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"Hammered down on every side" versus "just being positive":

A critical discursive approach to health inequality.

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Abstract

Socio-economic and health inequality are strongly linked, and are increasingly perpetuated by discourses of individual responsibility. However, little research from a critical discursive perspective has addressed how people affected may themselves account for this relationship. This research examined the ways in which people who are in debt, unemployed, or in insecure, minimum-wage employment construct health and negotiate identities around it. Data from semi-structured interviews with six participants were analysed and three main interpretative repertoires were identified: a medical repertoire of health as a lack of illness; health as adopting the 'right' behaviours and attitudes; and health as being heavily influenced by external factors, such as income and life circumstances. The analysis focuses on how participants managed the tension between these latter two repertoires by adopting various subject positions around health: that it is 'slipping' away from them; that it requires motivation; and that it is unattainable. Underpinning this is a 'common-sense' idea of health as something that is worked towards through culturally approved actions and attitudes.

"Hammered down on every side" versus "just being positive":

A critical discursive approach to health inequality

There are rising levels of insecure employment, personal debt and people struggling to survive on a low income in Western economies. Income inequality is at its highest level in 50 years in OECD (Organisation for Economic Cooperation and Development) countries, with the richest 10 per cent earning nearly 10 times that of the poorest 10 per cent (Keeley, 2015). A large body of research has demonstrated a clear link between income inequality and poor mental and physical health (e.g. Wilkinson & Pickett, 2010). People from affluent backgrounds live longer than those from the poorest areas – for example, male residents of the City of London live an average of 83.4 years; whereas men in Blackpool in northern England live to 75.2 years, on average (Bennett et al., 2015). In the UK, which is the focus of the present study, increasing numbers of people are unable to afford basic provisions; in 2015-16, UK food banks gave out 1,109,309 emergency three-day food supplies (The Trussell Trust, 2016).

Although debt, unemployment, poverty and the societal conditions that give rise to them can be seen as major public health issues, they are often understood as being a problem at an individual level, perpetuated by discourses of irresponsible citizens spending more than they earn (Walker, 2012a, 2012b) or being too 'lazy' or lacking the right attitude to find and maintain work (Gibson, 2009, 2011; Harper 2003). An individualistic understanding of the causes of unemployment can increasingly be seen in social policy too. In the UK Government's 2015 budget, it was announced that 350 job centres would have access to Improving Access to

Psychological Therapies (IAPT) therapists by the end of the year, and that free online

cognitive behavioural therapy (CBT) courses would be made available to 40,000

Jobseekers' Allowance claimants (HM Treasury, 2015). Friedli and Stearn (2015)

suggest that such measures serve to promote a discourse of unemployment as both

personal failure and psychological flaw.

The 'individual responsibility' and 'incorrect attitude' discourses around

poverty, problem debt and unemployment are mirrored by the way health is

constructed in contemporary Western society, with health inequality often explained

in terms of people making poor lifestyle choices (Day, 2012). The reasons for these

'choices' are usually framed in terms of individual cognitions and behaviours, carrying

the implicit assumption that they can be 'worked on' and changed (Day, 2012; Rose,

1999). For example, the policy statement 'Healthy Lives, Healthy People' (HM

Government, 2010, p. 29) states, 'We all make personal choices about how we live

and behave: what to eat, what to drink and how active to be.' It goes on to suggest

three main actions to improve health and wellbeing: strengthening self-esteem and

personal responsibility; promoting healthier behaviours and lifestyles, and amending

the environment to make these healthy choices easier. The understanding of 'the

environment' here is worth noting. Day (2012) argues that, while the importance of

social environment is acknowledged in mainstream health psychology and the

policies it informs, it is usually talked about as a variable that is separate from, and

often secondary to, individual cognition. Furthermore, it is conceptualised mainly in

terms of immediate surroundings such as family or neighbourhood, rather than wider

social, economic and political structures.

