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21 Narrating Women's Health Identities in the Context of Community Living

JUDITH SIXSMITH AND MARGARET BONEHAM

Abstract

This chapter presents a qualitative exploration of the relationship between social capital, health and womanhood for a group of younger working class women in a socially deprived community in Bolton, UK. The project, funded by the Health Development Agency involved interviews with 25 younger women aged between 19 and 38 years. Most were single parents of young children who were currently unemployed. Our research identified the complex ways in which younger women took ownership of their health within the social context of family, friendships and community living. Their narratives about health focused on experiences of motherhood and community living and were embedded in networks of social capital (Putnam, 1995, 2000). Women's health identities reflected social constructions of motherhood and caring, in which tiredness and depression were seen as normal parts of everyday life. These women took responsibility for their own and others' health becoming health experts in their own right and sometimes critical of medical expertise. Shared norms located in the common space of this socially deprived community were a basis for younger women's choices about lifestyle which were not always beneficial for individual or family health. The links between health and community living were made evident in this research emphasizing the importance of a narratives approach.

Introduction

Early research into women's health emphasized the masculine norm as a base from which women deviated. As such women were characterized as pseudo men who were inherently inferior, ie. the pathologised other, beings who are biologically different but non-gendered. Here, many specific studies into women's health have focused on biological/sexual differences (while ignoring socially constructed understandings of women and health). Consequently, there have been innumerable studies on pregnancy, birth, menopause, sexual dysfunction, infertility and so on. Biological difference is seen as problematic for women, hence the medicalisation of women's health status. Within this

framework women are inevitably seen as the sicker, weaker sex and the target of medical interventions. This has resulted in the marginalisation of research into women's health from a gendered perspective (Ussher, 2000).

Alternatively, research has conceptualized women as the bastions of health care within their family contexts while men are seen as risk takers. While women are deemed to be protective of health and inherently caring, men damage their health through risky actions and unhealthy lifestyles. However, such assumptions appear over simplistic in terms of the realities of women's behaviours. Alongside men, many women also take risks (eg. smoking and drinking) and live unhealthy lifestyles (eg. lack of exercise). In order to understand the complexities of women's health attitudes and behaviours, an exploration is needed of women's gendered conceptions of social and personal health in the context of everyday life and identity. Here, health identity can be viewed as an embodied identity, involving social constructions of womanhood as well as bodily experiences of health and illness. Taking a gendered perspective implicates the importance of identity and highlights the notion that each person's health identity is influenced by their past, present and future as well as the broader social context of family and community. As Lomas (1998) argues:

Individuals (and their health) cannot be understood solely by looking inside their bodies and brains; one must also look inside their communities, their networks, their workplaces, their families and even the trajectories of their life.

Social capital can be a particularly useful concept for locating issues of health within the context of individual, social and community networks. Putnam's (1995, 2000) notion of social capital has recently gained in popularity and has been described as:

... features of social organisation, such as networks, norms, and trust, that facilitate co-ordination and co-operation for mutual benefit" (Putnam, 1995: 67)

This concept has been criticized as highly ambiguous, class biased and less appropriate in a British context (Wall et al., 1998; Schuller et al., 2000; Sixsmith et al., 2001). Nevertheless, an interesting relationship has been identified between high levels of community based social capital and good health albeit using almost exclusively quantitative methodologies (eg. Kawachi et al., 1997). It could be argued that the notion of social capital has heuristic value in highlighting the role of social networking, trust, reciprocity and community participation in research into the development of healthy communities. In this sense, social capital encourages research to take a more holistic perspective on the ways in which women are embedded in their social networks and communities and how these operate to mediate health. In order to explore the relationship between social capital, young women's lives and

health, a qualitative approach is required which focuses on everyday accounts of community living.

This chapter presents a narrative approach to understanding women's gendered experiences of their health within a social context. The work was carried out in a socially deprived community as part of a larger Health Development Agency funded case study project into health, gender (both men and women) and social capital.

Community Context

The community under study was synonymous with largely white working class estate (Moor Park) in Bolton, UK. The estate appeared in places to be pleasant and safe but was multiply disadvantaged. A recent local government report into the area (Bolton MBC, 1994) highlighted unemployment at approximately ten percent whilst half of households were on housing benefit. Accordingly, there were high proportions of low-income households, mostly located in council terraced housing, with a large percentage of single parent families. Crime rates were above average; especially break-ins, youth violence and drug related crime. A local park was the focus of activity for drug dealing and youth gangs and so was an unsuitable environment for young children. Litter and dog fouling were health and environmental problems both in the park and on the streets. The area had few recreational or shopping facilities and there were no local pubs on the estate nor were there designated venues for older people to meet.

