Young People's Health Beliefs and Behaviours: Power, Performance and Spatialities

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Abstract

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Sitting at the intersection between Health Geography and Children's Geographies, this thesis explores the ways in which young people's health beliefs and behaviours are constructed, mediated and performed. Concomitantly, the thesis connects with interdisciplinary work relating to young people and health. Using a mixed methods approach, and drawing on the aims and values of participatory research, the empirical focus of the thesis is the Wear Valley area of County Durham, North East England.

Unlike much of the existing work in Health Geography and Children's Geographies, this thesis both makes explicit its understanding of space and scale and draws upon some of the recent reworkings of these concepts which view them in a fluid and abstract manner instead of a hierarchical, absolute or relative one. Space and scale are viewed as being produced and yet are also regarded as continually under construction and (re)formation; they are fluid and involve plurality, multiplicity and juxtaposition and thus cannot be reduced to simple networks or hierarchies. In addition, this thesis draws on the work of Goffman, Foucault and Judith Butler, both in the development of its theoretical framework and in its discussion of the sculpting and performance of young people's health beliefs and behaviours. Drawing on these theorists, particular attention is given to issues of power, discipline, performance and identity. Building on these discussions, the thesis will consider the ways in which global trends, globalisation and local culture intertwine in the sculpting and performance of young people's health beliefs through discussions of the media and technology, food, and understandings of the countryside and health. Issues of power, discourse, performance and identity will also be discussed in relation to young people's beliefs about, and experiences of, the countryside and the pervasive but problematic notion of the 'rural idyll' will be contested.

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List of Abbreviations

AONB	Area of Outstanding Natural Beauty
ECM	Every Child Matters
ESRC	Economic and Social Research Council
GCSE	General Certificate of Secondary Education
GIS	Geographic Information System
GP	General Practitioner (a non-hospital based medical doctor)
IMD	Index of Multiple Deprivation
LEA	Local Education Authority
NHS	National Health Service
NS-SEC	National Statistics Socio-economic Classification
Ofsted	Office for Standards in Education
ONS	Office for National Statistics
PAR	Participatory Action Research
PCT	Primary Care Trust
PSHE	Personal, Social and Health Education
SOA	Super Output Area
TV	Television
UK	United Kingdom of Great Britain and Northern Ireland
UNESCO	United Nations Educational, Scientific and Cultural Organization [sic]
USA	United States of America
WHO	World Health Organisation

Declaration

This thesis is the result of my own work and the material included has not previously been submitted for a degree at this or any other university.

The thesis does not exceed 100,000 words in length.

Statement of Copyright

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This thesis and the associated research could not have been completed without the involvement and support of many other people; both those receiving specific mention here and those who are being left anonymous but whose input has been greatly appreciated. I would firstly like to thank all the schools, young people and teachers whose contributions made the research possible, and I hope that I have done justice to your views, feelings and concerns. I also need to thank the ESRC for the provision of financial support under their +3 competition studentship scheme (award number PTA-030-2005-00952), without which this PhD would not have been possible.

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Chapter 1 Introduction

1.1 Introduction

With a specific focus on the Wear Valley area of County Durham, North East England, this thesis will explore the health beliefs, attitudes and behaviours which were articulated and performed by young people of secondary school age, and the influence of place, socio-economic environment and culture upon these. This thesis sits at the intersection between Health Geography and Children's Geographies, and also draws on debates from Social Geography, Cultural Geography and Rural Geography. At the same time, it also connects both with interdisciplinary work relating to young people and health and with aspects of health education and policy.

This chapter aims to set out the aims of this thesis and the key issues under discussion. I will begin by briefly situating this thesis in relation to existing work in Children's Geographies and Health Geography, before outlining the research aims and questions in Section 1.2. Section 1.3 will offer a brief introduction to the study with regard to the study area and methodology. There are a number of key issues and themes which cut across the different sections and chapters of this thesis, and these will be highlighted in Section 1.4. Finally, the last section of this chapter will offer a brief outline of the structure of the subsequent chapters in this thesis.

Geographical research involving children has traditionally been viewed as a small backwater of the discipline and, despite a recent proliferation of interest in this area (Aitken 2004), there is considerable scope for new research. Within Human Geography, research involving young people has tended to focus on either the construction of identities and stereotypes (e.g. Aitken 2001) or geographies of fear and crime and the use of public space (Nayak 2003d). There has also been interest in connections between place, space and social exclusion and the interplay between these and stereotypes, identities, fear and crime. Apart from Goodwin and Armstrong-Esther's (2004) discussion of young people's health in rural Wales, young people's health has been virtually absent in geographers' work. Furthermore, work with children and younger youth has been emphasised and, although highlighted by Matthews and Limb (1999), work with older youth is still lacking (Valentine 2003). As in other social science disciplines, an emphasis on deviance has resulted in the neglect of elite youth cultures and those who conform to social expectations (Valentine et al. 1998).

Health geographers, meanwhile, have given considerable attention to interactions between place, space, culture and the socio-economic determinants of health, particularly in relation to inequalities in health and health care. However, such

work (e.g. Curtis et al. 2004b; Popay et al. 2003) has generally focused on either adults or early childhood. Yet, other disciplines have shown increasing awareness of the transitory position and liminality of youth, recognising that their needs differ from those of both children and adults, requiring different policies and approaches to welfare and health promotion (Clarke 2001; e.g. Coles 2000). Despite such recognition, there has been a lack of consultation with young people in the formulation of health promotion strategies and policy. Building on the work of Gesler (1992) there has been increasing interest in therapeutic landscapes within Health Geography (e.g. Curtis 2004) alongside theorising in Cultural Geography about landscapes of despair (Dear and Wolch 1987) and symbolic landscapes (Cosgrove 1984). However, there has been little discussion of the bearing of these theories on the construction of (un)healthy places. Furthermore, rural areas have frequently been represented as idyllic, tranquil and therapeutic environments, and there has thus been a conflation of 'rurality' with 'health' which has obscured problems such as rural deprivation and inequality.

Outside of Health Geography, the four seminal studies about lay perceptions of health focused on adults or older people (Blaxter and Paterson 1982; Calnan 1987; Herzlich 1973; Williams 1983) and highlighted four main ways of conceptualising health. Firstly, health as the absence of illness or disease; secondly, health as physical strength, stamina or fitness; thirdly, health as an inner strength or capacity to cope with demands of life; and, fourthly, health as an aspect of character, influenced by traits such as temperament, constitution, willpower and self-discipline. More recent work has highlighted perceived differences between lay and professional understandings of health and the importance of considering lay views in research and policy (Prior 2003; Shaw 2002). In addition, work has been emerging in relation to lay beliefs about health risks including major health conditions (Smith et al. 1999), air pollution (Howel et al. 2002) and food risks (Lupton 2005). Whilst there has been a significant amount of work on risk perception, some relating to young people (Benthin et al. 2000; Cohn et al. 1995; Slovic 2000), much of this has focused on psychological and cognitive aspects rather than exploring beliefs and understandings. The main exceptions are France (2000) who explores social aspects of risk-taking among young people and Sigelman et al (2000) and Roy (2005) who discuss beliefs about alcohol and drug use. With the exception of Bush et al (2001), little attempt has been made to explore the interplay between issues of stigma and perceptions of risks to health, and this work did not discuss young people.

One of the key rationales for this study was to help develop a more nuanced understanding of young people's health beliefs and behaviours and the ways in which these are constructed, mediated and performed. In addition, this thesis speaks into a number of gaps in existing research and draws together issues and ideas which have

tended to be discussed in separation from each other. Firstly, it engages in an explicit discussion of how space and scale are understood – an issue which is frequently overlooked or left implicit in work relating to the topic – and illustrates ways in which a consideration of space and scale can further understandings of young people's health beliefs and behaviours. Secondly, it seeks to problematise the artificial binary which is frequently constructed between the 'global' and the 'local' and demonstrates ways in which these are mutually constituted and produced in the construction of young people's health beliefs and behaviours, and associated performances of identity and belonging. Thirdly, the thesis deals with issues relating to the ways in which young people view and understand 'the countryside'; bringing together ideas relating to representations of idyllic rurality, frameworks of rural reference and experience, and the concept of therapeutic landscapes. Finally, this thesis explores the ways in which young people's health beliefs, and the performances of these, are intertwined both with issues of place, culture and identity and with policy discourses and initiatives; and in contrast to the majority of studies which have focused on urban areas, this thesis places an emphasis on rural young people and their health and well-being including the impact of issues such as rural deprivation and inequalities.

1.2 Research Aims and Questions

The overall aim of this thesis is to explore the following overarching question:

- How are young people's health beliefs, attitudes and behaviours constructed, mediated, and performed?

With a focus on young people of secondary school age living in the Wear Valley area of County Durham, North East England, this thesis aims to investigate perceptions of health, and the influence of place, space, socio-economic environment and culture upon these. Within this there will be some exploration of conceptualisations of healthy and unhealthy places. Conceptions and perceptions of place are not fixed and involve interplay between aspects such as built environments, identities, social networks, social class and culture. This thesis will explore the dynamics of these interactions rather than attempting to distinguish causal factors. Scale is also an important consideration, as the relationships between health, youth and place will vary across interwoven and mutually produced aspects of scale, such as the family, peer-group, neighbourhood and global forces and networks.

The following research questions will be addressed:

- How do young people conceptualise 'health'?
- What is the impact of differing life experiences on young people's health beliefs and behaviours?
- What influence does place have upon these perceptions and experiences, and how can young people's conceptions of 'healthy' and 'unhealthy' places inform our understanding of their perceptions of health and risks to health?
- How are issues of space and scale implicated in the sculpting and performance of young people's health beliefs and behaviours?
- In what ways are issues of power manifest in the sculpting and performance of young people's health beliefs and behaviours?

1.3 Introduction to the Study

As noted, this thesis focuses on young people living in the Wear Valley area of County Durham (Figure 1.2); although it should be noted that a small number of participants resided outside of the Wear Valley but attended schools in this area. County Durham (Figure 1.1) is a predominantly rural area which has encountered significant socio-economic problems since the collapse of the coal-mining and steel industries which had previously employed large sections of the working population. Nevertheless, as illustrated in Figure 1.3, County Durham also contains a number of affluent neighbourhoods, many of which are in close proximity to areas of significant deprivation. Due to small geographic size of some Super Output Areas (which have been used as a proxy for neighbourhood), it has not been possible to include names on this map, but the relevant names are shown on the maps in Appendix 1. In addition, Appendix 2 also shows the names and locations of Electoral Wards in the study area.