Various authors (e.g. Stainton-Rogers, 2012; Wilkinson & Pickett, 2010)

argue that the predominant social cognition approach to health promotion, which

focuses on decontextualised health-related behaviours and attitudes, is ineffective, and can serve to obscure structural reasons behind the disparity in health behaviours and outcomes. As Day (2012) points out, such approaches are usually framed around 'health related perceptions' or 'health locus of control' beliefs and thus tend to conclude that people from poorer socio-economic backgrounds hold beliefs that result in them making less effort, such as that health is mostly influenced by social factors rather than individual ones. The implication here is that such beliefs are wrong and need to be changed.

However, it is necessary to look at the wider social landscape in which such behaviours take place. A discursive approach is ideally situated to do this as it provides a contrasting view of the psychological subject. Instead of theorising people as rational actors who use language neutrally to reflect individual, internal cognitions, emotions and behaviours, it treats attitudes and behaviours as socially constructed, fluid and context-dependent. As Edwards and Potter (1992) point out, language is fundamentally a practical activity that is both public and private, individual and social at the same time. As we construct our world through language, we simultaneously construct ourselves and, as our arguments are shaped by the material conditions of our lives and personal histories as well as wider societal influences, this approach allows for a rich exploration that can also incorporate other complex factors such as class, gender, culture and ethnicity.

A discursive approach also offers a different way of understanding the contradictions and inconsistencies that are fundamental to human thinking. Edelman's (1977) influential work on poverty and welfare identified conflicting explanations of poverty that are often used simultaneously: the individualistic idea that the poor themselves are to blame, involving themes of irresponsibility and weakness of

character, versus the social explanation which understands poverty as the result of an unequal society. These findings were echoed in Gibson's (2009, 2011) analyses of talk about unemployment, which found a common-sense understanding of the right to welfare as dependent on certain individual characteristics, such as making an effort. This draws on the suggestion by Rose (1999), that in neoliberal society, citizenship is based on the condition of proper self-governance, and where this is seen to fail, strategies to rectify individuals' supposed psychological failings are to be implemented. Neoliberalism here is defined as a political philosophy that applies the logic of market forces and values to businesses, organisations and people, who must work to maximise their own advantage through techniques of self-care (Rose, 1996).

Similar discourses of individual responsibility and conditional citizenship increasingly seem to circulate around mental and physical health. McDonald et al. (2007) argue that being a 'good' citizen and resisting marginalisation is increasingly defined as making the right health choices, or adopting the approved 'technologies of self', a term Foucault (1988) used to describe the behaviours and attitudes that are currently privileged and promoted by dominant institutional discourses. Radley and Billig (1996) suggest that health is best understood as an account given to others, arguing that through such accounts we can see how someone positions themselves in their social world, as well as how they articulate that world, in which they and their health behaviours will be judged. Accounts of health are therefore necessarily ideological as they involve evaluations of what constitutes a 'healthy life'.

For example, Tischner and Malson's (2012) investigation of how overweight women made sense of 'being large' found that participants worked to demonstrate 'good neoliberal citizenship' (p. 58) by constructing 'health' as a holistic state of wellbeing, rather than something that can be measured by body size. Here we can see

how people grapple with the binary dichotomies that emerge in discourse: fat/unhealthy versus slim/healthy, which mirrors the 'responsible citizen' versus 'incapable/failing' discourses found in literature on poverty and health.

However, as Billig et al. (1988) emphasise, people are not ideological dupes, but are able to wrestle with the dilemmas conferred by competing ideologies. Discourses, then, can also be potential sites for argument, resistance and alternative conceptions of 'reality'. This is indicated in Woolhouse, Day, Rickett and Milnes' (2012) study of working-class girls from northern England, who treated talk about dieting as 'girly-girl' and posh, which, the authors argue, is a form of social protest against a middle-class, normative femininity.