In terms of health statistics, coronary heart disease and cerebrovascular diseases within the community stood at twenty-six and twenty-seven percent respectively (Bolton MBC, 1994). A health centre provided for many people living on the Moor Park estate. This offered a wide range of services including a community dentist, health visiting service and speech therapy. Lone doctors surgeries scattered around the perimeter of Moor Park supplied further health care provision. It was in this community context that the current research was conducted using a narrative approach.

Research Approach: A Narrative Perspective

The narrative approach (Crossley, 2000) is a useful tool for understanding personal and social phenomena from the specificity and the uniqueness within which people live their everyday lives (Josselson, 1996). In this way, a holistic approach is emphasised in which past, present and future are integrated in the way people make sense of their own lives, very much mirroring Bakan's (1996:5) conviction that "*The most significant truths about human beings*

inhere in the stories of their lives". Such accounts are not meant to represent the persons actual lived experience, rather they are co-constructions between researcher and researched, grounded in the complexities of remembering and story telling. In this sense, narratives are partial tellings reflecting the personal and social ambiguities of everyday life (Larson, 1997).

The data used for this chapter derives from a wider qualitative study of the relationship between social capital, health and gender. This study was funded by the Health Development Agency and was carried out in a socially deprived community in Bolton. This involved a multi-method case study approach in which local community men and women took part in in-depth semi-structured interviews and group discussions. Fifty-three people were recruited via social networking, snowballing and contacts through community links. The approach to recruitment was based on inclusiveness in order to access the voices of a diverse community population (see Sixsmith, Boneham and Goldring, 2003) and the British Psychology Society's ethical guidelines (1993, 1995) were observed.

The interviews lasted on average one and a half hours and encouraged participants to tell their own story about their life experiences embedded, as they were, within their own communities focusing on health experiences, family, friendships and community ties. Thus, the personal level of analysis (Murray, 2000) was prioritised here but understood within a social context. Interviews were tape recorded and transcribed.

The current chapter explores the narratives of 25 younger female participants aged between 19 and 38 years. Most were single parents of young children who were currently unemployed and had lived in this community all of their lives. The narrative approach shows how these women drew on interpretations of their past, present and future lives to negotiate their identities and construct themselves in order to present a continuous and coherent story of their lives. As Murray (2003) has suggested, the creation of selfhood derives from personal narration, co-constructed in our peopled world (see also Frank, 2000). The ways in which social capital features in these narratives highlights the social nature in which identity, health and gender is continually forged.

Narrative Themes

Gendered Health Identity: Women's Problems, Tiredness and Depression

The younger women recounted health stories in terms of their identity as women. For them, being women and experiencing 'women's problems' was an inevitable part of their lives, to be endured personally and shared in talk with other women. Despite some very difficult and painful health problems, the women accepted their condition as normal and thus symptoms were minimised. Helen's smear problems was described during interview in casual terms:

Int: So is there any other health problems that you have had sort of in the last couple of years?

Helen: Pretty healthy really. I have had like a few women's problems. I have had a bit of treatment up at the hospital - smear problems.

Int: Right.

Helen: I have had that sorted out.

Helen declined to dramatise this aspect of her health and, dismissing any calls on sympathy, was keen to place this in her past. In a similar way, women's frequent experiences of tiredness and depression was very much linked to being a woman with domestic tasks and roles of responsibility and caring for partners and young children. Being continually tired and lacking in energy was a typical part of the story of being a young woman living in this community. As Francis argued, feeling tired is an almost inevitable part of her life:

I'm being stupid, I should pull myself together. I've got four children to look after, I shouldn't feel like this (tired) but I do. Francis

In a similar vein, Stacy maintained that tiredness goes with the territory of being a woman:

'Cos I'm tired yo' know it is, I just can't be bothered ... you have to kick yourself up the backside and get on with it ... Stacy

Here, Stacy talked about the degree of self-reliance needed to get on with life and embrace the responsibilities for becoming a more active person. Such tiredness was often linked by the women to caring for children. In some cases this was described in terms of being depressed:

I find mine's [depression] a more of a winter one as well. Yo' know when you're locked in. You're a single parent and your curtains are closed after six o'clock, you don't see people after that 'till morning and you're stuck with a child.