Figure 1.1 England and Wales with Location of County Durham

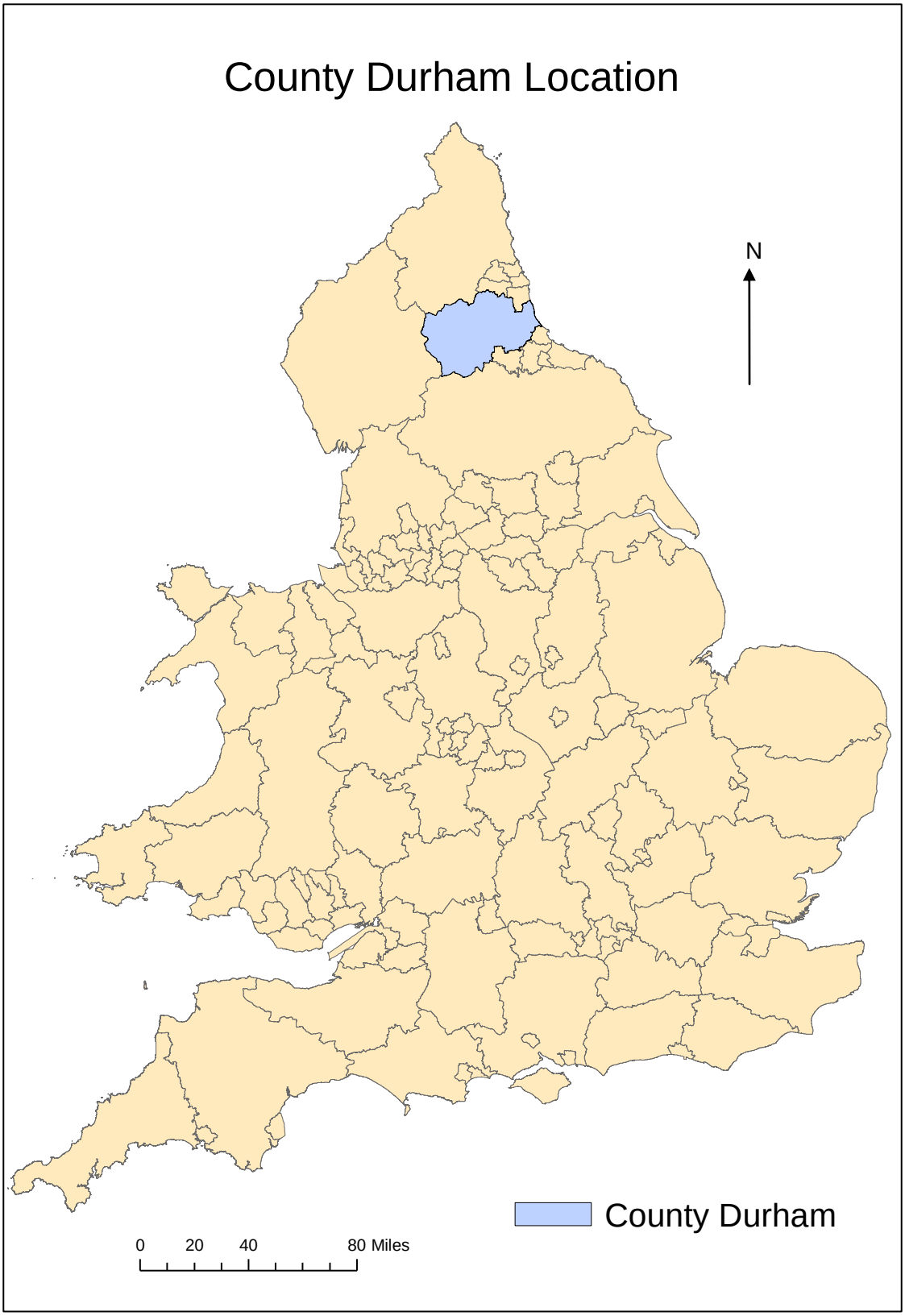


Figure 1.2 County Durham Districts with Location of Wear Valley

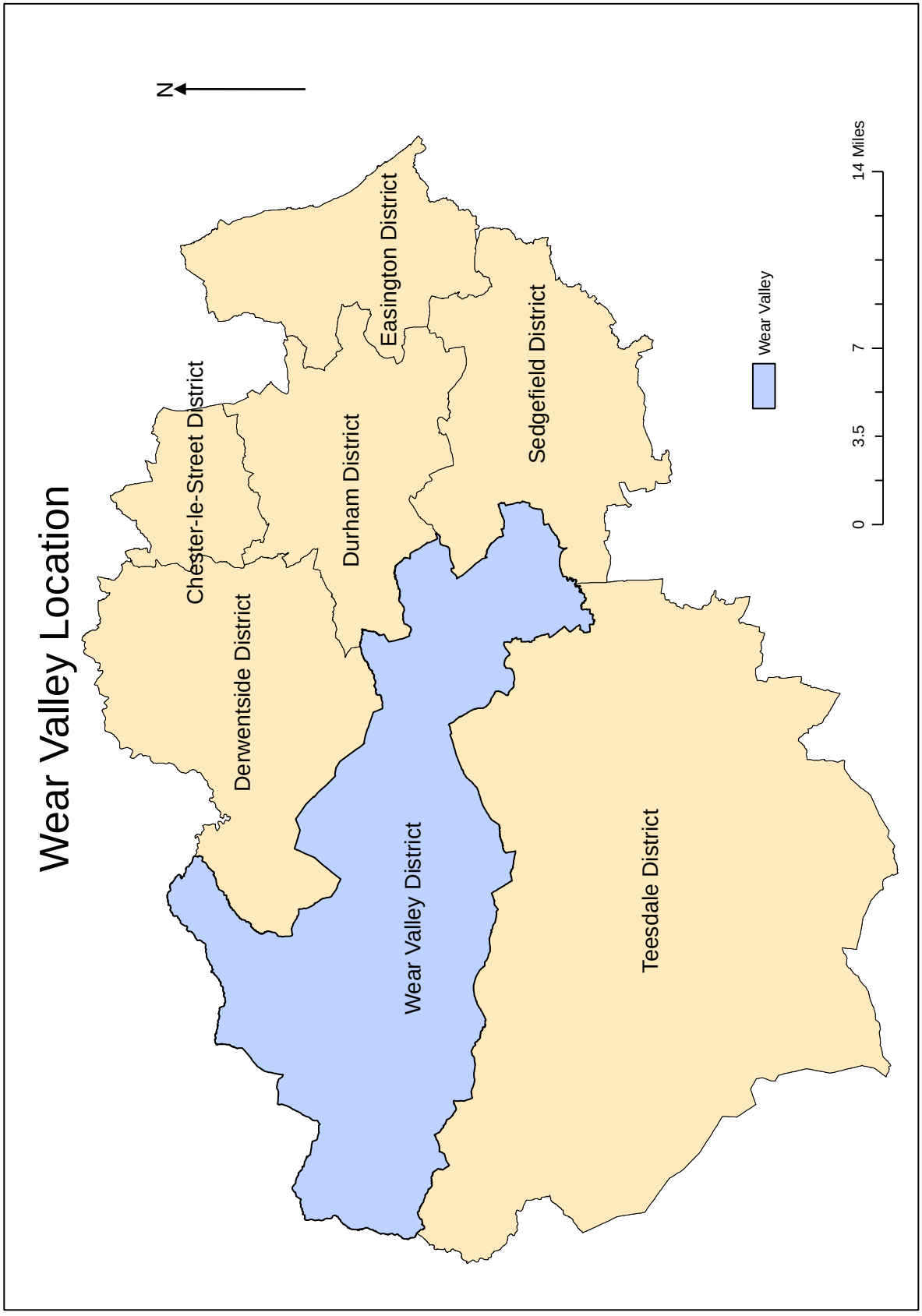
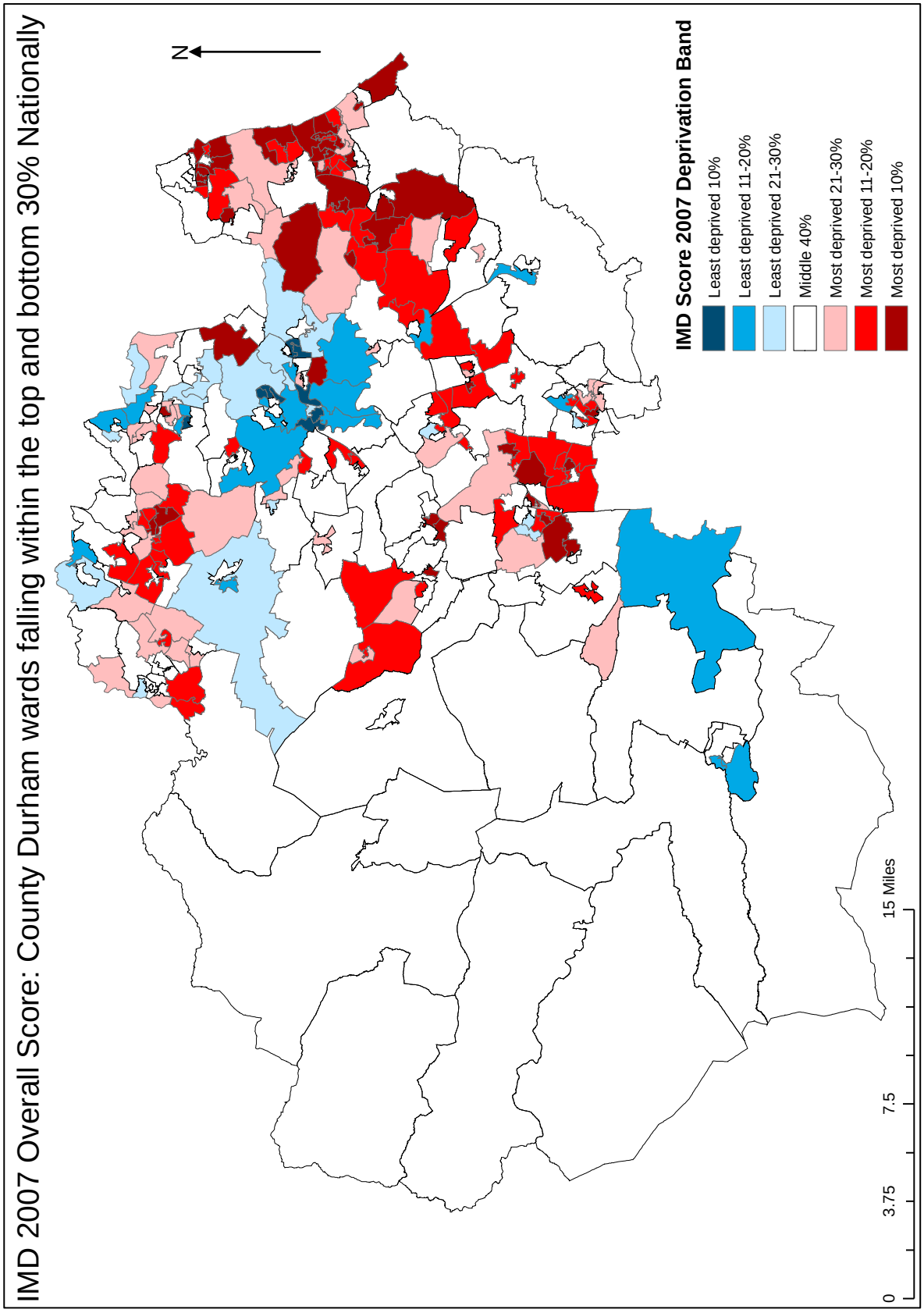


Figure 1.3 Overall Deprivation in County Durham (IMD 2007)



(Source: Department for Communities and Local Government 2008)

The research this thesis is based upon was heavily influenced by the aims and values of participatory research and took a mixed methods approach involving group discussions, participatory diagramming, interviews and questionnaires. All of the empirical work was undertaken in school settings, and this involved three secondary schools in the Wear Valley: Hillcrest High School, Meadowcroft Community College and Riverview High School. The schools will be introduced more fully in Chapter 4, but it is worth noting at this stage that they served contrasting catchment areas. The young people involved in the research were in school years 7-12, and Table 1.1 outlines the ways in which these school years related to ages.

Table 1.1 School Years and Ages

School Year	Age in years
7	11-12
8	12-13
9	13-14
10	14-15
11	15-16
12	16-17

Issues relating to research ethics will also be discussed in Chapter 4, but it should be noted that all of the names used in this thesis when referring to people and schools are pseudonyms. However, this thesis is dealing with real places and, in order to make a meaningful contribution to understandings of young people and health in the Wear Valley, it has been necessary to maintain 'real' place names as far as possible. Therefore, the names of places have only been omitted when their use might allow a participant to be identified.

1.4 Key Themes

Young people's health beliefs and behaviours are, obviously, a key theme of this thesis. These will be explored through a discussion of material from the empirical research undertaken. The thesis will highlight some of the ways in which young people's health beliefs and behaviours are shaped, and mediated, by official and school discourses and policies surrounding health, health education and health promotion. Whilst this thesis does not engage in any extensive discussion of health education and promotion policy or practice, a greater understanding of the ways in which young people's health beliefs are shaped and constructed could aid policy discourses.

Issues of space and scale are an overarching theme in this thesis, and I will argue that a consideration of space and scale can help illuminate the ways in which young people's health beliefs and behaviours are constructed, mediated and

performed. Unlike much of the existing work in Health Geography and Children's Geographies, this thesis both makes explicit its understanding of space and scale and draws upon some of the recent reworkings of these concepts which view them in a fluid and abstract manner instead of a hierarchical, absolute or relative one. Space and scale are viewed as being produced and yet are also regarded to be continually under construction and (re)formation; they are fluid and involve plurality, multiplicity and juxtaposition and thus cannot be reduced to simple networks or hierarchies.

The interplay between global and local forces and issues relating to specific aspects of globalisation will be explored in relation both to material from the empirical stage of this research and to the ideas of space and scale noted above. Like Amin, I recognise that "Globalisation…is centrally about the spatiality of contemporary social organisation, about meanings of place and space associated with intensified world-level forces…and raised global connectivity." (Amin 2002: 385). Yet, I will also argue that this cannot be separated from local issues and cultures.

Within the UK context, Health Geography has tended to focus on issues relating to urban areas or urbanisation, although Asthana et al (2002) suggested an emerging interest in the health experiences of those in marginal and rural areas. In this thesis, young people's conceptions of 'healthy' and 'unhealthy' places will be discussed with particular reference to young people's understandings of the countryside and rural living. I will also explore ways in which seemingly rural areas in the Wear Valley were not always regarded as such by the young people who lived there.

Issues of power and discipline, and the discussion of these, will cut across different aspects of this thesis. Consideration will be given to the significance of discourses and discipline, which are both mechanisms and producers of power; and the ways in which these helped shape social and cultural norms and expectations surrounding heath beliefs and behaviours, and resistance to these. This thesis argues that the disciplining of health beliefs and behaviours is intrinsically linked to regimes of power and knowledge. Power is considered to be a strategy rather than a property or possession and, like space and scale, involves plurality and multiplicity.

The final key theme in this thesis is the idea of performance. Some of the performances highlighted in this thesis were scripted, staged and role-played to conform with social norms and expectations, local peer group cultures and official or school discourses surrounding health, well-being and behaviour. Others involved reiterative and citational practices which served to reinforce and re-inscribe the notions, discourses and performances surrounding issues of gender, identity and belonging; especially in relation to white working-class masculinities and femininities. This thesis does not consider these two aspects of performance to be mutually exclusive and will illuminate the ways in which a consideration of such performances can help in seeking

to understand the ways in which young people's health beliefs and behaviours are constructed and mediated.

1.5 Structure of Thesis

In a departure from what is frequently considered 'standard practice', this thesis has not included a specific literature review chapter. The trans- and interdisciplinary nature of this thesis means that literature has been drawn in from a wide variety of fields and topics. This would have produced a large and unwieldy review had it been undertaken in a single chapter which, combined with the conceptual complexity of this thesis, would not have promoted the crystallisation of the key themes, issues and debates. Therefore, shorter literature reviews have been incorporated into the main chapters of this thesis alongside the key themes, issues and concepts under discussion.

Chapter 2 will set out the contextual background to this thesis in relation to children and young people, health and local governance, and this will provide a foundation for the subsequent theoretical, methodological and thematic chapters. It will highlight some general issues relating to the status of children and young people in the UK, before outlining some key academic discourses and debates with regard both to conceptualisations of childhood and youth and to understandings of health. Following this discussion, the chapter will outline some key aspects of the UK health systems, health policy and local governance and the key ways in which these relate to children and young people in the Wear Valley context.

In Chapter 3 I will discuss the theoretical framework which has been used in this thesis. As will be highlighted in the chapter, whilst some aspects of this framework were in place at the start of the research, several aspects of the theory used emerged from the data which were collected. This chapter will outline some key debates relating to the intersection between place and health before discussing the main areas of theory used. This thesis has drawn primarily upon three areas of theory. Firstly, that which relates to understandings and conceptions of space and scale; secondly issues relating to Foucault's work on power, discipline and gaze; and, thirdly, ideas surrounding performance and performativity. The last of these areas will draw both upon Goffman's discussion of scripted, staged and role-played performances and their role in the construction and maintenance of identity and social norms and expectations, and upon Judith Butler's work on gender and performativity.

The methodology used in this study, and its ontological and epistemological foundations, will be discussed in Chapter 4. As already noted, the research upon which this thesis is based was heavily influenced by the aims and values of participatory research, and these will be discussed near the start of this methodology

chapter. The chapter will then offer a more detailed discussion of the study area and the schools involved in the project. Following on from this, the main part of the chapter will outline the research methods which were deployed and the fieldwork which was undertaken, including some discussion of the ways in which the research unfolded across and within the schools involved. Key issues relating to data analysis will be highlighted, before the chapter concludes with a discussion of key ethical considerations.

Chapter 5 will offer a brief summary of key results and findings. Section 5.2 of this chapter will focus on the health beliefs and attitudes expressed by participants. Following this discussion Section 5.3 will summarise the factors which participants felt influenced their health, or that of other young people their age, and offers a brief discussion of health related behaviours. The focus of the chapter will then shift to issues of place; and will outline the types of places which participants considered to be 'healthy' or 'unhealthy' before moving onto to an exploration of the relationships between residential neighbourhoods, health status and health attitudes. The material included in Chapter 5 provides a foundation for the subsequent thematic chapters.

Chapter 6, which is the first of the two thematic discussion chapters, will discuss global-local interactions and will problematise the artificial binary which is often drawn between the 'global' and the 'local'. Building on the discussion of space and scale in Chapter 3, this chapter will consider the ways in which economic, cultural and cognitive aspects of globalisation, and the mutual production of global and local, have intertwined with issues of local culture in the sculpting and performance of young people's health beliefs and behaviours. Two topics will be used to help illustrate these processes. Firstly, issues relating to the media, technology and young people's health; and, secondly, issues relating to diet, food and food practices.

The second thematic discussion, in Chapter 7, will focus on the countryside and health. Drawing upon empirical material, this chapter will discuss young people's views on the relationships between countryside and health, with particular reference to the Wear Valley. It will consider ways in which dominant idyllic and romanticised representations of the countryside, and rural living more generally, inform young people's frameworks of rural reference and intersect with their frameworks of rural experience. The chapter will also explore what happens when the countryside is, in some way, considered to be 'not quite' countryside, and will highlight how Health Geography's concept of 'therapeutic landscapes' can connect with representations of rurality and frameworks of rural reference and experience.

Finally, Chapter 8 will offer an overview of the main issues and ideas discussed in this thesis. This will highlight the ways in which the substantive chapters of the thesis have addressed the research questions which are posed in Chapter 1. It will

also offer a number of key thematic, conceptual and methodological conclusions and will highlight the key contribution which the thesis makes both to understandings of young people's health beliefs and behaviours and the roles of space and scale within this, and to discourses surrounding young people and health in rural areas.