Despite the large body of research that has established the link between poverty, marginalised social status and ill health, little research has been done that takes a bottom-up approach to these issues by talking to people who identify as living in straitened circumstances. Similarly, while there has been some discursive work on welfare, 'responsible' citizenship and how people account for their health in relation to society, there has been little academic work that looks at these together. The present study aimed to investigate how people with a marginalised socio-economic status, either due to unemployment, problem debt and/or poorly paid, insecure employment account for their health, and what kind of identities they construct around it. By examining the different ways health and poverty are talked about we can start to understand the limitations in how people can construct themselves and others (Edley, 2001). This, in turn, can help to highlight the prevailing inequalities in society and the constantly shifting power relations between those positioned as 'lacking' and those who are 'responsible individuals'.

Method

Participants

The six participants were either current or former clients of food banks, job clubs or Christians Against Poverty initiatives run by church organisations in two cities in Yorkshire, northern England. Pseudonyms are used throughout. Denise, 59, and Dave, 58, were in part-time paid work, earning minimum wage; Sarah, 45, was a single mother of five living on child and housing benefits; Matthew, 52, and Adam, 43, were receiving Jobseeker's Allowance, having lost their jobs in the past year; and Grant, 38, received Employment and Support Allowance for what he described as long-term mental health problems. Data collection in a discursive approach is not for the purpose of creating data that are statistically generalisable or representative of a population (Potter & Wetherell, 1987), but to look at how people rhetorically manage a given social interaction. Therefore, it is proposed that six participants is enough to investigate the various discursive practices used to construct their identity in regards to health and socio-economic status, especially given the specificity of the sample being composed of people who have approached debt- and poverty-relief organisations.

Procedure

Participants were recruited through two organisations established to help people in financial difficulties. After the study had received approval from the university ethics committee, potential participants were approached with information about the research and were asked if they would like to take part. Six volunteered and

an interview date was set for each. Prior to the interviews, participants were invited to

ask questions and were given written information about their rights to confidentiality,

anonymity and ability to withdraw from the study for up to four weeks after the

interviews took place. Informed written consent was given by all participants.

Participants were interviewed face-to-face once, and interviews lasted between 31 and

76 minutes. The interviews were semi-structured and were audio-recorded and

transcribed for content and basic interactional features. The transcription conventions

can be found in Appendix A.

Approach to analysis

A critical discursive social psychology approach was adopted (Wetherell,

1998). This is based on the epistemological position of social constructionism, which

sees psychological constructs such as personality, attitudes and beliefs as social

categories that are constructed and negotiated through talk and text, rather than

descriptors of objectively observable or internally felt states (Potter & Wetherell,

1987; Wiggins & Potter, 2008). As people both actively create meaning through their

talk, and are passively constructed and regulated by socially available 'ways of being'

(Foucault, 1972), language is both constructive and constructed. The present study,

then, took the approach suggested by Wetherell (1998), of looking at both discursive

practices (*how* language is used to accomplish things such as blaming, justifying and

accounting, and to what ends) and discursive resources (*what* kinds of subject

positions are available to articulate matters of self, identity, class and biography).

The data were coded using the software package Quirkos into categories that

were relevant to the research questions, so all references to health, diet, exercise, debt,

poverty and socioeconomic status, however vague, were selected. However, as the

objects of interest were not always clear until some theoretical interpretation had taken place, coding was revisited during analysis (Edley 2001; Potter & Wetherell, 1987). Consistencies in the way participants constructed particular topics were identified, as well as variability in accounts, as what people say about a particular issue varies from context to context, as well as from person to person (Edwards & Potter, 1992). This allowed for the identification of interpretative repertoires, which are 'common-sense' ways of constructing the world, made up of culturally shared ideas, metaphors and evaluations (Potter & Wetherell, 1987; Seymour Smith, 2015). There are usually many available repertoires, which shift over time and context, and which can be drawn on in different ways to do different things (Edley, 2001). Some repertoires are more readily available than others, highlighting that certain ways of seeing the world are more culturally dominant at any one time (Wetherell & Edley, 2014). As people speak they also draw on interpretative repertoires to form subject positions – temporary identities from which they can carry out discursive actions such as blaming, accounting for, justifying or resisting. As interpretative repertoires and their associated subject positions can be contradictory, speakers are often presented with ideological dilemmas as they construct their identities (Billig et al., 1988). The patterns of accounting that participants use to manage these dilemmas is of interest both in terms of what rhetorical purposes they serve in the context of the research interview, and what they can bring to light about the broader cultural significance of discourse and how ideologies have shifted over time (Billig et al., 1988; Edley, 2001; Wiggins & Potter, 2008).