Trish (focus group)

Women said they felt oppressed by the childcare demands placed upon them. Trish explained that the loneliness of single parenthood and feelings of depression closed in on her when confined to home. She had few opportunities to share her responsibilities and felt socially isolated, tired and depressed. In general, such accounts were often underpinned by expressions of inadequacy and guilt centred around social constructions of motherhood. These women visualized motherhood as a time of caring and sharing lively quality time with their children. However, there was a gap between such expectations and the realities of tiredness and depression, as explained by Stacy:

Stacy: ... and I just try and catch up during the day when I've taken the little 'un to school. From a mum's point of view I feel awful sometimes cos I can't do with Jesse what she wants me to do cos I'm tired.

Int: Yeah.

Stacy: And then I feel guilty.

These narratives of the acceptability and normality of 'women's problems', tiredness and depression are surprising given that the women interviewed were relatively young and might be expected to project a more positive view of their health status. Such narratives of normality centred upon the notion of womanhood as a site of health stresses and strains in a way which seemed to be embedded as part of the women's sense of identity. For them, experiencing 'women's problems', feeling tired and depressed was simply another expression of being a woman.

Gendered Health Identity: Women as Health Experts

One narrative which continually surfaced in the women's accounts was that of women as health experts. They saw themselves as the primary health carers in their own worlds and the GP service as aiding them in this job. In this, their role was a much more proactive one than that of the medical profession based on safety and security rather than a strictly medical approach. Julie, as did the other women, took full responsibility for her daughter's health and well-being at the expense of her own freedom:

I don't like leaving her crying an' all upset (*with other people*) so I'd just rather not go (*out*) ... I don't see why anyone else should 'ave to look after her when she's sick ... I just feel like it's my responsibility to look after her. I might be overprotective, I'd just rather know that she's safe with me. If anything would be to happen then I'd feel guilty so I've got me life back when she grows up. I'm only young so I can go out and do whatever I want when she's a bit older.

The women would look for signs of illness in their family or proactively control the environment to ensure their children's good health:

I don't like people smoking in front of me daughter cos I don't think it's healthy ... I don't like it when there's loads of people around her smoking and she's getting a cough. When people come here (*her home*) and they want to smoke they'll either go in the front garden or the back garden. Julie

Women felt empowered to diagnose their own and their family's symptoms:

I don't really need to (*use the doctors*), well in my opinion. I don't think we need owt like that at all ... em, well I can tell the feelings when you feel depressed. Mentally I know personally how that feels and I know how it feels when I feel OK, and I feel Ok. So at least I can see those warning signs

Diagnosis and first attempts at treatment would often be made by the women themselves, and in consultation with other female family members or friends. If all else failed, it was mainly the women of the family who would make the decision to visit the doctor, although most were not confident that the doctor listened to them or were skilled at diagnosis, as was expressed strongly in the focus group talk about the usefulness of visiting the doctor:

Joanne: Doctor doesn't listen.

All talking at once.

Trish: I never go searching for an answer anyway.

Ellen: Antibiotics, that's all they ever give.

Joanne: Antibiotics and a bit of Calpol and you'll be alright.

Laughter.

Trish: I don't often go and I don't go searching for answers cos I don't think they're giving them these days.

Throughout their lives, the women had experienced a great deal of contact with health services for normal health problems such as the 'flu' to backache, menstrual problems and contraceptive use. Moreover, they had dealt with health professionals as intermediaries for their families and friends. However, relationships with the GP were generally described as 'unequal' and patronizing. Women, with serious concerns over their own or their children's health were sent away from the surgery and told to stop worrying, portraying them as hypochondriacs at worst or overprotective and time wasters at best. Not surprisingly, some women were extremely negative about primary health care:

... the doctor is an idiot ...

Francis

Moreover, many of the women we spoke to were generally skeptical about the value of prescribed medicines. Indeed, most of the younger women who had been prescribed drugs from their doctors for mental health problems were not taking them. As Francis revealed:

Francis: ... he (the doctor) went, right I'm gonna give you my favourite anti-depressant. He give me these Prozac and he went out and then they sent me up to another Clinic ...

Int: What are you on now?

Francis: Colaboxatyne.

Int: And that works, does it?

Francis: I don't know, I don't take them.

Int: Why don't you take them?

Francis: Because I don't like them, because I'm frightened of them. I'm frightened of being a smackhead on tablets.

Int: Right, yeah, but are they addictive?

Francis: I don't know.

Int: Does no one tell you anything about them ?

Francis: No. I didn't get a leaflet or anything so I don't take them.