Chapter 2 Young People, Health and Local Governance: The UK and County Durham Contexts

2.1 Young People, Health and Local Governance: An Introduction

This chapter sets out the contextual background for this thesis and provides a foundation for the subsequent theoretical, methodological and thematic chapters. The three main themes discussed in this chapter, namely young people, health and local governance, are frequently treated as separate entities in academic discourses but are being discussed together in the context of this PhD due to their pertinence to my research. My aim is not to provide a new all-encompassing single conceptualisation of these issues, rather it is to set out the ways in which they relate to the substantive themes in this thesis and introduce some key ideas which are required for later chapters.

All three of the themes discussed in this chapter are currently 'hot topics' in public and policy debates, and issues relating to young people and health also feature heavily in media discourses. This chapter will discuss public, media and policy discourses surrounding young people, health and governance as well as academic understandings of these themes. I will begin by discussing and contesting public, media and policy debates surrounding children and young people in the UK, before moving on to a discussion of academic understandings of childhood and youth. This will be followed by a discussion of different ways in which health is understood and the ways in which health care systems are structured in the UK. Some key issues relating to governance and, in particular, local governance will be introduced before these different themes are combined in a discussion of young people, health and local governance in County Durham.

2.2 The Status of Children and Young People in the UK

Debates about children and young people in the UK are often surrounded by concerns over moral panics. From the 1993 abduction and murder of James Bulger to the knife crime and stabbings which dominate the media's interest today (via, of course, the joyriding, teenage single parents and Tyneside riots of the 1990's and the northern mill town race riots of the early 2000's) young people have frequently been placed under the spotlight. Issues such as teenage pregnancy, binge-drinking, childhood obesity and illegal drug use frequently make the headlines of the UK media and fuel an image of young people out of control; a disordered and deviant generation bereft of moral values and human decency. However, behind this media image, which

I would suggest has been rapidly seeping into common parlance, lies a rather more mixed reality. Whilst some young people do inevitably fit the media stereotype of a delinquent youth, I believe that many young people are hard-working individuals with hopes, fears and ambitions for their futures and those of other people, with the commitment and passion to stand up for issues they think are important and a desire to see the world become a better place. In this respect, the young people of today are not that dissimilar to those of previous generations; yet, this is rarely mentioned in the media frenzy surrounding young people, antisocial behaviour and the decline of moral values.

In the UK context and the associated academic, policy and public arenas a distinction is often drawn between 'children' and 'young people'. The term 'children' generally refers to those of primary school age or younger who have not yet reached the teenage years or adolescence, whereas 'young people' refers to teenagers, adolescents or those who are of secondary school age or older. The terms 'child' and 'childhood' are often associated with ideas of innocence and purity whereas teenagers, adolescents or young people are frequently stereotyped as threatening or problematic (Aitken 2001; Sibley 1995). Furthermore, young people are frequently excluded both from the world of the child and the world of the adult. As Sibley notes,

> "adolescents are denied access to the adult world, but they attempt to distance themselves from the world of the child. At the same time, they retain some links with childhood. Adolescents may be threatening to adults because they transgress the adult/child boundary and appear discrepant in 'adult' spaces. While they may be chased off the equipment in the children's playground, they may also be thrown out of a public house for under-age drinking." (Sibley 1995: 34-35)

Young people thereby occupy a liminal ground in which they are no longer 'children', but at the same time are not seen as full adults in either practical or legal terms. In the UK, under-18s are legally classed as minors who are not fully competent and require protection, and most legislation governing work with children is based on their 'vulnerable' status. At the same time, children's rights have been increasingly recognised and incorporated into legislation such as the 1989 Children's Act, promoting the right of children and young people to express opinions and have them taken into consideration. This creates a paradox in which children and young people are simultaneously seen both as vulnerable or incompetent and as competent. Furthermore, young people are not a homogenous group and the status attached to

different groups may vary, with preference often given in both research and policy contexts to those who communicate well (Curtis et al. 2004a)[1].

Within policy discourses and initiatives, a significant amount of attention has been given to challenging perceived problems associated with young people and their behaviours or attitudes. For example, young people were a key target of the UK Labour government's 'respect' campaign which sought to challenge poor morals and antisocial behaviour including issues such as underage drinking, smoking and drug use (see, for example, discussion in McDowell 2007). The 2002 introduction of compulsory citizenship education in English secondary schools had a similar basis. It was intended to challenge, firstly, the perceived apathy and cynicism of young people towards politics and, secondly, the rise in social problems (including drugs, crime and vandalism) which it was considered demonstrated a need for education in social awareness, responsibility and community involvement. The Crick Report, which set out recommendations for the compulsory teaching of citizenship in English secondary schools, suggested that citizenship education should encompass three strands: social and moral responsibility, community involvement and political literacy (Crick 1998). This was followed in 2003 by the government's green paper *Every Child Matters*, which sought to protect children and young people up to the age of 19 and help them to achieve their full potential. The authors 'consulted'[2] with practitioners, academics, policymakers, and children and young people and suggested that:

> "There was broad agreement that five key outcomes really matter for children and young people's well-being:
> - **being healthy:** enjoying good physical and mental health and living a healthy lifestyle
> - **staying safe:** being protected from harm and neglect and growing up able to look after themselves
> - **enjoying and achieving:** getting the most out of life and developing broad skills for adulthood
> - **making a positive contribution:** to the community and to society and not engaging in anti-social or offending behaviour
> - **economic well-being:** overcoming socio-economic disadvantages to achieve their full potential in life." (Treasury 2003: 14)

This green paper has formed the bedrock for the UK Labour government's subsequent policies for children and young people such as the *Youth Matters* green paper which was led by the then Secretary of State for Education and Skills, Ruth Kelly. Whilst it

[1] I am not suggesting that this is a deliberate strategy. Rather, as Curtis et al (2004) discuss, it is often easier to access and include those young people who have better communication skills, and these young people may also be more inclined to volunteer to participate in initiatives or discussions.

[2] Questions have been raised in relation to both *Every Child Matters* and *Youth Matters* about the extent and value of the consultation undertaken and the coherence of the proposals made (Kumrai and Flynn 2006; Williams 2004). As I will discuss in Chapter 4, consultation is not the same as participation and there are questions about whether consultation is sufficient to foster participation and engagement in policy contexts and with politics.

does acknowledge that "Most young people deal successfully with…challenges and make the transition to adult life without experiencing serious or lasting difficulties" (Kelly 2005: 3), this green paper retains a particular focus on young people 'with problems' and on challenging issues such as antisocial behaviour.

The *Youth Matters* green paper also emphasises that young people have a 'responsibility' to take advantage of the opportunities which are available to them, in order to reduce problems such as antisocial behaviour. It suggests that "young people themselves and their parents will need to be fully involved in deciding how the proposals can be implemented" and that it is important "to put young people themselves in control of the things to do and places to go in their area." (Kelly 2005: 2, 5). There is a tacit emphasis on listening to young people and actively involving them in the planning and delivery of publicly funded services. Yet, despite this supposed move towards listening to, empowering and involving young people, Matthews and Limb's (2003) observation still rings true that, whilst there is an appearance that everyone is consulting and listening to children and young people, existing processes and structures often fall short of engaging, inspiring and empowering young people's participation (see also Stafford et al. 2003). As will be discussed in later chapters, this view that the idea of listening to young people is currently more of a rhetoric than a reality was echoed by many of the young people I worked with in the course of this PhD. It should be noted that the debates surrounding the ideas of 'listening to' and 'including' young people are not always synonymous between academic research and policy arenas. This section of the chapter has focused primarily upon the policy contexts. However, as the next section will discuss, children and young people have increasingly been a focus of academic research and there has in recent years been a noticeable trend towards actively including children and young people's voices and listening to them in research contexts.

2.3 Academic Understandings of Childhood and Youth

Children and young people have not only been the focus of public, media and policy discourses, they have also increasingly featured in academic research and debates within academia. As will be discussed later, the way in which childhood, and for that matter youth and adolescence, is theorised has significant implications for the research process. This section will firstly highlight some different ways of theorising childhood and youth or adolescence, before outlining my position and its implications for my research. At the end of this section I will offer some pointers towards ways in which researchers have been seeking to include young people's voices more fully; a theme which will be discussed in more depth in Chapter 4.

Other disciplines, especially Developmental Psychology and Sociology, have seen considerable engagement with theorisations of 'childhood', or of the development of individuals from childhood into adolescence and adulthood. Within Developmental Psychology, two of the key understandings of the development, or progression, of an individual from birth to adulthood have come from Jean Piaget and Erik Erikson. Piaget (1999 [1962]) identified four stages in the intellectual development of the child. The fourth of these stages, the stage of 'formal operations'[3], is of particular relevance to young people of secondary school age (see also Slater et al. 2003). With regard to the themes of this thesis, young people's intellectual development and an ability to deal with ideas and concepts can impact upon their beliefs and attitudes towards both health and risks to health. Erikson (1963) developed an eight-stage model for psychosocial development and the formation of personality and identity, placing a greater emphasis on an individual's social worlds including family, friends, society and culture (see also Bergevin et al. 2003). He suggests that at each stage of development there is a specific psychological task or conflict which must be overcome in order for an individual to progress to the subsequent stage; and that the 5th of these stages, the conflict between identity and role confusion, occurs during 'youth'. The development of identity is particularly important for young people, and I will return to this in later chapters because it can impact upon health beliefs and behaviours. Both of these models have been heavily critiqued and children and young people's development is neither rigidly definable nor linear. However, I would suggest that Piaget's ideas surrounding the incorporation of abstract concepts and reasoning during adolescence and Erikson's idea of a conflict between identity and role confusion do still retain some pertinence to this thesis.

During the past ten to fifteen years, Sociology has begun to engage more extensively with theorisations of childhood. James at al (1998) suggest that before this there had been five dominant understandings of what they call 'the presociological child'[4]; the evil or Dionysian child, the innocent or Apollonian child, the immanent child, the naturally developing child and the unconscious child. The idea of the 'evil child' assumes that all children are inherently naughty, unruly and unsocialised whereas the idea of the 'innocent child' assumes that children are originally good, innocent and untainted by adult ways (see also Jenks 1996). A number of geographers have

[3] According to Piaget, the stage of formal operations occurs from the age of around 12 years onwards. Its key features are an ability to reason on the basis of hypotheses and propositions as well as on the basis of objects; the ability to deal with possibilities as well as realities; the ability to manipulate ideas and information and deal with abstract concepts and the ability to simultaneously use more than one system of reference (see Piaget 1999 [1962]; Slater et al. 2003 for further discussion).

[4] James et al (1998) use the term 'the presociological child' to refer to the ways in which childhood was understood before it was theorised by sociologists. This term does not mean that children had previously been 'pre-social' or that the authors suggest there is a phase of development in which a child is separate from society and social worlds.

suggested that popular conceptualisations of childhood have alternated between that of the evil child or 'devil' and innocent child or 'angel', and that these understandings result from the way in which adults construct children as being different or 'other' (see, for example, Aitken 2001; Holloway and Valentine 2000; Sibley 1995; Valentine 1996). The idea of the immanent child assumes that children and young people have inherent mental processes, perception and reason which will develop if an appropriate environment is provided. In some respects, this is similar to the idea of the naturally developing child which draws on the work of developmental psychology and, in particular, that of Piaget; although James et al (1998) suggest there is a fundamental difference in that the idea of the naturally developing child assumes that children are natural phenomena and not social ones, thus denying the impact of an individual's social worlds. The idea of the unconscious child draws largely upon Freudian psychoanalytic theory and suggests that children develop as a result of drives and instincts. This approach removes the possibility of intentions and agency and is therefore, in many respects, diametrically opposed to the understandings which currently dominate in Sociology and Human Geography.

In his discussion of Sociology's 'rediscovery' of childhood, Corsaro (1997) argues that childhood, like other social objects such as class and gender, is a social product or construction and should be seen as being interpreted, debated and defined through social action. Sociologists working in this vein are interested in children's experiences of the social worlds they inhabit and consider them to be agents who participate in the construction of knowledge and daily experiences (Mayall 2002). Another important strand within the sociology of childhood draws more upon poststructuralist theory and is interested in deconstructing varying discourses about, and representations of, children and childhood (Mayall 2002); and James et al (1998) suggest that social constructionist approaches are also interested in plurality and the diversity of constructions. Perhaps unsurprisingly, there has been a tendency to discuss and conceptualise childhood in relation to or in comparison with the normative adult world (Jenks 1996) and, as will be discussed later, there is still considerable debate about how to actively include children's voices in research. At this stage, it is sufficient to note that, even when children are seen as competent social actors or agents, ensuing representations or constructions of childhood are still socially produced, culturally relative and, often, politically motivated (Wyness 2006).

Interestingly, Sociology's recent emphasis on theorisations of 'childhood' appears to have lead to a lack of theoretical engagement with 'youth' within that discipline; although there has been a considerable amount of work on masculinities and femininities (see Connell 1995; Frosh et al. 2002; Mac an Ghaill 1994; McRobbie 1991; O'Donnell and Sharpe 2000 for examples), some of which relates to young

people. Whilst there has been some theoretical engagement with youth within British Cultural Studies, especially with regard to representations of youth and youth subcultures (Clarke et al. 1975; Gelder and Thornton 1997; Griffin 1993; Miles 2000), it is in relation to theorisations of youth that geographers have made a particular contribution. These contributions of geographers have focused loosely around three issues. Firstly, a significant amount of attention has been given to the liminality, otherness and ambivalence of youth. Here, the work of Sibley (1995) has been very influential, as have discussions of the blurring of boundaries between childhood, youth and adulthood and the complexity of boundary crossing between these (see, for example, Aitken 2001; Skelton 2000; Valentine 2003). Secondly, geographers have shown a significant interest in inclusionary and exclusionary practices involving young people. This has focused largely on practices in specific places and spaces, with a particular emphasis on public space (Jones 2000b; Matthews and Limb 1999; Skelton 2000; Valentine 2004). However, there has also been a significant interest in inclusionary and exclusionary practices in the conduct of research, and a number of geographers working with children and young people have been influential in developments in participatory research (see, for example, Cahill 2004; Pain 2004). Finally, attention has also been given to the formation, representation and performance of youth cultures and identities and the ways these relate to space, place and scale (Cahill 2000; Horschelmann and Schafer 2005; Nayak 2003c).

More generally, there has recently been considerable attention given to the status of children and young people in research contexts (see, for example, Evans 2008 for fuller discussion). The status which the researcher attaches to children and young people can influence the choice of research methods (Punch 2002) and therefore requires early consideration. In research contexts, 'childhood' has traditionally been viewed in binary opposition to 'adulthood', with children being seen purely as research subjects rather than persons in their own right. However, alternative theorisations have viewed children as 'social actors' (Christensen and James 2000; Christensen and Prout 2002) and as participants and co-researchers (Alderson 2000; Woodhead and Faulkner 2000). As will be discussed more fully in Chapter 4, the most appropriate view in the context of this research appears to be that of children as participants and co-researchers, and this fits both with the epistemology and methodology used in this project and with the aims and values which underpin participatory research. Children are viewed as social actors with their own experiences and understandings, and emphasis is placed on their competence. Distinctions between children and adults are not taken for granted, with the selection of research methods following the same principles as with adults, and children are seen as active participants in the research process in the same way as they are in societal life. In line

with my stance on 'childhood', I consider young people to be competent social actors and believe that the points I have just made about children, participation and competency also apply to young people. As this section has discussed, there are a number of different understandings of childhood and adolescence. The stance I have taken has implications for my research and methodology, which will be discussed in more detail in Chapter 4. The next section of this chapter will explore the notion of agency, which Bucholtz (2002) suggests has been given insufficient attention in sociological and interdisciplinary approaches to childhood and research relating to youth cultures.

