers' concept.

I shall now turn to the analysis of the accounts of health given by these respondents during the course of the ethnographic interviews. I will be particularly concerned to elucidate ideas related to the concept of balance expressed in the repsondents' accounts and relate my findings to those of other researchers.

RECOGNITION OF THE HEALTH EFFECTS OF WORK [1]

A major point that emerged from the interview transcripts was that respondents were very clear about the health effects of work. These were of course expressions of their own perceptions of health effects rather than objective measures of health and illness. In the interviews respondents viewed work as having features which could have good or bad effects on a person's health. On the one hand work was seen to be good for a person both in the physical and mental sense. Various respondents spoke of work as exercise, for

example:

> R536: 'Ah think working hard has a good affect, hard work; it hasn't done me any harm. Ah think if you do anythin' that keeps you fit you know ... you're usin' your muscles all the time you know an' ye get up the next day fresh an' ye enjoy yer, ye look forward to a holiday then right enough.'

Some respondents spoke of their work being good for their health because it 'always kept them going,' others described their jobs as being 'energetic.' Window cleaners stressed ladder climbing and the agility they needed for their work. A joiner stated:

> R125: 'When you are a joiner, you could say you are taking it out on your body physically all the time, but you always felt you were healthy, you know.'

Protected environments were also mentioned in regard to health, with comments being related to the type of work carried out. Manual workers spoke of inside jobs which protected them from the weather, and jobs away from dust and chemicals. Dust and chemicals were however the most important considerations - one respondent who thought his own inside factory job was unhealthy because of dust thought his son's health would be better because he worked outside 'getting the healthy

air' (R313).

Work was also seen to be beneficial in that it gave variety and time-structure to a person's day. This has been commented on by other writers (Warr 1982; Jahoda and Rush 1980). In the present study, the mental stimulation provided by work was often starkly contrasted with the problems of unemployment:

> R518: 'I have a job. I suppose that is a big help to your mental state. You read in the paper that folk commit suicide and that because they have not got a job. At least you have somewhere to go every day. Different surroundings from home, whereas if you are unemployed you are sitting in every day of the week.'

The benefits of variety were also recognised by respondents who were unemployed. In response to being asked what he would like to do to be healthier one unemployed respondent said:

> R528: 'Ah'd like tae get back tae ma old job, it would give me something tae think about.'

And another respondent expressed these feelings graphically in the following manner:

> R515: 'Sometimes ah get bored, in seven days a week. Only time ah get out is when ah go up and sign the bru an' ah'm straight back in again an' ah never get aff this chair ... that's made me feel depressed an ah'm no' doin' much tae try an' pass ma time away in other words ... och, I feel bad because maybe it's because ah'm fed up.'

A third respondent when asked what had a bad effect on his health described such problems as follows:

> R210: 'Aye unemployment for a start. You tend not to do anything, you still get up the same time in the morning and things like that right enough, but you are no getting up to go to your work you know and then come back at night. You just float about all day, you go to the job centre and then that is you, then you just float about.'

In this instance the respondent had developed a rudimentary time table and he mentioned a couple of benchmarks in the course of the interview: getting up at the same time that he would have for work, and going to the job centre during the day. The rest of his time, however, was not structured and had an empty quality.

Nevertheless, although work was seen to be more beneficial to health than unemployment, and to be healthy in many respects, it was also seen to have

detrimental physical and mental effects:

> R362: 'I think lot of the illness is inflicted through the style of life of the occupation or the environment ... people in, who are working in industries where there are a lot of fumes, em, dangerous chemicals, things like that.'

Another respondent when asked if there was anything about his life which had a bad effect on his health, said:

> R250: 'In certain cases. Not so much, in that I don't actually work in tools any more. I am away from dust particles. I work in a clean environment but I still go down to those areas. You go down to these areas and you can see the dirt.'

Other respondents mentioned the hazards of smoky environments, dangerous machinery, shifting from cold to hot areas when at work, and noise. Sedentary occupations, described as being 'desk bound', or 'spending a lot of time in a car,' were seen to be detrimental to health because respondents were deprived of exercise.

There was a general awareness of the direct physical hazards of work, but an indirect hazard also

mentioned by a large proportion of respondents was the problem of stress in their occupations. It was cited in relation to the content of work (for example working with people), the volume of work a person had to do, fears of redundancy, working under pressure (for example, working extra hours), working with high degrees of responsibility, or working away from home.

Among these varying contexts, stress was most often related to time pressure. Although as we have seen the time structure imposed by work can be beneficial to a person's health, time pressure, for example how many tasks a person has to complete in a particular period, can have detrimental effects. It can also vary from occupation to occupation, in one job from year to year, or over the course of the working day. Time is 'squeezed' in different ways for the manual and non-manual groups: more informally for the non-manual occupation, with deadlines rather than the imposition of piece work. Over-time and extra hours are other examples, not of the squeezing of time, but the addition of time to the working day with its potential toll on health.

The self-employed respondents had particular problems in this respect and had to deal with the extra stress involved. They were continually aware of the need to keep working both for themselves and for their families. As one self-employed property manager said he: 'worked long and hard but had to take the strain'

(R921). Further analysis on the family and respondents' ideas about responsibility in relation to health can be seen in the next chapter.

Stress could be brought on by numerous conditions in addition to time pressure but its results were generally linked to heart disease; although three respondents mentioned migraine and six reported both exhaustion and sleep difficulties:

> R156: 'If you have a lot of stress at work and you can't get things done the way you would like them done you could get heart trouble, and things like that.'

Such findings, both on the pervasiveness of ideas about stress in lay conceptions of health and its link to heart disease, have also been highlighted by Pollock (1988).

Mental stress was not only mentioned by respondents from the non-manual group. Stress was also mentioned by manual workers. This contradicts the ideas of Young (1980) who views lay ideas about stress as being restricted to the middle classes. However, on closer analysis such workers either had a supervisory component to their work or were in driving jobs where they met many people over the course of their working day. For example, one respondent, a quality assurance engineer (R250), had to make decisions on the safety and soundness of others' engineering work. He was thus

conscious of the extra strain this put him under, although at the same time he was aware that due to his promotion he now worked in 'a clean environment' and was therefore protected from the physical dangers experienced in his previous grade.

Respondents often described their occupations as having both good and bad points (a person rarely had a wholly good or bad job), although they tended to stress the negative features of their occupations. It was also possible, however, to place interviewees in one of three categories by their responses to the health effects of their jobs. Jobs were seen to be either predominantly physically tiring with little mental stress, physically tiring with mental stress, or mentally stressful with little physical stress. A lack of physical stress, however, was also seen as being unhealthy as it led to a person becoming overweight.

These Glaswegian men, while they clearly recognised the health giving aspects of being in employment, thus also recognised the dangers of their own occupations. In the course of interviews they related these perceptions to measures which they adopted to offset such dangers.

MAINTAINING EQUILIBRIUM - COPING WITH THE HEALTH EFFECTS OF WORK

Many respondents presented coping strategies to deal with the negative health effects of work. These varied in degree from attempts to compensate for the problems

of work to attempts to control the work environment.

Compensation

When describing compensating, interviewees highlighted forms of disengagement where they would consciously distance themselves from involvement in the work process. This took the form of either physical or mental disengagement. Such disengagement can be seen as a form of role distance. When for one reason or another the given time structure of work became too oppressive respondents often cut themselves off from a too close involvement with their work duties. Such disengagement may be physical and involve leaving the immediate workspace, going to another department of their factory or office, or, in the case of the following respondent, going for a drive:

> KM: 'How do you handle the pressure? Or do you need to?'
>
> R307: 'Yes I do need to. I find, I mean yesterday afternoon for instance I just had to get away for a period. We have a depot in Dundee, and that drive there managed to, you know, bring me together again.'
>
> KM: 'Anything else you do when you're under strain?'
>
> R307: 'I go for a little drive. I get away from it all. I sit down maybe in a car park, the motorway services, just sit in the car and sort

> of cool down. As long as I can get away from it.'

The term 'walking away' from straining situations was often used.

Mental disengagement, by contrast, involved some form of role-distance, not allowing oneself to become too involved with one's task. Again, which respondents could utilise which form of disengagement depended on the degrees of control they had over the structuring of their work tasks and also the extent to which they were supervised. Respondent's use of such disengagement was closely linked to the perceived health effects of their occupations, e.g.

> R250: 'I am not really involved in my work that much. I would not let myself get in a state. I would stop what I was doing and take a couple of days off. I have seen too many people in my work under strain and having a heart attack. One of my old bosses died at 47 with a heart attack. He was told to stop work but he did not do that. I work for money, I don't work for the joy of working for my company.'

Here is a respondent who argues for limiting his work involvement on the grounds that too much stress has caused heart attacks amongst his colleagues. He presents himself as utilising a form of role distance to

disengage from, and compensate for, the stressful overstimulation of his job.

Time disengagement, be it physical or mental, was closely related to feelings of stress and their relief. Indeed respondents stated that they had changed their approach to work when they had gone through a period of crisis or if they had seen a colleague go through such a period. One respondent described his changing attitude to work after suffering the symptoms of a heart attack. He said that now 'work can wait'.

Above, stress and a few of the coping strategies adopted by respondents to deal with this problem have been considered. But jobs could be damaging to health in other ways. Many respondents were in jobs which did not give them adequate amounts of physical exercise, and they saw this as a potential health hazard. Lack of exercise was mentioned not only by those in non-manual desk-bound occupations but was also mentioned by manual workers in particular styles of occupations. An important group were those for whom driving took up a large proportion of their working day. This group included taxi drivers, bus drivers, delivery drivers, and travelling salesmen. Respondents who were aware of the dangers of lack of physical exercise at work tended to show concern over their weight and their lack of physical fitness. They mentioned their diet, spoke of reducing their intake of specific foods, and had often cut down on their alcohol intake.

In addition to focussing on diet many engaged in some form of physical exercise in leisure time or took part in sports. Jogging was done during lunchtimes or in the evenings. Some respondents had exercise bars at home or went to local sports clubs, while others played golf with their colleagues and friends. Although these activities were primarily seen as a means of improving their physical condition they were also seen to have beneficial mental effects. They provided a break from the working routine and aided relaxation.

Self-contradictory Compensations

Simple and consistent compensation strategies of respondents have been detailed. But another important feature of the interviews was the use of strategies which had internal contradictions. The consumption of both tobacco and alcohol as a means of coping with the pressures of work was contradictory in that behaviours which were acknowledged to damage health were used to limit the negative health effects of an occupation. In part, this was a legacy from the past - our attitudes to such behaviours have not always been so proscriptive as they are at the present time (Markle and Troyer, 1979; Ashton and Stepney, 1982), and indeed our attitudes towards alcohol are still coloured by a deep ambivalence with regard to both its use and effects (Mullen, 1990b). Again, as we shall see, although respondents were generally in agreement with official health education

about the health affects of smoking and drinking, they often saw themselves as involved in a trade-off between conflicting priorities. Graham (1984; 1987) has explored a similar use of tobacco by women at home with small children.

An important feature of the interviews was the use of tobacco as a means of coping with the pressures of work. In most occupations there are certain times in the working day when improved efficiency is needed, either in terms of concentration, or speed of work. The use of tobacco is important in this connection. Some respondents would smoke at times of stress in their work:

> R625: 'I tend to find that when I am left on my own with some reports or something that I tend to smoke more than I should. If I am thinking hard and have a deadline to meet I think it would be stressful. That is when I think I smoke probably more.'

Respondents said they reached for a cigarette when they had to make an important phone-call, or were working on a complicated task. As one respondent stated:

> R124: 'I did have the tendency to smoke in times of stress or any other reason like that, apart from just a habit, making that phone call you don't want to make, and

> instances like that. I would always find myself coming off the phone with a cigarette in my hand which I didn't really want, er that sort of instance I found myself doing that an awful lot'.

Non-smokers also spoke of such situations:

> R132: 'I am aware of people who can't make an important phone-call without first lighting up a cigarette.'

Some respondents stated that they smoked because it increased their concentration when at work. This was particularly mentioned by those who had to write reports as part of their work activities. Again, one respondent mentioned difficult and dirty tasks:

> R101: 'It is maybe work where I am going to get my hands dirty. It is times like that I would have a cigarette.'

Another mentioned an increase in his smoking when the organisation of his work changed, adding to the pressure of work:

> KM:'When did it start going up would you say?'
>
> R133:'Well that would be 1974. I remember times when I would be working on the machines I think it changed then, I would

always have a cigarette going you know.'

One respondent, (R153) a bus driver, only smoked at work when he was in the cab, not at the bus terminus or between shifts. Similarly one school teacher (R682) smoked if there was what he described as a mini-crisis with the children at school but not at other times.

Above I have highlighted those times of the day when special efforts needed to be made and how this was often connected to stress and tobacco use in the minds of my respondents. Respondents also mentioned breaks during the work period where they would smoke, partly to wind down from the tasks of the day. These work breaks acted as time markers in the working day. They were either formal, officially sanctioned by the employer, or informal and taken by the workers themselves. Again the relationship between tobacco use and such breaks appeared to be important.

One type of informal break mentioned by respondents was when they stopped after completing a particular task. Tobacco could be used at such times as a self-given reward (outwith formal work control) to produce satisfaction at having completed a particular job. One taxi driver, when things were going well at work, described smoking as follows:

R133: 'It is like a pat on the back to myself. If you have got a good hire over the radio or something like that.'

And another example:

> R608: 'After I have done something (at work) I stand back and say that's fine, that's O.K. and then I will sit down and have a smoke. While I am having a smoke I am relaxing for 10 minutes.'

Two out of five teachers interviewed spoke of breaks taken in the staff-room in this way. The other three mentioned colleagues smoking at such times.

The general structure of time at work allows for only short breaks. This need for short and controlled use of time at work has led to the preference of the cigarette and cigar over the pipe. Again however this is linked to occupational class. Respondents among the more leisured non-manual occupations still have time to smoke a pipe. One respondent who had smoked a pipe before switching to cigars clearly saw differences between cigar and pipe smoking in terms of relaxation.

> R504: 'Cigars are much more convenient, ehm a pipe tends to be much more leisurely. Eh, when I was smoking a pipe I attempted to smoke it during the course of the working day, again because I enjoyed it em, but I found then that I wasn't enjoying it because I would start my pipe up and then I would have to go and do something perhaps in a room where I couldn't smoke, so em, I would

> leave my pipe, em so like for a short smoke if you like then the cigar was perhaps the better option.'

Pipe smoking could be relaxing but substantial periods of time were needed to enjoy it.

Tobacco was, therefore, used as a coping mechanism to deal with the pressures of work, and such a use of tobacco was to be found by respondents from both manual and non-manual occupations. It could be used as a response to both the physical and mental strains of an occupation - strains often caused by particularly difficult tasks in a respondent's occupation or by the pace of work. It had, however, a two-edged nature - its ability to reduce stress was counteracted by the fact that it was itself a health hazard.

Respondents' use of alcohol shared certain features with tobacco use. Just as tobacco use could be used as 'time out', a break from the work routine, during the course of the working day, alcohol use could be used in a similar fashion in non-work time.

For some respondents alcohol was integrated into their occupation. This was particularly true of those who worked in a sales capacity. These men were often aware of the potential dangers and threat of a fall into alcoholism, and often gave examples of colleagues who had been unable to control their drinking.

For the majority of the respondents, however, although alcohol was not directly linked to their

occupations, their jobs had developed occupational drinking cultures. Respondents could drink with workmates or colleagues outwith work hours either at lunchbreaks or in the evenings before going home. One respondent (R211), a parts delivery driver, expressed this by saying that lunchtime drinking was 'the done thing' to do. Workers from the building trade or engineers described lunchtime drinking, particularly at the end of the week. The irregular working hours of some occupations also led to particular drinking patterns among those who worked shifts or travelled away from home. The reasons which they gave for drinking at such times also varied depending how alcohol related to their occupational subculture. Most, however, considered such drinking, although largely undertaken with work colleagues, to be a relaxation from work. One respondent (R221) described how such times got people out of the 'usual mundane routine of work', and those in manual occupations had a greater tendency to drink at such times as an escape from the boredom of their occupations, that they 'couldn't face reality stone cold sober every day of the year'.

All such periods were times of relaxation although not all were completely divorced from work. For many respondents in non-manual occupations such periods involved a relaxation of formal work roles and allowed them to wind down. Work situations could then be discussed with work problems being seen in a new light.

In these cases although respondents drank with colleagues not all were on the same status level in their occupations. An important point about such times are their ambiguous qualities, where they take on aspects of both work and leisure. In all cases, however, the general aim of drinking at such times was one of relaxation, to wind down from the pressures of the day.

Not all respondents took part in such drinking cultures. Some had developed ways of avoiding these situations and recognising the dangers of such times. As one window cleaner said:

> R259: 'Well tomorrow for a start I will be feeling like an outcast when the people I work with get their wages and they all go to the pub, and I just drive home. I get a wee tang that I would love to go in there but by the time I am halfway up the road that wee urge has disappeared you know. People that drink say the same thing, and I say try it yourself, drive halfway up the road and say I'm glad I got away from that you know. They say the same thing themselves. The big thing is to get over that hurdle, get to the bus station and jump on the bus or in the car and get halfway home. At the time you are so close to the pub it is just getting away from it.'

Some respondents, as in the case of this window cleaner, had stopped being part of the occupational drinking culture because of the problems they were having at work - missed days, and potential work hazards. A parts delivery driver (R211) and a fire officer (R758) both stopped drinking at such times for safety reasons. Other respondents in their discussion of work colleagues whom they saw as alcoholic often mentioned the particular dangers they could cause in their work environments both to themselves and others. Such strategies, however, were less possible where alcohol was more integrated into the work culture, particularly for those working away from home.

Control

So far coping strategies which have involved a person altering their own behaviour in relation to work have been discussed. But Kahn (1981) also mentions forms of adaptation where individuals attempt to alter aspects of their job environment rather than their own individual characteristics. The difference is between compensatory activity which is largely reactive in nature and controlling activity which is both pro-active and directed towards the structure of the occupation. I also encountered this in the talk of respondents.

Some interviewees said they responded to stress by attempting to control the amount of time which they spent at work. They either attempted to work less hours

or tried not to take their work home with them, not to work overtime.

Others attempted to relieve pressure by altering the way in which work tasks were carried out. One hospital engineer (R846) when under time pressure took extra care with the most important aspect of his work, in this case the checking of hospital equipment. Another, a medical laboratory scientific officer (R769) broke down his job task into smaller units on which he could concentrate, completing each before going onto the next. In both cases these respondents had developed a technique which narrowed their work focus and enabled them to minimise their sense of pressure.

Another believed that the experience of the crisis situation of having his business go into receivership had taught him to handle stressful situations. Again he mentioned 'keeping active', 'working through' situations, and not 'dwelling on' problems. In this case someone who could have been described as addicted to work had not changed his general attitude towards his job but had rather learned the means to cope with highly stressful situations.

Some interviewees had also developed and learned specific stress management techniques. This was the case with a pharmaceutical area sales manager (R763) who practiced a form of self-hypnosis in the evenings to calm down from the days work. He also carried out deep breathing exercises before he was due to give

presentations on his products to potential customers.

Similarly a Church of Scotland minister (R915) had, in collaboration with his colleagues, set up a self-help group to deal with the stresses and strains of the ministry. The idea was that anyone in the group could, if they heard that someone else in the group was overworking, visit the minister concerned and talk through whatever difficulties the person was experiencing. This self-help group, therefore, acted as a stress buffer to the potentially excessive demands of the ministry.

This was the only description of collective as opposed to individual coping; indeed accounts of union activity on issues of health and safety were not given by respondents. Although respondents were aware of the dangers posed by dust, chemicals, and fumes, they did not mention ways in which they had been able to minimise such health hazards:

> R419: 'As a welder I am out in the fresh air but some of the fumes I swallow is unbelievable you know. So what do I do? Chuck my job because of the fumes; you know what I mean.'

However, leaving their occupations and finding another job was an extreme way in which respondents changed their work environment. This was the result of a failure either to compensate for, or control their job characteristics. Their only alternative was to escape.

For those who mentioned such a change, however, it had led to an improvement in their employment situation. One respondent had left his job as a lecturer and shifted to local government to get away from the time pressure and the unpredictability of his previous work load to a job where he had 'an even spanned day'. Another a taxi driver (R133) had decided to become self-employed in order to gain a degree of control over his work situation.

To sum up, then, accounts of the way in which respondents coped with the negative health effects of their jobs were varied but could be characterised by whether they compensated, by adapting themselves to minimise risk, or whether they attempted to control their work environment. The styles of compensation and control were also related to the types of health effects produced by their occupations and whether such effects were seen to be psychological or physical. Where a job's physical demands were low, dieting and physical exercise protected the individual from potential health problems; while respondents whose occupations had a moderate level of physical activity were less concerned with exercise or dieting.

Respondents also referred to numerous techniques which compensated for psychological stress. Various techniques can be grouped under the category of job disengagement. This could involve physical disengagement where the respondent took short breaks, or

left the immediate workspace; or mental disengagement where the person thought of non-work related activities while carrying out his work task. Some of these breaks were officially sanctioned, as in the case of tea breaks, others not.

Again the compensations which some respondents made for the negative health effects of their jobs were often self-contradictory - in reducing stress, they were recognised to promote other health risks. In both instances the use of tobacco and alcohol for signalling temporary 'time out' from work was important - alcohol use outwith official work time and tobacco use both in and outwith official work-time.

Other coping mechanisms mentioned by respondents highlighted attempts to control elements of their work environment. One common approach was for respondents to re-organise their work tasks, often breaking down their job into components and tackling them one at a time. This narrowing of their focus helped to reduce stress. Another respondent described the creation of a self-help group to handle stress at work. And of course those respondents who had changed jobs demonstrated a failure either to compensate for or to control the strains in their occupational environment.

Not only did the health effects of occupations vary, however, but so did respondents' strength of commitment to their work. This also had implications for maintaining an acceptable level of health risk in

the workplace.

JOB ORIENTATION AND COPING

So far I have considered the perceived health hazards of particular occupations and the coping strategies which respondents linked with each. The multi-disciplinary literature on work behaviour (Neff 1985; Landy and Trumbo 1980) draws attention to another factor which can influence the goodness-of-fit between a person's subjective ideas of work and aspects of their work environment, and this is the individual's orientation towards work. Kahn (1981) has described three styles of work orientation: work as affliction, work as addiction, and work as fulfillment. In the course of interviews respondents presented their ideas about their commitment to their occupations in styles which broadly corresponded to those of Kahn, though with some qualifications. For example, as we shall see below, Glaswegians did not see work straightforwardly as fulfilment. This and other typifications were more complex, and were not merely isolated statements of job orientation, but respondents often compared and contrasted their own approach to work with that of others.

The first category was those who saw themselves as being in the wrong job, either in the wrong profession or in the right profession but at a level which did not engage their full capacities, and who did only what was

necessary and unavoidable. This was the case for one respondent (R103) who worked as a research economist for local government rather than in an academic department. Another worked as a heating engineer (R609) but wished to take up music and was planning to achieve his aim by entertaining in his spare time. Others, however, for example a labourer in a chemical works (R421) and a window cleaner (R475), saw work as an affliction but had no hopes or plans to change jobs.

A second category of respondents saw work as in some respects moderately fulfilling, though in other respects problematic. They varied in the strength of their commitment to their occupations. Most were merely satisfied with their jobs and accepted the bad aspects of their work. They were mainly characterised by not having any strong aversion to their employment. This category included respondents from various occupational groups: a divisional environmental health officer (R625), a fire officer (R758), a teacher of physical education, a medical laboratory scientific officer (R769), and a clerk of works (R125).

The final category were those respondents who said they worked hard for long hours. It would be overstating it to say they saw their work as an addiction. Their commitment did not necessarily mean that all gained fulfillment from their work, but rather some worked to earn money which gave them freedom in other areas of their lives, for example the ability to

go on more overseas holidays, or to move into larger houses. This was true for one taxi driver (R133), a window cleaner (R259) and a parts delivery driver (R211). Such workers have been described in the literature as instrumental workers (Landy and Trumbo 1980; Taylor 1968; Braude 1975; Goldthorpe, Lockwood, Bechhofer, and Platt 1968) who see work as a means to an end, which holds little satisfaction in its own account. Others in this group were hard workers in a different way, because they found their chosen occupations fulfilling and also because their jobs often demanded high levels of involvement. This was particularly true of occupations related to selling, be it pharmaceuticals or milk products. One respondent who was employed in property management (R921) was also addicted to work as was a Church of Scotland minister (R915). Despite their differences, I group all these people together because their health accounts are similar.

Those respondents who saw their work either as an affliction or as a strong commitment came from various social classes. However, by contrast, no unskilled and semi-skilled manual workers saw their jobs as fulfilling. People could view their jobs as an affliction whether they were in manual or non-manual occupations and whether their jobs entailed physical or mental health effects. Those who found their work moderately fulfilling were, however, all in non-manual and skilled manual occupations. Similarly respondents

whom I categorised as being highly committed to work could have manual or non-manual occupations, but there were differences between these two groups. Those in manual occupations were instrumental workers and were addicted to their jobs in terms of how much money they could earn from their employment rather than for the intrinsic interest their work provided. Those in non-manual occupations by contrast derived satisfaction from their work activities.

How then did respondents' orientations towards work inter-relate with the health effects of work and coping styles? One way to introduce this problem is to take particular case studies of respondents with varying work commitment.

Those respondents whom I would put in the intermediate category did not necessarily find their work fulfilling all the time. Most saw their work as having a mixture of both good and bad points which on balance made for a worthwhile occupation.

One clerk of works (R125) expressed satisfaction with his job. He had previously been a joiner and although he was always looking for improvements was happy with his current situation. In terms of the health risks of his occupation he viewed his job as physically damaging as it was sedentary, a 'desk job', which didn't give him enough exercise. It also involved a certain amount of mental stress, particularly when reports had to be written.

This man had developed means for coping with the particular health effects of his occupation. In order to counteract the effects of the sedentary nature of the job, he dieted, and exercised, both in the home (for half an hour streches) and by walking. To alleviate the mental strain he used to smoke, as he had found this relaxing and was an easy option due to the time discretion he had at work. This was, however, no longer an option, as he had given up smoking two years prior to interview, and currently he tended to eat more when under pressure which aggravated his weight problem. If under more extreme pressure he temporarily disengaged from work. As he stated he: 'walked away from work if under stress'. In other words he compensated for the health risks of his job by means of exercise, dieting, and disengagement. There was an element of self-contradictory compensation in his use of eating to relieve minor stress, as this added to his weight problem; but this had replaced smoking, the greater health hazard.

Another respondent who expressed satisfaction with his job was a medical laboratory scientific officer (R769). He viewed his job as being both mentally and physically damaging to health. He worked in a hot environment so he was susceptible to colds due to changes in temperature, he was worried about the possibility of developing heart associated diseases. The work was stressful as the tests he did had to be

accurate, carried out at speed, and meet deadlines.

He took compensatory action to minimise these dangers:

> R769: 'The job can be stressful and the way to relieve the stress is that as well as working hard I try to play hard as well.'

This involved swimming and playing squash in the lunch-break, and working out in the gym. During the working day he used coffee breaks 'to get away' so that he could come back to his work fresher. His use of alcohol, as a self-contradictory compensation, was also geared to reducing strain and he drank to wind down and relax at the end of the working week. He also, when under particular time pressure, took control of his work routine and eased the strain by breaking down his tasks into particular units, checking one part at a time.

Those respondents who viewed their work as moderately fulfilling used the full range of coping styles, compensation, self-contradictory compensation, and control, to counter any health effects of their occupations. This can be contrasted with the coping styles of respondents who displayed other levels of commitment to their employment.

The case of the pharmaceutical area sales manager illustrates the complex interactions, for someone strongly committed to work, between the health hazards of his occupation and the coping strategies which have developed over time.

At interview his attitude towards his job would place him in the highly commited category, although being under constant stress and strain had led him to re-evaluate the positive and negative aspects of his occupation. He was constantly aware of the threat to his present position of young people coming up through the ranks. He mentioned the deterioration in his memory and eyesight and the fact that he could no longer assimilate research material as quickly as before. In fact during the course of the interview he stated that he would consider early retirement if the opportunity presented itself.

On the one side his was a high stress occupation. He had continuously to keep up to date with all the latest research reports on the newest drugs on the market. His occupation was also stressful because of the large amount of socialising his job required. It entailed a great deal of travelling away from home and extended stays at conferences. At such meetings he had to give detailed presentations of his company's products, on which sales, and ultimately his job, could depend. The socialising also entailed drinking, which was an additional health hazard. He had to work to strict schedules and was consequently under time pressure.

This respondent had developed various means of adapting to the requirements of his job, although the structure of the occupation created difficulties for the

adoption of certain coping techniques. He was aware that his job did not give him enough exercise and that his diet had been high in cholesterol. He described himself as 'heart attack material'. So he had changed his diet and cut down on smoking, but he found it difficult to increase the amount of exercise he took each week. He described his work schedule as 'eating into his relaxation time.' Golf was no longer possible, though he had managed to take up swimming as a substitute. Thus there were limits to his use of compensation.

In terms of self-contradictory compensation he had managed to reduce his smoking but due to the link between alcohol, the social aspect of his job, and efficiency at work, he found it difficult to reduce his alcohol intake. At conferences however he drank a special electrolyte mixture in the evenings to minimise the effect of alcohol and leave him with a clear head the following morning. He had also learned specialised relaxation techniques involving deep breathing and self-hypnosis to control particularly stressful situations - for example the presentation of conference speeches.

Above we saw how a pharmaceutical area sales manager had run up against limits of the possible use of compensatory techniques. He tried to minimise stress and strain without reducing his commitment to his chosen career. He does this by various means of adapting to, and also of controlling, his job situation. The end

result is far from perfect, still involves stress with its potential health effects, but is perhaps the best that can be achieved in his particular circumstance. It may however also be a precarious balance and as we have seen a change in one of the factors might produce different responses. Given a few more years and increased competition from younger colleagues this interviewee might well opt for early retirement.

Respondents in manual occupations could also be highly commited to work, and coping styles were used in the same way for the same purpose. One taxi-driver (R133) worked long hours in order to buy his own cab and hence become self-employed. To cope with the pressure of the long hours his smoking had increased with his pace of work. He drank with his workmates at the end of a hard week, again as a release from the stress of work. Like the pharmaceutical area sales manager, his lengthening work-day had eaten into the time which he normally used to keep healthy. Again this respondent was encountering limits in his use of compensation techniques in combatting the health effects of his occupation.

In terms of those respondents whom I categorised as being highly committed to work, although they had similar coping styles to those who viewed their work as fulfilling, differences could be found in their use of these styles. They could be characterised as being pro-active rather than reactive, more concerned with control

than compensation. Coping was designed to make them more able to deal with the stresses and strains of work. In terms of compensation strategies, disengagement from work, although practised, had to be temporary, and was geared to increasing efficiency after the break period was over; they were indeed at the limits of the possible use of compensatory techniques. Exercise and diet was also a far greater preoccupation for this group. Indeed respondents in this group were very aware of the health dangers to which they were exposed due to their increased commitment to their work. They were ambivalent about the self-contradictory compensation strategies of alcohol and tobacco use. Smoking and drinking were almost exclusively means of handling stress rather than countering boredom. They realised its importance in the alleviation of stress but recognised its dangers in increasing their susceptibility to heart disease. A few in this group had in consequence managed to stop, or cut down, their tobacco and alcohol intake.

The ideas of respondents who could be categorised as highly committed to their work have been presented; I will now turn to look at those who could be seen to regard work as an affliction, first a labourer in a chemical works (R421).

This man saw his work as physically tiring although he was not under much mental stress. As he said:

R421: 'It's just a labouring job I do, you

> know. It's just a matter ... the only strain is that it's physical you know, and you're used to that. Mentally it doesn't affect my health.'

Although here he says that he is used to the physical strain later in the interview he said that he often felt exhausted at the end of the working day. Again although he did not view his job as stressful he saw it as boring and this produced a certain mental strain.

Those were the perceived health effects of his occupation; his general attitude towards his work was that he viewed work as an affliction. As he stated:

> R421: 'I get fed up. It's not really with me, it's when you've got to do something you don't want to do. I consider that I do something I don't want to do for seven hours carrying this every day.'

The boredom of the job and the lack of possibilities of moving to a better position had affected his whole outlook. He had lowered his employment aspirations and distanced himself from the work tasks, trying to avoid any major problems which cropped up and generally not letting things upset him. As he stated:

> R421: 'I don't think I really want much out of life. I don't, well that's not really

> true. At one time people expected to get what they wanted out of life because they were intelligent, and then they realised they were not intelligent. It's just going through the rest of their lives doing what they could do with as little hassle as possible you know. I just make my way through it and I don't let anything bother me.'

In practice however this aim was difficult to achieve and his self-contradictory use of alcohol and tobacco as compensation reflected this. He drank to escape the boredom, to stop worrying about his life. As he stated, he 'couldn't face reality sober.' At work he said he smoked at tea breaks because of boredom. This hopelessness was also reflected in his opinion on class differences in health attitudes. He believed the upper classes held different attitudes towards health, that they were more health conscious because they had more to live for than the working classes.

Not all those who saw work as an affliction had manual jobs. One research economist (R103) who worked for local government also found his job boring and mentally stressful. He felt he had little control over his work tasks and to compensate for the lack of physical activity in his job he took part in physical exercise after work. Like the labourer he had given up hope of finding satisfaction in his current job but was

not resigned to his situation and continued to search for more interesting work in his field. He still felt it was possible to control the future direction of his career.

The use of coping styles of those who considered their work to be an affliction can be described as being involved in danger limitation. Their aim was to get through their work adequately while at the same time minimising its adverse health impact on them. This group was characterised by an adoption of coping styles which involved disengagement. Their self-contradictory use of alcohol and tobacco as compensation was also distinctive. A lot of respondents were bored with their occupations, either because they thought they were in the wrong job or because the work-tasks themselves were highly repetitive, and drank or smoked as a way of relieving their boredom and blotting out their frustration.

To summarise, the three levels of commitment to work have different implications for the coping styles of respondents. Those who saw work as an affliction did not mention any methods of job control. They were also limited in their use of compensation. Coping with work involved the self-contradictory use of alcohol and smoking to counter the boredom of their occupation rather than as an antidote to stress. By contrast those respondents who were highly commited to work could not disengage from work but controlled their job tasks.

They were still, however, limited in their use of compensation. If their work was time-absorbing and sedentary, they could only use a limited range of exercise to cope with the sedentariness. Again, in contrast to the afflicted, their self-contradictory use of alcohol and smoking was aimed at the reducing stress not eliminating boredom. However, if their job was stressful and sedentary they couldn't then reduce their alcohol intake due to restrictions on the availability of other compensatory strategies. None of the above limitations applied to those whose work was neither afflicting nor entirely absorbing.

Those in the category of being moderately fulfilled at work could be seen as being close to the mean, where their room for manoeuvre at work, in terms of coping and adaptation, was at its maximum. Respondents in the other two categories by contrast suffered restriction in their ability to cope, in relation to work, in a positive and health enhancing way.

CONCLUSION

In this chapter I have shown how respondents were very aware of the impact their work could have on their health. Although they endorsed the view that their work was less detrimental to health than unemployment, their own jobs were still seen to entail different mixes of physical and mental stresses and strains. Stress could occur if the tasks of a job produced either too much or

too little mental and physical stimulation.

Further, respondents presented themselves as adopting coping strategies to counteract such stresses. These strategies could be compensatory, largely reactive and adaptive in character, where respondents' behaviour was in the direction opposite to the stress being imposed by work. They could involve degrees of disengagement from work. Or they could be pro-active, and concerned with establishing control over the respondents' work environment.

In this context health behaviours could hold different meanings for respondents. For those in sedentary occupations diet and exercise were compensatory activities where workers counteracted the lack of physical activity in their jobs. Those in manual trades which demanded a high degree of physical involvement, did not view diet and exercise in these terms. Again, although not normally viewed as health behaviours, and although respondents were aware of detrimental health consequences, alcohol and tobacco were often used as important aids to coping strategies: either in a compensatory fashion, as forms of relaxation and disengagement, or pro-actively as a means to enhance efficiency and control work activity. These findings for men complement those of Graham (1987) on the paradoxical relationship between women's smoking and family health. And, like the work of Graham, show the importance for research to analyse health behaviours

within the context of people's everyday lives.

It was also shown that respondents had different levels of commitment to their occupations and that their level of commitment was related both to the choice and range of coping strategies which were available to them. Those highly committed to work, for example, had greatest difficulty in counteracting the health hazards of their occupations, as not only did their commitment increase the stress and strains of their working day but it also favoured increased alcohol and tobacco consumption while restricting their time to engage in appropriate coping strategies. Again they used pro-active styles while those who saw their work as an affliction adopted coping styles favouring disengagement.

The results from the study add to Kahn (1981) and Warr's (1987) hypothesised models of balance. While social scientists hypothesise that the optimum level, for health, of most job components is in the mid-range, of not too little not too much, respondents use a similar logic to account for their health behaviour. This furthers the discussion by Pollock (1988) on the similarity between lay and professional ideas about stress and health. The adoption of a qualitative methodology also does justice to the creativity people bring to the development of their coping styles. They by no means saw themselves as passive recipients of the health influences of their occupations. I have also

shown that coping styles involve a mix of strategies. The compensatory logic depends on the person's commitment to their work. Those who found work an affliction are limited in their range of compensating mechanisms as are those who are highly committed.

Further my findings inform the inequalities and health debate by showing the complexity of the relationship between social class and lay health beliefs. Compensatory practices related to an implicit equilibrium are found in accounts from all social classes. By contrast, the findings of D'Houtaud and Field (1984: 39) suggest that equilibrium as an expressed idea is a predominant feature of middle and higher class accounts. Again, although coping strategies have been shown to vary depending on the weight of physical or mental strain in each occupation, the balance between such components in each occupation is not clearly demarcated between social classes. Each occupation needs to be considered by its own characteristics. The taxi driver and the local government officer, though one has manual and the other a non-manual job, both have sedentary occupations.

These findings indicate that traditional occupational class measures obscure much of how occupation is felt to influence health; but one social class relationship has been found, that unskilled and semi-skilled workers have only two choices, both of which exert limitations on their coping styles: either

to regard their work as an affliction, or to become intrumentally committed to their occupations.

Finally these findings have implications for health promotion. Although a materialist position could be taken which argued that major health improvements can only come about through large scale alterations in our society's occupational structure, important health improvements can also be suggested by a detailed examination of the micro-environments of occupations and workers' responses to them. A health education approach, as normally favoured by those who support the behavioural and cultural explanations for class inequality, would seem to be unlikely to be particularly effective since most workers are already aware both of the health dangers of their jobs and the hazards of smoking, drinking and lack of exercise.

NOTES

1. The following section has been previously published in slightly revised form (Mullen 1992).

CHAPTER 9

ELEMENTS OF LIFESTYLE: HEALTH AND MARITAL STATUS

INTRODUCTION

The concern of the present section is with the relationship between social context and the health beliefs of respondents. In the previous chapter the relationship between occupation and health was considered, this chapter focuses on how the influence of the family and marital status was believed to affect health and well-being. The accounts of respondents of different marital status and from contrasting family types (those who were married, single, separated or divorced, and from families with and without children) are analysed. The social class and economic dimension is also taken into account.

The literature on the relationship between health and marital status covers a wide range of themes but varies in its findings. The work which has been done on mortality is reasonably conclusive. Researchers have found a gradation in mortality rates over marital status with the divorced faring worst for almost every cause of death, with the single occupying the mid position, and the married being best off (Morgan 1980; Macintyre 1986).

There have been few studies on morbidity, however, and the findings from these studies have produced a confused picture. Morgan (1980) has suggested that the

contradictory findings can be accounted for by both the different health perceptions of respondents of different marital status and also by the fact that age is often not controlled for; thus the younger age profile of the single is ignored. My own findings of a secondary analysis of G.H.S. data, quoted by Macintyre (1986), showed that the married were, or more accurately said they were, in better health than the single; and up to 60 years of age the married were less likely to report long standing chronic illness than the single or formerly married. Blood pressure has also been shown to vary by marital status, with the single the highest, co-habiting next, and the married the lowest levels (Macintyre 1986; Shaper et al. 1981). Rates of psychiatric disorders have also been shown to be greater among the separated and divorced than among the married (Goldberg and Huxley, 1980).

In terms of health damaging behaviours, however, Marsh and Matheson (1983), found that the married with children and the married without children had more smokers (both groups 47%) than the single (42%). But they also found that the group with the greatest proportion of ex-smokers was the married without children (31%) followed by the married with children (24%) and lastly the single (11%).

Above I have briefly summarised the findings with regard to marital status and health, as can be seen, among researchers there is a general acceptance of a

health differential between the divorced and separated, the single and the married. Various hypotheses have been but forward to account for this finding. These can be grouped into ideas related to the influence of change and selection and those which stress the importance of the social roles of marriage and the single state on health.

Various researchers have attempted to explain findings by using a social selection model, whereby the healthier are more likely to get married whilst the unhealthy have a greater chance of becoming divorced. The strength of such selection processes are also seen to increase for those who suffer from either a genetic or chronic disease. Although not all writers accept such health selection operates for all health conditions they do tend to accept its operation for serious conditions.

The effects of marital status change has also been discussed. Here the difference in health between those who are married and those who are separated or divorced is often explained in terms of the similarities between the process of divorce and that of bereavement. Burgoyne and Clark (1983) have for example shown the deterioration in diet which precedes separation.

Apart from selection and change the other focus of explanation has been on the importance of different social roles for encouraging and promoting or damaging health. Marriage is seen to give men in particular a

well-defined and socially acceptable role which is held to be conducive to low stress levels. The separated and divorced, by contrast, are seen to be stigmatised, and are thus in a similar position to the single. The stigmatizing effects of these roles, is also seen to vary with age.

Not only do different marital statuses have different levels of stigma but they also vary in their kinship networks. Kin networks are seen to provide support, are protective, and are also greatest with the married with children. And it has been shown that mortality rates are also lower for the married with children than those without (Kobrin and Hendershott 1977). The early work of Durkheim also placed emphasis on the importance of the social integrative aspects of marriage; he found that marriage reduced the risk of suicide by one half (Durkheim 1951). Marsh and Matheson (1983) have demonstrated the pressure exerted by spouses in getting their partners to stop smoking. Morgan (1980) has also described the single as having dangerous lifestyles.

The mutual interaction of family roles, while exerting a mainly positive influence, can also have negative consequences for health. The important point which has been found is that families share the good and the bad. Families have been found to share and reinforce smoking, drinking and eating behaviours. They can therefore stabilize and minimise health damaging

behaviours but can also produce inertia and inhibit change towards health enhancing lifestyles (Doherty and Campbell 1988).

In the literature, however, a lot of these ideas remain on the level of suggestive but largely untested hypotheses, as little work has been done on the internal dynamics of family life and how they would influence health. An exception to this has been the work which has focussed on the disfunctional influence of family life on psychological health. Early psychological literature often tended to focus on the potential of the family to cause psychological or psycho-somatic disturbance, for example hypertension, skin disorder, and asthma (Ackerman 1958). Later work implicated unhappy marriages with high levels of stress (Renne 1971; Brown, Birley and Wing 1972). And of course the work of Laing, Esteron and Cooper (Laing and Esteron 1970) examined those dynamics of family life which could lead to the production of schizophrenia. More recently Denzin (1987) has discussed 'the alcoholic family' and how the non-drinking spouse may collude with the drinker to produce the stable features of 'alcoholism'. Of course all of this work has been carried out on families which have a problem of one kind or another - it is research on abnormal or disfunctional families. And it has been pointed out that such families are the exception rather than the rule (see Fletcher 1988). And again in terms of the methods of such studies little has

been done of morbidity or on the actual operation of illness behaviour within families.

In the presentation of data below I aim to explore these ideas about the relationship of marital status to health through the views of my respondents, what did they see as the main mechanisms contributing to good or bad health? In other words, how close are lay to professional ideas in this area?

THE MARRIED AND THE SINGLE

What came through clearly in the interviews was that respondents believed marriage had positive effects on their own and other people's health. Most respondents who were married believed that it gave them greater stability in life. This was reflected in their feelings of increased balance. In answer to the question: what had a good effect on his health, one married respondent said:

> R103: 'My job is stable, my home background is stable, and I am healthy and taking exercise.'

In answer to the same question, another respondent stated:

> R347: 'Well I would say I would take that to be work, or family and work. I've a good family, I've a good wife, two nice kids who don't give me any problems so

> far... I don't have any pressures which should make me feel not well.'

Respondents often believed that since getting married they had become 'more settled'. Part of this stability was reflected in their answers to questions on their satisfaction with their lives. Those who were married tended to display a positive orientation towards the future. They would make plans about their future in terms of improving their houses or developing their careers. Respondents also referred to themselves as 'family men' and this general type was seen to be characterised by stability and a relaxed frame of mind.

For example when asked to describe any good effects on his health, one respondent mentioned family in the following manner:

> R121: 'Yes I would say I am more content with my life than I was for a long period, particularly through my teens and twenties. Now I feel quite established and I would consider myself to be a family man, my main interest in life is my wife and children you know building up a home etc.'

Married life then, was seen to produce stability which in turn was viewed as conducive to health. These findings thus would seem to give additional support to the research literature (Morgan 1980; Macintyre 1986)

which sees the married having better health than the divorced and separated, and the single. But why was marriage seen to be good for health? Marriage was generally viewed as a restraint on the freedom of choice respondents had when they were single, but such restraint was believed to have positive health consequences. The comparison between the single and married way of life were made both by those who were married and by those who were single.

The single saw themselves as being free from responsibilities and able to make their own choices. One single respondent mentioned financial constraints:

> R550: 'I am single right enough I think I have a free choice (in the decisions he makes in life). I could see a guy with maybe three or four wains and Christmas is coming up and he has not got much of a choice you know. It is a lot harder for him than it is for me you know.'

For married respondents marriage had acted as a restraint but this had enabled them to cut down on an unhealthy lifestyle. Most said that their drinking consumption had decreased dramatically since they were married. One respondent stated:

> R682: 'I certainly think when I was younger and I was unmarried and I had less commitments I was a bit irresponsible, but

> now I have got responsibilities and I can't do that. Being married has altered my whole approach. I am not saying that if I had not got married I would have been an alcoholic kind of thing. I could have been an extremely unhealthy person.'

Marital status was indeed shown to be an important influence on the patterns of alcohol and tobacco consumption among respondents. Marriage was seen to act as a general constraint on alcohol consumption. A key issue here relates to the connection between sociability, relaxation and drinking. As we saw in chapter seven, one of the major reasons why people drank was to be sociable. Respondents presented a clear dichotomy in the course of interviews between the public house and the home. For the single person the main focus of social life was often found in the public house, for the married person it was his family. Although married respondents still drank in public houses this was limited both in terms of time and frequency, for example going for a pint with a friend after a football match. Both married and single respondents drank in the house, for example to wind down after the hard day, but it was the married respondents who drank when guests or relatives were invited for dinner, or if they themselves invited friends. Again, married respondents would often go out for a meal in a hotel or restaurant and have a bottle of wine on such

occasions. Thus the pattern and social context for drinking was different for the single and married. In most cases such patterns favoured increased drinking among the single. For the single to enjoy social company drink was involved, this was not the case for married respondents.

However, this reflects only part of the situation. Although my married respondents shared the assumption that the single tended to drink heavily, this was not always found to be the case among my single respondents. My single respondents were often very health conscious and some stated that they had moderated their drinking from their youth. Indeed a few, when they spoke about heavy drinking mentioned that it was associated with the young rather than with people who were single. There was definite life-style which could be associated with `the health conscious yuppie'. Although all of these respondents were now in the middle classes some mentioned that they had come from a working class background; and such respondents credited their adoption of this particular style not with presently being in the middle class but rather to ideas of moderation which stemmed from their family backgrounds. One respondent (R439) spoke of `the family atmosphere' in which he was brought up.

Although it was the case that my single respondents in the manual occupations generally had unhealthy lifestyles, respondents from the working class were

still health conscious. One respondent (R249) was typical of the working class in that he had tried to take part in formal health exercise, in this case keep fit club, but had found it boring. He believed his health was protected by the fact that he looked after his mother and no longer frequented the public house as much as he used to. This was a conscious decision. He had wanted to stop drinking so he had bought a car, which enabled him both to stop drinking and to help his parents. Here we have an instance of a respondent using a family member as an excuse to improve their health behaviour. In this case the respondent also believed his action in buying a car and reducing his drinking had resulted in the loss of his girlfriend.

My single respondents, then, maintained that there were dangers to health in being single. They thus agreed with researchers in the field (Morgan 1980; Macintyre 1986; Davis and Strong 1977) that to be single was to have a 'risky lifestyle'; they often took action to protect themselves against such dangers. And there was a gradation of action from the working to the middle-class. In the working class although respondents were aware of health dangers they often had difficulties safeguarding their health, this was not so much the case in the middle class.

CHILDREN AND MARRIAGE

Comparisons were not only made in the interview transcripts between being married or being single, but were also made between marriages. The major distinction was between those marriages with and those without children. Although extra sacrifices were seen to be necessary to bring up children the result was seen to be a happier marriage. One respondent compared his own life situation to that of a friend who had more material comforts:

> R769: 'To me money is not everything... For instance one friend in particular, he and his wife said they would rather not have children so that they can get what they want. Like things for the house or change the car every second year or even move to a bigger house. I do know that the male member of that couple would love children.'

The presence of children in a marriage was seen to be important both in terms of physical and psychological well-being. Again this parallels the hypotheses given in the literature to explain mortality differentials between people in marriages with and without children (see Kobrin and Hendershott 1977). Children were seen to always keep people mentally and physically active.

One respondent said his children kept him healthy because:

> R475: 'You are always on the go with them, never a dull moment with them.'

Respondents said they kept themselves physically healthy by looking after their children's health. They took their children to the swimming baths or to various sports. Children were also seen to be important for psychological well-being. Respondents believed the natural cheerfulness of children stopped them from becoming too depressed.

Although respondents with young families were less likely to take part in formal health activities than those without children, this was compensated for by being kept active by their children. One respondent summed up the influence of his children on health as follows:

> R915: 'The children, the children are good and they are totally absorbing... From a very selfish point of view you get a lot of satisfaction just out of their general responses, and seeing them coming on and developing. The children are important to me. There is an interest shared with people getting out and about as a family with my wife... that can be good and draws you together. I think the children are

very important generally.'

In this quotation we can see the importance of children in consolidating the marriage relationship; turning a marriage into a family. For my respondents then family ties and social support, as has been hypothesized in the literature (see Tunstall 1965; O.P.C.S. 1978), were seen to be important for health.

In the previous chapter I showed how a person's occupation and their orientation towards work influenced their ideas about health. A person's occupation and their ideas about the importance of work also influenced their relationship to their family. Some occupations, for example oil rig workers, taxi-drivers, and those in the prison service, did not have regular hours. Although this could be disruptive for family life it could also mean that respondents employed in these occupations could spend more time with their children when they were off-duty. This was mentioned by numerous respondents. Other jobs, however, put respondents under so much pressure that priorities were tilted towards work rather than family life and this produced tension which could be detrimental to the health of respondents.

Respondents' ideas of the effect family had on health also surfaced in their discussion of their own family background and their ideas of hereditary disease. This was particularly true in respect of their own parents' smoking and drinking and the effect it had on

their own behaviour. Some respondents had followed the advice of their own parents not to smoke or drink, while others didn't smoke, or drank moderately, in response to their own parents excessive smoking and drinking. Whether respondents followed or reacted against the example or advice of their parents, most were aware of the influence their parents had exerted.

In turn respondents were careful about their own behaviour and how this might affect their children. In the following quotation a respondent describes both these influences - of his own parents on him and his influence on his children:

> R121: 'I would not actually say I would never touch a cigar again. I might smoke one but I think also the children have played a major role in it. My daughter a couple of years ago when she was two walked in and saw me smoking a cigar at a dinner party and had a shock, so I never smoked again in front of her... I think so many things can be passed on from father to the child, children look to their parents and copy them. That is one thing I don't want my children to copy from me... My father is a heavy smoker and I never copied him I never smoked. I think you receive ideas and things from your parents you know. If your parents vote

> one way your children tend to vote the same way as their parents because they hear these ideas in the house. My father smoked heavily but he would have thumped me if he caught me smoking so I may well have smoked if I had not been frightened.

Respondents were not only careful about the example they set their children but they also used their children as a catalysts to changing their own health damaging behaviours:

> R667: 'I have problems even now, if I think about it hard enough I would like a cigarette. It took a while for the feeling to wear off. How I engineered it was all my children got me to promise to give it up for lent, you see... and I have not smoked since. For the first few weeks it was very difficult I still had a craving for it.'

This process of involving children in order to get respondents to stick to their resolve was common:

> R306: 'You just feel that you want one. This last time it was a bit easier. I think there was a no-smoking campaign at the beginning of the year. My older

> daughter had been on and on at me for years and the younger one had been doing it at school, so I told them to behave and I would stop in my own time, and I did.'

So far I have considered the beneficial and supportive effects of family and children on health. From time to time, however, children could produce strain in a marriage. This was frequently mentioned in regard to young children who were so demanding that they made respondents physically exhausted. The marriage or family unit acts as a mediator for health:

> R758: 'When people in the family are ill then your own health suffers. Looking after them or doing things for them or maybe being kept awake during the night. Mainly when the children are ill.'

But again most believed that everybody with young children felt tired.

More serious problems were also discussed however, mainly related to older children. One respondent (R302) described the emotional disturbance and problems one of his sons had suffered and how this had adversely affected his own health over a period of time. Another respondent (R667) worried about his loss of control over his children as they grew up and gained in independence.

Turning to those respondents who were married without children or whose children had left home, they

also reported feelings of psychological stability which they related to their marital status. Their marriages were seen as providing a firm foundation in their lives and this was seen to reduce stress. Respondents mentioned that they tried to influence each other towards better health behaviours. R644 gently tried to get his wife to stop smoking by not buying her cigarettes but did not push things too much in case it started arguments. A similar finding was uncovered by Marsh and Matheson (1983). Another interviewee (R103) and his wife both worked out their diet which was seen to be `very much part of the family context'.

However, although those married without children tended to describe positive health effects of the marriage relationship, similar to those married with children, there were some respondents whose lifestyle had aspects both of the single and married state. This was particularly noticeable in regard to drinking styles. Various respondents (R103, R421) still continued to drink heavily either with their old friends in the public house or at home with their wives. As one respondent stated:

> R682: `I go out every Friday night, it is just a throw back to when we were all unmarried'. He also drank heavily at stag nights, went to parties, and took part in heavy drinking at the golf club. As he said: `I like beer on a Friday night out with the boys'.

This respondent then is, in this instance, demonstrating a half-way drinking style between being single and being fully integrated into the marital state.

One young co-habiting respondent also described quite high levels of alcohol consumption:

> R609: Well I think you could say that I drank more than a little just now you know.
> KM: Over a period of a week approximately how much would you have?
> R609: My wife and myself we like a glass of red wine before meals. Every night like, I don't really drink tea and things like that much at all. When I am having my meal I like red wine with it. So we drink a bottle of red wine a night, a couple of glasses each with our meal.
> KM: And that would be how many nights a week?
> R609: That would be 7 nights a week.
> KM: And in terms of beer or lager?
> R609: Thursday night I normally go down and usually buy 14/16 Budweisers and just keep them in the fridge. I probably have got about 8 or 9 left from last week you know. I don't drink much lager I drink about 4 lagers over the weekend. Every weekend I am drinking Tia Maria coffee's, maybe two on Saturday night and two on Sunday. I might go through about half a bottle of vodka every weekend. That is probably a lot.

Here we have a description of a drinking style with an overall consumption of alcohol which would be rated high by alcohol researchers; and the interviewee, on reflection, was also aware of the scale of his and his partner's drinking as can be seen by his concluding comment.

The married without children, or those whose children had grown up and left home, described the free choice and control which they had. The married without children could thus be placed in a mid-state, both in terms of autonomy and their freedom over decisions, between the single and the married with children in the home. This led to role segmentation within the marriage. For example R644, whose children had grown up and left home, had plenty of time, most nights and weekends, to be involved in Church work.

DIET AND FINANCE

In the interviews it was also clear that the complementary roles of husband and wife in the family structure had, as Doherty and Campbell (1988) suggest, a mediating influence on health. This was most important in the areas of diet and finance. Indeed the two were often interlinked. In general the wife was responsible for the main cooking and structure of the family's diet. Financial considerations were also important, and in this respect the amount of money set aside for food was

often seen to be influenced by a families smoking and drinking habits. Both married and single respondents said the married had other priorities on which to spend money than alcohol.

What came through in the interviews was that most respondents had clear ideas as to what they thought was a healthy diet. Most, when they spoke about diet, mentioned, brown bread, cutting out butter and frying, reducing the intake of junk foods and carbonated drinks, eating more green vegetables, fruit, and the better cuts of meat. Such ideas were being picked up via the media either through television or radio or reading summaries of the latest medical reports in the newspapers. This knowledge as to what constituted a healthy diet was prevalent in both the manual and non-manual groups.

It was also an area in which respondents believed individuals could and should take responsibility for their health. Some respondents watched their diet as a matter of course; others had started regulating their diet after the onset of a particular illness.

Respondents' wives had often been delegated the major responsibility for organising the diet as can be seen from the following two quotations:

> R625: 'My wife watches my diet closely, not for any other reason that the fact that she has a very good knowledge of diet. The wife being the cook in the

> house she takes care of my diet. She restricts herself to a high fibre diet. She once put us all on, for a week, to her high fibre diet.'

And again:

> R802: 'I would suggest that my wife makes sure that we all eat a good diet, not a lot of junk food not a lot of oily foods.'

Respondents often said that they had tried to improve their diet to safeguard the health of their children. This went along with an awareness that children's diets had deteriorated in recent times. Those who were single were less likely to mention the importance of diet for health.

Changes in marital status and separation were again associated, in the minds of respondents, with problems of diet and weight. They believed that general depression and strain had caused them to eat either too much or too little. Such findings echo those of Burgoyne and Clark (1983).

Above I have shown how marital status and the presence of children in a marriage were thought to influence diet. Finance was also seen to be a major restriction on diet. This was reflected in respondents' ideas that low-income families could not afford a healthy diet. Lack of accessibility and variety of

foods in low-income neighbourhoods was also mentioned as were particular problems suffered by the unemployed.

MARITAL BREAKDOWN

Above I have mainly highlighted the positive aspects which marriage and family were seen to have on health. But as we have seen in the literature, researchers also present the hypothesis that families can be psychologically detrimental to a person's health (Renne 1971; Laing and Esteron 1970; Brown, Birley and Wing 1972). Did I find any examples of this idea in the accounts of my own respondents? Although respondents accepted that married life would have its ups and downs, crises which had to be coped with, they also believed that some marriages were beyond repair. Respondents made a distinction in their accounts between 'good' and 'bad marriages'.

One respondent outlined the difference between people in stable marriages to those who went from one marriage to another. Some respondents compared their previous to their present marriages. Some respondents demonstrated this by detailing how their present `good marriage' compared with their previous 'bad marriage'. R419, who used to be a heavy drinker, compared his previous pub-orientated `bad marriage' to his current home centred `good marriage'. Divorced respondents described their failed marriages. A good marriage, was seen to be beneficial and protective to health while a

bad marriage was seen to have damaging consequences.

Distinctions were also made between families in terms of their economic status. The marriages and families of the unemployed and those on low income were seen to be particularly under stress from economic pressure.

Alcohol was often mentioned with regard to problems in a marriage. The direction of the causal relationship between alcohol and marital breakdown was, however, problematic (see Denzin 1987). Some respondents thought people's drinking caused breakdown in marriages, others believed that problems in a marriage relationship could lead to heavy drinking. An example of the former is as follows:

> KM: 'Did it (heavy drinking) produce any problems for this person?'
> R841: 'They could not work so eventually lost their job. A breakdown in the marriage as well.'

And the later:

> KM: 'Why do you think other people drink?'
> R419: 'Because they are unhappy with life, they think the answer is in a bottle. Because I went through that years ago, I had a very bad marriage and would go down

> to the pub and get plastered and that was you. If you have not got a life in the house you have got to go out somewhere and look for a bit of company. If I go out, she (his second wife) goes out, right, that is what a marriage should be about.'

Those who were divorced and in general those who described as being 'unhappy people' also reported to be prone to heavy drinking.

The financial implications of heavy drinking on the family were also stressed. For the drinker to maintain high levels of alcohol consumption large amounts of money were needed which caused a heavy drain on family resources. This in turn had consequences for children's diet: Respondents also tended to be more disapproving of heavy drinking among women as they were seen to be the major shapers of families. These concerns are highlighted in the following quotation:

> R915: 'When people are drinking too much it places strain on relationships. Husbands/wives, boyfriend/girlfriend, parents/youngsters, in both directions. There is that level which creates tension and stress and feelings of guilt. If it becomes addictive there is obviously problems there of money, money which could be spent on children. Very often if mothers are drinking, I

> think that the effect can be even worse, if the cash is not getting to kids, for toys, books and for clothes. Things like that.'

When discussing such problems respondents occasionally gave examples of drink problems of their own parents or relatives, of their neighbours or of work colleagues.

CONCLUSION

In this chapter I have looked at various dimensions of marital status and have uncovered a tripartite division in respondents' ideas: they made distinctions between the unmarried (the single and divorced), the married without children and the married with children. I have shown how being single was associated with freedom and individual choice while being married brought constraints and responsibility. A moderate degree of restraint was generally seen to be beneficial for health. Social integration increased from the single and divorced, through those who were married without children to those who were married with children. It has been shown that greater social integration was seen by respondents to be beneficial for both physical and psychological health. Explanations given related to increased human contact producing more emotional stability and the beneficial effects of greater financial and dietary structure.

Being married was found to be more protective for health than being single. Health damaging behaviours were minimised. The presence of children in a marriage was also believed to give extra benefit to the psychological health of respondents. Marriage, then, was typically viewed as having protective functions which enhanced respondents' coping capacities. But married without children occupied an ambiguous position in this schema; although the married role provided beneficial aspects of stability there remained the possibility of the continuance of health damaging lifestyles into the marriage relationship.

Respondents also saw exceptions to these rules: being married was not always believed to be conducive to health and different types of marriages were seen to have different types and levels of difficulty. Respondents described short-term crises as well as long-term functional problems. 'Good marriages' scored high on factors supportive for health while 'bad marriages' scored low on such factors.

Again, although the single lacked the specific protective influences of marriage and were open to various risk factors (for example heavy alcohol and tobacco consumption) there were variations among the single which put some more at risk than others. Some single respondents had developed means to cope with these factors.

These findings show that lay thinking mirrors the

various hypotheses about the nature of the link between marriage and health as presented in the reviews of the field by Morgan (1980) and Macintyre (1986). Marriage is generally seen to be protective of health and the nature of the protection is seen to relate to social support, social integration, and being safeguarded from the 'risky lifestyles' of the single. I have also shown that because my respondents perceived such a relationship between marital status and health they often, as in the case of my single respondents, attempted to minimise the risks by health enhancing activities - cutting down on smoking and drinking, and taking part in exercise. In the case of the single, however, those in manual occupations had less possibility for manoeuvre.

In this chapter we have seen how respondents often spoke of the influence of the family as providing moral guidance; in the next chapter wider issues of the moral concerns in respondents' accounts and the related topic of religion will be addressed.

CHAPTER 10

MORAL AND RELIGIOUS ISSUES IN HEALTH

INTRODUCTION

Recurrent themes in respondents' discussions about health were their ideas about control over health and illness and the related topic of where responsibility should lie for the maintainance of health. Both these topics were found to have strong moral and religious components and I therefore decided to extend my analysis to a detailed consideration of these issues. The hope was that by choosing a focus which held strong resonances for all, I could relate the ideas of the religious respondents to those professing no religion.

In the fields of medical sociology and social psychology, when control is mentioned in relation to health and illness it is often presented in a uni-dimensional manner. Writers see control over health being generally and systematically expropriated from people in society, Navarro (1976) via the process of alienation and Illich (1975) by clinical, social and structural iatrogenesis. In the literature on lay health beliefs a clear activist/ fatalist dichotomy is often presented which is again directly linked to class position (RUHBC 1989). The middle-classes are positive and aim to enhance their health while the lower social classes are seen to be passive recipients of health services. In the field of social psychology the Health Locus of Control construct, an adaptation of Rotter's

original Locus of Control Scale applied to ideas of control over health and illness, while adding an extra dimension of 'powerful others', still rests on the internal/ external dichotomy, those who attribute their state of health to their own behaviour and those who attribute it to chance (Wallston, Wallston, Kaplan and Maides 1976; Wallston and Wallston 1978; Stainton Rogers 1991).

This chapter aims to take a fresh look at ideas about control and responsibility for health. Research on lay health beliefs has uncovered the deeply moral nature of much of lay health discourse (Cornwell 1984; Blaxter and Paterson 1982; Pill and Stott 1982). Although this has been highlighted, sustained analysis of specific topics within this discourse has rarely been attempted, and, with the exception of Williams (1990), the direct influence of religious beliefs has tended to be ignored. This chapter aims to contribute to the literature on one theme of this moral discourse, that of ideas of control and responsibility for health, by also considering the influence of religion. Central to issues of control and responsibility were respondents' conceptualizations of the person, the link between the mental and the physical, and also the location of responsibility and control.

An important framework for considering these issues has been given by Helman (1985:ch.5) in his discussion of the sites of illness aetiology. He states that the

aetiology of illness can be seen to lie either within the patient, the natural world, the social world, or the supernatural world. Western societies tend to see illness as predominantly lying within the patient or the natural world, while non-Western societies see illness as stemming from the social and supernatural worlds. In each of these different sites, however, there can be a different partitioning of control and responsibility. In other words just because the site of an illness is seen to lie within the person it doesn't mean that the person is seen to be responsible for, or has control over, his or her illness. (See Pill and Stott 1982; Helman 1978.)

Within the individual, responsibility is seen to be related to certain conditions, especially malfunctions of the body, and conditions brought about by specific health-related behaviours, for example smoking and drinking. Certain stigmatizing conditions and some traumatic injuries are also seen to be the responsibility of the individual. In such cases the individual can be held personally accountable and thus may feel guilty about having a particular condition. Other conditions however, where aetiology is still placed within the body do not carry this sense of guilt or responsibility. Here Helman discusses ideas about vulnerability, type of person, hereditary proneness, and notions of imbalance.

Helman also discusses the aetiology for illness

stemming from the natural and social world. In the West natural causes include climatic factors, germs, bugs, viruses, accidental injuries and environmental irritants. Here control and responsibility do not normally lie with the person. Helman's (1978) own work on the distinctions between colds and fevers illustrates these points. Sites of disease in the social world are seen to be more common in non-Western societies although the notion of stress in its relation to disease has an equivalent place in our society, where spouses and workmates can be blamed for being a cause for pressure. Infections can also be blamed on other people.

Although Helman holds that the placing of the causes of illness in the supernatural world is rare in the West, he does mention Snow's (1978) research on Blacks of low socio-economic status who saw illness as divine punishment for sinful behaviour. And he also sees a modern equivalent of supernatural intervention in blaming ill-health on 'bad luck' or on 'an act of God'.

Ideas of responsibility and control have also been discussed by Foster and Anderson (1978) in their analysis of the aetiology of disease. They made distinctions not by site, however, but by whether cause was seen to be personalistic or naturalistic. Personalistic cause involves the purposeful active intervention of an agent, either supernatural, non-human (for example germs), or human. Naturalistic cause involves impersonal systems (humoral balance) or natural

forces (cold, wind, damp, etc.) Both personalistic and naturalistic cause hold different implications for control and the allocation of responsibility.

In the analysis which follows I will show how different ideas about control and responsibility for health could be discerned in the accounts of respondents; and how these affected both the coping strategies of respondents and their allocation of blame. Particular attention will be paid to the various loci of control and responsibility for health, and the occasions on which it is seen to rest within the social world, the natural or the supernatural world. It will be shown how feelings of responsibility and control took on different meanings in each of these realms; and how ideas with regard to one realm could hold implications for the others.

However, although Helman's analytical scheme is used it is adapted more adequately to reflect and clarify the logical structure of respondents' thought. Broader headings are used in order to clarify the antitheses which emerge within them and certain ideas about health and illness are discussed under different types of headings.

I shall now turn to the analysis of the accounts of health given by these respondents during the course of the ethnographic interviews. Of particular concern will be the elucidation of ideas of control and responsibility as they relate to their ideas about the

social, natural and supernatural worlds.

THE SOCIAL WORLD

In my respondents' accounts of health two broad dimensions could be discerned, describable as activist and fatalistic approaches. But both ways of thinking could be present in the accounts of any respondent; and there were important personal, social and religious dimensions to activism and fatalism.

Personal activism assumed that the individual had control, and it could be spoken of on either the physical or mental level. Examples of activism on the mental level were to be found in the accounts of those respondents who believed it was very important to think positively as this could directly influence their health. The converse of this idea was also present in the accounts of those who believed that if a person suffered from depression or was prone to hypochondria this could detrimentally affect their health. Again examples of activist approaches on the physical level were beliefs that it was important to watch your diet and take part in exercise. Respondents did not need, however, to subscribe to activist thinking on both physical and mental levels. They could be activist with regard to their physical health but did not need to believe that their mental state influenced their health.

Aspects of personal activist thinking about health were brought out in different ways in the accounts

given. Some linked the very concept of health with activity; a healthy person was an active person, an unhealthy person an inactive person. This was also related to work as the primary centre of men's activities: to be working and therefore active was to be healthy. This is a functional definition of health: health is related to what you are capable of doing rather than how you feel. It also shows how closely the Protestant work ethic had come to be related to health in the accounts of my respondents.

Thus personal activist thinking was characterised by laying great stress on one's own efforts to improve one's health. Responsibility for one's own health was accepted, and mental states could be seen to affect health.

On the other hand people could also be activist in a social sense, the idea that we all, as a group, i.e. society or the state, can act to improve health. Although all stressed the importance of individual and democratic freedoms they varied in the strength with which they endorsed such freedoms when issues of health were concerned. Some were willing to see a large amount of state intervention in issues of health.

Of course, even where respondents identified with social action, they were aware of, and anxious to discuss, the difficulties and ambiguities involved in achieving it. For example, where they thought the state should assume greater responsibility and control for

health they also saw barriers to such intervention in the compromised position of the government. The government raised a great deal of revenue from the taxation of tobacco and alcohol products and was thus seen to be unlikely seriously to wish to cut back, to any great extent, on people's drinking and smoking.

Again in their discussion of the control of those businesses whose products were injurious to health they voiced moral dilemmas. Respondents tended to make a distinction between direct advertising and sponsorship; and they were more ambivalent in their attitudes towards sponsorship. Some were against sponsorship and saw tobacco companies as being both hypocritical and manipulative in using sport, which was aimed to improve health, to advertise health damaging behaviours. Others did not have such strong proscriptive feelings about sponsorship. A common reason given for this lack of proscriptiveness was that the respondents were in favour of sport and believed that various sporting activities would not have the money to continue if it wasn't for the financial help provided by the tobacco companies.

Respondents also tended to be less concerned with the health implications of tobacco and alcohol use when business and employment considerations were involved: if they sold tobacco products themselves, or if they viewed the tobacco and alcohol industries as businesses like any others which contributed to the total wealth of the country. This was often mentioned in relation to the

blight of unemployment and the fact that any health campaigns potentially put people's jobs in the alcohol and tobacco industries at risk.

Aspects of social activist thinking also covered the role of the family. The importance of family upbringing for instilling good attitudes towards health in their children was stressed. Respondents often spoke of their own upbringing as imparting a sense of moderation.

Personal activism often ran counter to social activism. Because so much emphasis was placed on one's own efforts there could also be less endorsement of state intervention or worry about the effects of sponsorship. Two respondents were strongly activist, accepting personal responsibility for health, and as a corollary to this didn't have faith in state intervention.

However, not all respondents individual or social activism as opposed alternatives with regard to health; many combined both while in various subtle ways highlighting the tensions between these two levels. This will become clearer if the conflicting factors of control and responsibility are explored with regard to the health damaging behaviours of alcohol and tobacco use. Although I have already touched on some of these issues I will now consider them in greater depth.

I will begin with respondents' ideas about alcohol. One of the key aspects of alcohol use mentioned by

respondents was that it allowed people to relax their normal controls. This is alcohol's facility to induce 'time out' where certain elements and obligations of the social world are suspended or bracketed for the duration of the drinking period (Cavan 1966; MacAndrew and Edgerton 1969). Here, in the context of 'normal drinking', or 'moderate drinking' alcohol is viewed as a facilitator for the release of social control.

At such times other aspects of the personality can emerge. Alcohol was, in moderation, seen to produce slight alterations in mood and character leading to greater informality and sociability. Alcohol was seen to increase the possibility of sociable conversation. Alcohol was in fact seen to 'bring out' the person's true self. And it did this by reducing the social controls normally in operation in the work-a-day world. The acceptability, credibility, and truthfulness of the content of a drunk person's speech was an important issue. There was a common belief that a drunk person told the truth. As one respondent stated:

> R125: 'Their responses can get dulled; they can say things they don't mean to say. I don't know if there is any truth in the fact that drunks never lie.'

Thus a balance needed to be kept between two different aspects of the individual's personality: being their true selves by acting spontaneously as they felt,

and being their true selves by acting responsibly in the light of their social relationships. The everyday world of social relationships was seen to be over-controlled and alcohol was viewed as a much needed release.

However, there was a fine line between the relaxation of control and its loss. One respondent said:

> R166: 'There is a difference between someone being drunk and being happy. You see some guys being happy and having a carry on and having a joke. When you see someone who is drunk, their words are all a slur and they are falling over the place, just totally no regard for anybody round them.'

In respondents' accounts drunks were described as 'being out of control' or having 'lost control'. They were, 'not in control of their senses' or had 'lost control of their faculties'. Such loss of faculties often elicited pity from respondents. Perhaps more importantly, however, drunks were seen to be unable to communicate appropriately.

An alcoholic was also someone who had 'lost control'. Central to this loss of control were ideas about will power. Will power could be seen to be an inherent characteristic of individuals: some people were seen to 'lack will power', and to lack will power was viewed as a moral failing. For some respondents, people

who were alcoholics demonstrated this lack of will power. For others, alcoholics were seen to have allowed themselves to lose control through drink and again this was seen as a moral weakness.

Such ideas were also seen to hold implications for recovering control; in suffering from an addiction a person had lost control over their behaviour and thus only the state or others could help. Some measures taken by the state, however, would also be useless because of this lack of control and responsibility on the part of the addicted person; the result of increased taxation would only turn people to crime in order to be able to pay for their addiction. The only resolution was the necessity for the person concerned to realise their predicament: alcoholics had to realise they were helpless and wish to be cured.

Alcohol, then, in moderation was seen to relax social controls and allow the expression of aspects of an individual's personality which could not occur outside the context of alcohol use. Indeed there was a certain moral responsibility placed on the person to allow for this to happen. On the other hand if control was lost then the person would incur blame; and if loss of control was seen to be total, and the person was viewed as an alcoholic, they were no longer responsible for their actions.

Just as respondents' thinking about alcohol consumption raised issues about control and

responsibility for health, these topics were also discussed when they gave their opinions about tobacco use. Elsewhere (Mullen 1987) I have shown how the main reason respondents gave for smoking was to relax; that they could control their anxiety and stress by means of tobacco. Nevertheless social pressure against smoking was considerable. The growing acceptance of the health hazards of smoking had also led, on the part of smokers, to general feelings of unease about smoking in the presence of others. As one respondent expressed it:

> R522: 'I do think people feel more guilty about lighting up a cigarette and stuff like that. There are no-smoking areas now.'

A sense of increasing isolation was also felt by smokers. Cigarette smoking in Britain was seen to be on the decline; it is now no longer viewed as the norm, or at least has problematic aspects, almost as if smokers indulged in a deviant activity often restricted to the company of other smokers. Similar shifts to these have been documented in America (Markle and Troyer 1979, Nuehring and Markle 1974). As one respondent said:

> R521: 'If you are a smoker you are a minority. It is very unusual for people to smoke now, I find, amongst my circle; I don't know many people that smoke. So it has become an anti-social habit. There is a lot of times I don't smoke because I would be the only one smoking and nowadays to smoke is a sign of weakness, a sign of ill-health.'

Others described the steady decline of the number of smokers at work. This had led smokers to restrict the context of their smoking:

> R522: 'In the evenings I smoke. I smoke more when I am with other people that smoke ... I think at work, I work with my hands a lot quite a lot, and I work with people. It is not convenient and it is not nice. I just made it a habit not to smoke when I am working.'

It could also lead people to stop smoking and was often given as a reason.

Such social pressures were reflected in the high proportion of dissonant smokers in my sample, smokers who would like to give up smoking if they could do so easily (McKennell and Thomas 1967, Chapanis and Chapanis 1964), and a general acceptance of the health education message was found among respondents. Dissonant smokers agreed with tougher measures to stop smoking. One

respondent who smoked 7 packets per week said:

> R625: 'If Maggie Thatcher banned cigarettes tomorrow it would not bother me too much.'

This same respondent thought cigarettes should be 'banned from a health point of view'. He also looked for non-smoking seats on trains and chose to sit in non-smoking seats aboard aeroplanes, actions typical of dissonant smokers. Respondents' dissonant attitudes were also brought out with regard to the price of cigarettes. Some were in favour of an increase in price as this might force them to cut down on their own smoking:

> R609: 'I am the sort of person that if I am getting something reasonable I would probably indulge in it more you know. So I would keep the price up.'

Dissonant smokers wished; but were unable by their own personal willpower, to give up smoking, they thus were willing to endorse elements of social control to increase the pressure on them to give up. Although smoking helped men to control their own stresses this was not given the moral value that was given to spontaneous sociability through moderate drinking. Changing social attitudes towards smoking had led to feelings of exclusion and guilt among smokers and that this was reflected in the high proportion of dissonant

smokers in my sample. Most smokers accepted that smoking was damaging to their own and other people's health yet they continued to smoke. They thus accepted moral responsibility for the perceived damage caused by smoking and at the same time saw themselves as unable to control their own tobacco intake.

To sum up, the tension betwen personal and social control was differently resolved in the cases of alcohol and tobacco. Personal management of stress and the emergence of the 'true person' was less acceptable with tobacco than with alcohol, since with tobacco social control was much stronger.

Above, components of activist thinking have been considered. Personal fatalism was, in contrast, a belief that control was not within individuals' grasp but with social agencies outside them with whom they could not identify. The mental was still seen to affect the physical, indeed even more so, but the possibilities of internal control were relinquished.

One respondent (R421), a labourer in a chemical works, demonstrated personal fatalism and its implications for health. He saw himself as being nearly on the bottom rung with only alcoholics below. Health was not given a high salience and he stated that he did not expect much out of life. He believed that higher up the social scale people had more sensible ideas about health and that they had more to live for. He drank to overcome timidity; he smoked. Again although he

believed the government could do more to stop people smoking he thought this would only be effective for the young and not for a hardened smoker like himself. Here we have someone stating that the influences on health rest not with the person but are outwith his control and lie in a social environment which others make use of more effectively.

Another respondent (R125), a clerk of works, demonstrated further aspects of personal fatalism. He did not believe people had control over their lives. This respondent also placed the cause of alcohol problems on the social environment; he blamed poverty and not the individual for high rates of alcoholism. He believed that people had little control over their own drinking.

Personal fatalism, therefore, can be characterised as a position where control is seen to lie outwith the person in a social world which belongs to others. Little by way of personal control over health is seen to be possible. People who held strong elements of such thinking were less likely, therefore, to endorse active programmes of personal health improvement, for example cutting down smoking, and drinking, or taking part in exercise and dieting. As a corollary the cause of ill health was placed elsewhere than with the person, on the social ordering of the everyday living environment, or on the involuntary behaviour of close social group and peers.

Attitudes of personal fatalists towards the possibility or desirability of state intervention were generally negative. They saw little possibility of the state either wishing, or being able to alter those aspects of the status quo which they saw as the major influence on health. They were therefore unwilling to endorse proscriptive state measures. This was a realistic response, particularly with regard to tobacco and alcohol legislation, where they could see drinking and smoking compensating for the disadvantages of their own position, and were unwilling further to penalise themselves and others in the same situation.

There were a few exceptions to these findings, although such respondents fell into two clearly defined classes. First, there were self-confessed alcoholics who, by great personal effort, had given up drink, and thought that others in a similar position should have the strength to do the same. Second, were respondents who had either given up smoking or were dissonant smokers; they wanted stronger state measures to increase the pressure on people to stop smoking. In these cases there was a clear difference in the types of activism associated with alcohol and tobacco use : activism expressed itself in an individual form with regard to alcohol use, and in a social form for tobacco use. Again, those who had given up smoking or drinking had done so under strong pressure because of social or health problems; to this extent even in their activism

they displayed fatalistic tendencies.

The Social World - Conclusion

To conclude, with regard to the social world the predominant mode of thinking among respondents was activist rather than fatalist. However, activist thinking took either a personal or social form. And, individuals who were strong in their personal activism with regard to health were less concerned with social activism.

The tension between individual and social activism was seen at play in the management of conflicting aspects of control and responsibility with regard to the health damaging behaviours of alcohol and tobacco use. The imperative with moderate drinking was to relax social controls and achieve personal authenticity but not lose personal control and become a proper object of social coercion. The imperative with smoking was not to be selfish, even though this might help personal control of stress, but rather to identify with the social effort to stop smoking.

Again personal fatalism, was not mere passivity, but rather a belief that influence over health rested with other people, though it was not within the speaker's control.

Although fatalist thinking and ideas of powerlessness were rare, though not absent, in respondents' ideas of health and the social world, they

were more prevalent in respondents' ideas of health and its relation to the natural world.

THE NATURAL WORLD

In the sphere of the natural world I include those causes of health and illness which are not initially the result of human agency either on the individual or on the social level. I will, however, still be talking about some aspects of nature which were seen to be internal to the person, but these were not seen to rest within the individual's control. Nature also, in this context, implies those things over which one has little control.

This definition is broader than that of Helman (1985:77) who mainly includes: 'aspects of the natural environment, both living and inanimate, which are thought to cause ill-health'(p77) but restricts his definition to causes which are initially external to the person. Certain conditions, for example hereditary proneness, notions of imbalance and others, Helman places within the patient, but I would wish to place these in the natural world. Helman is primarily concerned with them as locations of health and illness; I am more interested in their use as the agents of health and illness. In English, as in the Latin (natura), the conception of nature has a dual meaning which includes both the cosmic order and the essence or character of a particular thing.

Although such causes of illness and health were placed in the natural world respondents could still relate to them with varying degrees of activism and fatalism. Respondents sought to modify or adjust nature's effects rather than control them. Examples will clarify the distinctions between those aspects which I would consider to be in the social realm and those which I would place in the realm of the natural world.

The concept of luck was often mentioned, and luck, being outwith the person's control, did not imply any responsibility on the part of the person for his disease. The concept of luck was related to some but not all disease. Cancer was often seen to be a matter of luck, outwith the person's control: childhood cancers were particularly viewed in this regard. A certain degree of ambivalence among respondents was also found in their opinion about the cause of lung cancer. Some saw such cancer as being 'in them' and, although smoking might precipitate the disease, stopping smoking might not stop cancer from appearing in another form later in life. Again respondents described cases of people who had smoked heavily to a ripe old age without getting cancer as though cancer was not 'in them'. This fatalistic belief that if a certain disease was 'in you' there was little that you could do to avoid it, and that this absolved the person from doing anything to counteract the specific disease, was not restricted to

talk of cancer but was mentioned in connection with other health problems.

Age, of course, is something over which we have no control although control can be brought to bear on the effects of age. A few of my respondents were very aware of the effects of aging in relation to both physical and mental decline. They often said they no longer had the capacity to take part in activities which they used to enjoy when they were younger. They did not give up easily, however, and many attempted to stave off the worst results of such decline. Aging, then, implied a loss of their powers, a deterioration in health which they had to fight against.

Some, however, also saw the aging process as being beneficial for health. Age was taken to be a maturing process, and these respondents described how they had grown out of the health damaging behaviour of heavy drinking. Another frequently mentioned aspect of this maturing process was that it made people more mellow, more balanced, and less prone to extreme swings in ideas and mood.

Respondents also mentioned the importance of the constitution for lifelong health. However, although constitution was seen to be important it was not necessarily seen as fixed; a weak constitution could be changed for the better by active intervention and the adoption of positive health behaviours. Respondents had a sense of a natural law, natural justice and balance;

they believed that any attempt to improve one's health should result in an appropriate reward in health gain; conversely neglecting one's health would result in health loss. As respondents often said, 'you only get out of life what you put into it'. As shown in the previous section, some people were also seen to have the capacity to alter their mental states: they could think positively, stop being negative, or pull themselves out of depression. For others, however, mental state was related far more to a person's character and personality and as such was fixed and outwith control. It was related to the nature of the person. Respondents described some people as being hypochondriacs. Other respondents described themselves as not being 'worriers'. Similar distinctions are mentioned by Helman (1985) in his discussion of responsibility when the location of ill-health lay with the patient.

Although there was, therefore, a close affinity between a belief in the causes of health and illness being in the natural world (for example due to luck) and a fatalistic way of viewing health behaviours, a few respondents attempted to impose a certain amount of control over this influence. But the more usual implication was that if the cause of health and illness was placed in the natural world a fatalistic stance followed, as in the example of a parts delivery driver (R211), who did not always think it was people's fault if they became ill. He typified himself as 'not a

worrier'; in other words he believed he was protected from stress not because he took any positive action to reduce stress but by the fact that he had a particular type of character. Thus he also saw himself as being lucky.

Ideas of fatalism and powerlessness were stronger in respondents' discussion of the natural as opposed to the social world. The ideas were of a different order, although they reinforced each other in the thinking of respondents from manual occupations - for example they were confirmed in their belief that the upper classes can act but I can't, by the belief that chance or luck and the laws of nature decide it all. Thus also the belief of one parts delivery driver above, that by nature he had a lucky character, meant that this respondent was ambivalent about sponsorship and thought that government bans would only drive problems underground.

THE SUPERNATURAL WORLD

So far in this chapter I have considered ideas of control and responsibility both in relation to the social and to the natural world. I will now turn to see if respondents' ideas about religion, and thus their orientation to a supernatural world, were seen to influence their beliefs about health.

In general most respondents did not think that their religion affected their attitudes towards health,

though they affected their attitudes to suffering and their health related practices. Although some believed that if other people were religious it would affect their health attitudes, the few comments in which respondents spontaneously spoke of religion in relation to their own health attitudes can be categorised as follows. Most placed emphasis on taking care of one's body which was seen to be God-given. The following two quotations illustrate this point:

> R809: 'I think we have a duty to the body we are given, although susceptible to pain and suffering and death, it is one which is God given, one which is marvellous and miraculous and beautiful in its abilities to conceive and understand and to operate. It is one that should be looked after, in fact it is the temple of the living God and what you do to your body, you are fast diminishing many of the spiritual aspects of my religion by abusing the body that I own. So it is part of my beliefs, although you would not think of it from my smoking, that I know the gift of life, the gift of my body and the way I look after my body should all be positive.'

And again:

> R889: 'The idea of your body as being a temple for the holy spirit here on earth and therefore the way that you look after it is in there somewhere.

Both of these quotations are from respondents belonging to Protestant religious groups. The first a Christadelphian, the second a member of the Church of Scotland. In these quotations we clearly see how specific beliefs in God and in the relationship between God and humanity entailed ideas of responsibility. As the body was God given, and hence a gift, people were seen to be accountable, to have a responsibility to God to preserve the health of their bodies.

Closely connected to ideas of general health, however, were respondents' ideas on the nature of suffering. Suffering faces people with a loss of control over aspects of their health, and this loss of control has to be coped with and managed. It also faces people with the questions: why does suffering exist, and why do some people suffer and not others? Respondents varied as to whether they believed suffering had a divine purpose. All those who stated they were non-religious denied such a relationship. But only half of those who were Protestant, and a smaller percentage of Catholics (44%), denied any relationship.

Again, those who believed that suffering had a divine purpose gave different explanations. Some believed the awareness of suffering had opened their

eyes to the problems of others. This either gave them the feeling of being fortunate, or helped them overcome their habitual self-centred way of looking at the world. One respondent stated that the suffering of others made him feel lucky and fortunate compared to other people. Another believed that people in the modern world wished to ignore suffering. This was related to his other ideas that people were self-obsessed and ignored the problems of others. A third saw suffering as 'opening your eyes', a shift from the normal, narrow mundane view of things. And one respondent believed that suffering helped you to understand the other person. For these men, suffering, either their own or that of others, helps people to break away from their own limited concerns. It turns the focus away from the self to others, to community with others.

Other respondents saw suffering more in terms of a trial; suffering could be seen as a burden, or as a test which could result in improving the person. One respondent saw suffering as character building and this reflected his strong self-reliant nature; he had improved his social position from the working class. Another again mentioned suffering in the context of a test and this again was reflected in his strongly self-reliant activist approach to life. Closely connected to this type of explanation was the idea of suffering as a warning of imbalance which would result in the person seeking a remedy.

For the first group of respondents the idea that suffering was closely linked to the divine had influenced their outlook on the social world and their relationship to it. Their awareness of suffering had given an open quality to their lives; suffering had opened them to the experience of others, and they now saw themselves as part of a wider humanity. Those who viewed suffering as a trial reflected a more individualised concept of suffering. This is more closely connected with the notion of the natural world being in some sense alienated from humanity but that there is a responsibility placed on people to overcome adversity. Although the first would seem to reflect a Catholic and the second a Protestant sensibility both concepts could be found in the accounts of Catholics and Protestants.

Protestants, however, unlike Catholics, could be ambivalent about the origin of suffering. As one stated in answer to the question whether suffering had a divine purpose:

> R415: 'Yes and no. It depends what the suffering is. I mean obviously someone suffering from cancer, and they are suffering pain and they die, then that is divine control. Somebody could be suffering from something else which they are not going to die, but they are there for the rest of their life with this and again you wonder why this has happened. Another example is a person having a stroke in a young person. I have a friend who is 38 and he was driving to work one morning and he ended up in a 14 car crash because he took a stroke. Where is the divine control there?'

Another stated:

> R422: 'I would say 50/50.'

And a Church of Scotland respondent said he would have to qualify his answer depending on whether he was 'talking as a Christian or talking from the medical point of view.' The above quotations reflect that strand of Protestant thinking which regards suffering as God-given, and thus meaningful, if it tests and improves a person spiritually. If, however, the suffering cannot be seen in this light it is viewed as without meaning and needs to be overcome and conquered.

Those who were non-religious were more forceful in their rejection of the idea that suffering had a divine purpose, they could say 'rubbish' to the question or 'I

think that is silly' (R146) and laugh. Another non-religious person (R625), in reply said: 'I would say "bullshit" to that.'

Although religion was not often seen to affect health beliefs, it was more readily seen to affect health practices and in particular smoking and drinking. The general form of the connection given by respondents was to highlight the moral injunction of various religions not to smoke or drink. The following quotation is given as an example:

> R306: 'It probably has [affected my beliefs] to a certain extent, yes, more so in the last few years in that we have more an evangelical type of ministry within the church, which tends to be rather puritan, "and thou shalt not drink, smoke or whatever". I probably do tend more to think about what I am doing you know.'

Again, all those mentioning an injunction were either from a Protestant background or if not from such a background their comments were about people from a religious denomination which formally had injunctions against smoking and drinking. The religious, however, also mentioned ideas of moderation, as well as proscription. Respondents also tended to believe religious injunctions against smoking were weaker than

those against alcohol use, and I will now look in greater detail at these ideas.

It was apparent that although each religious group displayed a range of responses from the more to the less tolerant, the balance was different for each. One way of conceptualizing these differences is to place these groups on a continuum, from the non-religious, the least proscriptive, to the Catholics in the middle, to the Protestants, the most proscriptive. Protestants tended to be more proscriptive in approach, condemning the person more than the drink. The non-religious and the Catholic groups had similar beliefs although there was a greater tendency to condemn drunkenness among Catholics. For the church-attending Catholics, drunks were 'foolish' and it was seen as 'humiliating' for a person to have lost control through drink. The non-religious often said that drunks were okay, as long as they did not bother them. However a few also said they were 'daft' or that drunks were 'sad'.

Although both Protestant and Catholic respondents condemned drunkenness there was a slight tendency for Protestant respondents to be more negative in their comments about the drunk individual; particularly with regard to being a nuisance and lacking will-power. As one regular attending Church of Scotland member said:

> R158: 'There is a distinction between a heavy drinker and an alcoholic. The alcoholic must be less strong willed. A strong willed person might know what they were leading themselves onto if they continued to drink excessively a lot of the time.'

Catholic respondents tended to emphasize the damage to the body by way of contrast:

> R504: 'Well I don't see any sense in punishing your body...too much alcohol is bad for you, it obviously leads to dehydration.'

In sum, although few respondents believed that religion would directly influence health attitudes (those that did were from Protestant religious groups and stressed the central importance of looking after the body), for religious respondents suffering could be seen to open people up to the problems of others or be viewed as a trial. These approaches were found in the thinking of both Protestants and Catholics, although Protestants were also found to be more ambivalent about the origin of suffering. And although most respondents did not think religion would affect health beliefs it was seen to affect the health related behaviours of smoking and drinking. Protestants were more proscriptive than the non-religious with Catholics taking the mid-position.

THE THREE WORLDS

I will now turn to look in greater depth at how ideas of control and responsibility were interlinked in individual respondents' accounts, and how these ideas were in turn influenced by their orientation to the social, natural and supernatural worlds.

The accounts of three respondents are chosen to cover the dimension of strongly activist versus fatalistic thinking and also the religious/ non-religious divide - only three because no religious respondents were fatalistic in their thinking.

First a non-religious respondent (R550) who had strong elements of fatalistic thinking about health in his account. He believed that people were not in control of their situation as 'one could never know what was round the corner'. This respondent took no exercise, continued to drink heavily, and had little thought of changing his lifestyle. He also hadn't worked for years but just accepted this fact.

In terms of alcohol use he considered his own drinking bouts acceptable since he was single and as he said: 'I only harm myself by drinking,' unlike people with families to support. He also believed that people were entitled to get drunk now and again. He thought alcohol had little effect on the personality and that those who became violent with drink only used alcohol as an excuse.

He believed that there was more drunkenness today

than in the past and that this was due to the extra social pressure which was being put on people. But even here he was not proscriptive but believed that the real problem related to lack of money:

> R550: 'I think money is the biggest problem you know. I think most people [spouses] put up with a drunk, I am talking about married people you know. I think most couples will put up with a drunk as long as there is money there.'

Again he believed if prices for drink were higher people would continue to spend money on drink and then the health of the children would suffer. He placed the causes of heavy drinking on the 'environment', both upbringing in the family and the social life of the community. Again, what can be read as a fatalistic statement, that he believed that it was better for young people to drink than to take drugs, was also a realistic statement about the need to make the best rational moral choice between two health damaging behaviours. This respondent was not against tobacco or alcohol sponsorship, and believed that it was the companies which should be taxed, not the 'punter'.

Not all this man's views were entirely fatalistic. He made a distinction between himself and those he thought to blame for their ill-health:

> R550: 'I think people can let themselves go. They can maybe just sit and drink and sit and eat you know, all the time and things like that. I think people can make themselves sick.'

In his own case too he believed that you did not 'get nothing for nothing', but although at the time of interview he wasn't working, he stated that he would always earn money when he really needed it: it was beyond this point that he felt himself to be limited.

He had also managed to give up smoking, but as the result of advice from his cousin and general health fears. Similarly he was in favour of the external control of smoking and favoured bans in canteens and buses. To this extent he was a personal and social activist, though by the same token he found it difficult to act positively about health outwith the context of environmental and group pressures; and in general he saw no effective way of changing them.

These ambiguities allowed for a small space of personal control over income and of social control over smoking; but otherwise this respondent's personal fatalism was linked to feelings of powerlessness over the social world, which had become, and was also experienced like, 'a second nature', (Grundmann 1991), enforcing restrictions on the individual; the power of the social world was felt as real.

Another respondent (R625), who viewed himself as being non-religious, displayed, in contrast to the first

respondent, various strands of personal activism in his account. He felt in control of his life situation and looked after his diet. Health was given a high salience and was not seen to be a matter of luck. Thinking too much about your health was also seen to make you ill. This respondent also took part in golf, football, and squash.

People were held to blame if their health deteriorated because they drank, smoked, or had a bad diet:

> R625: 'The lung cancer case who smoke 40 cigarettes a day for 40 years. The bottle of gin a day man, these are all self-inflicted. Diets in the West of Scotland seem to be particularly poor. Especially in the West of Scotland and especially among younger kids. There is a lot of things that the individual could do to improve his health, and by not doing so becomes a victim through either default or ignorance or whatever.'

Though he smoked, he had the attitudes of a dissonant smoker, and stated that he was going to try to stop smoking on his 40th birthday. He was in favour of state intervention to get people to stop smoking and stated he would not mind a complete ban. He also approved of, and sat in, non-smoking areas on planes and trains which enabled him to cut down on the number of cigarettes that he smoked. He was also proscriptive in

his attitudes towards under-age drinking and was in favour of increasing the drinking limit to 25.

This man relied entirely on personal activism and, where that was insufficient on social activism to back it up. It was a consistent, though not necessary, aspect of his thinking that he believed that suffering had no divine purpose and that religion had no bearing on his ideas about health.

This respondent then, although being strongly activist in his general ideas about health, was aware of the contradiction posed by the fact that he continued to smoke. He felt responsible and took blame for this and aimed to rectify this situation in the future. He had a strong belief in the power of individual control; the power of natural factors was denied, while the force of social restrictions could be used for his own ends. He believed in both personal and social activism.

Another respondent (R364) was self-employed and very conscious of his health. He too took an activist approach and believed it was people's own fault if they became ill through the misuse of drugs, tobacco and alcohol. Mental attitude was also seen to influence health, and he viewed himself as not 'a worrier'. He was a strong believer in self-improvement and saw himself as having worked hard to get away 'from the schemes' (housing estates). As a corollary to this belief he saw the poor as not wanting to better themselves but turning to drink instead. In this they

were responsible for their condition.

He was proscriptive with regard to alcohol and tobacco use and he himself did not smoke or drink. As he said: 'even though I sell cigarettes I still would like to see a ban on it.' He believed that a lot of people didn't stop smoking because they had no willpower, and he saw aggression as being linked to alcohol.

Correspondingly he felt that his religious outlook and Catholic beliefs gave him a positive outlook on life; he viewed suffering as having a divine purpose, was grateful to God for his living situation, and because of this viewed himself as being lucky in comparison to other people.

These activist beliefs were however qualified in two respects. First, while in his own occupation of selling tobacco products from a van, he may have seemed to be compromised, especially because of his ideas about the addictive nature of smoking, he saw the selling of cigarettes as just one part of his business and therefore unavoidable, and at the same time, as I have mentioned, was prepared to argue for a total ban on smoking.

He believed that the government was compromised in its approach to tobacco restriction. He stated that it was the government, rather than people like himself, the retailers, or indeed the tobacco companies, who made the really big profit and who were thus the most

compromised. And, just as they were making the biggest profit, he believed they should be doing the most to prevent people from smoking by means of large scale health advertising. In this way he restored consistency.

Secondly, he qualified the responsibility of the people in the schemes for their condition with the idea of luck. He believed it was difficult for them to improve their situation due to lack of money, and while he thought that taking personal responsibility for health should result in a health gain, and lack of responsibility in a loss, often this did not seem to occur in practice and here the concept of luck was brought in to account for the discrepancy:

> R364: 'Some folk are born and they seem to get everything, you know and yet they've not abused their health, and yet other ones that are healthy have abused it. I would say there is quite a lot of luck.'

Luck was here used to explain and take account of what otherwise would be seen as life's unfairness; but elesewhere it became apparent that more lay behind the term than sheer chance: his own luck was something he should be grateful for, while he also believed suffering to have a divine purpose.

This respondent can be seen to have fought to improve his social position. His religious belief both

reinforced his activist approach to life and tempered his individualistic tendencies. Correspondingly he was qualified in his views about those who still remained in the schemes, partly blaming them for lack of drive and partly blaming society for their condition.

CONCLUSION

In this chapter the relationship between control and responsibility for health in each of the three realms of the social, natural, and supernatural, has been considered. The activist/fatalist dichotomy in respondents' thought is about the location of control over health and thus who is to be held responsible for safeguarding or improving well-being. Activist thinking, however, has been shown to have three strands: personal activism, where the individual by his own efforts can improve health; social activism, where individuals as a group can get together or influence social agencies to improve health; and religious activism, where the individual can get in touch with God and by co-operating with him improve health.

Again, fatalistic thinking is not about passive submission but rather the belief that control lies outwith the person in the realm of the social, natural or supernatural worlds. Ideas of fatalism and powerlessness were stronger in respondents' accounts of the natural as opposed to the social world. However, forms of religious fatalism were not found in the

accounts of these respondents: for those who believed ultimate control over health rested with God, co-operation was still possible - the individual was not helpless. Also none of those voicing fatalistic ideas believed suffering had a divine purpose. The religious were activist in their approach towards health. However, although Christianity in the West of Scotland is predominantly activist, its approach to the nature of suffering, and the feelings of powerlessnes which suffering often brings, shows that it can also offer quite subtle positive accommodations to this dilemma. Such findings contradict Helman's (1985:75) assertion that ideas of the social and supernatural worlds have lost much of their influence on the lay health beliefs of people in the developed world.

Tensions existed between individual and social activism and these came to light in the different responses towards alcohol and tobacco use. For tobacco, the moral pressure was to endorse social action against its use even though respondents might see it as important for the control of stress; for alcohol there was little public pressure against its use in the absolute but rather for its consumption in moderation, as the individual was still held responsible if he lost control over his drinking. Lay ideas about tobacco use were thus more in line with current public health thinking, which has been proscriptive towards tobacco for some decades, than lay ideas on alcohol use, which

have only recently been under pressure from what has been called 'neo-prohibitionism', where the focus is on the social problems which the moderate consumption of alcohol brings rather than on its consequences for the individual drinker (Mullen 1988; Tether and Robinson 1986).

Attitudes towards social activism were also ambiguous; depending on people's self-identification they could see it as either 'we are winning' or 'they are winning'. Further in the thinking of any individual respondent various strands could be found in combination: activist and fatalist thinking could be combined, as could personal and social activism; the tensions this produced were then managed in quite complex ways.

Such findings demonstrate the subtle ways in which people relate to issues of control and responsibility in the health realm - a subtlety which is not fully brought out either in the largely theoretical work of Illich (1975) and Navarro (1976) or in the fairly simple division between middle-class activism and working-class fatalism of many social scientists, including those working in the health field. Again, these findings award a high place to varied forms of activist thinking among the general population; even if, as Illich and Navarro suggest, the people's health is being expropriated it is not being accomplished with out a struggle.

CHAPTER 11

CONCLUSION

INTRODUCTION

In the introduction to the thesis I outlined the starting point for the study and the initial research questions. Although designed to be a general enquiry into lay health beliefs, I wished to pay particular attention to those health beliefs related to diseases contributing to high mortality rates in the U.K. in general and the West of Scotland in particular. This concern led to questioning respondents not only about their general ideas of health but also about their health related behaviours, to their ideas of tobacco and alcohol use. What were the main features of their conceptualizations of health; how did social context relate to alcohol and tobacco use; and how did they see their health related behaviours influencing health? As a secondary theme in the analysis I wished to consider questions about social class and religion. Since the salience of a social class and a religious divide in the culture of Glasgow clearly persists to the present day, it was important to consider both these topics in the research. From the beginning, therefore, the research themes were grounded in the everyday culture of male Glaswegians. By the nature of the qualitative method these research questions were modified and clarified as the study got underway.

The review of the literature helped me to both focus the research and site my own work in the wider research context. The field of research into lay health beliefs is fragmented. This is partly the result of the late start to serious research in this area. There are a limited amount of research studies which have been carried out and consequently these studies have had different research foci. This had led to a lack of progression in this area. Although the literature is fragmented, I have extracted a few key issues and themes which run through this material. These are issues arising from the bed-rock of lay health beliefs themselves as much as from the varied concerns of different researchers. Such issues, of the nature of relaxation, control, and responsibility for health, have been discovered in my own material and I have tried to improve our theoretical understanding of these concerns.

The findings of the current thesis has advanced this work on various fronts. It has filled in gaps in our knowledge, in particular it has clarified our understanding of male health beliefs. It has also deepened our theoretical understanding; the concept of balance between control and release in lay thinking about health has been explored in depth, and the effects of social class and religion on lay health beliefs have been shown to be mediated by occupational, lifestyle, and moral factors.

THE CONTRIBUTION OF THE RESEARCH METHODS

The thesis demonstrates the importance of the in-depth interview method for looking at beliefs about health. Due to the flexibility of its approach it can uncover the subtleties of people's ideas on a topic. It can also highlight any seeming contradictions in an individual's set of beliefs and attempt, by further questioning, to resolve them. If contradictions remain, then we can be certain that such inconsistencies between beliefs are genuine, and not due to a misunderstanding on the part of the interviewer.

This interview method is also of value in showing the importance of the way in which questions are framed. To give an example: if one asks general questions about drinking nearly everyone will be in favour of moderate drinking, but if one asks specific questions about quantities then people will express different ideas. Again, if one asks questions about the effects that alcohol has on respondents, they are likely to give a different answer from their perceived effects of alcohol on other people. This highlights the need for researchers to be aware of these relational shifts in the attitudes of respondents. Again, the ethnographic method, by allowing the interviewer to ask similar but varied questions on a specific issue, safeguards the researcher against such problems.

The thesis has shown the importance not only of the qualitative interview method, but also of the specific

contribution of grounded theory and analytic induction in the analysis of data. The use of the methods of grounded theory and analytical induction, by the process of continuously going back and forth between the data and theoretical ideas, allowed for the refinement of the research issues. Although the research began with clear objectives and topic areas these were expressed in a general way. As analysis progressed these topic areas were clarified. The themes of relaxation and ambivalence were discovered to be central to respondents' ideas both of tobacco and alcohol use; these lay concepts were then explored in greater depth. Ideas of balance were also found to be central to lay thinking about health and again this theme was followed in the analysis.

One of the initial aims was to explore issues relating to social class and religion in lay health accounts. Early analysis demonstrated the central link for respondents between ideas of activity and concepts of health and how these were closely tied to their conceptualizations of work and occupation. The occupational component of class was thus analysed. The focus then shifted to the wider aspects of social class, those connected with lifestyle factors, again the prominence respondents gave in their accounts of health to issues concerning the family and marital status helped set the agenda for the next phase of analysis. Such analysis is thus driven by the accounts of

respondents as well as by the initial research questions.

When the influence of religion was considered it soon became clear that the wider but linked aspect of moral issues in lay accounts of health needed to be addressed. Although religion was infrequently mentioned in a direct and spontaneous fashion in interviews, the moral tone of statements about health could not be ignored. For this reason the analysis was broadened to take into account religion in the wider context of moral beliefs and also aspects of what has been called invisible or customary religion.

ASPECTS OF SOCIAL CLASS AND RELIGION

The thesis has shown that if one wishes to gauge the impact of social class or religion on lay health beliefs it is vitally important to study both of them in their components: class in terms of the specific context of occupation and the lifestyle elements of the family and marital status, and religion through the broader theme of general moral concerns. Doing this brings to light the subtle thinking of respondents and the logic in their lay health beliefs.

The findings of the thesis expand on Calnan and Johnson's (1985) often confused statements on the influence of class by showing that finer detail is needed, particularly on the influence of occupational context on ideas of health. It has also been shown that

complementary practices related to an implicit equilibrium are found in all social classes and are not, as D'Houtaud and Field (1984) suggest, a predominant feature of middle and higher class accounts. Traditional occupational class measures obscure much of how occupation is felt to influence health.

A lot of the analysis has also been on the type of coping strategies which respondents use in managing their health. Indeed the type of coping strategies are closely linked to aspects of social class and religion. In the thesis I have shown that respondents are not passive recipients of health care measures or ideas but take an active part in managing their health. They are actively involved in coping strategies. The other point that needs to be made is that certain respondents have a wider range of coping styles and strategies to choose from than others. Unskilled workers from the lower section of the working class are particularly restricted in the availability of health enhancing coping styles. We have also seen how certain aspects of lifestyle, in particular the married role and the presence of children, are also protective for health, shielding people from the risky and health damaging behaviours of tobacco and alcohol use.

The findings from the thesis also add more detail to William's (1990) discussion of the importance of religion in lay health accounts, by extending the topic to the related concern of moral issues. It was found

that not only were respondents generally activist with regard to their health but that this activism took various forms: personal activism, where the individual by his own efforts can improve health; social activism, where individuals as a group can get together or influence social agencies to improve health; and religious activism, where the individual can get in touch with God and by co-operating with him improve health. Interactions were also discovered between aspects of religion and class; fatalist thinking was uncovered but again this was seen to be closely related to the section of the population who were unskilled manual workers.

These are the general findings in relation to social class and religion, but the method of analysis allowed for other themes to emerge as the study progressed, themes which allow for greater integration and give deeper meaning to these findings.

SUBSTANTIVE THEMES

The close analysis of respondents' accounts has brought to the surface key themes running through lay thinking about health, tobacco and alcohol use. These themes are those of relaxation, ambivalence, control and responsibility. They are themes highlighted by other researchers and relate directly to the nature of the capitalist ethos and how this is reflected in lay health beliefs. The relationship between activity and work,

and the associated concept of control has been presented most forcibly at a theoretical level by Navarro and Illich. Currer and Stacey (1986), Blaxter (1990), and Cornwell (1984), have discussed the empirical evidence for the validity of these ideas. Again, medical sociologists, most notably Williams (1990) and Crawford (1984), but also Stacey (1988), have often tried to untangle the relationship between the Protestant work ethic and specific elements of lay health beliefs.

One of the clearest presentations of the salient issues has been that of Crawford (1984) who presented the dichotomy of control and release. Here the sphere of consumption is reflected in health beliefs by the metaphor of release, and this is counterpoised to the sphere of production and the metaphor of control. In Crawford's work release is presented as a coping strategy for the relief of stress. What is clear from the findings from the present thesis is that the release mode is full of problems for Glaswegians. The whole idea of release is somehow against the notion of the true Calvinist spirit; it is difficult for the Glaswegian to comfortably take part in this mode. The release mode is thus viewed with a great deal of ambivalence.

This idea also finds expression in Scottish literature. Running through Hind's (1968) The Dear Green Place is the underlying theme of the Calvinist work ethnic and the difficulties and guilt that

accompany any attempt to escape from it. When the central character skips work in order to write his novel he does so with the same feelings as a child playing truant from school. This avoidance of work also brings dire consequences in the form of the loss of his job and standing in his family. The Scottish character, at least in its Calvinist form, is a character of extremes.

This is echoed in other works both of, and on, Scottish literature; for example in Stevenson's (1987) Dr Jekyll and Mr Hyde, Hogg's (1970) Confessions of a Justified Sinner, Kerrigan's (1983) exposition of the poetry of Hugh Macdiarmid Whaur Extremes Meet and Finlayson's (1984) biography of Boswell. In Stevenson's tale, Dr Jekyll is so ill at ease with conventional society that he leads a double life, but this only increases his discontent until he decides to effect a complete separation of the warring sides of his character, as only then can each side, the good and the evil, fully establish its own integrity. In the transformation the evil side is projected into the world. One reading of the narrative is that it is a metaphor about the impossibility of establishing a workable harmony in the soul, and of difficulties in the location of the true self (see Jefford 1983). Indeed the main protagonist Mr Utterson is all too aware of the problems he has with his own latent 'Mr Hyde'.

The culture which can produce such a literature presents a world of extremes, of an extreme control and

its forceful release; but this is not quite the same as Crawford's dichotomy as any relaxation of control brings with it, guilt, remorse and possible disaster. The extremes expressed by Scottish respondents, then, are not those of control and release where release is viewed as relaxed consumption. Release is not expressed as consumption in the Calvinist. It is release from control but not into capitalist style consumption.

The major contribution of my thesis is that in addition to considering aspects of control and relaxation in a general sense, I have gone further and analysed respondents' emotional responses towards these two poles: the central feature of ambivalence with regard to relaxation, and feelings of responsibility in relation to control. In my research the dichotomy between control and release has been discovered to be central to the lay health beliefs of Glaswegian men. On the control side we have the stress on responsibility, and this theme was associated with the world of work. There were, however, problems associated with the release side of the dichotomy; although this was associated with the world of consumption and leisure there was little room for an easy conviviality. This lack of conviviality produced ambivalence in the minds of respondents.

The recurrent theme of balance has also been presented and analysed in the thesis. A balance is attempted between control and release. Compensation is

practised by using the consumption side as a complementary opposite to the work side. But we have encountered problems with an easy balance between these poles. In the chapter on work, we discovered that both work addiction and work affliction are both failures in this complementarity. We have also seen, particularly in the chapter on alcohol use, the failure of Scottish culture is the failure to create socially responsible forms of conviviality, resulting in a split over the location of the true self - is it the responsible self of work or the convivial self of leisure?

The chapter on moral and religious concerns in health demonstrated the failure to keep the poles in balance, or rather to understand the true nature of their opposition. Hence activism is synonymous with control but is shadowed by fatalism which is viewed as passivity and loss of control. Extremes which are viewed as mutually exclusive are presented. It is only in supernatural understandings of suffering that the two are in balance so that loss of control remains active.

There are differences between Protestants and Catholics. The close link between aspects of the Protestant ethic and the capitalist ethos, and how these are reflected in lay health beliefs, has been demonstrated. A lot of the health literature discusses health as a value, as health capital. Thus, in the same manner as economic wealth, health is attained by individual efforts and may thus be seen as `a state of

grace,' something for which the individual can be justifiably proud. If stored as health capital in order to do something else, then it is ascetic, and thus Protestant. The Protestant sensibility may be seen as instrumental with regard to health. If health is for pleasure this may be seen as an expression of a Catholic sensibility; this idea is closely linked to Herzlich's (1973) concept of health 'as a value in itself'.

Again, it has been shown how the major forms of release available in Scottish culture are health damaging be they alcohol or tobacco use. They are also gender defined. For example, there is a very strong sense in which the public house is the central pivot of the social life of male Glaswegians, and the public house continues to be a male preserve. Drinking and smoking are strong symbols of male virility and machismo in Scottish culture; and, as Hemmingway found out to his cost, expressions of virility are damaging to, rather than protective of, health.

What can be said is that people are involved in balancing aspects of their lifestyle in an attempt to produce an optimum functioning, but that health may not be the only element in the equation. My findings show that although the dichotomy of control and release is an over-arching theme in respondents' pre-occupations, health is subsumed under it.

But although a balance which maximises health is difficult to achieve it is attainable, and both

marriage, and in particular marriage with children, and religion provide people with alternatives to drink and smoking and draw people towards responsible conviviality. The compensation principle means that such lifestyles give a balance to occupation.

CONCLUSION

So what are the implications of these findings for the health of male Glaswegians? What does the above tell us about the high levels of certain diseases in Glasgow and their possible reduction? The main barrier to health is their use of health damaging behaviours for the purpose of relaxation. The continuing centrality of tobacco and alcohol use as the ubiquitous forms of relaxation has to be faced; and this has to be understood in its paradoxical nature as short term relief of stress versus long term health consequences.

Again, although high levels of activism, and positive health consciousness were found among respondents, I have also uncovered a particular group, unskilled manual workers, who exhibit high levels of fatalism, and negative coping styles. We may wish to see such a group as a problem and target specific measures in their direction.

These comments relate to the situation of Glaswegians, but they have wide relevance since this is an analysis of general aspects of the capitalist ethos in its relation to health. In the recent White Paper:

The Health of the Nation (H.M.S.O. 1992) concern has been shown about the high levels of heart disease and cancers in England, it is hoped that the findings from this thesis can add to our understanding of these problems. The Scottish dictum 'whaus like us, nae many' is not altogether true in the context of lay health beliefs.

APPENDIX

RESEARCH DOCUMENTS

1. Initial letter signed by Dr S. Gatehouse

2. Contact letter after return of first questionnaire

3. Map of study region

4. Screening questionnaire

5. Main study schedule: final version

6. Supplementary question sheet after interview.

MRC
INSTITUTE OF HEARING RESEARCH
SCOTTISH SECTION

MRC Institute of Hearing Research
Scottish Section
Glasgow Royal Infirmary
16 Alexandra Parade
Glasgow G31 2ER

Telephone: 041-552 3535 Ext. 5135

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SG/ND

Dear

Thank you for your help in completing our questionnaire and for taking part in the National Study of Hearing. Your answers will prove very useful. I am also glad to see that you have no problems with your hearing.

Although this is the end of your involvement in our study can I take this opportunity to ask if you would be willing to be part of another study currently being undertaken by the Medical Research Council?

This study will look at the relationship between everyday lives and health of people living in Glasgow. This involves studying the daily lives, and attitudes towards various health issues, of selected individuals.

If you would be willing to take part in this study please fill out the enclosed questionnaire and return it in the reply-paid envelope. All information which you provide will be kept STRICTLY CONFIDENTIAL.

Once again thank you for your help and co-operation.

Yours sincerely,

Stuart Gatehouse

Dr. Stuart Gatehouse
Scientist-in-Charge

MRC
Medical Research Council

MRC Medical Sociology Unit
6 Lilybank Gardens
Glasgow
G12 8QQ
telephone 041-357 3949

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Your reference

Our reference

Thank you for completing and returning our questionnaire that was sent to you by Dr Stuart Gatehouse. Your answers are proving very useful to our research.

As was mentioned in the last letter our study is concerned with examining the relationship between the everyday lives and the health of people living in Glasgow.

To do this effectively it is important for us to also interview a selection of those people in the community who have kindly completed and returned our questionnaires.

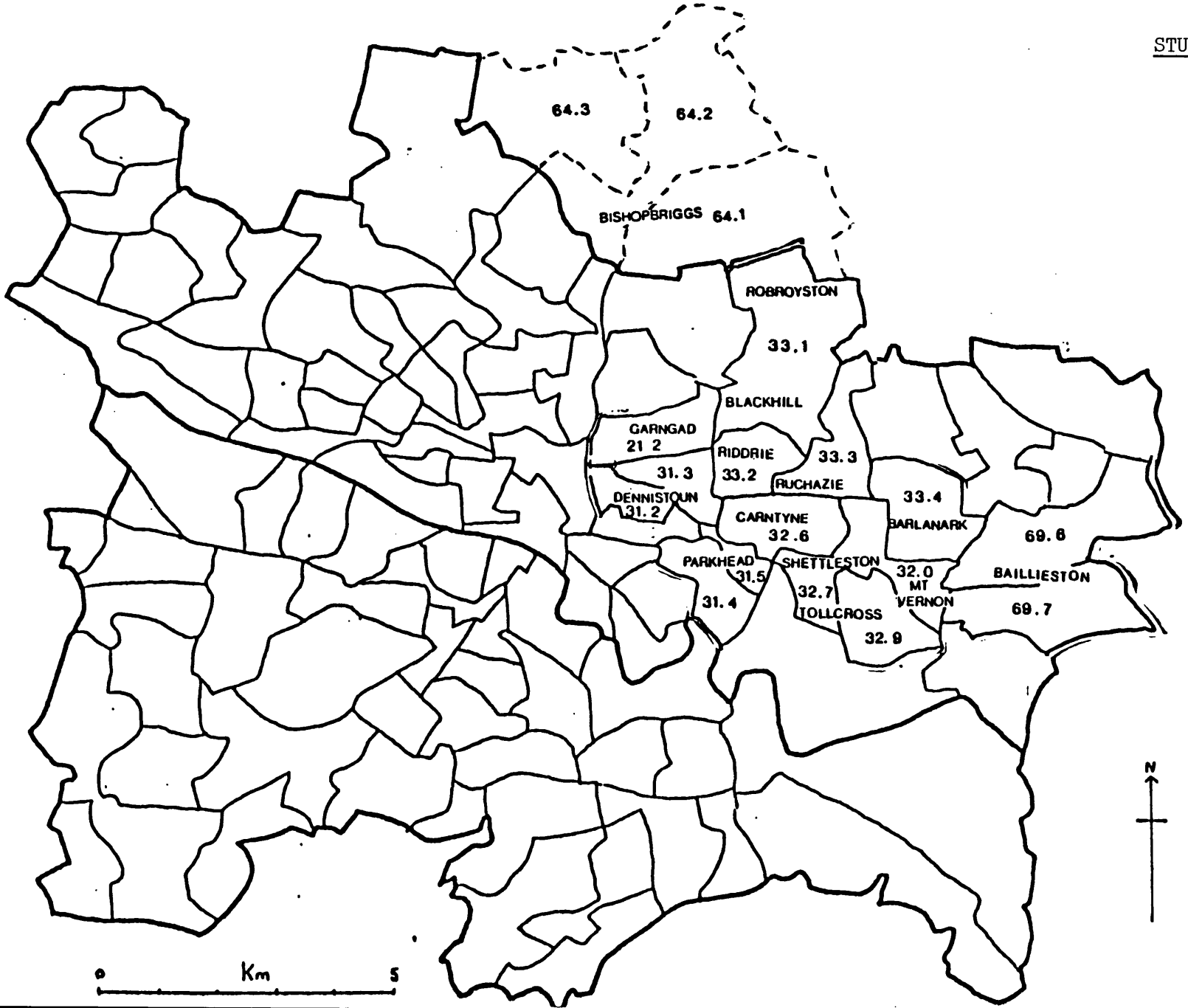
One of our interviewers will, therefore, be calling on you within the next week to see if you would be willing to help us further and take part in such an interview. If you would be willing to be interviewed our interviwer will then arrange a time which would be most convenient for you.

I do hope you will be willing to take part in this important study.

Yours sincerely,

Kenneth Mullen MA. M.Litt.

STUDY AREA POST CODE SECTORS



MRC
Medical Research Council

HEALTH AND WAYS OF LIFE STUDY

ffice Use Only:_____

der to maintain anonymity we ask you not to put your
and address on this form. The serial number allows us
eck who has replied.

STRICTLY CONFIDENTIAL

HEALTH AND WAYS OF LIFE STUDY

Please complete all the questions in this questionnaire by circling the number of the appropriate answer.

SECTION A

In this section we would like to ask you a few questions about your general health.

A1 Over the last twelve months , would you say that your health has, on the whole, been?

1 good
2 average
3 not good

A2 Do you have any long standing illness, disability or infirmity? (By long standing, I mean anything that has troubled you over a period of time or that is likely to affect you over a period of time)

1 yes (*if yes answer b and* c)
2 no (*if no go to A3*)

b) What long-standing illness, disability or infirmity do you suffer from?

.....

c) Does this long-standing illness or disability limit your activities in any way?

1 yes
2 no

A3 Now I'd like you to think about the two weeks ending yesterday and the things you do every day; at work, about the house, during your free time etc. During the two weeks ending yesterday did you have to cut down on any of the things you usually do because of illness or injury?

1 yes (*If yes answer b, c, and d*)
2 no (*If no go to B1*)

b) On how many days was this in all?

1 one
2 two or three
3 four or five
4 six or more

c) What was wrong?

.....

d) Indicate whether you received medical help or not.

1 GP
2 Hospital
3 Outpatient clinic
4 none
5 other (*Please specify*).....

SECTION B

We would now like to ask a few questions about your leisure activities

→ B1 Are you a member of any clubs or organisations?
(*You can circle more than one number*)

1 sports club
2 trade union club
3 political party
4 social club
5 none
6 other organisations (*Please specify*).....

.....

B2 Which religious faith do you belong to?

1 Christianity (*If you circled 1 answer b and c*)
2 Islam (*If you circled 2 go to B3*)
3 Judaism (*If you circled 3 go to B3*)
4 Hinduism (*If you circled 4 go to B3*)
5 None (*If you circled 5 go to B3*)
6 Other (please specify).....(*Go to B3*)

b) Please indicate which Christian denomination or group you belong to?

.....

c) How often do you attend Church?

1 more than once a week
2 once a week
3 once a month
4 less frequently

B3 In the last seven days how much time overall did you spend on gardening?

1 over ten hour
2 five to nine hours
3 three or four hours
4 less than two hours
5 none
6 no access to garden

B4 In the last seven days how much time have you spent on DIY (car maintenance, building, carpentry etc) ?

1 over ten hours
2 five to nine hours
3 three to four hours
4 less than two hours
5 none

B5 Have you ever smoked a cigarette, cigar or pipe?

1 yes (*If yes answer b and c*)
2 no (*If no go to question B6*)

b) Do you smoke nowadays?

1 yes
2 no (*If no, when did you stop? Please indicate below*)

.....

c) Please indicate about how many packets of cigarettes, number of cigars or pipes you smoke each week nowadays/ or smoked at the time when you gave up.

.....packets of cigarettes per week

.....number of cigars per week

.....ounces of tobacco per week

B6 Have you ever drunk alcohol?

1 yes (*If yes answer b and c*)
2 no (*If no go to C1*)

b) Do you ever drink any kind of alcohol nowadays, including alcoholic drinks that you brew at home?

1 yes
2 no (*If no, when did you stop? Please indicate*)

.....

c) Thinking of today, or of the time when you gave up drinking, would you describe yourself as someone who:

1 hardly drinks/drank at all
2 drinks/drank a little
3 drinks/drank a moderate amount
4 drinks/drank quite a lot
5 drinks/drank heavily

SECTION C

As our study is looking at the relationship between health and ways of life in their broadest sense we need to ask a few questions about your present living circumstances and background. All information will be kept strictly confidential.

C1 How old are you? (*Please indicate*)

.....

C2 Where were you born?

1 Glasgow (*If you circled 1 go to C3*)
2 elsewhere in Scotland (*If you circled 2 answer b*)
3 Wales (*If you circled 3 answer b*)
4 Northern Ireland (*If you circled 4 answer b*)
5 England (*If you circled 5 answer b*)
6 other (please specify).....(*Then* answer b)

b) How long have you lived in Glasgow?

1 one to four years
2 five to nine years
3 ten to nineteen years
4 over twenty years

C3 Are you:

1 single
2 married
3 divorced
4 widowed
5 separated
6 other

C4 Are you:

1 unemployed and looking for work
2 unemployed and not looking for work
3 permanently sick and disabled
4 employed

C5 Please indicate the title, and the decription, of the job you do at present or, if you are not working, your previous main occupation.

.....

SECTION D

COMMENTS (Please add any comments you may have)

.....

.....

.....

THANK YOU FOR TAKING THE TROUBLE TO FILL IN THE FORM. THIS WILL BE OF GREAT HELP. ALL YOUR ANSWERS TO THESE QUESTIONS WILL BE KEPT STRICTLY CONFIDENTIAL.

PLEASE RETURN THE FORM TO US IN THE REPLY-PAID ENVELOPE.

WE MAY WISH TO WRITE TO YOU AT A LATER DATE TO ASK IF YOU WOULD BE WILLING TO TAKE PART IN A INTERVIEW

ONCE AGAIN MANY THANKS FOR YOUR HELP

MAIN STUDY SCHEDULE

The Interview Schedule

Purpose of the Survey

As you know from the letter this study is designed to look at the relationship between people's health and various aspects of their everyday lives - things they do and how they think about life. Today, therefore, I would like to discuss certain ideas and attitudes you have about aspects of health as well as asking questions about your daily life. In particular I will be focusing on aspects connected with alcohol and tobacco use. I am interested in discovering your own ideas and feelings about these issues.

A. Health and Life-satisfaction

Health of Interviewee

I will now switch on the tape recorder.
I will begin by asking some questions about your own health and your general ideas and attitudes about health

1a. In the questionnaire you said that you suffered from .....
How long have you suffered from this complaint?

(for those without a health problem)
2a. In the questionnaire you said that your health has been good over the past twelve months.
When was the last time you were ill?
b. What was the problem?

(attitudes towards health and illness)
I would now like to turn to your general ideas about health.
3a. Think of someone you know who is very healthy.
Are they male or female?
b. What is their age?
c. What makes them healthy?

4a. At times people are healthier than at other times :Describe what it is like when you are healthy?
-prompt- What do you mean by that?-

5a. Do you do anything at the moment to keep yourself healthy or to improve your health?

b. What things do you do?

c. Are there anythings you would like to do to keep yourself healthy but don't do them?

d. Why?

6a. Do you think its ever people's own fault if they get ill?

b. Why do you think its their fault if they get ill?

7a. Are there anythings about your life now that have a good effect on your health?

b. What are they?

c. In what ways does this influence your health?

8a. Are there anythings about your life now that have a bad effect on your health?

b. What are they?

c. In what ways do you thing this has a bad effect on your health?

(Health psychological)

9a. How often do you feel that you are under so much strain that your health is likely to suffer?
-never, occasionally, most of the time.
b. Have you felt like this for a long time?
c. Have you ever felt like this?

10. How often do you feel bored or lonely?

11. Do you ever feel-really exhausted, tired out or worried about the future?
-irritable and touchy?
-losing confidence?

(sense of control)

12a. Some people seem to get most of the things they want out of life while others no matter how hard they try never really seem to get the things that they want. What sort of person are you?
- completely satisfied, neither satisfied or dissatisfied , dissatisfied.

13a. Some peolpe feel that they have complete free choice over the decisions they make in their lives. Yet others believe they have no free choice. What category do you think you fall into?
- usually have free choice, sometimes have free choice, never have free choice, dont know.

14a. Some people feel that they have complete control over the way their lives turn out. Yet others feel they have no control. What category do you think you fall into?
- usually have control, sometimes have control, never have control, don't know.

15a. Could you tell me more as to why you feel the way you do?

16. I am now going to say a few things that people have said about health. I'd like you to say how far you agree or disagree with each statement.
- it's sensible to do exactly what the doctors say
- to have good health is the most important things in life
- generally health is a matter of luck
- if you think too much about your health, you are more likely to be ill
- suffering sometimes has a devine purpose
- I have to be very ill before I'll go to the doctor
- people like me don't really have time to think about their health
- the most important thing is the constitution (the health) you are born with.

I would now like to turn from your ideas on health and illness to talk about alcohol and tobacco use.

B. Attitudes towards Smoking

First I would like to talk about smoking.

In the questionnaire you said that you smoked:

.....cigarettes per week

.....cigars per week

.....ounces of tobacco per week

.....never smoked

(for those who smoke)

17. When do you smoke: weekdays, weekends, at any particular times ?

b. Where do you smoke?

c. Did you smoke cigarettes before smoking a pipe?

d. Do you consider differences between cigarette, cigar and pipe smoking?

e. What are the differences?

f. Have you always smoked this amount?

(If any changes in smoking behaviour)

18a. What were the reasons for the changes? -stopping, starting, changing from one type of tobacco to another, increasing or decreasing?

(stopping and starting)

19a. Have you ever attempted to give up, or start?

b. How often?

c. How long has this lasted?

d. What happened why?

e. Why did you attempt to give up and start?

f. Did you feel better or worse for giving up, what was your experience?

(intention of giving up smoking)

20a. Do you want to give up smoking, or to cut down?

b. Why?

c. Do your friends ask you to give it up?

d.Does your doctor ask you to give it up?

e.What do you feel about it?

(addiction)

21a. Nowadays do you ever find yourself smoking when you are not really enjoying it?

b. Some smokers say they will do almost anything to get cigarettes if they run out, how true is this of you?

c. How difficult would you find it to be without cigarretttes for a day, week etc?

(family attitudes support, pressure etc.)

22a. Does your wife, family, friends, etc. smoke?

b. What is their attitude towards it?

c. What do you think about this attitude?

d. What were their attitudes when you tried to give up?

e. Do the people you know smoke?

f. Did your father, mother smoke?

23a. How do you feel in non-smoking situations?

b. -would you smoke? and if so how?

(for non-smokers)

24a. How do you feel in smoking situations?

b. -would you tell people to stop smoking?

c. Do you avoid such situations?

25a. Would you like to see a ban on smoking? Why? Where about? Why not?

b. What about tobacco company sponsorship? What are your views?

(for both smokers and non-smokers)

(Attitudes towards government)

c. Do you think the government should do anything about smoking?

-taxation, legislation?

(smokers only)

26a. Do you think smoking costs more money than the pleasure is worth?

b. How expensive would cigarettes have to be before you gave up?

(relationship between smoking and health)

27a. Do you think there is a connection between smoking and ill-health?

b. Do you think there is a strong connection?

c. What do you think is the nature of this connection?

d. What problems - medical or otherwise do you think it produces?

(for non-smokers)

28a. Compared with other non-smokers, do you think that non-smokers who live or work in a smokey atmosphere stand less chance of getting some of these illnesses, more, or does it make no difference?

(for smokers)

29a. Do you think your own smoking affects your health, in what ways? in the past now and in the future?

C. Attitudes towards Alcohol Use

I would now like to turn to ask about your ideas and feelings with regard to alcohol use.

In the questionaire you described yourself as someone who:

- drank no alcohol
- drank hardly at all
- drank a little
- drank a moderate amount
- drank quite a lot
- drank heavily

(for those who drink)

(pattern of the respondents own drinking)

30a. Where do you drink?

-prompt/ in the home , in the pub etc.

b. Who with?

c. How often?

(Drinking problems)

31a. Have you ever had a hangover?

b. -been unable to remember things?

c. -found your work affected?

d. -felt ashamed?

e. -taken another drink to cure your hangover?

(Changes in drinking behaviour)

32a. Have you ever tried to cut down or stop drinking?

b. -why?

c. -how did you attempt to do this?

d. -what happened?

(reasons for drinking)

33a. Why do you think you drink?

b. Why do you think other people drink?

(for abstainers)

34a. I am interested as to why you have never drunk or have not drunk recently. Can you tell me why you have never drunk or have not drunk recently?

b. -does not drinking produce any problems?

c -how are these handled?

(reasons for drinking)

35a. Why do you think people drink?

(for both drinkers and non-drinkers)

(Alcohol and behaviour)

36a. How do you think people behave when they drink alcohol?

(Approval of drinking)

37a. Do you approve of people drinking?

b. When would you think that it is all right to drink?

c. -on what occasions and for what reasons?

(Alcoholics/ alcoholism)

38a. Have you ever personally known anyone who you would say was an alcoholic?

b. -why would you call them an alcoholic?

c. -can you describe their drinking?

d. -the problems that it produced?

e. -what did you do?

f. what did you think should be done in this case?

39a. Do you think that alcoholism is a serious problem in our society?

b. -what do you think should be done about it?

(Drinking of peer group and family)

40a. I'd like you to think of all the people that you know. Think first of the men . How many drink?

b. How many would you call heavy drinkers?

c. Now think of the women that you know. How many drink? d. How many would you call heavy drinkers?

e. Are there any particular sorts of people generally you think are likely to be heavy drinkers?

f. Where do they drink?

(attitude to female drinking and youth drinking)

41a. What do you think of women drinking?

b. What do you think of young people drinking?

(drink and health)

42a. Do you think drinking is good for people's health?

b . Do you think that drinking can ever damage people's health?

c. -in what ways?

d. What do you think are the healthiest drinks to drink?

-the least healthy.

(the concept of heavy drinking)

43a. What do you think is the most common drink among heavy drinkers?

44a. How much would someone have to drink before you would call that person a heavy drinker?

(drunkenness)

45a. If you were to say that someone is drunk. what would you mean by that expression?

b. What do you think of people who are drunk ?

c. Have you ever been drunk? What happens to you when you get drunk?

(Drinking as a social problem)

46a. Do you see drinking as producing social problems?

b. What sort of problems do you think it produces?

c. What do you think should be done about them?

d. Is enough being done?

D.Social Class and Religion

Finally in this last section I would like your ideas about a couple of areas of your life, your background, and how you think they affect , and relate to the areas and issues we have been discussing: general aspects of health, and your ideas about smoking and drinking.

47a) First, you have heard people talking about social class. What social class would you place yourself in?
b) Do you think social class excerts any influence on your own or on other peoples health?

Next, in the questionnaire you stated that your religious background was .....
48a How often do you attend church?
b) Would you describe yourself as being deeply religious?
c) How do your religious views influence your attitudes towards health? smoking? and drinking?

We have now come to the end of the interview. Thank you very much indeed.

Is there anything you wish to add to what you have said?
Or any points you wish to go over?

HEALTH AND WAYS OF LIFE STUDY

As our study is looking at the relationship between health and ways of life in their broadest sense we need to ask some further questions about your present living circumstances and background. All information will be kept strictly confidential.

A1 a) Is your accommodation owned either outright or on a mortgage or is it rented? Please tick the appropriate box.

Owned outright ☐

Mortgage ☐

Rented ☐

b) If it is rented, who is the accommodation rented from?

Local authority/council ☐

Housing Association ☐

Private individual ☐

Property Company ☐

Employer ☐

Other (Please Specify).....

.....

(Please turn over the page)

A2 Could you please indicate below the number of people living in your household at present, and also indicate their relationship to you?

Enter the Numbers in the Boxes below

Wife	☐
Son/s	☐
Daughter/s	☐
Other relatives	☐
Other people	☐

Total living in household (including yourself) ☐

.....

ALL YOUR ANSWERS TO THESE QUESTIONS WILL BE KEPT STRICTLY CONFIDENTIAL.

THIS IS THE END OF YOUR INVOLVEMENT IN THIS STUDY.

ONCE AGAIN MANY THANKS FOR YOUR HELP.

For Office Use Only : _____

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