In the context of living in a community high in crime and drug related offenses, such concerns are to be taken seriously. Francis had seen the devastating effects of drug taking on others and was not willing to submit herself to similar dangers when taking drugs she knew little about, even if this was on doctors orders. Concerns over taking tablets, distrust in the doctors diagnosis or efficacy of the medications meant that the women rarely took prescribed medication. This was certainly the case for two women who had experienced side effects from taking medication and thus doubted not only the value of pills but also the expertise of the doctor.

Gendered Health Identity and Community Living

As indicated in the previous theme, women's conceptions of health were located firmly within their experience of everyday community living. In this context, women identified their own and others mental health as a highly problematic issue. Most described having experienced mental health problems ranging in severity from feeling down, to being stressed and suffering from depression. Depression was very visible within this community. Helen makes this point, but also evidences a less than sympathetic attitude towards depression sufferers, arguing that women should take responsibility for their own mental well-being despite difficult living conditions:

A lot of people look depressed ... 'God we wish something good would happen to us like'. Yeah, a lot of people are like that. I think it's the situation that they're living in. A lot of them, they just don't see no end to their problems and but I think what they don't realise is they've got to do it themselves. They can't expect anyone to do it for them. Helen

In their role as caretakers of family health, these young women were very aware of issues of community health and the unhealthy state of their own environment including the problems of drug taking, litter and fouling and public drinking.

Drugs: Women spoke of the drugs problem in their community from a social as well as personal perspective. They referred to health risks of drug abuse not just for drug addicts themselves, but for children living in the area. Women's concerns were related to their motherhood, their responsibility to care for their children by ensuring their safety in an environment of discarded needles and drug culture violence:

Sylvia: We have drugs on the street and we have a lot of violence through it but they tend to just congregate around a corner.

Joanne: It's life really, I'm used to it.

Trish: If it doesn't affect you or your child personally, you don't bother with it.

Int: Can you ignore it?

All: Yes.

Trish: As long as I feel I can educate my child against whatever then she can make her own mind up.

Lyn: As long as you can keep them away from certain things, then yeah.

In this sense these young women were protective of their families yet remarkably tolerant of the prevalent drug abusing culture around them.

Anti-social behaviour: One of the unpleasant community health issues reported was linked to anti-social behaviour including littering and fouling. Dog fouling was an endemic problem discussed at length amongst the women, however, one young woman recounted her story of human excreta found regularly on a footpath near her house. She had young children who used this footpath as a play area. This next quote is taken from the younger women's focus group:

Joanne: I get up near enough every morning and there is human pee and shit in my ginnel.

Outcry.

Joanne: Somebody pees and shits in my ginnel. I have to go out and clean it.

More outcry.

Lyn: How do you know it's human?

Joanne: You just know. Whoever it is, it's a fella cos they pee up the wall.

More outcries.

Rebecca: Can you not tell the difference between dog shit and human shit?

Joanne: Whoever it is it's a fella cos they pee up the wall. And I've rang the council up and they say, "Sorry, nowt to do with us, clean it up yourself".

Joanne voiced great concern for her children and the need to protect them from this health hazard. Joanne also expressed disgust that neither the council nor the community police would do anything to assist her to resolve the situation. The shared sympathies for her plight by the other mothers were apparent. No one however, was able to provide a solution to this particular problem.

Drinking: The women felt that excessive drinking was a health problem for their community. They suggested that women themselves could be main abusers here, but explained women's drinking habits in terms of socialization in a community with few outlets for women's social life. Discussion in the focus group centred around the lack of facilities for women and the problems of excessive drinking:

Rebecca: You go pub and have a drink.

Trish: But there's nothing else, we don't do nothing else, there's nothing else and I think it's a bit, you get to the point when you think, its alright but you want something different.

Int: And where do you go for this drink?

Trish: If it's a nice night, you're sat on the street.

Int: So your still at home, aren't you?

Trish: You're at home with your kids there, and then it looks as though, "Oh these mothers on their own Which we are, but it's the only opportunity we get to have a talk, a socialize. At the same time, the kids are on holiday so they're just like having a play ... but some complain though.

Joanne: You get some of them whingeing ... people who don't enjoy themselves or who're in a clique.

Ellen: Older people sometimes are a bit bitter.

Street socializing and drinking was a public activity where mothers met in the summer so children could play. The outdoors location help to offset feelings of loneliness and isolation but street drinking by women could be viewed as somewhat threatening to those who had been excluded such as older community residents.

Throughout the narratives, a strong sense of belonging to this community emerged. This notion of belonging helped to explain the women's tolerance of unhealthy living conditions, as long as their children were safe. Their own indulgence in street drinking was explained as an opportunity for socialising and relieving isolation, despite acknowledgment that this was criticized within the community.