2.4 Young People and Agency

Jans (2004) equates agency with individualisation and the display of unique identities. In their paper, Emirbayer and Mische argued that:

> "the term agency itself has maintained an elusive, albeit resonant, vagueness; it has all too seldom inspired systematic analysis, despite the long list of terms with which it has been associated: selfhood, motivation, will, purposiveness, intentionality, choice, initiative, freedom, and creativity. Moreover, in the struggle to demonstrate the interpenetration of agency and structure, many theorists have failed to distinguish agency as an analytical category in its own right—with distinctive theoretical dimensions and temporally variable social manifestations. The result has been a flat and impoverished conception that, when it escapes the abstract voluntarism of rational choice theory, tends to remain so tightly bound to structure that one loses sight of the different ways in which agency actually shapes social action." (Emirbayer and Mische 1998: 962-63).

However, recent work on agency has in some respects gone to the other extreme, emphasising agency to the point where it becomes detached from context, social relations and social and structural conditions. Whilst, like Emibayer and Mische, Bauder (2001) argues that agency must be separated from other factors and discussed theoretically, I believe that agency cannot be viewed in isolation and that social norms and conventions, structure and agency are inherently interlinked. Like Rugkasa et al, I consider that the relationship between agency and social structure "should be seen as interactive and of mutual influence" (Rugkasa et al. 2001: 132). With regard to young people's health beliefs and behaviours, this thesis will suggest that agency cannot be fully separated either from the influence of social and cultural practices, norms and expectations or from contextual issues such as socioeconomic or structural conditions.

Existing work in Children's Geographies has tended to present a top-down researcher oriented view of agency and has frequently ignored the tensions, subtleties and contradictions involved. For example, Valentine and Skelton suggest that their respondent, Anatol, "regards his future as entirely a product of his own agency" (Valentine and Skelton 2003: 312); yet, a few sentences earlier, they had stated that

his self-motivation, confidence and independence "are attributes that he credits his family, particularly his mother, with instilling in him" (Valentine and Skelton 2003: 311). The authors discuss the ways in which Anatol's confidence and independence allow him to make his own decisions and display his agency, yet his confidence and independence are attributed to his upbringing. Thus, whilst Valentine and Skelton consider agency to be a discrete entity which can be identified and discussed in isolation with the researcher making decisions about what is and isn't attributable to agency, I believe that contradictions in this example highlight the interdependence and co-construction of structure, culture and agency.

In his discussion of young people's school-work transitions Lehmann argues that "In efforts to consolidate notions of structure and agency, school-work transitions researchers have tried to conceptualize transitions processes as involving reflexive and acting individuals, but whose agency is nevertheless constrained by very real structural conditions that exist *de facto*" (Lehmann 2005: 331 emphasis in original). His paper highlights the reproduction of social inequalities and expectations embedded in working and middle class school-work transitions and the ways in which beliefs, values and expectations are re-inscribed and performed through these transitions; and these ideas resonate with this thesis' later discussion of the sculpting and performance of young people's health beliefs and behaviours. However, whilst Lehmann goes on to argue that "Despite this overwhelming empirical evidence of socially reproductive processes, apprentices also insisted that their career decisions were based on choice and agency" (Lehmann 2005: 337) the young people involved in the research undertaken for this thesis generally struggled to articulate reasons for their beliefs and actions.

In her discussion of young people and risk taking, Sharland similarly argues for a greater understanding of the interplay between structure, agency and context; suggesting that:

> "when we seek to understand young people's risk taking, we need to consider them as agents in their own lives, pursuing their own trajectories, situated within their own social, material, cultural and relational worlds. Neither the life politics of reflexive individualization [sic], nor the determinism of social structuralism, nor the regulatory thrust of governmentality, is sufficient to explain the complex interplay of agency, power and structure involved. To understand these, we need to look more closely at what risk taking means to young people, its dynamics, and the relationships and resources surrounding it." (Sharland 2006: 259-60).

Working in a Global South context, Jennings et al (2006) argue for a relational understanding of children's everyday geographies. In their discussion of children's work[5] they suggest that a relational understanding can accommodate multiple

[5] In the context of Jennings et al's (2006) study, which was based in Mexico, 'children's work' refers primarily to the practice of employing children on supermarket floors.

perspectives on complex social scenarios and that, whilst children's work allows them to display autonomy, responsibility and individual agency, meanings are socially and culturally inscribed and reproduced through the home and through practices in work settings.

In an attempt to overcome the complex interactions between structure, culture and agency, a number of authors have drawn upon the notion of bounded agency. For example, Evans (2007) argues that agency is socially situated and that attempts to act upon agency may be frustrated, or bounded, for those who lack power in their social landscape. Similarly, Schoon (2007) equates agency with individual aspirations, and argues that the circumstances in which expressions of agency are manifest are constrained by available options, and socio-economic conditions, and aspirations are associated with social background. These sentiments are also echoed by Côté and Bynner (2008) who highlight the impact of socioeconomic conditions, and social and cultural norms and expectations, upon transitions into adulthood.

There have been suggestions that the recognition of children and young people's ability to act responsibly, make sophisticated judgements and make their own decisions conflicts with their relatively weak social standing in comparison to adults. For example, Smith argues that

> "The consequence of such judgements is paradoxical; children are seen as *acting* irresponsibly, whilst at the same time their *active* participation in determining what counts as responsible behaviour is denied to them. Failing to accord children agency works to underestimating their own capacity for making morally responsible choices, and denying them the opportunity to do so in practice." (Smith 2009: 253-54 emphasis in original).

Smith then goes on, later in his paper, to suggest that:

> "it is important to recognise two key points: that our concepts are characterisations of childhood are, inevitably, 'socially constructed', and that children's capacity to act as independent social actors must be acknowledged. Interestingly, this also means creating space and opportunity for children to act 'responsibly', rather than simply following directions." (Smith 2009: 259).

Yet, he also argues that the discussion of agency requires recognition of the experiences and actions of the 'tribal child', and their validity, even when these may take challenging or 'unacceptable' forms of expression.

With regard to young people's health, both Allen (2008) and Smette et al (2009) have discussed young people's agency in relation to sexual behaviours. In their discussion of adult-minor relationships, Smette et al (2009) argue that notions of 'protection' can come into conflict with those of agency and responsibility in discussions of young people's sexual behaviours and that the notion of agency is interwoven with gendered sexual scripts. The authors also suggest that:

> "[Young people] perceive themselves as agents, and they receive a multitude of messages from society saying that they are expected to be capable and knowledgeable agents. Denying the existence of their agency has the potential to undermine prevention efforts because it contradicts young people's self perception." (Smette et al. 2009: 368).

However, despite this apparent emphasis on individual responsibility, Smette et al still consider agency to be constrained by social and cultural norms, expectations and practices. In her exploration of the sexual culture in secondary schools, Allen (2008) highlights the ways in which young people are positioned as 'at risk' and discusses issues relating to power and agency. The question of power and positioning will be discussed further in Chapters 3 and 4 of this thesis. First, it is necessary to explore some of the different understandings of health, and these will be discussed in the next section of this chapter.

2.5 Understandings of Health

> "Definitions of health contain within them complex ideas about what it is to be healthy, whose responsibility it is to maintain health and how illness and disease should be interpreted." (Jones 2000a: 18)

Health is a contested concept which has been defined in numerous ways. As the quotation above suggests, the ways in which health is defined or understood can have wide-ranging implications and can impact upon issues such as health promotion and health education. Health can be considered as a socially constructed phenomenon which Curtis (2004) suggests is related to individual and collective ideas and beliefs about identity, the nature of the body and its significance. There is a tendency for some elements of such beliefs to be shared and reinforced more collectively within a given society or social or ethnic group and, as a result, culturally specific understandings of health often emerge. As will be discussed in later chapters, this development of culturally specific health beliefs and behaviours may be apparent within relatively small geographic areas due to variations in local cultures; even when the majority of the population share the same or similar ethnic heritages. This section will outline some of the main ways in which health is understood in the UK context, including both 'lay' and 'professional' viewpoints, and will then briefly highlight the approach being taken in this research.

The academic literature relating to understandings of health is generally dominated by two contrasting understandings of health; the biomedical model and the

social model[6]. The biomedical model forms the basis for western medicine and has therefore been extremely influential in developed countries such as the UK.[7] Developments in science have, since The Enlightenment, transformed the treatments which are available to medical practitioners and their patients and it cannot be denied that these have often lead to significant decreases in mortality and morbidity[8]. The biomedical model draws heavily on biology and other clinical sciences to offer physical, biological or chemical explanations for health and ill-health. This model of health has often been likened to the idea of the 'body as a machine'. Illness is considered to be a physical malfunction of the body or its components which requires either correction or some form of treatment to reduce further malfunction and health is seen largely as the absence of disease (see Curtis and Taket 1996; Jones 2000a; Lloyd and Shakespeare 2000 for further discussion).

In contrast, the social model of health considers health to be something which is influenced by social, economic, cultural, psychological, political and environmental factors as well as biological ones (Jones 2000a). Some supporters of the social model have gone beyond this, suggesting that biological factors are not significant and this can be illustrated particularly well by the disability rights movement which argued that the challenges faced by individuals with disabilities resulted from a failure on the part of society to provide the correct socio-economic, environmental and political conditions rather than from physical or biological defects on the part of the disabled person. Jones (1994) argues that the social model is underpinned by a belief that the health of both individuals and communities results from complex and interacting material-structural and behavioural-cultural conditions and Curtis (2004) suggests that, unlike the biomedical model, the social model incorporates socio-economic and political determinants as well as medical care. It is sometimes suggested that the World Health Organisation's (WHO) definition, outlined originally in 1946, offers a good starting point for the social model of health. This stated that health "is not merely the absence of

[6] I am using the terms 'biomedical model' and 'social model' to describe two common understandings of health. It is recognised that these models are sometimes given alternative names and, for example, the biomedical model is sometimes referred to as the medical or Cartesian model. It is also recognised that there are other ways of conceptualising or understanding health and I do not wish to present the biomedical and social models as the only models or understandings of health.

[7] I am not intending to deny the influence which the biomedical model of health has had on developing countries in the Global South; rather I am focusing more exclusively on the UK context because this is more pertinent to my research. Thus I am not discussing the situation outside of the developed world.

[8] It is recognised that some authors have contested the benefits of medical treatments and of the medicalisation of healthcare and have suggested that medical care causes more harm than good (Bunker 2001; Illich 1995). The nuances of this debate are beyond the scope of this thesis and whilst I recognise that medical treatments can *sometimes* cause harm, developments within medicine have enabled treatments for previously incurable conditions and, alongside general improvements in living conditions, have been associated with improved mortality and morbidity rates.

disease, but a state of complete physical, mental, spiritual and social well-being" (WHO, 1974, quoted in Jones 1994)[9]. However, the WHO definition has been criticised because its emphasis on complete well-being is utopian and is often unachievable. The understanding of health based on the WHO definition is often referred as the holistic model of health rather then the social model, and it is important to recognise that the boundaries between different models of health are not clear-cut. Nevertheless, the WHO definition is often used as a starting point in health promotion discourses.

Both the biomedical model and the social model are understandings of health which have been developed by professionals such as medical practitioners or disability workers. Nevertheless, elements of these models are apparent in many lay understandings of health. In her introduction to geographic understandings of health and inequality, Curtis (2004) suggests the main lay understandings of health are the ideas of health as balance and ill-health as imbalance, the body as a machine and illness as a malfunction of this, health as a locus of control (by the individual over his or her health), health as the outcome of fate or divine will, health as a freedom to do as one pleases or carry out the key roles required, health as a resilience against infection or hazards, and health as the access to the means for good health. Many of the understandings Curtis (2004) suggests are apparent in the four seminal studies on lay understandings of health, which are outlined in the following paragraphs.

Herzlich (1973) undertook his study with a sample of predominantly middle-class adults in both urban and rural areas in France and identified three types of conceptions about health which he termed 'health-in-a-vacuum', 'reserve of health' and 'equilibrium'. He suggests equilibrium is the most common of these concepts although it is rarely achieved. The concept of 'health-in-a-vacuum' assumes that health is the absence of illness. Health is considered to be a matter of fact and a state of being; you either are healthy or you are not. In the concept of a 'reserve of health', health is something you can have. This involves both physical strength or robustness and a potential to resist attacks, fatigue and illness. It is a characteristic of the individual which can be affected by their character, temperament and constitution. With the concept of health as 'equilibrium', health is considered to be a state of doing; the full realisation of a person's potential for health and something they would like to attain or keep. This includes physical and psychological well-being, evenness of temper, an abundance of strength and physical resources and good relationships with other people.

[9] It has not been possible to obtain a copy of the original 1946 document. The quotation I have used relates to a re-iteration of the 1946 definition in the WHO's 1974 Alma Ata declaration.

In the study undertaken by Blaxter and Paterson (1982) the sample consisted of working-class married women and their mothers in a Scottish city. The main conceptions of health the authors identified were, firstly, health as the absence of disease or illness requiring hospitalisation; secondly, being able to work and carry out normal tasks; thirdly, the capacity to cope with illness, pain or disability and; fourthly, health as a strength of character and a matter of willpower and self-discipline. In contrast to the other studies discussed in this section, general well-being and physical fitness did not feature in respondents' conceptions of health.

Williams' (1983) study was undertaken with a mixture of middle-class and working-class elderly people in Aberdeen, Scotland. Two dominant conceptions of health were identified; firstly, health as the absence of illness and disease and, secondly, health as strength or stamina. These two conceptions were generally completely separate and respondents would often consider a person healthy if they met one of these and not the other; i.e. if they had an illness or disease but had an inner strength and capacity to cope with it or if they lacked physical strength or ability but avoided illnesses.