In terms of the local context, it is important to note that, as the data used for analysis were generated through semi-structured interviews, they exhibit various features that distinguish them from discourse that would be found in more

'naturalistic' settings (Seymour-Smith, 2015). For example, the 'flooding' (Potter & Hepburn, 2005) of the dialogues with the researcher's concerns (e.g. the prompts to discuss 'health') means that the accounts analysed here are unlikely to reflect the structure of accounts that may be found in other contexts and, as such, our analysis treats the accounts as co-constructions between the participants and researcher.

The analysis also attended to the role of the interview process in the production of data, and as such it is worth noting that the analysis focuses largely on discourse used by participants in response to three main questions:

1. 'What is good health to you?'

2. 'Do you see your financial/socio-economic status as affecting your health, and if so how?'

3. Do you think your health could be improved, and if so, how?

However, it is worth noting that this should not be taken to suggest that these specific questions were deterministic of participant responses. These questions may occasion the use of particular repertoires, or the adoption of particular subject positions, but the repertoires and subject positions themselves draw on wider cultural resources. This position thus draws on Wetherell's (2003, p. 13) argument that although '[t]he interview is a highly specific social production, … it also draws on routine and highly consensual (cultural/normative) resources that carry beyond the immediate local context, connecting local talk with discursive history'.

Analysis

Participants drew on three main interpretative repertoires to talk about health.

First, health was occasionally constructed in straightforward medical terms as the absence of illness. Far more dominant, however, was a repertoire of health as adopting the 'right' behaviours and attitudes. All participants oriented to this idea, by mentioning things they did or felt they should do, such as exercising, eating vegetables and not smoking. With one exception this was the first repertoire of health drawn on in response to the question 'what is good health to you?' Most participants' talk also worked to extend these obligatory behaviours into the realm of the psychological, with constructs such as 'motivation', 'worth' and 'positivity' being invoked as necessary to performing health. A third account of health as something strongly affected by circumstances, life events and relationships was also commonly used, and was heavily interlinked with how participants talked about their socio-economic status. The bulk of the analysis focuses on how participants managed the tensions between these latter two repertoires, examining the subject positions they adopted to negotiate the ideological dilemma of health being both individual and social.

Health as lack of illness

Straightforward understandings of health as the absence of illness were apparent on occasion. In extract 1, Clare, a 45-year-old unemployed single mother in receipt of welfare benefits, draws on a medical repertoire when asked if she felt her health could be better:

Extract 1

```
1    Emma:      Do you feel like you would want to improve

2               your health at all?
```

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3      Clare:      Erm (1) I don't class myself as being ill and

4                  un- unhealthy especially, so I'd probably say

5                  no to that 'cos (.) I don't class any of us, I

6                  don't think we have any issues as a family
```

Here, Clare constructs health as a lack of illness, thus adopting a subject position of 'healthy'. This can be understood as being tied to the immediate context of the interview – when asked directly if she could improve her health she immediately worked to resist a deficit or 'failed individual' identity by stating that she had no 'issues' (line 6), which allowed her to answer 'no' (line 5) to the suggestion that she could improve her health. It is notable that Clare not only responds on behalf of herself, but also for her family (lines 5-6). This works to position her as a good, responsible mother who is able to meet her obligations to her children by ensuring they are healthy. However, it is also worth noting Clare's use of the modifiers 'especially', 'probably' (line 4) and 'I don't think' (line 5-6). These work to present her as not overly defensive or resistant to the idea that there may be 'health-related issues'. Indeed, Clare constructed health quite differently at other points in the interview (see extract 2).

Health as adopting the right behaviours and attitudes vs health as socially situated

When asked what good health means to them, all participants oriented to a broadly individualistic repertoire of health by mentioning the normative ideals of eating nutritiously, exercising, not smoking and cultivating the 'right' attitudes and

emotions. However they all also drew on a social repertoire of health as something that was to some degree beyond individual control, and strongly linked to socio-economic status or life circumstances. The participants adopted various subject positions to negotiate the tension between these two contrasting accounts: that health is 'slipping', that health requires motivation, and that health is unattainable, which we examine in turn.

A 'slipping' healthy identity

In extract 2, Clare draws on both individual and social repertoires of health to explain her current situation:

Extract 2

```
1    Emma:      What, what does, like, being healthy mean

2               to you, and what do you think (1) being

3               healthy is?

4    Clare:     Well, good health, I suppose it means (3) the

5               finances to eat (.) a good, balanced diet (1)

6               to be able to exercise, to be able to go out

7               and do things, although things to me are (.)

8               just part of the big umbrella of (.) good

9               health (1) for me it's (1) general (1)

10   Emma:      And do you feel like at the moment you have

11              the (.) opportunity-

12   Clare:     I can- it's slipping because (.) we're getting

13              to the point that more with (.) food shopping

14              is becoming harder and harder. Like, for
```

```
15              example, a bag of apples, for five apples is

16              three pounds, you can get a packet of biscuits

17              for fifty pence (.) and they're going to get

18              at least two biscuits from that packet but one

19              apple (1) isn't going to do the job sometimes.
```

Here, we can see Clare use the mainstream construction of health as the

adoption of culturally approved behaviours, suggesting that a broadly consumerist and

individualistic conception of health is readily available to participants, particularly

when negotiating their identities around health. For example, in lines 5 and 6 Clare's

references to exercise and 'a good, balanced diet' position her as health literate, and

by using the phrase 'to be able to' (line 6) she invokes the idea of a proactive

consumer who can choose the services and goods needed to attain 'good health', thus

maintaining the social norm of self-reliance (Tischner & Malson, 2012). However, in

line 5 Clare explicitly links being able to eat healthily with finances; and her use of

'to be able to' also works to reference socio-economic position: it implicitly carries

with it the contrasting position of *not* being able to. The terms 'big umbrella' and

'general' in lines 8 and 9 also invoke the current understanding of health as broad and

holistic, encompassing many areas of life. Clare's inclusion of the ability to 'go out

and do things' (lines 6-7) as a facet of this broad definition of health hints at choices

and freedoms that are unavailable to her, potentially impeding her from fully

inhabiting the identity of 'healthy individual'. Instead her talk centres on the health-

related choices she *is* able to make: food shopping, which she talks about as

'becoming harder'. She goes on to account for any potential failure to achieve a

healthy status by constructing a narrative where her 'good' intentions are thwarted by

environmental constraints. She achieves this by using a rhetorical device that was also

adopted by other participants, of using the logical argument of comparing the higher cost of 'healthy' foods to the lower price of 'unhealthy' ones in lines 14-17. By doing so, she works to maintain the position of 'responsible individual' in terms of her socio-economic position – she is spending within her means; and in terms of parenting – whereas apples won't 'do the job' (line 19) of keeping her children sated, biscuits will. Clare therefore rhetorically defends herself against any attributions of blame by talking about what could otherwise be construed as a personal shopping choice in terms of rationality, and therefore as being based on something external to her (Edwards & Potter, 1992). However, by doing so, Clare's positive positioning within the 'health as the 'right' behaviours' repertoire is threatened. This is indicated in her use of the metaphor 'slipping' in line 12, which suggests a precariousness in being able to maintain the position of 'health-seeking consumer'. This reflects Tischner and Malson's (2012) findings that 'neoliberal healthism' (p. 57) has become the norm, being spoken of as something that is hard to achieve, taking effort and resources, and which can therefore only be 'done' properly from a position of relative privilege.

Health as maintaining motivation

In participants' talk, demonstrating the 'right' behaviours also extended to cultivating particular attitudes and emotions. 'Motivation' was frequently drawn on to account for a direct link between participants' socio-economic status and their positioning around health. For example, in extract 3, Matthew, 52, who had been made redundant five months before the interview, is talking about his experiences of unemployment:

    Extract 2

```
1    Emma:      And do you feel your health has been affected

2               by your change in circumstances?

3    Matthew:   (4) Ye:es (.) um (2) I think since being

4               unemployed (3) um, obviously my confidence has

5               taken a knock and because of that (.) hh it's

6               a bit of a spiral thing, I've then felt less

7               motivated and less inclined to exercise and

8               eat (.) nutritiously and then clearly finance

9               comes into it because (1) you know, your five

10              a day, your guidelines involve effort and (1)

11              again I'm being a little bit generic but fresh

12              food tends to be more expensive
```

Here, Matthew situates himself within the 'health as the 'right' behaviours' repertoire, referencing exercise and eating nutritiously (lines 7-8), but like Clare, this presents him with a struggle to achieve a positive health positioning. He defends against potential accusations that he is not acting in the 'right' way not just by referencing finances, but by using the psychological terms of 'confidence', 'motivation' and 'inclination' (lines 4 & 7) to explain his difficulty in properly accessing the 'healthy, responsible individual' role. The account of health he constructs sees physical health and mental health as strongly interlinked, and his use of the metaphors 'taken a knock' (line 5) and 'a bit of a spiral' (line 6) allude to the Western understanding of depression as being down or low – a position from which it is harder to make the physical and psychological 'effort' (line 10) mandated by the individualising repertoire of health. Matthew, then, hints at struggles with mental health, using the less stigmatised notion of 'confidence' to account for how his

unemployed status has caused not just financial, but psychological difficulties. In line 4, his use of 'obviously' works to construct this link as common-sense, helping him manage his accountability by alluding to the 'known fact' that unemployment is related to depression.

 Similarly, Grant, 38, who claims Employment and Support Allowance and volunteers at a community centre, directly linked health to motivation, answering the question of 'What does being healthy mean to you?' by saying 'Being healthy, it's, like, keeping yourself motivated'. In extract 4, Grant is responding to a subsequent enquiry about where he thinks this motivation comes from:

 Extract 4

```
1     Grant:      So yeah, motivation, it's like, you know
2                 (1) it's like, if, you know, even though your
3                 body's not wanting to do something, you know,
4                 your mind, it's like, telling you to do, to do
5                 it, you know what I mean? So yeah (.) it's
6                 just about forcing- making yourself do things
7                 you don't want to do, sort of thing …
8     Emma:       And is there anything else related to health
9                 that you think (2) is something that you don't
10                want to do?
11    Grant:      Er (1) no, no I don't think so no (.) I don't
12                know really, it's just being positive isn't it?
13                (1) you know, it's like, setting yourself,
14                like (2) tasks… I do feel like motivation is a
15                big thing of being healthy (1) because you're
16                constantly on the move, obviously (.) you're
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17           constantly doing things, you're keeping

18           yourself fit where, you know, when you're sat

19           at home lounging around day in, day out (.)

20           and I did experience that, and (.) just doing

21           nothing at all, you know, you just (1) it's no

22           life.
```

In extract 4, Grant positions himself as healthy and active with an account that contrasts his current experience of voluntary work with his former experience of 'lounging around' (line 19), drawing on a discursive resource of 'effortfulness' (Gibson, 2009, 2011). He uses extreme case formulations of 'constantly doing things' (line 17) versus doing 'nothing at all' (line 21) to make his account more effective (Edwards & Potter, 1992), and he takes a moral stance with his evaluation that not to be busy is 'no life' (lines 21-22). Although at other times in the interview Grant mentioned his difficulties growing up in foster care and longstanding mental health problems, he plays down the significance of his experience here, saying 'it's just being positive isn't it?' (line 13) when talking about health. The use of 'just' serves to simplify the complex determinants of health, reflecting Grant's uptake of the increasingly common idea that all you need to be healthy and happy is the 'right' attitude: positivity. By drawing on this individualising repertoire, and using the psychological construct of 'motivation' Grant constructs health as happening predominantly at a mental level, and is therefore able to position himself as responsible, explaining how, despite his lack of finances, he is still able to undertake healthy behaviours like 'keeping fit' (lines 17-18). By referring to 'forcing- making' himself do things (line 6), however, Grant demonstrates that adopting this upbeat mindset is not easy. Likewise, his construction of 'motivation' in lines 3-4 draws on a

common-sense understanding of mind-body dualism, with 'your body not wanting to do something' but 'your mind telling you to do it'. This metaphor of two competing systems suggests an ideological hierarchy when it comes to health, with 'the mind' in the top spot, controlling the body, with the implication that, left to its own devices, the body may work *against* health.

Health as unattainable

In extract 5, Denise, 59, a carer in minimum-wage, insecure employment constructed health as currently unachievable for her, citing her circumstances as the reason:

Extract 5

```
1    Emma:      In terms of health, where would you like to
2               go?

3    Denise:    Well I'd like to be a lot healthier physically
4               (1) erm, but it's like, you know when you've
5               been really (1) hammered down on every side
6               (.) by your circumstances (.) you can't deal
7               with everything at the same time (.) it's a
8               journey, step by step, day by day (.) erm (2)
9               and I can only process so much of (1) what's
10              going on (2) at a time (.) but I'm, I'm hoping
11              to become (.) smoke free (.) and (.) fitter.
```

Here, Denise constructs health as being important to her with her statement that she'd like to be 'a lot healthier physically' in line 3. However, although she talks about health in terms of adopting the 'right' behaviours of exercising and becoming

'smoke free' (line 11), she positions herself as having less control over this than she'd like. This is accomplished in lines 4-5 with the vivid analogy of being 'hammered down on every side', which works to position her as passive and at the mercy of 'circumstances'. Her use of the generalised *you* (line 4: 'you know when you've been...') works to introduce normativity and consensus to her talk (Edwards & Potter, 1992). This constructs the impact of adverse circumstances as common knowledge, and treats their status as preventing physical health not just in personal terms but as something that would affect anyone in the same way (Edwards & Mercer, 1987).

Even though the dominant repertoire here is of health being strongly affected by social environment, Denise still orients to normalised ideas of self-help and individual responsibility with her use of the phrase 'deal with everything' (lines 6-7), which invokes individual agency. Denise works to negotiate this contradiction between individual and social repertoires of health by talking about 'processing' in line 9 – by doing so, she draws on a common-sense understanding of psychological processes based on a lay social cognition model: that if something requires 'effort' only so much can be done at any one time. Denise's evaluation of health, in this account, is that it is difficult, involving higher cognitive capacities, to be worked on and 'achieved' when other, more pressing concerns such as work and financial worries are 'dealt with', and she therefore adopts a 'deficit' identity around health – as someone who is not in a position to properly pursue it.

Discussion

The present research looked at how a sample of people living with unemployment, debt or low-paid, insecure work talked about health. While health was occasionally constructed in medicalised terms as a lack of disease, this tended to serve a specific purpose within the context of the research interview: to counter or reject a deficit position of being unhealthy. Instead, health was talked about as complex and holistic, involving mental, emotional and social elements, as found by Tischner and Malson (2012). The interpretative repertoire of health as adopting the right behaviours and attitudes was drawn on frequently, with participants reinforcing a broadly individualist, consumerist construction of health by positioning themselves as responsible, effortful citizens who worked to adopt culturally approved 'healthy' behaviours and attitudes.

Participants also talked about health as strongly affected by life circumstances and therefore as socially situated, but when participants located the main source of ill health as outside themselves, they were vulnerable to positioning in terms of 'failed individuals' due to a perceived lack of agency to change their identities around health. To counter the blame attached to such a position and manage the dilemma of health being a matter of individual agency *and* affected by social factors, participants spoke variously about health as 'slipping' despite their best efforts; health as predicated on levels of 'motivation'; and health as being currently unachievable.

Of particular interest was the frequency with which psychological states, such as 'motivation' and 'positivity' were used to account for both an ability to achieve the status of 'healthy, responsible individual' and for perceived failures to do so. They also served as accounts for how work and socio-economic status affected health, with participants reproducing the culturally dominant idea that to demonstrate 'good, neoliberal citizenship' you must be working, effortful and an autonomous, self-

regulating individual. This 'self-regulation' was often constructed in terms of health as being difficult and requiring 'higher' cognitive processing. As Foucault (1988) argued, such discourse serves to individualise and to reinforce power structures by constraining the understanding of health in any other terms. For example, the possibility of understanding socio-economic position and health as socially produced is minimised, and the idea that growing social injustice is at the root of unemployment, poverty and health inequality is therefore obscured.

These patterns of accounting are of interest both in terms of what rhetorical purposes they were used for in the context of the research interview, and what they can bring to light about the broader cultural significance of discourse about health, and how ideologies have shifted over time (Billig et al., 1988; Edley, 2001). While it is important to acknowledge that these data should be understood in the context of an interview in which the researcher's concerns of talking about health and poverty are foregrounded, following Wetherell (2003), it is suggested that such a context is insufficient to explain the content of the accounts. Clearly, repertoires of individuality and social context can be (and have been) identified in different settings, in relation to different substantive topics, and what is interesting about the present data is the extent to which these tried-and-tested ideological explanations can be seen to be drawn on and wrestled with in regards to the relationship between health, employment and economic position.

Stainton-Rogers (2012), among others, has argued that the current public health approach of exhorting people to adopt healthy eating and exercise behaviours is problematic and potentially even counterproductive. While we should be cautious of generalising from the present study, the analysis nevertheless indicates the importance of challenging wider structural inequalities, as well as the language of

individual responsibility that underlies health advice, creating narratives of blame around those who fail to 'achieve' it and therefore further difficulties for people living in poverty.

It is hoped that, by drawing attention to how health is increasingly constructed in terms of exclusivity and difficulty, requiring resources, cognitive processing and a particular 'mindset', this research can point to changes in the way health initiatives work to construct health, to ensure that discourses of agency are not emphasised to the point where they override social and economic concerns. Future research could expand on this by looking at the way the 'self' is constructed in everyday talk – particularly the growing focus, informed by positive psychology, on cultivating particular mental states, attitudes and emotions. As numerous authors have pointed out (e.g. Wetherell, 2012), researching emotions is not about simply describing, explaining or measuring them, but looking at what they do. One area of future investigation, then, could look at how emotional language works to establish cultural behavioural norms and ideologies of participation and membership, particularly in the crucial areas of health, mental health and work.

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Appendix A

Transcription Conventions (adapted from Hutchby & Wooffitt, 1998, pp. vi-vii)

(.)   A dot enclosed in parentheses indicates a pause in the talk of less than two-tenths of a second.

(1)   The number in parentheses indicates a time gap to the nearest second.

hh   An 'h' indicates an out-breath. The more h's, the longer the breath.

-     A dash indicates the sharp cut-off of the prior word or sound.

<u>one</u>   An underlined fragment indicates speaker emphasis.

:   Colons indicate that the speaker has stretched the preceding sound. The more colons the longer the sound.