Social Capital: Narratives of Support

Most of the women felt they had someone they could call on in ill health and stressful times. In this sense, the women lived in a community which felt rich in social capital. Their narratives of support suggested that they could call on their social networks in times of great need.

When my dad died, we (*the family*) stuck together. Michelle
It's being there for each other really isn't it (*friends*), when you're down. Michelle

Several women had either moved house to become neighbours with their friends or family, or their friends had moved into houses close by. As Sarah said:

Me and Rhea are very close cos we live next door to each other, we do a lot of things together ... (*We are*) more like friends rather than sisters, there's only 18 months between us and we've grown up with each other.

Sarah's sister supported her by jointly attending the antenatal clinic and by reassuring her and offering advice when Sarah felt unwell. Living close by accessible support was extremely important for the women interviewed in their attempts to negotiate health problems. For example, Francis suffered from long-term mental illness and moved next door to her closest friend. This proved to be of great benefit when Francis went into labour at home and her friend, Karen was there to assist:

She helped us, I mean, I had my youngest little girl, me baby, I had her at home. I mean, it were an accident, she caught her ... she's a friend. She was supposed to cook for my kids if I went in (*to hospital*) but she didn't get t' chance. Francis

However, support was not freely available and the women were keenly aware of how and when they could ask for help. They were reluctant to seek favours of other young women, knowing the pressures of single motherhood:

Sam wouldn't ask me to babysit for her, or Emma wouldn't or maybe only for half an hour if she had to nip somewhere but not all the time cos we think that you've got your own kid. You don't wanna be stuck babysitting for my kid too. Julie
Knowing who and what you could ask for was not just a matter of tacit knowledge, but a matter of prior discussion especially amongst single parents who could not easily draw on a partners support. Julie described her lack of contact with the father of her child and his reluctance to take responsibility for his daughter. However, she did need some respite from childcare but could not access this:

I'm rushing around trying to get the housework done, get her ready, give her a bath ... cos I'm on my own. An' if he just took her, say, on a Saturday say from 12 o'clock til about 3 o'clock ... just a little bit of a break ... But I won't take the responsibility for him not seeing her, that's his responsibility.

These young women had similarly pressurised lifestyles and shared common understandings of the difficulties of bringing up children in this community. Therefore they were not always able to access social capital for fear of burdening others already highly stressed. Despite the illusion of much support being available, only in the case of special friends or family were they able to effectively call on support networks in times of need.

Concluding Remarks

Whilst the richness of the data has indicated the importance of health narratives in women's lives, it must be acknowledged that these research findings are only twenty five women and cannot be representative of all single mothers. The age range is quite wide and more in depth studies of women close in age might be valuable to bring out differences in older and younger women. The narratives presented here are a co-construction between the researchers and the participants; hence the analysis and concluding remarks must be interpreted in this light (see Frank, 2002).

- 1) Despite the limitations above, the women's narratives were inspiring in terms of revealing the positivity with which they faced a harsh environment yet created a supportive space for themselves and their children.
- 2) There was a sense of empowerment in the narratives especially with respect to expertise in health. The women expressed a great deal of control over their own and their families' health. This allowed them to critique the existing medical knowledge.
- 3) It was surprising to reveal the extent of tiredness and depression amongst these young women which was accounted for in narratives of normality. This reflects Popay's work (1992: 108) where "chronic tiredness clearly (*was*) seen to be a consequence of the way their lives were organised". Hence tiredness was not something to be concerned about, just a natural part of being a woman.
- 4) Currently the dominant view of depression is of a mental disorder affecting individual women but this neglects to examine the lived experience of depression within the social and cultural context of women's lives

(Stoppard, 2000). The material circumstances of a woman's life, her efforts to cope with single motherhood within the context of loneliness and community decline must be considered. Indeed our women could not talk about feeling depressed without recourse to the detailing the circumstances of their lives.

- 5) Women appeared to live in a community high in social capital in the sense of extensive social networks with friends and family. However shared norms of personal responsibility for childcare and sensitivity to pressured lives of others inhibited their ability to access the benefits of social capital.

The research findings discussed in this chapter highlight the need to go beyond dominant biological and medical models of health in understanding the meaning of health for women. This narratives approach has indicated the ways in which health is very much tied into women's everyday community based lives and sense of identity. As Chambers (2003) has argued, "We need to engage with the woman's view of the world to really understand the ways she constructs her health". Consequently, it is important to listen to women's narratives rather than assume the prevailing negative stereotypes of powerless and dependent single mothers in society.

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