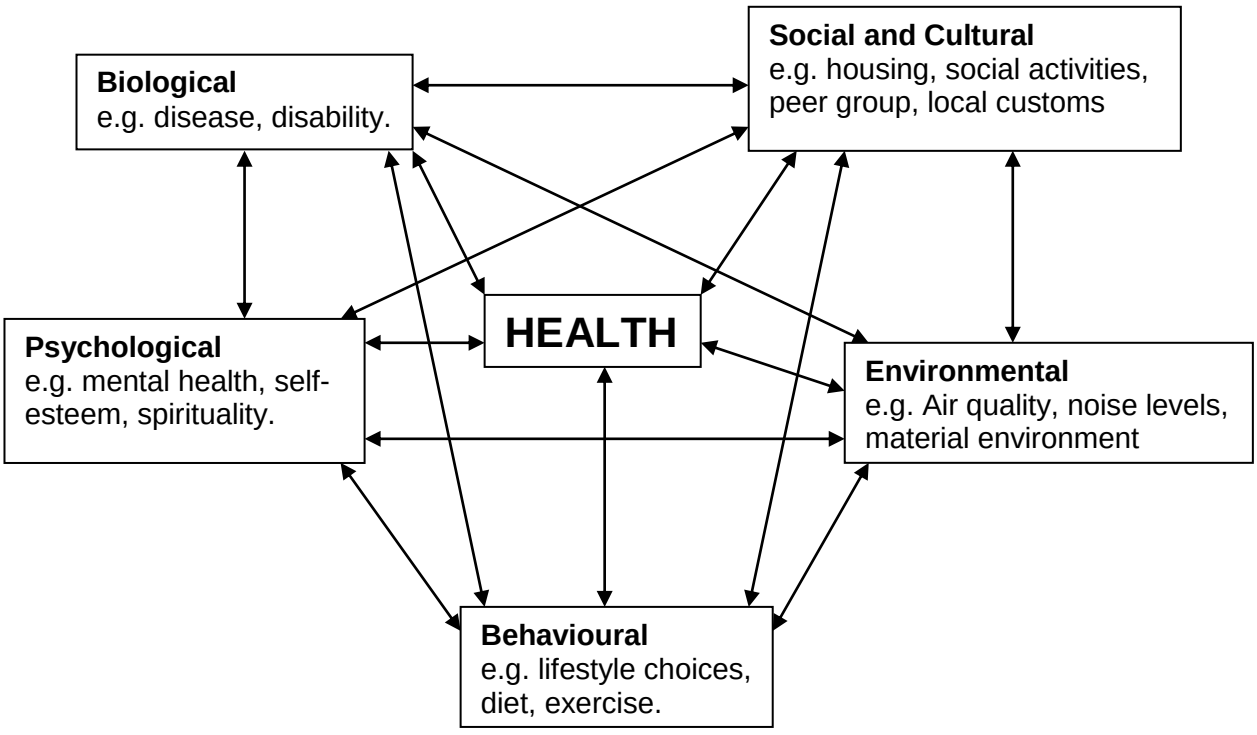
In the final study I wish to introduce, Calnan (1987) explored the beliefs of women in south-east England. The main conceptions identified in this study were health as the absence of illness, health as an ability to cope with life crises, including illness and chronic illness, health as being fit, strong, active and taking exercise and health as meeting the demands of daily living and being able to get through the day. In contrast to the previous studies I have described, Calnan maintained that that it was important to look at differences between different social classes with regard to conceptions of health, although these proved not to be completely clear-cut. In general, there was a tendency for middle class women to mention fitness and exercise while working-class women were more likely to mention functional aspects such as getting through the day.

Whilst the four studies I have introduced here are now somewhat dated, they still give a good overall picture of the different ways in which health is, or has been, understood by people in the UK and more recent studies have not covered the same breadth. However, it is important to recognise that there are some gaps in the studies I have introduced so far and weaknesses in the models these studies propose. As noted above, Williams (1983) suggests that the two components of health identified in his study are completely separate, and all four of the studies outlined above have been criticised for oversimplifying understandings of health and not adequately acknowledging the complexity and diversity of views or the ways in which individuals and communities weave their own understandings and health narratives (see, for example, Curtis and Taket 1996; Nettleton 1995; Stainton Rogers 1991). In this thesis

I am interested in exploring not only the ways in which young people's views do and do not fit with established understandings, but also alternative understandings which co-exist alongside those which might be perceived as more mainstream. As will be discussed in later chapters it was clear that the young people I worked with had "access to more than one kind of explanation, varying in either their content, or form, or both" (Stainton Rogers 1991: 93). Moreover, as Curtis notes in her later book, individuals often work with more than one framework or understanding of health, creating "complex and variable frames of reference" (Curtis 2004: 3).

Furthermore, research about lay beliefs has generally focused on adults or older people. The health beliefs held by young people have not been explored extensively, and many of the existing studies involving young people have focused on specific issues such as smoking which have been defined from an adult or professional viewpoint. As noted in Chapter 1, I am seeking to explore young people's own understandings of health and have tried to prioritise the views of the young people I worked with. Nevertheless, this is inevitably sculpted by my own gaze, positionality and beliefs. I personally hold a fairly holistic view of health, broadly in line with the social model discussed above, and consider health to be a complex web of different components, which are illustrated in a simplistic manner in Figure 2.1. Whilst all of the components may be interconnected they are not static or equally weighted and the different aspects of health may become more or less important at different times and in different contexts, allowing multiple understandings to develop.

Figure 2.1. The Web of Health



As noted at the start of this section, the ways in which health is understood can impact upon issues such as health care, health promotion and health education. The next section of this chapter will discuss health systems and policy in the UK and the beliefs and principles which underpin them. The potential implications of differing health beliefs will also be discussed in later chapters.

2.6 Health Systems and Policy in the UK

Writing at the end of the twentieth century, Green and Thorogood (1998) suggested that health policy had, in the UK, become a key political issue. They argue that this is reflected in the amount of attention health and health policy received from both politicians and the media; and this has, if anything, increased over the past decade. In the UK, most state organised health services have, since the introduction of the post-war welfare state, been free at the point of access; at least in principle if not in practice. However, in reality the picture is far more complex. This section will briefly introduce the British National Health Service (NHS) and its evolution since the introduction of the post-war welfare state in the UK[10]. It will then discuss some different conceptions of, and priorities for, health care and health policy and their implications. Some links will be drawn with social policy more generally before relevant aspects of current policy are introduced.

As Clarke et al (2001a) discuss, the nationalisation of health and education in 1948 was a key aspect of the post-war welfare state which was intended to help underpin the post war economic regeneration of the country. It was based on the principle of services being accessible to all citizens and free at the point of use, with the finance to fund this coming from general taxation. There was an emphasis on treating ill-health in order to maximise the numbers available for employment, and the heath professions – especially medicine itself – wielded considerable power through and within this process. Although there have been significant changes in the NHS since its creation, these underlying principles remain largely intact (Alcock 2003) and the system in the UK contrasts with that in countries such as the USA and Germany which rely on private health care and health insurance.

The Thatcher era saw some significant changes in the structure of healthcare in the UK. Whilst the biomedical model remained dominant, the 1980s were characterised by an increasing emphasis on what came to be termed 'New Public Management' and the control of services shifted from health professionals to non-

[10] There are currently some important differences between NHS services in the different countries within the UK, but this has not always been the case. My discussion of the 'British' NHS focuses largely on the period before Scottish devolution and the establishment of the Welsh Assembly. My discussion of recent policy and practice will focus on the English context only, because this is the country where my research is based.

medical managers. The 1990 NHS and Community Care Act drew a distinction between the purchasers and providers of services and lead to the introduction of the internal market into the NHS. This act resulted in the establishment of quasi-independent NHS Trusts which acted as the providers for services which District Health Authorities, Family Health Services and GP Fund holders purchased (Alcock 2003; Clarke et al. 2001b; Paton 1999). The internal market was intended to improve efficiency and competitiveness and, alongside this, the private health sector was more actively encouraged; leading to popular concerns that the government was seeking to privatise the NHS – an idea which it denied (Alcock 2003).

There have also been further shifts in the UK health system since New Labour gained control of the government in 1997. The past decade has seen considerable divergence between the constituent countries of the UK with regard to health care, and my focus here is exclusively on the English context. Within its aim of 'modernising' the welfare state, New Labour placed considerable emphasis on NHS services in England through its *The new National Health Service: Modern, dependable* white paper and campaign (Paton 1999). New Labour's 'Third Way' was intended to accommodate changing social conditions, especially in relation to the family, culture and work, and centred around three core ideological themes of family, work and nation (Clarke et al. 2001b). The establishment of Primary Care Trusts (PCTs), which are independent of the health authorities and have devolved financial responsibility, was part of a move towards encouraging the development of services that had a greater focus on user needs whilst continuing to meet national standards (Alcock 2003). However, alongside this tacit focus on meeting users' needs there has been an increasing emphasis on meeting nationally set targets for issues such as cancer survival, heart disease and smoking, and Paton (1999) suggests this has resulted in a tension within health policy between meeting local needs and the health service's national status.

Each of the shifts in NHS structure or services noted above has, to some extent, been accompanied by a corresponding shift in the models of health and health care being used. The NHS has traditionally adopted a biomedical model of health, with a focus on diagnosing and treating existing illnesses rather than preventing them (Alcock 2003) and, in the past, NHS services have tended to ignore social and environmental aspects of health and well-being. In its founding period, the NHS was based on a nationalised model of health care in which services were provided by the state, but were in many respects controlled by the medical profession. Whilst the biomedical model of health continued to dominate during the Thatcher years, there were moves towards a neo-liberal market-based model of health care in which the power of the medical profession was diminished. During this period there was also an increased emphasis on individual responsibility for health, and poor health was

sometimes equated with an individual's failure to behave 'correctly'. There was a tacit assumption that all sections of society had an equal chance to access health services and to remain healthy, and the impacts of issues such as area of residence, social class, gender and ethnicity were often overlooked. Under New Labour, the state's commitment to the provision of health services has remained, but there has been an increasing emphasis on individual responsibilities for health and a greater recognition of the variations in local needs. Increasing attention has been given to tackling inequalities in health and their socio-economic determinants, although it seems that progress in reducing inequalities is slow. There has also been a move towards involving users and stake-holders in the planning of services, although questions remain about how effective this is in promoting lay participation and improving understandings of local needs (Frankish et al. 2002; Jordan et al. 1998; Lowndes and Sullivan 2004). In many respects, these changes also reflect changes in public perceptions regarding health and a questioning of the status of professional knowledge. As I have already discussed, understandings of health are socially constructed and I agree with Curtis's assertion that "Lay views, held by people in wider society, on how to best care for health also need to be understood as socially and individually constructed, and subject to variation and to debate." (Curtis 2004: 4).

It is worth noting two initiatives which are of central importance to current policy and which epitomise aspects of New Labour's 'Third Way'. Firstly, the white paper *Our Healthier Nation* placed a greater emphasis on public health, individual responsibility for health and on the need for the wider causes of ill-health to be tackled at community level. In terms of the paper's rhetoric, there are parallels with the 'Every Child Matters' and 'Youth Matters' green papers which were discussed in Section 2.2; especially with regard to issues such as responsibility and community involvement. The Our Healthier Nation paper also set targets for the reduction of cancer, coronary heart disease and stroke, accidents and mental health problems which PCTs are still intended to work towards, and this has impacted upon policy at the local level. Secondly, the National Healthy Schools Program has placed a greater emphasis on health education and health promotion work in schools. Its main focus has been on enabling children and young people to gain the knowledge and understanding required to make informed decisions about health and life choices and thereby to improve their future potential. Questions about health policy and the way this is managed are often linked to questions of governance, and the next section of this chapter will introduce some key issues relating to governance.

2.7 Local Governance

Although this thesis is obviously an academic endeavour it is hoped that it will intersect with, and hold a relevance to, issues outside of academia. As noted in Chapter 1, I believe that there are connections between the work undertaken for this thesis and issues which are of pertinence to health promotion policy and practice. Furthermore, as will be discussed later in this thesis, and in Chapter 6 in particular, Health promotion policy and practice, particularly in relation to young people and schools, does play a role in the sculpting of young people's health beliefs and attitudes; albeit in conjunction with other factors. For these reasons it is important to include some consideration of issues relating to governance and, in particular, local governance.

Before discussing local governance and its relevance to this thesis, it is necessary to consider what governance means. As Pierre (2000) notes, governance literature can be confusing because the term 'governance' can refer to one of two broad concepts; the empirical effects of state adaptations to the external environment or representations of the ways social systems are coordinated and the role of the state in this process. I am interested in this second understanding of governance and agree with Pierre's suggestion that:

> "In much of the public and political debate, governance refers to sustaining co-ordination and coherence among a wide variety of actors with different purposes and objectives such as political actors and institutions, corporate interests, civil society, and transnational organizations." (Pierre 2000: 3-4)

Also of particular relevance to this thesis are what Hirst (2000), in his discussion of types of governance, describes as 'governance as new public management strategies' and 'governance as new practices of coordination'. As noted in the previous section, the idea of 'New Public Management' was introduced during the Thatcher era. It is particularly relevant to public administration, including the NHS, and the wider public sector. Rhodes (1997) suggests that the new public management had two elements. Firstly, managerialism and, secondly, new institutional economics; both of which are reflected in the changes in the NHS discussed previously. In this context, managerialism refers to the introduction of private sector management methods into the public sector and the idea of new institutional economics refers to the introduction of market competition and other incentive structures into public services. Despite the changes in government policy over the past decade the new public management strategies remain influential, especially within the NHS.

The idea of governance as new practices of coordination has become more important under the UK Labour Government's regime and in some respects parallels the government's 'Third Way' rhetoric. This understanding of governance refers to new

ways of coordinating activities via networks, partnerships and deliberative forums (Hirst 2000) and is particularly apparent in local governance, although I do not wish to deny its existence elsewhere. Three strands of these new practices of coordination are of particular interest in this thesis; firstly, those which exist within the NHS, secondly, those which exist within local government and, thirdly, those relating to the notions of community participation and active citizenship.

Within the NHS there has been a trend towards NHS Trusts involving stakeholder groups or steering panels in the planning and evaluation of services. Alongside this, there have also been attempts to include the views of service users, usually through consultative initiatives. The emphasis on public management has remained, although Leach and Percy-Smith (2001) suggest that there is now a greater emphasis on the integration of different services and on accountability, coupled with a devolution of responsibilities to area-based organisations.

With regard to local government, the situation in England is complex. All areas within England have some form of democratically elected local government and alongside this some areas also have an elected mayor. Some areas have a single tier of local government, others have multiple tiers. Regardless of the format of local government, there is an increased emphasis on understanding local needs and on inter-agency collaboration and cooperation, plus a greater emphasis on accountability (Leach and Percy-Smith 2001; Stoker 2004). As Leach and Percy-Smith (2001) note, some of the processes and structures for participation and consultation have been established by statute, but local authorities have the discretion to initiate other forms of participation provided these do not go against those established by statute.

Notions of active citizenship and community participation have been central elements in New Labour's rhetoric and were an important facet in some of the policy initiatives discussed earlier such as the respect campaign and Every Child Matters (ECM) agenda. In his 2003 'Scarman lecture', the then UK Home Secretary, David Blunkett, set out his agenda for civil renewal, stating that "at its heart is a vision of strong, active, and empowered communities – increasingly capable of doing things for themselves, defining the problems they face and then tackling them together" (Blunkett 2003, 1). He goes on to suggest that this civil renewal should encompass three key aspects; active citizenship, strengthened communities and partnership in meeting public needs. Behind this is the idea that participation at the community level will encourage engagements with established forms of governance and with politics and will, at the same time, reduce apathy and encourage citizens to take greater responsibility for their own actions and contributions to society.

However, despite the current emphasis on new forms of governance, active citizenship and community participation, it is important to question whether these

trends are actually making a tangible difference at the grass-roots level and whether they are in reality more inclusive that previous models. As already noted in Section 2.2 there has been an increased interest in including children and young people's voices and this will be explored further in Chapter 4. At this stage, it is sufficient to note that the rhetoric surrounding local governance, community participation and inclusion does not always match the reality (Hill 2006; Matthews and Limb 2003; Skelton 2007). In particular, the ways in which young people should participate frequently remain adult-defined and, even within the ECM discourse, the ECM website section on 'strategy and governance' is focused on what adults should do for young people rather than ways in which young people can contribute to these areas (Every Child Matters Website 2009b). It is also important to recognise that there are significant local variations in the ways notions such as local governance are implemented, and the final section of this chapter will briefly introduce some key issues relating to young people, health and local governance in County Durham.

2.8 Young People, Health and Local Governance in County Durham

County Durham, at the original time of writing, had a two-tier system of local governance with a series of District Councils and overall County Council[11]. Some services and policies were organised and implemented at the County level and others at a District level. As was noted in Chapter 1, this research is focused primarily on the area which fell under the remit of the Wear Valley District Council. The situation with regard to local governance is currently quite complex because of a government decision to abolish the District and County Councils and replace these with a single-tier unitary authority; and the county is currently in a transition phase in which the District Councils still partially exist but are working towards the establishment of the unitary authority. It should be noted that whilst the County Council was in favour of the move to a unitary authority, all of the District Councils were against this and a referendum on the issue showed that 76% of residents who voted were against the establishment of the unitary authority (BBC 2007). This realignment of local governance has implications for young people and health in relation to the provision of services and facilities, which will, in the future, be organised at the County-wide level rather than each District Council providing for its immediate locality and local needs.

Services for young people are organised at both levels within the county. At the county level, the focus is generally on work with young offenders, the Duke of Edinburgh Award scheme and groups of young people facing specific challenges such

[11] Although the structure of local governance in County Durham has changed very recently, the bulk of this thesis was written before the change and all the empirical work had already been undertaken. Therefore, I am outlining the system of local governance which was in place at the time this research was undertaken.

as young carers. Other youth services have in the past been organised at district level, but these have now merged with the county council's youth service in preparation for the unitary authority. Currently, the county council is now running youth work and services such as youth clubs through five operational areas, which broadly correspond with the district council areas[12]. State provided youth work and clubs are nevertheless limited within County Durham, and many services are provided by third sector or voluntary organisations.

At the time this research commenced, County Durham was covered by five separate Primary Care Trusts (PCTs), each of which focused on their local area whilst also engaging in county-wide and national initiatives. These have recently been amalgamated into a single PCT. As will be discussed in more depth in Chapters 4, 5 and 6 of this thesis, County Durham contains some areas of significant socio-economic and health deprivation. Issues of particular concern for those formulating health policy and services, as outlined in PCT policy documents, include rising levels of obesity, smoking, binge-drinking and teenage pregnancy (Crawford et al. 2006; Cresswell 2007). To date, health education and promotion within the county has tended to take a top-down approach with professional viewpoints being prioritised. However, some initiatives have emerged more recently in which young people are involved more directly in planning and evaluation; for example, through the healthy schools programme, the recent introduction of student-led School Nutrition Action Groups in some local schools and the increasing profile of school councils.

This chapter has outlined some key issues relating to young people, health and local governance which underpin the material in subsequent chapters of this thesis. In Chapter 4, I will revisit the question of including young people's voices in research and will discuss the methodological implications of the issues raised in this chapter; and Chapters 5, 6 and 7 will include some further discussion of the County Durham context. As will be discussed in the next chapter, issues of space and scale are a significant focus in this thesis. In addition, as will be noted in Section 6.2 of Chapter 6, health policy and practice frequently draws upon a hierarchical understanding of scale in which different scales such as 'local', 'national' and 'global' are viewed as discrete entities. This thesis argues for an alternative understanding of space and scale which recognises fluidity and multiplicity of scale and the mutual production and constitution of global and local; and Chapter 6 includes an extensive discussion of this issue in relation to young people and health in County Durham. First, Chapter 3 will outline the theoretical framework for this thesis, including discussions of the use of theory in

[12] The five operational areas are North Durham, Durham, The Dales, Easington and Sedgefield. The 'North Durham' operational area corresponds with the areas covered by the Derwentside and Chester-le-Street district councils and 'The Dales' operational area corresponds with the areas covered by the Wear Valley and Teesdale district councils. The other operational areas correspond to the district councils of the same name.

Health Geography and Children's Geographies, the significance of space, scale, flows and networks and the ways in which the work of some key theorists can contribute to an understanding of young people's health beliefs and attitudes.

Chapter 3 Conceptual and Theoretical Foundations

3.1 Chapter Introduction

This chapter aims to outline key aspects of the theoretical framework I am using for this thesis. At the start of my PhD, instead of beginning with an aspect of theory that I wanted to work on, and then finding a topic which would fit neatly within this, I began with the topic I was interested in studying and the theoretical framework I am using has evolved around my topic. This was a deliberate choice because the ability to take a more grounded approach to theory building was, in the context of my particular project, fundamental to the aims and objectives of the research. The idea of grounded theory was put forwards by Glaser and Strauss, who suggested that grounded theory

> "is the discovery of theory from data systematically obtained from social research…[Glaser and Strauss's] basic proposition is that generating grounded theory is a way of arriving at theory suited to its supposed purposes…[and they] contrast this position with theory generated by logical deduction from *a priori* assumptions" (Glaser and Strauss 1967: 2-3 emphasis in original).

I cannot claim to have used grounded theory as it was originally conceived, because the theoretical and conceptual ideas relating to children and young people, which were outlined in Chapter 2, do predate the empirical phase of the research and, as will be discussed in Chapter 4, informed the epistemology which underpins the project. Furthermore, even the more grounded or emergent aspects of the theoretical framework used have drawn heavily upon pre-existing theory, and have to some extent been fitted to such theory (see Suddaby 2006 for discussion of these issues). Nevertheless, there are some similarities between grounded theory and the approach taken in this thesis; and some re-workings of the concept of grounded theory, such as situational analyses (Clarke 2003), resonate with the approach taken here (see also Locke 1996). The absence of a rigid theoretical framework at the outset of the research undertaken has allowed greater flexibility during the fieldwork phase of the research and has therefore enabled the research agenda to be at least partially shaped by the people involved in the project. The approach I have taken also allows a more creative use of theory which can help to push boundaries in relation to the ways theory is used within a given area of the discipline.

Neither Health Geography nor Children's Geographies have traditionally been viewed as 'theoretical' sub-disciplines, especially when compared to areas such as Cultural Geography, because 'applied' research has traditionally dominated in these two sub-disciplines. With regard to Health Geography, Kearns and Moon (2002) suggested that the idea of Health Geography engaging itself with critical social theory

was relatively new and described Health Geography as a 'magpie discipline' collecting relevant pieces of theory from elsewhere. However this does not mean that Health Geography is, or has been, a-theoretical (Litva and Eyles 1995). As with other sub-disciplines, some health geographers have not engaged explicitly with theory, but there have inevitably been implicit theoretical and epistemological assumptions which underpin their work. Nevertheless, there was a significant shift in the 1990s from the 'old', largely positivist, Medical Geography towards a 'new' Health Geography[13] which Brown and Duncan (2002) argue led to more explicit engagements with theory and a recognition that this was crucial for the further development of the sub-discipline. This shift from Medical Geography to Health Geography was generally accompanied by a move away from a biomedical understanding of health and illness towards a social or holistic model; both of which were discussed in Chapter 2.

Children's Geographies has, in many respects, seen some similar debates in recent years. Like Health Geography, Children's Geographies is often viewed by outsiders as a marginal or narrow sub-discipline and although, as Aitken (2004) discusses, there is now a burgeoning interest in the area it is yet to gain the widespread acceptance and recognition which areas such as Cultural Geography or Feminist Geographies enjoy. He suggests that it is important for children's geographers "to raise questions of relevance to larger disciplinary, spatial, societal and global contexts" (Aitken 2004: 173) – a challenge which has only been partially met. Nevertheless, now that Children's Geographies has reached more of a 'critical mass' those working in this field are beginning to constructively question and challenge the direction of the sub-discipline, and the use of theory appears to be an important facet of this (see Vanderbeck 2008). Horton and Kraftl (2005) suggested that work in children's and youth geographies was largely a-theoretical. Furthermore, they argued that where there is a theoretical basis for work this is taken for granted with no reflection or discussion of the theoretical and philosophical groundings; thereby effectively making it a-theoretical. However, as I have highlighted elsewhere (Beale 2006), theoretical engagements are important because they help to create a vibrant intellectual environment and there is a need for children's geographers to engage more with theory; yet, as the paper argued, I believe that such engagements with theory should recognise the diversity both of the sub-discipline and of theory. Children's Geographies is in an important evolutionary phase of its development which offers

[13] It is recognised that the idea of an 'old' medical geography and 'new' health geography is somewhat problematic because there are common elements in the work undertaken in both and the extent to which the 'new' health geography is actually 'new' has been questioned (Curtis and Taket 1996). It should also be noted that some geographers (especially in North America) whose work would, on the basic of the above distinction, fit with health geography do still consider themselves to be medical geographers, and vice versa. However, the idea is being used here to reflect some profound shifts which occurred in the sub-discipline during the 1990s and the use of the terms is in line with many of the health geographers writing at that time.

considerable scope for researchers to work creatively with theory. Whilst I recognise that there are problems with the extrapolation of theory and use of selected elements in new areas where the context differs from that originally intended, theory cannot evolve without its boundaries being pushed or challenged.

Although, as was noted in the previous chapter, children's geographers have showed considerable interest in the relationships between children and young people, place and space (Holloway and Valentine 2000), critical engagements with theory relating to space and scale are still lacking. There has been a general focus on the ways in which children and young people relate to places and use spaces, without an explicit consideration of what 'space' actually is. This thesis will engage in a more explicit discussion of issues of space and scale as they relate to the sculpting and performance of young people's health beliefs and behaviours. In addition, much of the existing 'theoretical' work in Children's Geographies mirrors the emphasis within Cultural Geography on poststructuralism (see, for example, Harker 2005; Horton and Kraftl 2005, 2006) and, as I have previously discussed (Beale 2006), there are other areas of theory which could be embraced productively by children's geographers. Despite Horton and Kraftl's (2005) call for children's geographers to draw upon poststructural and non-representational theory, this thesis has taken a different route in terms of both the theory used and the ways this was developed.

The theoretical framework I am developing has three key strands. The first of these is work on space, scale, flows and networks. Drawing on the work of authors such as Foucault (1986), Lefebvre (1991), Swyngedouw (1997) and Marston et al (2005), I will explore some of the more recent understandings of space and scale which view these in a more abstract manner. Space is produced and can take a variety of juxtaposed and intersecting forms including, for example, physical, emotional, institutional and technological spaces. Although scale, flows and networks have often been seen as hierarchical (see Storper 1997 for an example of this), I consider them to be nested, intersecting and, often, horizontal. Scale is fluid not fixed, and different manifestations of scale such as 'global' and 'local' can be mutually constituted and produced, creating intersecting flows and networks and channels of power and influence. Alongside this work on space and scale, the second key strand of theory I am considering is the idea of performance. This strand will draw on the work of both Goffman (stigma, presentation of self and staging) and Butler (gender and performativity). The third strand in the theoretical framework considers issues of power, and will draw on the work of Foucault in relation to power, discipline and gaze. The work of these three theorists will be discussed chronologically, beginning with Goffman and ending with Butler, because Foucault has built on some of the ideas of Goffman, and Butler, in turn, builds upon both. The later sections of this chapter will

engage in a more detailed discussion of the theory I am using in my work, and will highlight the reasons for the inclusion of these areas of theory. However, it is first necessary to discuss the relationships between health, place and space, as they have been understood to date, in the context of Health Geography. This will be the focus of the next section, and will provide a foundation for the remainder of this chapter where I will seek to address some of the gaps in current theorisations.

3.2 The Importance of Place and Space for Health

It is widely accepted both within and beyond Health Geography that place and space can influence health and well-being. As Poortinga et al (2008) note, the idea is well documented that poorer health is generally experienced by people living in neighbourhoods which are socially and economically deprived, but the basis for this apparent relationship is not always clear. In their discussion of British Health Geography at the end of the twentieth century, Asthana et al (2002) suggested that the question of area versus individual influences upon health differences has been, and will be, an important focus within the sub-discipline. A significant amount of work on this topic emerged during the late 1990s and early 2000s as part of the ESRC's *Health Variations Programme*, which included a number of separate research projects related to the programme's overall theme. Writing near the start of this programme, Mitchell et al (1998) posed the question "are geographical inequalities in health and illness just a reflection of socio-economic differences among their inhabitants (composition) or do places add their own contribution to patterns of health variation (context)?" (Mitchell et al. 1998: 4). As will be discussed below, there has been considerable debate about whether health inequalities are attributable to contextual or compositional factors, or both; and more recent suggestions that this division is false.

As Smith and Easterlow (2005) note, and then critique, contextual understandings of health inequalities have often appeared to dominate within Health Geography. There have been suggestions that the health of individuals who have similar social characteristics is affected by the socio-economic setting and environment in which they live (see Curtis and Rees Jones 1998 for a fuller discussion). Macintyre et al (2002) argue that most of the studies undertaken in the late 1990s to explore contextual and compositional explanations of health inequalities found that, once compositional features had been considered, there were still residual area effects which pointed towards the significance of contextual factors. Many of the existing studies have explored contextual health inequalities using extensive quantitative methods and/or professionally constructed notions of health status or health outcomes. Nevertheless, some studies (for example Airey 2003; Davidson et al. 2008; Poortinga et al. 2008; Warr et al. 2007) have emerged more recently exploring lay perceptions of

the interplay between place and health or of health inequalities more generally. Although Stafford et al (2007) note that few studies have unpicked what they describe as the "black box" of area deprivation in order to explore the specific modifiable social and physical environmental characteristics which impact upon health, this is not a challenge I will take up in this thesis. This is largely because existing work has generally focused on adults and I believe it is necessary to explore young people's perspectives, beliefs and attitudes before trying to identify individual 'problem' characteristics of their neighbourhoods. Exploring *both* young people's beliefs and attitudes *and* identifying specific causal characteristics of their neighbourhoods is beyond the scope of this thesis and I have focused primarily upon the first of these issues. Nevertheless, there will be a limited engagement in later chapters with the ways in which characteristics of the neighbourhoods in which I worked might help sculpt young people's beliefs and attitudes.

Over the past few years some attention has been given to conceptualising both 'place' and 'place effects' and the ways these impact upon health. Macintyre et al (2002) organise their conceptualisation around five types of features of local areas which they consider might impact upon health. Firstly, physical features of the environment which are shared by all residents within the locality; secondly, the availability of healthy environments at home, at work and for play; thirdly, the services which are provided (either publically or privately) to support people in their everyday lives; fourthly, a neighbourhood's socio-cultural features and; finally, the area's reputation (Macintyre et al. 2002). In their recent summary Flowerdew et al (2008) suggest a number of contextual effects; specifically, the natural environment and ways in which it is (not) conducive to health, the local availability of health care, social and cultural norms including the availability of social capital and the impact of relative deprivation.

A number of authors have disputed the focus on contextual understandings of health inequalities and emphasise the impact which compositional factors may have. Towards the end of the paper in which they pose the initial question of whether health inequalities are simply a reflection of the differing socio-economic statuses of inhabitants or if places add their own contribution, Mitchell et al (1998) state that "Although we have shown that some areas do contain concentrations of needy people, thus far our research supports the primacy of individual circumstances in determining adverse health outcomes." (Mitchell et al. 1998: 5). Nonetheless, as Smith and Easterlow (2005) discuss, health geographer's have tended to overlook the contribution of compositional factors. Drawing upon household trajectories, Smith and Easterlow suggest that health itself may influence the structuring of society and space and that people with poorer health may be sifted and sorted across housing stock. They

identify a number of households who moved into poor health-profile neighbourhoods having already developed adverse health conditions, a number who moved into such places before they developed an adverse health condition and were then unable to move out of the area, and a further group with adverse health conditions who lived in neighbourhoods with healthier profiles but felt that they were under pressure to move out of these areas or were facing the possibility of displacement from their area (Smith and Easterlow 2005). As other authors discuss, this idea of sifting or a 'drift hypothesis' was previously explored in relation to mental health and issues such as schizophrenia (DeVerteuil et al. 2007; Philo et al. 2003). However, as will be discussed in Chapter 5 of this thesis, the young people I worked with focused primarily on physical aspects of health and well-being and I therefore will not be engaging fully with the debates within Health Geography surrounding mental health.

Whilst the context versus composition arguments often seem to present the idea that health inequalities result from either one or the other, authors have increasingly been arguing for an approach which allows the contribution of both. As Bernard et al (2007) discuss, the contextual versus compositional framing of the debate is an oversimplification. Writing later in their project, Mitchell et al (2000), whose previous emphasis on the primacy of individual circumstances was noted earlier in this section (Mitchell et al. 1998), argue that their "evidence suggests that health is a function of characteristics of both individual *and* area of residence as well as the individual's sense of belonging to their place." (Mitchell et al. 2000: 78 emphasis in original).

A number of studies have sought to explore the relationship between social capital and health as a means of explaining inequalities between different areas (Abel 2008; Araya et al. 2006; Carpiano 2007; Hutchinson et al. 2009; Snelgrove et al. 2009; Stephens 2008) and these are in many respects an attempt to bridge the apparent divide between contextual and compositional explanations. Work on social capital and health generally draws upon Putnam's understanding of social capital in which it is stated that ""social capital" refers to features of social organization such as networks, norms, and social trust that facilitate coordination and cooperation for mutual benefit." (Putnam 1995: 67). There have been suggestions that people living in areas with greater access to social capital have better health than those in similar areas with less social capital (see, for example, Subramanian et al. 2003).

Another way of bridging the supposed divide between contextual and compositional factors has been proposed by those arguing for the adoption of a relational approach to understanding the impact of place upon health. Cummins et al (2007) argue that health geographers need to move beyond the false dualism between context and composition and recognise that people and places are interrelated. They

suggest that this should include a focus "on the *processes* and *interactions* occurring between people and places and over time" and will "require a reassessment of existing articulations of *location* and *scale* that have been typically used in the study of health and place in the past." (Cummins et al. 2007: 1828 emphasis in original). A relational approach has also been used by Bernard at al (2007) in their discussion of the nature of neighbourhoods and the ways these contribute to the production of everyday health inequalities.

Whilst I agree that it is necessary to bridge the divide between contextual and compositional understandings of health inequalities, and I am in agreement with aspects of both the social capital and relational approaches introduced above, none of the approaches outlined in this section fits completely with the approach my project has taken or the theoretical framework I am seeking to develop. With regard to the social capital approach, I do recognise that the availability of social capital can impact upon health and well-being. However, as will be apparent from discussions in later chapters, the young people involved in my research did not engage in meaningful discussions about factors or ideas which could be equated with aspects of social capital. Furthermore, authors who support to the social capital approach, or related ideas, tend to draw upon the work of Bourdieu in the development of their theoretical framework (Gatrell et al. 2004; Stephens 2008) and the relational approach suggested by Cummins et al (2007) draws heavily upon Actor Network Theory. I am not using either Bourdieu or Actor Network Theory in this thesis because, whilst they might superficially appear to resemble aspects of my work on space and scale, neither of them fits neatly with questions of power, gaze or performativity, which I will draw upon later.

Although, as Asthana et al (2002) discuss, health geographers have begun to explore the relationships between local processes and wider scale ones, reflecting the wider interest within Human Geography surrounding the interaction between global trends and local contexts, there has been little engagement with theorisations of space and scale. The recent editorial by Procter and Smith (2008) notes that both global and local scales are important and that considering "multiple scales of place is crucial if we aim to better understand the importance of place in health" (Procter and Smith 2008: 303). However, it appears that my work diverges from Procter and Smith's stance in two key respects. Firstly, whilst the special issue which Procter and Smith edited focuses on studies which have explored the relationships between place and health at specific scales, and the contributions which studies at each scale can make, I am interested in the intersections, enmeshments and intertwinings of scale. Secondly, it appears that my work is drawing upon a rather different understanding of space and scale to that which is most commonly used by health geographers. The understanding of scale I am drawing upon will be outlined in the next section of this chapter, and will

be explored further in Chapter 6 in relation to young people's health beliefs and behaviours, and I will point towards the contributions this understanding of space and scale can make to work within both Health Geography and Children's Geographies.

3.3 Space, Scale, Flows and Networks

As the previous section discussed, there has been widespread recognition that place and space are important for health but, whilst there have been some theoretical engagements with 'place', issues relating to space and scale remain under-theorised within Health Geography. Despite the work on young people's use of public space mentioned in Chapter 2, theorisations of space and scale also remain inadequate within Children's Geographies. After summarising the ways in which space and scale have previously been understood in Human Geography, and recent re-workings of these concepts, this section will outline my stance on issues relating to space and scale and will point towards the contributions this could potentially make to work in Children's Geographies and Health Geography.

As Gregory (2000) discusses, Geography established itself as a 'spatial science' in the 1950s and 1960s, but this period saw little critical engagement with space as a concept. As he notes, geographers at this time "simply took it for granted that space (like time) was a universal of human existence, an external coordinate of reality, an empty grid of mutually exclusive points, 'and unchanging box' *within which objects exist and events occur*" (Gregory 2000: 768 emphasis in original). In effect, studying space centred around an ability to fix locations on the surface of the earth. This concept of absolute space, which enjoyed a period of hegemony in Anglo-American Geography, did come under increasing criticism and gradually came to be largely replaced with the concept of relative space.

Supporters of the concept of relative space argued that space should be defined between objects and events, rather than between fixed points on a co-ordinate system. Thus Smith argues that:

> "With the 'production of space' human practice and space are integrated at the level of the concept of space 'itself'…While the emphasis here is on the direct physical production of space, the production of space also implies the production of the meaning, concepts and consciousness of space which are inseparably linked to its physical production". (Smith 1984: 77)

Despite this interest in objects and events, space was often still considered to be a measureable and quantifiable object and there remained an emphasis on spatial analysis and mathematical modelling. There has often been a tendency for geographers to conflate spatial relations with social relations, and this has been critiqued. Harvey (1973, 1996) suggests that it is necessary to consider ways in which people make use of different conceptualisations of space and argued for what is

sometimes referred to as a relational concept of space (Gregory 2000) in which space is folded into social relations.

Whilst, as noted earlier, the nature of 'space' is rarely discussed within Health Geography and Children's Geographies, there is generally a tacit adoption within these sub-disciplines of the concept of relative space[14]. However, elsewhere in the discipline, more abstract relational understandings of space have, over the past few years, increasingly come to the fore; especially in areas such as Cultural Geography and Urban Geography. In many respects the more abstract understandings of space are an extension of the relative and relational understandings of space mentioned above, but they draw upon different epistemological foundations (usually poststructuralist or non-representational). The quotation from Smith (1992) below shows an early example of the relational understanding of space being stretched towards a more abstract understanding in recognition of the complexity, fluidity and interdependence of social and spatial relations:

> "Long conceived as dead, fixed and immobile, space is both available as a foundational metaphor and at the same time being rediscovered as produced, mutable, an intrinsically complex expression of social relations. Not only is the fragility and transitoriness of contemporary social relations expressed 'in' space; the production of space is increasingly the means by which social difference is constructed and reconstructed." (Smith 1992: 64)

Many of those working on the more recent relational and abstract understandings of space have used the work of Foucault (1986) and Lefebvre (1991) as a starting point. Foucault states that:

> "The present epoch will perhaps be above all the epoch of space. We are in the epoch of simultaneity: we are in the epoch of juxtaposition, the epoch of the near and far, of the side-by-side, of the dispersed. We are at a moment, I believe, when our experience of the world is less that of a long life developing through time than that of a network that connects points and intersects with its own skein." (Foucault 1986: 22)

Thus, for Foucault, space takes the form of relations among sites. Yet, in contrast to the concepts of space outlined at the start of this section, these relationships are complex, multifaceted and non-linear. Space can simultaneously be both juxtaposed and dispersed, it can have different manifestations, follow differing trajectories, and cannot easily be reduced or quantified.

For Lefebvre, space is produced; it is not a pre-given entity. As with Foucault, Lefebvre believes that space can take a variety of forms. He states that "What is involved, therefore, is a *production* – the production of a space. Not merely a space of ideas, an ideal space, but a social and a mental space. An *emergence*. A decrypting

[14] It should be noted that not all health geographers have rejected the concept of absolute space and this is often seen as the most appropriate understanding for work which adopts a positivist epistemology or relies heavily on methods such GIS or multi-level modelling.

of the space that went before." (Lefebvre 1991: 260 emphasis in original). As this quotation suggests, space does not exist in a vacuum; rather it is formed, re-formed and thereby 'produced' – both through the things which exist in the here and now and through interpretations of those which have existed in the past or are represented as having existed in the past. Lefebvre argues that the space which established itself in the Middle Ages was "by definition a space of exchange and communication, and therefore of networks." (Lefebvre 1991: 266). However, he goes on to state that "It would be a mistake, though, to define the new space solely in terms of these networks…Social space is multifaceted: abstract and practical, immediate and mediated." (Lefebvre 1991: 266). This has had a profound impact on the way in which a number of geographers now conceptualise space.

Massey (2005) suggests that space necessarily entails plurality and multiplicity. It is the product of interrelations, formed though interactions (which are embedded in material practices) and is always under construction and (re)formation. Space is the coming together of what Massey describes as 'stories-so-far'; but it is not a finished product. Furthermore, Massey argues that space is a sphere of possibility and the multiplicity this encompasses allows for a greater emphasis on 'difference' and heterogeneity. Massey's approach not only allows for both the production and emergence which Lefebvre previously conceptualised; but also, although she does not explicitly discuss the idea herself, leaves scope for the idea of 'becoming'.

In his discussion of 'time-space', Thrift argues that space and time cannot be separated, stating that "it is neither time nor space that is central to the study of human interactional orders, but time-space" (Thrift 1996: 1). Thrift focuses on connectivity and the flows of knowledge and information which shape and (re)produce social relations across a range of spatial scales. He is also interested in diversity, multiplicity, plurality and, as Warf (2004) notes, context. But, for Thrift, context does not have to be local (Thrift 1996). It is a performative social situation which involves plurality and time-space but does not need to occur at a particular spatial extent or be temporally specific. Context is summed up by Thrift as "a parcel of socially-constructed time-space which is more or less 'elongated' (and in which socially constructed 'notions' of time-space' must play their part") (Thrift 1996: 41). Thrift argues that we account for space and time practically rather than living 'in' space. Contexts are thus productive time-spaces which are themselves produced; they are active and emerging, rather than passive.

Many of the recent re-workings of relational and abstract understandings of space also raise questions, either explicitly or implicitly, about scale. Building on the work of Massey, Harvey and Thrift, Amin states that:

> "space, place and time have come to be seen in relational terms, as: co-constituted, folded together, produced through practices, situated, multiple and mobile. I take this to imply a reading of spatiality in nonlinear, nonscalar terms, a readiness to accept geographies and temporalities as they are produced through practices and relations of different spatial stretch and duration. I take it to suggest a topological sense of space and place, a sense of geographies constituted through the folds, undulations, and overlaps that natural and social practices normally assume, without any a priori assumption of geographies of relations nested in territorial or geometric space." (Amin 2002: 389)

Amin's understanding of space has four key elements. Firstly, he argues that the materiality of everyday life is constituted through a very large number of spaces; such as discursive, emotional, affiliational, physical, natural, organisational, technological, and institutional spaces. Secondly, he suggests that these spaces are also recursive spaces; they can act as the carriers of organisation, stability, continuity and change. Thirdly, he questions the traditional relationship between space and scale by suggesting that the geography of these spaces cannot be reduced to planar (single or multi) or distance-based considerations. Finally, drawing loosely on Rose's assertion that "space is also a doing, that it does not pre-exist its doing, and that its doing is the articulation of relational performances" (Rose 1999: 248), Amin also emphasises the ways in which space is shaped through, and co-constituted alongside, practices and relations.

Drawing on Lefebvre (1991), Smith argues that "Different societies not only produce space, as Lefebvre has taught us, but they also produce scale. The production of scale may be the most elemental differentiation of geographical space and is every bit a social process." (Smith 1992: 73). This notion that scale is produced rather than being a pre-given entity marks an important shift in the way in which scale is understood and there are parallels with the move away from the concept of absolute space. Nevertheless, I have a rather different understanding of scale compared to Smith. Despite his emphasis on the 'production' of scale, Smith still sees scale as being hierarchical – a view which has been criticised.

Using Levinas's concept of intersubjective space, Howitt (2002) argues in his discussion of space and scale that:

> "Levinas represents relations between the self and the other in terms of an ethical imperative in which the face-to-face encounter develops terms for our understanding of our place in society. "Intersubjective space" – that space in which one relates to the other(s) – "is not symmetrical"." (Howitt 2002: 300).

Levinas (1989a) challenges the common binaries upon which many approaches to scale are based, such as the self-other binary, and Howitt argues that this "opens material, discursive and conceptual spaces that are not captive to the dominant pole of the self, and which are not to be defined, discussed or engaged with as a binary in terms of the absence of that pole" (Howitt 2002: 303). On the basis of his reading of

Levinas, Howitt argues that intersubjective space can be constituted as a moral space and that we occupy moral landscapes in which ethics frame and shape interpersonal, structural and political relationships. Here, 'ethics' includes attributes such as responsibility, reciprocity, proximity, collectivity and co-existence. For Howitt, space is not merely metaphorical; it involves face to face engagements.

Following his discussion of Levinas, Howitt (2002) argues that there are three dimensions to scale: scale as size, scale as level, and scale as relation. At first sight, this may appear to be a hierarchical understanding of scale which is something I am keen to move away from in this thesis. Nevertheless, Howitt does support an abstract understanding of scale and suggests that "It reflects facets of space, time, culture and environment. It has dimensions of size, level and relation, and is paradoxically simultaneously both hierarchical and non-hierarchical…Scale…is simultaneously metaphor, experience, event, moment, relation and process." (Howitt 2002: 306)

It should be noted that I do not agree entirely with Howitt's (2002) reading of Levinas (1989). To me, in *Time and the Other*, Levinas (1989) is talking primarily about ways in which people relate to each other (and is not really interested in the idea of space as a concept) and I am concerned that Howitt is extrapolating Levinas's idea of intersubjective space too far. Nevertheless, I am supportive of Howitt's general understanding of space and scale and am happy with his use of Levinas's later essay *The Transcendence of Words*. In my view, a clear interpretation of Levinas's understanding of space and scale can be gained from one of his other essays in which he states that:

> "Space does not accommodate things; instead, through their erasures, things delineate space. The space of each object in turn is divested of its volume, and from behind the rigid line there begins to emerge the line as ambiguity. Lines shed the function of providing a skeleton and become the infinite number of possible connections…There is a variation on themes [which] is precisely simultaneous and spatial." (Levinas 1989b: 146-47).

Here, the way in which space is produced through 'things', such as objects and relationships, comes across more clearly. The idea that space is demarcated by ambiguity rather than rigid lines also points towards a more abstract and fluid understanding of scale.

The traditional hierarchical understanding of scale has also been challenged by Erik Swyngedouw (1997), who argues that the global and the local are 'deeply intertwined'. Local actions can influence global money flows and global processes can impact upon local actions, meaning that "In short, the local and the global are mutually constituted." (Swyngedouw 1997: 137). Swyngedouw argues that other spatial scales are also heavily involved in these events. Furthermore, he goes on to state that "places and spaces at different geographical scales are invoked in attempts to account

for dramatic events that have major local, national, and international implications. These "scalar narratives" provide the metaphors for the construction of "explanatory" discourses." (Swyngedouw 1997: 139).

For Swyngedouw, spatial scale is something which, like space, is produced. According to Swyngedow, the production of scale is:

> "a process that is always deeply heterogeneous, conflictual and contested. Scale becomes the arena and moment, both discursively and materially, where sociospatial power relations are contested and compromises are negotiated and regulated. Scale, therefore, is both the result and the outcome of social struggle for power and control." (Swyngedouw 1997: 140).

Swyngedow argues that spatial scales are never fixed and therefore cannot offer a starting point for socio-spatial theory. As the start of the quotation above indicates, Swyngedow believes that it is necessary to begin with 'process' instead of 'scale'. For Swyngedouw, scale can be both horizontal or vertical (or both) and he suggests the abolition of the terms 'local' and 'global' in favour of a politics of scale. Although the terms 'local' and 'global' need to be kept in my work because of their prevalence in policy discourses, I agree that it is important to begin with a consideration of processes and am not using the hierarchical understanding of scale which dominates in the policy arena.

As Swyngedouw suggests, it is important to recognise that changing socio-spatial relationships can transgress or transform both established norms and routines and the ways in which these are regulated, for example in institutions or governance. As I will argue in later sections of this chapter, it is important to consider the ways in which power plays out within and across space and scale. Swyngedouw points towards this with his observation that:

> "Scale is hereby fundamental as it embodies a temporal compromise, solidifies existing power relationships, regulates forms of cooperation, and defines competitive and other power strategies. Scale reconfiguration, in turn, challenges existing power relations, questions the existing power geometry, and, thus, expresses the effects of sociospatial struggles." (Swyngedouw 1997: 147).

In their discussion of 'geography without scale', Marston et al advocate a 'flat ontology' composed of what they describe as "complex, emergent spatial relations" (Marston et al. 2005: 422). They argue that:

> "in contrast to transcendent ontologies and their vertical semiotics of scale, flat ontologies consist of self-organizing systems…where the dynamic properties of matter produce a multiplicity of complex relations and singularities that sometimes lead to the creation of new, unique events and entities, but more often to relatively redundant orders and practices" (Marston et al. 2005: 422).

The above quotation from Marston et al includes two points which have often been overlooked in the recent re-workings of space and scale. Firstly, Marston et al consider

both multiplicities and singularities, whereas other authors have been focusing more exclusively on multiplicity and plurality, and, secondly, they acknowledge that although spatial and scalar practices can have a transformative potential they do not always realise such potential.

Marston et al suggest that a coherent flat ontology has three key elements. Firstly, they argue that it is important to include an analysis of composition and decomposition which resists the common trend towards representing the world as a mixture of unrestrained and unconstrained flows and they emphasise that it is important to also consider "the large variety of blockages, coagulations and assemblages…that congeal in space and social life" (Marston et al. 2005: 423). Secondly, the differential relations which constitute the driving forces of material composition need to be considered alongside a problematisation of the widely accepted tendencies for geographical objects to be stratified and classified. Thirdly, they argue that it is important to examine both the localised and non-localised emergent events through which differential relations are realised and in which the 'social' unfolds. For Marston et al it is essential that spatial concepts need to both consider the materialities and singularities of space and avoid the danger of these being pre-determined by either hierarchies or boundlessness.

It is important to recognise that there are spatial politics associated with much of the recent work on space and scale (Allen 1999, 2004; Massey 1999, 2004, 2005; McDowell 2004; Thrift 1996, 2004). This is articulated well by Swyngedouw who states that:

> "some new social movements and, in particular, progressive ecologists, feminists, and socialists, have begun to struggle through the difficult process of formulating cross-spatial strategies that do not silence the other, exclude the different, or assume the particular within a totalizing vision. The politics of scale are surely messy, but they ought to take center [sic] stage in any emancipatory political strategy. The discourse on the global and the local, however intellectually stimulating and theoretically insightful they may be, seem to be increasingly out of step with the politics of scale, where the everyday struggle for power and control is fought out." (Swyngedouw 1997: 160-61).

However, whilst I recognise that the type of research I am doing, which crosses academic and policy boundaries, does inherently relate to politics and has an intrinsic politics of its own, I am not considering such politics openly in this thesis. The rationale for this omission is that this thesis is setting out the foundations upon which such a politics could manifest – i.e. on the social, spatial and scalar practices and performances which shape young people's health attitudes and enactments of these – rather than discussing the politics and political implications which emerge. The politics and political ramifications involved are of interest, but remain beyond the scope of this thesis.

As mentioned in the introduction to this chapter, I am using a more abstract understanding of space and scale than that which has generally dominated in Health Geography and Children's Geographies. Like Thrift (1996), Amin (2002) and Massey (2005), I am interested in the diversity, multiplicity and plurality of space; but also, like Marston et al (2005), in the singularities which accompany this. I consider space to be both bounded and boundless, fluid and constrained, real and imagined. Space is an emergence and a becoming and yet allows for other emergences and becomings; it is produced and yet at the same time is also a producer. Space can be linear, but is often folded, stretched or juxtaposed. Very recently[15], Ansell (2009) has discussed some ways in which Marston et al's (2005) flat ontology can inform work in Children's Geographies, and Chapter 6 of this thesis will explore this in relation to two themes. Firstly, young people and the media, technology and health and, secondly, food and health.

Scale is both a product and a producer of space. Like space, scale is a plural and multifaceted emergence and a becoming. Scale takes multiple forms which can be simultaneously both intersecting or juxtaposed and distant or discrete. Space and scale can be mobilised both to create binaries such as self and other and to deconstruct or decompose them. As I will argue later, space and scale are vested with, and vehicles for, power and can be used both to discipline or constrain and to challenge or re-imagine. In addition, like Lefebvre (1991), I believe that an important aspect of both space and scale is the idea of flows and networks. Although understandings of flows and networks can often be hierarchical, especially if there is an economic emphasis (see Storper 1997 for an example), this hierarchical understanding is something which I am keen to move beyond. I consider flows and networks to be nested, but at horizontal, intersecting and juxtaposed scales rather hierarchical ones. Flows and networks can be multiple, intersecting and fluid but can also, at the same time, be tangible and material. Like space and scale, flows and networks can simultaneously be both abstract and real. Chapters 6 and 7 of this thesis will explore these ideas about space, scale and networks further in relation to the ways in which young people's health beliefs are shaped and performed, and will draw extensively on material from the empirical stage of this project.

The major difference between the theoretical framework I am developing in this thesis and the frameworks surrounding the recent re-workings of space and scale which I have discussed in this section lies in the other aspects of my framework. Many of the authors involved in the re-workings of space and scale discussed are interested

[15] It should be noted that Ansell's paper was published after this thesis was drafted. Whilst my work on space and scale connects with what Ansell has recently written, the material in this thesis relating to young people and issues of space and scale is based on my own thinking and not on Ansell's paper.

in poststructuralist theory and, in particular, non-representational theory. Non-representational theory is about presentation and *not* representation (Thrift 1996), whereas I consider *both* presentation *and* representation to be important. Therefore, beginning with a discussion of the work of Erving Goffman, the next three sections of this chapter will outline the other key aspects of my theoretical framework and the ways in which these can contribute to understandings about young people, health, space and scale.

3.4 Erving Goffman: The presentation of self, staging, interaction ritual and stigma

The work of Erving Goffman is focused largely around questions of how people relate to and interact with each other especially, but not exclusively, in public settings. My discussion of Goffman here will focus around three aspects of his work. Firstly, his ideas about the ways individuals present themselves and the performances and staging which may be involved; secondly, his discussion of interaction rituals and; thirdly, his understanding of stigma and identity. This thesis's interest in the work of Goffman arose, firstly, from the way in which many of the young people involved in the initial group discussion appeared to initially follow the scripting of the school Personal, Social and Health Education (PSHE) curriculum; secondly from the roles and identities which participants performed and; thirdly, from the interplay between performance, identity and issues of stigma.

Goffman (1959) describes the social world as being a performance on stage. His understanding of performance is outlined concisely in his early statement that:

> "A performance may be defined as all the activity of a given participant on a given occasion which serves to influence in any way any of the other participants. Taking a particular participant and his performance as a basic point of reference, we may refer to those who contribute to the other performances as the audience, observers, or co-participants. The pre-established pattern of action which is unfolded during a performance and which may be presented or played through on other occasions may be called a 'part' or 'routine'." (Goffman 1959: 26-27).

Thus, Goffman sees individuals as being actors participating in social action and interaction. Actors may adopt roles in which the interaction follows a pre-established pattern, often in accordance with social norms.

An important aspect of Goffman's understanding of performance revolves around the idea of 'front'. In *The Presentation of Self in Everyday Life*, Goffman refers to the idea of front in three different contexts. Firstly, he presents the idea of 'front' being part of an individual's performance. Here, he suggests that the front "functions in a general and fixed fashion to define the situation for those who observe the performance…[and]…is the expressive equipment of a standard kind intentionally or

unwittingly employed by the individual during his performance" (Goffman 1959: 32). Secondly, he includes the idea of a 'personal front' to refer to items of expressive equipment such as clothing, age, racial characteristics, body shape or facial expressions which can be most intimately identified with the performer himself/herself. Thirdly, Goffman uses the idea of a 'front region'[16] to refer to the place where a performance is given. Goffman argues that, when in the presence of other people, some aspects of an activity or role are accentuated whilst other aspects which might present a less favourable impression are suppressed, stating that it "is clear that accentuated facts make their appearance in what I have called a front region; it should be just as clear that there may be another region – a 'back region' or 'backstage' – where the suppressed facts make an appearance" (Goffman 1959: 114). In the empirical work undertaken for this thesis, a number of the group discussions appeared to provide a 'front region' where participants' performed roles and identities were mitigated by social norms and expectations, the image and identity which they wanted to present to others and concerns about the way in which others might view them. Whilst the follow-up interviews did offer more of a 'back stage' environment, they were still performed.

For Goffman, performances are also influenced by their 'setting', which includes things like furniture and physical layout as well as other background items which provide scenery and stage props; and this issue will be discussed further in Chapter 4 in relation to the methodology used in this study. In order for a performance to be successful the audience, observers or co-participants must be convinced that the performer is sincere. Such a performance is often maintained through the use of pre-defined (or socially-defined) scripts which set out how the performer should behave or interact with others in a given role or setting. Thus, performances are "'socialised', moulded, and modified to fit into the understanding and expectations of the society in which it is presented" (Goffman 1959: 44).

Branaman (1997) suggests that there are apparent paradoxes in Goffman's work and argues that two definitions of the self appear. There is firstly a view that the self is entirely a social product and secondly a view that the self contains an unsocialised component which drives an individual's engagements with, and withdrawals from, social intercourse. In addition Branaman argues that Goffman's suggestion that individuals are not entirely socially determined, due to their ability to manipulate social situations and the impressions which others gain from these, contradicts his emphasis on ways in which individuals are constrained by social norms and expectations and are thus unable to freely choose their own self image. I would suggest that rather than presenting unworkable contradictions, Goffman is actually

[16] This is often referred to as the idea of 'front stage'.

embracing important tensions between individual autonomy and agency and the impact of societal norms and expectations. Such tensions are in fact discussed by Goffman who, for example, suggests that "when an individual presents himself before others, his performance will tend to incorporate and exemplify the officially accredited values of the society, more so, in fact, than does his behaviour as a whole" (Goffman 1959: 45). The interplay between young people's autonomy and societal norms and expectations will be explored further in Chapter 6 in relation to food practices.

Many of the ideas presented in Goffman (1959) are developed further in his subsequent discussion of relations in public (Goffman 1971) and interaction rituals (Goffman 1972). As is widely accepted, Goffman believes that individuals live in a world of social encounters which involve face-to-face or mediated contact with other people; and that this involves a pattern of both verbal and non-verbal acts. Building on some of the ideas previously introduced in his discussion of 'front', Goffman (1972) argues that "The ultimate behavioural materials are the glances, gestures, positionings, and verbal statements that people continuously feed into the situation, whether intended or not" (Goffman 1972: 1). For Goffman, the face is an important vehicle for such behavioural materials and can help to maintain a consistent image or, conversely, can undermine the image which a person is attempting to present. In *Interaction Ritual* Goffman includes an extensive discussion of 'face-saving' practices which are adopted in social encounters and interactions and also argues that an individual may possess multiple selves which they are required to present or withhold on certain occasions and during particular performances. Such practices, and the ways in which they are performed, can impact upon the information which is disclosed in research contexts.

In *Relations in Public* Goffman (1971) explores connections between social relationships and public life. He argues that the routine dealings which any set of actors have with each other become subject to ground rules which may be restricting or enabling; but that these are only one component of an organisation. Claims and territories can also be influential. For Goffman, territories vary in terms of their organisation and examples include personal space, 'the stall' (a bounded space to which an individual can temporarily lay claim), 'use space' (the territory immediately in front of or surrounding an individual which he or she is able claim due to instrumental needs), 'the sheath' (a person's skin and the clothes covering this), 'possessional territory' (objects identified with the individual which are arranged around the body), 'informational preserve' (facts about the individual which he or she wants to control access to or disclosure of when in the presence of other people) and the 'conversational preserve' (control exerted by the individual over who can talk to him or her, when and how). Whilst Goffman himself suggests that not all of the territories he discusses are spatial, I would argue that this assertion is based on the concept of

absolute space which was dominant at the time when he wrote and that all of the territories he discusses can in fact be spatial when using the more abstract understanding of space outlined in the previous section.

Another important facet of Goffman's work is his discussion of stigma (Goffman 1963). It is widely accepted that stigma may be attached to those people or places which are seen to differ in an undesirable way from social norms or expectations. In relation to people, Goffman (1963) identifies three categories of stigmatisation; blemishes of the body such as physical deformities, blemishes of character or behaviour such as alcoholism and tribal stigma associated with membership of a particular social group. He also argues that stigma may be either enacted or felt. Enacted stigma is experienced through the ways other people act towards or around the stigmatised person, whereas felt stigma is where the stigmatised person internalises their fear of stigma being enacted and does this in a manner which limits their behaviour or opportunities. