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Chapter 3

Men and masculinities: accounts of health and social capital

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Summary

In recent years, the links between social capital and health have attracted much research effort. This body of research has largely neglected to address the gendered way in which social capital is developed, maintained and accessed. Moreover, existing studies have not fully examined the notion of social capital within a UK context nor ascertained its validity in the lived experience of members of a disadvantaged community.

This chapter is based on findings from research funded by the Health Development Agency into the relationship between health and gender in a socially deprived estate in north-west England. These findings underscore the complex ways in which men construct their health experiences and how these are enmeshed in diverse social networks. Men tend not to be involved in health enhancing social networks, being constrained by the playing out of hegemonic masculinity. This is reinforced by a community context in which men are often excluded from the very female spaces within which social capital is manifest. In this chapter, men's stories about health and social capital are examined to show that younger and older men live very different lives in their community. This has an impact on their ability to develop and access health-enhancing social capital. The social policy implications of these research findings are considered alongside the future of social capital as a theoretical framework for research.

Social capital: a useful concept for understanding men's health?

This chapter explores the relationship between men's health and social capital based on the findings from a qualitative research project in a socially deprived community in north-west England. First, the chapter briefly reviews existing research into men, masculinity and health, moving on to the contribution and insights which the concept of social capital can bring to the debate. Second, the qualitative approach taken in the project and the methodology used are then described. Third, an analysis of the men's accounts follows under key themes such as the significance of trust, community space and notions of masculinity. Finally, the concluding section explores these key themes in terms of social policy implications and suggestions for a more complex understanding of social capital in the British context.

Men, masculinities and health

Past research has indicated that the experience of stressful life events and ill health have a differential impact according to both age and gender (Arber and Ginn, 1995). Men and women experience their health and stress-related problems in different ways (Carroll, 1992; Ussher, 2000). While ill health in later years for women is often (although not always) related to the reproductive system (eg menopause, breast cancer), for men there is an increased risk of heart attacks and cancer of the prostate gland. Moreover, men are more likely to ignore disease symptoms than women (White and Johnson, 2000; Cameron and Bernardes, 1998). While men have shorter life expectancy, women tend to suffer more in terms of morbidity (Renzetti and Curran, 1995). On the whole, men engage in more unhealthy behaviours than women, including increased smoking and drinking (Ogden, 1996). Women, on the other hand, are heavier users of health services than men (Carroll, 1992) and are often the primary source through which healthcare is channelled into family life.

This might be explained in terms of women's more extensive and diverse social support networks (Cooper et al., 1999). In comparison to men, there is evidence to suggest that women engage in more reciprocal and confiding relationships that mediate their experiences of ill health and stress although such support networks can change as the person grows older (Scott and Wenger, 1995; Wellman and Frank, 2000). Men also differ from women in terms of the source of their support. Whereas men rely on social support from wives and partners, women tend to rely more on wider family and friends (Wood, 1998). Consequently, research suggests that men tend to have poorly developed social support networks and so are restricted in terms of access to help when needed (Fleming, 1999). This limits the range of support and health information they receive, with possible damaging consequences that can have major implications for men's health (White and Johnson, 2000). So, more recently, attention has been focused internationally on the causes of men's higher mortality rates and their reluctance to engage in preventative strategies (Meryn and Jadad, 2001).

It is important here not to assume a common pattern among all men in this context. Both gender and age are complex and diverse phenomena: masculinities can be manifest in very different ways (Mac an Ghail, 1996);

while age categorisations do not always correspond to homogeneous experiences (Bytheway, 1995). Indeed, both gender and age can be conceptualised as situational, relational and dynamic such that the situations and relationships within which health problems are experienced can differ tremendously between younger and older men. Notions of masculinity may prevent men from seeking help in times of ill health especially as Moynihan (1998: 1074) argues that 'they [men] constantly invent and reinvent themselves as people with a "stiff upper lip" as "boys who don't cry"'. So social constructions of masculinity are influential in the decision to report illness (Hillier and Scambler, 1997) and the practice and experience of ill health (Courtenay, 2000; Williams, 2000).

Men's health and social capital

It was argued earlier that men tend not to draw as effectively as women on social support in times of ill health. However, little is known about the reasons for this and the nature of the potential barriers that prevent men from reporting illness and seeking help. Using social capital as a framework for research emphasises the complexity of the links between an individual and their family, friends and community at times of ill health and stress.

The notion of social capital that has gained most in popularity was identified by Putnam (1995, 2000) and has attracted considerable academic and political attention in recent years. This approach forms the theoretical basis of the research presented in this paper. Within Putnam's work, social capital has been defined as:

'Features of social organisation, such as networks, norms, and trust, that facilitate coordination and cooperation for mutual benefit.' (Putnam, 1995: 67)

A community or neighbourhood which is rich in social capital has been described as a socially cohesive, cooperative and caring community in which people work together for mutual benefit. Accordingly, social capital has been seen as:

'Both a glue that bonds society together and a lubricant that permits the smooth running of society's interactions (both interpersonal and among people, groups, and organisations).' (Smith, 1997: 170)

Conversely, a community poor in social capital might be described as one where people become isolated, suspicious of others and reluctant to participate in social, economic and political life. Indeed, a community lacking in social capital is said to be characterised by the breakdown of the social fabric that binds people together within their communities (Cooper et al., 1999).

While the concept of social capital has been heavily criticised as being ill-defined and romanticised (Wall et al., 1998; Schuller et al., 2000), it can also be argued that the notion has heuristic value in highlighting the role of social networking, trust, reciprocity and community participation in explaining community cohesion or decline. In this sense, social capital encourages researchers to take a more holistic perspective on the ways in which men are embedded in their social networks and communities and how these operate to mediate ill health.

Currently, qualitative research into social capital has been limited, and there are more questions than answers concerning the health-enhancing capacity of either bridging or bonding social capital. Campbell's research suggests that there are different types of social network which may vary in their potential to be health enhancing. Indeed, Campbell (1999: 33) argues that:

'Certain dimensions of social capital might be more relevant to health than others ... trust and perceived citizen power/civic engagement, with less emphasis on local place-based community identities.'

However, it still seems unclear which 'type' of social network is most beneficial to the health of both the community and the individual. Most of this research has assumed that social capital operates in the same way for men and women, despite known gendered differences in social networking. Moreover, there is clear evidence that communities consist of places which are structured by gender. Spain (1992: 7) argues that:

'... a thorough analysis of gender and space would recognise that definitions of femininity and masculinity are constructed in particular places – most notably the home, workplace and community.'

It is in such gendered places that social capital is both created and used as a community and individual resource. If social capital is health enhancing, then research needs to examine what aspects of social networking and

community living are most conducive to the creation and development of social capital and how this might translate into healthier lifestyles and communities differently for men and women. At the moment, there is little understanding of social capital as a gendered concept, particularly from the perspective of men and masculinities. A fuller understanding of the social construction of these masculine identities can be achieved by exploring how men of contrasting ages use their social capital at times of ill health.

A qualitative approach

Much existing research has been done on social capital using a quantitative approach within a positivist paradigm (eg Kawachi et al., 1997). The result of this emphasis is that there is little understanding of the mechanisms and processes through which social capital is created, maintained and used as a personal and social resource. The objectives of the research described here were to reveal the complexities of the relationship between social capital and health from a qualitative and gendered perspective. The study concentrated on a geographically distinct socially deprived community in Bolton. The aims of the research were threefold.

First, the project aimed to elucidate the relationship between social capital and health at the holistic individual, community and social level. Here, in-depth analysis of community participant constructions of health were examined alongside community level participation and the wider social and organisational context within which the community was enmeshed.

Second, an investigation was undertaken of the mechanisms and processes by which social capital is created, sustained and used. This involved an exploration of trust, reciprocity, bonding and bridging ties in terms of their capacity to help create health-enhancing networks. The third aim was to understand people's gendered experience of their own health and wellbeing and how this was mediated through their involvement in social and community support systems and groups.

The research adopted a qualitative methodology primarily since this has the potential to reveal the significance and intricacies of the lived experience of community members. This viewpoint is highlighted by Henwood and Pidgeon (1995: 15), who contend:

' [The] qualitative paradigm privileges the search for meaning and understanding rather than abstract universal laws ... The gathering of non-numerical data is deemed to be desirable within the paradigm because it frees researchers to explore and be sensitive to the multiple interpretations and meanings which may be placed upon thought and behaviour when viewed in context and in their full complexity.'

The project methodologies were located in a case study approach (Yin, 1984). Case studies are considered a suitable methodology when a holistic, in-depth investigation is required (Feagin et al., 1991). The benefits of this technique allow investigators to scrutinise 'contemporary phenomenon within its real life context' (Robson, 1993: 146). Similarly, the approach enables the use of several layers of evidence, affording 'rich or "thick" description' (Robson, 1993: 148) that unravels the lived experience of those in the community from their own perspective.

The flexible and adaptable approach of the case study was beneficial to this project as notions surrounding social capital and health were exploratory rather than concrete, and to strictly pre-structure the methodologies used and data collected would have been counterproductive within the community setting (see Robson, 1993). So the qualitative case study was conducive to unpacking the notion of social capital in some detail and to locate it within social constructions of gender. In this way, the experience and meaning of health and social capital within everyday life was exposed.

A multi-methods, case study approach was taken, using the following methods for data collection:

- A newspaper analysis of representations of health extending over the period of one month
- Interviews with professional and voluntary organisational representatives
- In-depth individual interviews and focus group discussions with community residents
- Street interviews.

Participants were recruited via a number of different strategies including introductions through community groups and activities, social networking and snowballing. The resulting sample was structured by age and gender as indicated in the table opposite.

Sample size and composition

	Semi-structured interviews		Street interviews	Focus groups
	n = 46	Mean age	n = 69	n = 4
Younger men	13	31	11	8
Older men	11	65	25	7
Younger women	11	28	9	8
Older women	11	66	24	8

For the purposes of this chapter attention is focused on analysis of the men's in-depth, semi-structured interviews and group discussions. These methods have complementary advantages. One of the benefits of the flexible format of the semi-structured interviews is that it facilitates unforeseen conversations and so enables the participant perspective to be revealed (Wilkinson, 1998). This semi-structured approach encourages the participant to give their accounts and keep to their own agenda which Smith (1995) suggests allows for greater opportunities for participants 'inner perspective' to shine through. The individual interviews were conducted by one male and one female researcher and took place in the homes of the community participants.

Focus group discussions have the advantage of using 'group interaction to generate data' (Barbour and Kitzinger, 1999: 4). This is achieved by the researcher encouraging discussion and interaction among the group, rather than asking questions of individuals (Barbour and Kitzinger, 1999), so producing realities and narratives that would otherwise be inaccessible (Morgan, 1988). The structure of the group can include strangers, acquaintances or friends. The research project recruited community residents into the group discussions which were convened in local community centres.

The interviews and discussions, which were tape recorded and later transcribed, often lasted up to two hours and the interview schedules encouraged the participants to talk about their health experiences and status, coping with life transitions and the role of community and social networks in supporting them in times of stress and ill health. As such, the schedules did not operationalise the concept of social capital; rather, they allowed issues of

social networking, trust, reciprocity and participation to emerge in a data-driven way as people talked about their everyday community and health experiences. These accounts were analysed thematically, whereby all transcripts were subject to multiple readings and key themes were identified (in accordance with Charmaz's work, 1995).

During the process of this analysis gendered constructions of health and social capital emerged. The resulting analysis indicated that the wider social, organisational and community context helped to shape the gendered relationship between health and social capital. It is from this data set that the current analysis of men's accounts of their health and social capital have been derived. For further information about the project, including analysis of the women's interviews, see Sixsmith et al., 2001.

Social capital, masculinity and health: analysis

In the study 21 younger men (aged between 18-40 years-old) and 19 older men (aged between 56-79 years-old) talked about their health, family and community life. The following section considers the analysis of these accounts under key themes relating to social capital, health and masculinity.

Bonding ties

The men discussed strong bonding ties with family and friends and clearly felt they were enmeshed in wide social networks. In the case of younger men, friendship networks were very important, while for older men family ties predominated. In both younger and older men these

networks were constructed in terms of practical support based around everyday life activities. For instance, for the young men friendships were maintained through drinking and being together – listening to music or sharing humorous stories.

Older men, on the other hand, were much more engaged in family business and their ties revolved around preserving family security. So for both older and younger men social support was largely valued as instrumental and as such their emotional needs were neglected. This was the case even at times of difficult life transitions or ill health when men would fail to call on their social networks for personal support. This extended to an unwillingness to even discuss the problems they were facing with family or friends.

The older men in the sample seemed to actively shun any form of social support during periods of great stress and sorrow due to bereavement, desertion or chronic illness. Here, narratives of independence, privacy and mistrust were used to explain their lack of proactivity in seeking support:

'I didn't turn for help as it was more of a private matter, I mean it's a bit shattering when someone turns round and says I've left you after [all these] years of marriage.' (Bill)

'... don't involve outsiders – those kind of things are family problems – nothing to do with anybody else.' (William)

Moreover, asking for help was seen as:

'... using your friends and I don't work like that.' (Bill)

This notion of 'using' people was very evident in the men's interviews. Friends were there for 'genuine need', not to be used. There was a feeling that others might interpret asking for support as unnecessary or even mercenary and that one could develop a reputation as being weak or manipulative. So men would not reveal their inner feelings unless they felt they could trust implicitly the person to whom they were confiding.

Social trust and mistrust

The notion of trust was confined to close family and friendship networks and based on familiarity and proof of personal integrity. Trust could only be given to those

family and friends who had proved they could be trusted. Such proof often took the form of keeping secrets, not gossiping and also for the younger men, fighting together and protecting one another. Peter sums this up in talking about his friend:

'Well I could say something and it won't go any further, he won't say anything whatever, I can trust him, I could trust him with me life. Just like an example, say there's 15 lads or 15 blokes beating me up I could actually trust him to be there with me or help me, y'know what I mean?' (Peter)

It also appeared that the trust found in these relationships needed to be earned and constantly negotiated through the demonstrable norms of keeping a confidence and not gossiping. On this basis, some men were not even trusting of their friends, many of whom they had grown up with:

Interviewer: *'Do you trust your mates?'*

Ian: *'No.'*

Jimmy: *'Some of them you can.'*

Ian: *'I wouldn't trust them as far as I could throw 'em.'*

Peter: *'I do, you don't nick off your mates, some people do, don't they.'* (Young men's focus group)

Interestingly, for younger men, trusting others was not part of streetwise behaviour. They felt that anyone who was 'trusting' was ostracised as a 'fool'. When asked, 'Do you trust your mates?', Liam answered:

'Not really no, cos you get the odd one who goes stirring it up just as a joke. And people could take it the wrong size. We do trust each other quite a lot, well the close mates, but I trust my work mates more than my close mates. I've experienced what they've done with each other, I've watched as they've slagged each other off, to me and I think, you know, I'll not say anything to this guy cos he'll go and tell him, so I just keep it hush hush, I don't tell 'em much.'

Interestingly, to know someone as a community member was not necessarily to trust them. Here, Putnam's (1993, 2000) notion of generalised trust was conspicuous by its absence. Indeed, both older and younger men characterised their communities in terms of generalised suspicion, borne out of a need to navigate the crime and violence which was part and parcel of their everyday life:

Interviewer: *'So you trust people you know, close to you'*

Liam: *'Well I'd never trust anyone else, not in this area ... if I knew them very well I would trust them but I won't trust, not many people in this area. A lot are drug dealers who would rob you, it's as simple as that, they would do anything to get in your house. They would backstab you. If you look out for them, they will just turn round and rob you, it's as simple as that round here. There's a lot of people nice people but there's more of them are scumbags really.'*

This generalised suspicion limited the amount of interaction between neighbours, which also reduced the level of trust people had for one another. This was clearly the case with older men in the sample, who were deeply suspicious of younger people on the estate.

'Erm ... they don't, how can I put it, it's so difficult to put into perspective, people don't want to seem to be congregating together today with their neighbours they just want to mind their own business, and a lot of that is to do with the youngsters that are roaming the street, er, a lot of people are trying to just come home and leave their house at night, worried what they might come home to.' (Bill)

Community space and masculinity

For men, suspicion and mistrust in the community may be a product of their lack of participation in local community activities. This feeling of distance from community life was compounded by their construction of community spaces as women's domains:

'More ladies than men go to the community centre ... there is nothing actually for them [men] at the centre, they'd rather go for a pint and a chat to a pub or club, women aren't as bothered that way.' (Richard)

Men felt that the daytime estate was a place frequented mainly by women and children, with men being at work. Both older and younger men talked about feeling out of place in community settings such as the local community centres. Some suggested that community centres failed to provide activities for men and so they struggled to see a role for themselves in such venues.

Younger men did reclaim community space as their own during the night-time hours. This was when groups of

young people, both men and women, would congregate at street corners and in the park to socialise, drink, smoke and sometimes exchange money for drugs.

Unfortunately, this reclamation of space, predominantly by young men, felt extremely threatening to the older men and ultimately resulted in older men feeling alienated from their local environment and locked inside their homes. Older men linked such gatherings of young people to escalating violence and crimes:

'... These 'ere teenagers round 'ere that can't find nothing for do. They've cocked it up for their own little brothers and sisters. They've ripped all the cushion flooring out of the floor. They've set it on fire. They've smashed the swings. Now that they've done all that they've got to find something else what do while not on park, 'aven't they. So last year they 'ad, erm, the egg throwing thing – any cars coming up and down the road, they threw eggs at 'em. Er, in the last few week, they've been doing it wi' bricks. They've been bricking cars goin' past the park. I've not been in "Feathers" for a month or two like, but I called in last week while I were passing, I'd been somewhere else, and old bloke were in that just lives on road there and 'e were telling me about this bricking. He says there were a woman going down and 'ow the 'ell she managed it, I don't know. 'Ouse brick straight through front window of 'er car. Just missed 'er. She swerved out road like and she had to try brake and everything before she hit some other cars that were parked on either side. Just bricked 'er.' (Roy)

Despite the undertones of night-time violence, becoming involved in day-time community life was portrayed as a statement of femininity rather than of masculinity. Community action was seen as women's preserve and men often excluded themselves from participation.

One participant reflected that men only came with their wives to the community centre as social activities were more aimed at women. This applied to both older and younger men:

Steve: *'Well yeah, community centre they have aerobics classes, mother and baby stuff like that but that's only thing that I think's women's.'*

Interviewer: *'What about blokes, is there anywhere for blokes to go?'*

Steve: *'No not really.'*

So men's relative invisibility in the community was predicated upon gendered expectations of community life which constrained men from building and maintaining social capital by excluding them from participating in group activities. As men avoided community groups and tended to live their social lives at home or in the houses of their close friends and family they were less able to build the sorts of bridging ties that Putnam (2000) suggests is important. This meant that when the men did suffer from ill health or great stress they were unable to draw on support, knowledge and advice outside of the constraints of shared norms of family and friends.

Men's constructions of health

Health was not a topic of conversation for most of the men. None of the men said that they instigated health talk. Several reasons were suggested for this. On the one hand, the men felt they weren't sufficiently knowledgeable about health matters and did not want to appear foolish in front of others, especially friends. Here, maintaining face was important. It was implied that men should be knowledgeable about the world; if not, then the safest strategy was to avoid the subject. On the other hand, they felt that talking about health was a feminine activity rather than a masculine activity:

'Women talk about health, not men. It's a male thing.'
(Peter)

Furthermore, dwelling on health was perceived as a form of hypochondria and indicative of an inability to cope with life:

'I don't believe in moaning, I'll not moan.'
(Alistair)

The notion of health, and more particularly, their own health was something they appeared not to have reflected on in any detail:

'Health, my health? I think health is just something, it's just life in general and how it's treating you. There's always a down side.' (Steve)

Health was conceived of always as 'ill health' rather than 'good health' and was not disentangled from everyday life. Ill health meant not being able to do everyday tasks:

William: *'I can't dig me garden, that's one thing, I used to love me garden, an' I can't carry heavy weights, I can for a short distance and walking, on a day like today, if I went out an' I started walking, I be able to walk say to shops round corner, an' then I'd have to stop, get me breath back an' everything an' start again.'*

Interviewer: *'And that's about five minutes away?'*

William: *'Yeah, whereas before I started having the heart trouble an' that I used to walk all over, never 'ad a car, well I had one but I used to walk for miles and miles with kids. But now, well.'*

Health was very much a relational concept in terms of activity and age. So the men judged their health status in terms of what they could and couldn't do in relation to what they used to be able to do or in terms of what the majority of men could or couldn't do at their age. Many of the young men, by dint of being young, felt invincible and so when ill health struck, they evaluated their condition in relation to their age:

'At 19, being knackered all the time isn't normal.'
(Guy)

For some, such loss of good health was felt deeply in terms of an assault on their sense of manhood:

'In all respects I was lucky because my eldest son he was old enough, in fact he was married at the time, and the next to eldest son he was in the army but when he came home on leave he used to be able to do these jobs that I couldn't do. Biggest part of time it used to get up my nose because the way I looked at it was my manhood had been attacked, and many times I used to think I'm only half a bloody man now.'
(William)

For most of the men, ill health was something to be endured. They described how a man's way to experience illness was to suffer in silence until the pain became unbearable, and then to get help:

'Even if I've got a headache I don't take a pill. I had a pulled back muscle and left it a week. My lass says to go to the doctor, but I'm stubborn. I did go, but it was very painful. I mean, way back when humans started, if you had a headache you'd just suffer with it.' (Peter)

Suffering from mental ill health was experienced as a deep disruption between masculinity and identity. The

men were unable to construct mental ill health as part of masculine identity in the sense that they had always associated emotional life with femininity and the lack of control of emotions experienced during mental ill health challenged this. Men who suffered panic attacks/anxiety described themselves and their health problems in negative ways. As Steve said:

'My partner's not very sympathetic. Nine times out of ten if I get a panic attack I'll go to my mum's cos she like understands. She's known me longer ... I don't tell my friends cos they say, "What's up with you, are you a man or a mouse. Betablockers? That's for old people.'"

Mental illness was seen much more in terms of weakness than was physical ill health, and for these men weakness was not an acceptable masculine status.

While seeking help in ill health contradicted established notions of masculine independence, this did not preclude them from seeking women's advice (mothers, wives and partners) when suffering became extreme:

Guy: *'I couldn't sleep at night – I think I went about four days without sleep. I was knackered. I told me mum eventually and she says she thinks it's stress or something and I should go and see the doctor. I was having panic attacks at night because I couldn't breathe.'*

Interviewer: *'Right, what about your kinda best friend or partner?'*

Guy: *'Yeh, I told my girlfriend. She didn't know what it was she just goes, "Go the doctors and get it sorted out.'"*

Moreover, the very way in which men constructed their notions of health and ill health diverted their attention from locating health in a social context and concentrated their energies on self reliance in the face of extreme suffering. Both younger and older men tended to conceive of health issues in a highly objectified way, ie they divorced themselves as people from their health and construed health as an independent problem to be dealt with on a medical basis:

'If it's bad [prostatitis] I go the doctors. I've got some anti-inflammatory tablets to take. If it gets really bad the doctor will prescribe some anti-biotics to help the infection go quicker.' (Simon)

As in the example, it was typical of the men to talk about illness in terms of 'it' ('If it's bad ...') placing the emphasis on the illness as separate from themselves rather than claiming ill health as part of their own identity. Here, the body was experienced almost as a machine. When it broke down, the doctor could fix it. Both young and older men expressed trust in the expertise of the medical profession.

Men, work and health

Older men experienced conflict when trying to maintain a working identity in the face of ill health. The men could maintain their working identity firstly by denying the existence of their symptoms to themselves and secondly by not admitting illness to their workmates. Older men referred to their past experiences when ill health interfered with work. This was the case for Fred whose breathlessness affected his ability to carry out his lifting job. Rather than explain to workmates about his health, he attempted (unsuccessfully) to hide his problems. He felt that his age and health was disapproved of by workmates. It was only when his doctor diagnosed asthma and issued him with an inhaler that he felt able to reveal his situation and find acceptance from colleagues:

Fred: *'When I was at work, when I was doing something at work, I had to keep stopping to catch m' breath, I was a bit of a liability to m' mate then I was lifting things and I'd have to walk away y'know until I had to tackle it, doctor about it. And he said, "Yes, you have got asthma.'"*

Interviewer: *'When you were getting out of breath, and you had to stop, well did you say anything to your friend, your work colleague?'*

Fred: *'Well you know how you are with your mates, you're talking and I used to say, "Howd on Jack [changed name] bloody 'ell, not agin." like y'know, he'd say things like that. I'd say, "I won't be a minute. I don't bloody know." Anyway, things went on and I said, "I can't help it, I can't breathe." Finishing up like, we'd one or two harsh words but like I say, it become right when I got treatment for it.'*

Interviewer: *'What did you say when you got treatment, when you got your inhaler?'*

Fred: *'I didn't say nothing to him, it were two or three days after when he noticed. He said, "What the bloody 'ell 'ave you got there?" and I told him. He said, "It's made a bloody difference, hasn't it, Fred." [Fred chuckles] I says, "It has, it's a bloody good thing that*

[Jack] ... *He'd seen me do it, and I told him, when I'm gettin' short a breath, I shove it in and it opens m' pipes up, that's what doctor says. I felt good when he said it, I mean, I'd been feelin good m'self, y'know but when someone else says it, I was really chuffed, I felt like a king, it felt wonderful.'*

For other men, the desire to continue with work despite illness was very strong. Being ill and losing a working identity was very difficult to take. Richard expressed this when he lost his job after becoming seriously ill with a collapsed lung:

'... tried to get back into my work life after it happened, I went to a therapy centre in Riverside [name changed] ... I had to go and see a doctor there cos I was a bit depressed at the time. I mean, from being fit to being completely knackered if you will, and I tried to get myself goin', motivated again. I had to go and see this specialist and he got me into a woodwork class there. All it was, were for therapy to get me goin', t' get me mind occupied. And I did that for about four years ... at first, I thought, well I want to go back to work, but I couldn't get a job. I mean, my age wasn't for me, I had just turned 50 when it happened and it were a shock to me system . I went back to work when it happened, but I couldn't do m' job [HGV driver] ... I couldn't do any lifting, that had gone from me. I mean, I was used to loading wagons up and unloading wagons all me life.'

This loss could be extremely difficult to come to terms with when the men had previously enjoyed very good health:

Paul: *'... had to retire three year ago ... up to then, never been ill, never bin off work, never lost a day's work all my life.'*

Interviewer: *'That must have been a big shock.'*

Paul: *'Yeah it were. It upset me a bit, y'know wi' not used to bein' ill and that, it took me quite a while t' get over it ... I was upset for quite a while, y'know I didn't want do anything, it were the shock.'*

Health and responsibility

Men defended any breach of hegemonic masculinity posed by ill health by maintaining that health matters were essentially the concern of women or doctors, not as part of their own expertise or responsibility:

'Women know more about health. I think they've been brought up more health wise, that's been passed on since the war. They look after the blokes.' (Guy)

'No, I don't look after my own health. That's for the doctors to do.' (Alistair)

When the men did relate health and personal responsibility they framed this not in terms of maintaining and managing their own health but in terms of work, family responsibilities and their breadwinner role. For example, Bill described his ill health:

Interviewer: *'I mean what is the state of your health, can you give me a description of what's going on in your health?'*

Bill: *'Well I've 'ad seven eights of me stomach removed. Erm, I've 'ad a loorooop.'*

Int: *'Excuse me?'*

Bill: *'A loorooop, it's a by-pass from before the stomach to the intestine. A tube fitted before the stomach into the intestine. Which I'm in need of another one, but they won't do it unless I'm dying.'*

Int: *'Right.'*

Bill: *'I've 'ad me gallbladder removed.'*

Int: *'Alright.'*

Bill: *'Erm I 'ave a condition which is the opposite of diabetic.'*

Int: *'What does that do?'*

Bill: *'It means that when I 'ave a cup a tea I 'ave five or six spoonfuls of sugar in me tea.'*

Int: *'Oh right.'*

Bill: *'Er and unfortunately due to a smash up in 1973 I've 'ad a bad back. Other than that I'm alright.'*

Despite this awful catalogue of illness and surgery, Bill conceived of his health not in terms of bodily dysfunction but in terms of his masculine role as family provider:

Bill: *'Well basically because all I were looking at at the time were working an' giving my kids what they want.'*

Interviewer: *'So that's your responsibility?'*

Bill: *'And I class my responsibilities with great importance, right, so when you think of things like that, having time off work, like you think to yourself, without going to the doctor you think, "Oh I don't feel so well today I'll have a day off and stop in bed." you can't because your conscience is pricking because they need this and they need that, but then you're pushing yourself to work all the time.'*

In this way, men could legitimise their admission of health problems and seeking and accepting without question the help of women and health professionals:

'I always think, if the doctors given you some medication, you don't mess about with it. Cos some medication, you can take other things that can interfere with the medication taken, you can have a reaction with it, so as far as I'm concerned, what they give me, I take and that's it.' (James)

Very few men felt let down by the medical profession and most felt able to communicate effectively with their GP. However, this was usually underpinned by the doctor's attempts to relate their illness to men's mechanical understandings of their bodies:

'... and the surgeon, the doctor that did it turned round an' said, "To you, it's superglue, you'll know it as a common person as superglue," but the proper name for it is alkaline talc. It sticks your membrane of your lung up ... I've a tear in m' lung, a tear in m' lung through coughin', what caused it was coughin', I coughed hard and tore m' lungs.' (Richard)

Often, when men did attempt to seek support from family and friends in times of ill health and stress, they did this in a very indirect way: by talking about the changes in their lives and assuming that other people would then offer support without being asked. When Bill's wife left him, he highlighted that he did not go to see his long-standing friends expressly to 'spill the beans' but approached this in the course of everyday life:

'Oh yeah, I didn't use them deliberately, erm I went to see them in the normal manner that I do go and see them, which is not very ... y'know I'm not the sort of person who I go visiting on a regular basis, people, it's a surprise when I go and see any of my friends. And I don't go specifically because I want to say she's left me, I went because I wanted to see them and they had a right to know as well and I told them.' (Bill)

Bill justified to himself his need to talk by framing it as the rights of his friends to know what had happened to him.

Men, health and self destruction

Bill was one of a minority of men whose illness was so severe, and compounded by highly stressful life events that seeking social support was almost inevitable.

However, for many of the other participants in the study, high levels of stress and ill health were very private matters. These men felt unable to access social support and were subsequently vulnerable to a downwards spiral of 'self-destructiveness'. When life transitions included unexpected illness and enforced retirement, their former support networks were further diminished alongside their workplace relational skills. Their attempts to cope with stressful life transitions could include excessive smoking and drinking:

William: *'... an' with me having the heart trouble the wife got custody of the kids, my solicitor told me, he were quite civil, he said I could go for custody but the courts would refuse it because they look at it from the child's point of view and like he said, they'd look at you with your history of heart trouble.'*

Interviewer: *'How did you cope when you got thrown out? [of the marital home]'*

William: *'Well, I got thrown out and ended up in one smelly scabby little room on Park Street, eh, it broke my bloody heart. That's when I started drinking heavy.'*

Int: *'I mean can you give me an example of what drinking heavy is to you?'*

William: *'Put it this way, when me and wife broke up, my favourite pub was Dunning Arms [name changed] down New Street [name changed], an' I used to go in there at 11 o'clock in morning, in them days the pubs didn't open till 12, but I went in there at 11, cleaned the bar, an' most times it was after midnight when I left ... I used to get me Invalidity Benefit it was called then, I used to get that on Fridays and by Monday morning I didn't have a penny left.'*

Int: *'Were you not worried about affecting your health even more doing that?'*

William: *'I just didn't care, it didn't go on that long, I divorced the wife on grounds of adultery and when solicitor sent me that letter stating the divorce was all through and I was a single fellow an' he sent me that paper to sign then I started pulling meself together.'*

But William's heavy drinking had huge repercussions for his social networks and his capacity to draw on social support as his drinking fuelled violent behaviour. He lost all his friendships after being thrown out of the social clubs and pubs for using violence towards other members. This left him with a highly restricted social network:

'You can't really say I've got friends apart from my own family.'

Conclusions

The notion of gendered health was a significant feature of daily life within the researched socially deprived community. It would seem from the men's accounts that those who participated in the project do have access to social capital manifest mainly in close bonding ties with extensive networks of family and friends in the local community. In line with Spain's (1992) analysis, there is evidence that communities consist of places which are structured by gender. The community in which these social networks were embedded were indeed highly gendered. Community daytime life and activities within community centres were perceived as feminine by the male residents. This meant that the men were essentially excluded from participation in community groups.

In this study, younger and older men experienced community life in very different ways. Younger men made use of space on the streets and at night while older men's activities were more restricted to the daytime. Neither group, however, was able to enhance its networks through community participation in the centres which women so successfully frequented. So men were effectively denied access to social capital available through meeting in community space. This meant that they were unable to develop the sorts of bridging ties which might have enabled them to access health-enhancing advice and knowledge. So social capital for men did not operate in health-enhancing ways.

One reason for this was that both younger and older men constructed health issues very much in terms of their sense of masculinity, as Courtenay (2000) has argued. Men felt that being ill displayed a form of weakness which was not consistent with social constructions of masculinity. They did not want to reveal inner feelings or health concerns, an activity they felt to be feminine.

Both younger and older men sought to maintain a masculinised image of themselves as private, independent, courageous and confident. This meant that they tended to objectify their health status. For them, health was a personal lived experience interpreted not in terms of symptoms but in terms of limiting activities and their ability to engage in their role as breadwinners. They felt that their working identity was threatened if they gave the appearance of losing their health and with it the status of employment to support their families. On this basis, social constructions of masculinity linked to

working identity drove the men to disregard or deny symptoms of illness.

When confronted with ill health the men were largely unable to engage in health talk. To many men, the notion of health was a private affair not discussed outside the realms of very close family. Their first strategy when suffering was to seek the advice of women in their families. Having gained their advice and approval to visit the doctors, only then would the men accept medical assistance. However, in some instances, to discuss health with even close family was an option of last resort. This was not simply reluctance on the men's behalf to 'do' health in public. Rather, this was a conspiracy of silence negotiated by the men and their families.

Analysis of the accounts revealed that the men also tended not to discuss health with their friends as this was seen as a gender transgression. The issue of trust was important here. Divulging health concerns was confined strictly to friends (usually women) who could be trusted not to gossip about them or ridicule their problems. Moreover, younger men viewed themselves as invincible and so health talk was irrelevant for them. Older men, who had experienced more episodes of illness or who suffered from chronic ill health also declined to discuss their health concerns. Talk on health, being perceived as feminised, detracted from their sense of masculinity since the younger men's masculine script for friendship revolved around talk of work, sex, drinking and humour with friends. For older men, friendships were about maintaining status as working men and not about sharing stories about health. The problem here was that in negotiating masculinities the men failed to develop or access social capital – they were not talking about health, their health worries were not addressed, serious illness could not be identified in the critical early stages and an expertise in health matters could not develop.

In general, the men devolved responsibility to women on health issues, deferring both to women's (their girlfriends, wives and mothers) and doctors' greater wisdom. For men illness was best dealt with on a medical basis. The men adopted an unquestioning attitude to their health and tended to relinquish decision-making about health matters to the medical profession.

The social policy implications of this work are evident. It is clear that recent initiatives draw attention away from the state's role in welfare, requiring the individual and the

community to take charge of welfare (Lister, 1998). At the heart of the present government's white paper, *Saving Lives: Our Healthier Nation*, is the notion of the individual basis of health, with rational people taking responsibility for their health and making informed decisions (Department of Health, 1999). This reflects a view of members of society as composed of citizens and community participants, revitalising notions of a civil society (Lewis, 1998). Such ideas resonate clearly with Putnam's concepts of social capital and suggest strong bonding ties within the community can act as buffer to stress and ill health (Cooper et al., 1999).

The current research has shown that the building and maintenance of social capital varies according to gender. Men in the community are not prepared for the task of taking on responsibility for their health. They have relatively few personal and social resources with which to undertake this role successfully. Furthermore, it has been demonstrated that communities are extremely diverse phenomena, comprising highly gendered spaces. The operation of policies to reduce inequalities by improving the health of deprived communities are thereby in danger of excluding men. Men's reluctance to take personal responsibility for their health and the perceived feminisation of community centres need to be addressed in policy making.

The research has emphasised the important role of social capital in health status, enabling new insights into the ways in which men socially construct health in terms of hegemonic masculinities. This clearly points to the need to explore further gendered notions of social capital, which is not a universal concept applicable in the same way to all people. In this research project, the men were steeped in bonding capital which they could not access in health-enhancing ways. Moreover, they were unable to develop the sorts of relationships in which bridging capital could feature due to highly gendered community settings. So assumptions of the inevitable positive value of social capital evident in the work of Putnam (1995, 2000) does not accord with the current research findings as the development and use of social capital is constrained by masculinity and dependent on the nature of the social networks embedded in the community setting. As Campbell (1999) has argued, there are different types of social networks which vary in their potential to be health enhancing. In this way, the accounts of health and social relationships presented here have provided some insights into the complex relationship

between social capital, health and masculinity. Certainly, the current research has uncovered differences in the way younger and older men construct both their health and masculinity. Future research needs to unpack these complexities and the role of both bonding and bridging ties in relation to gender and health.

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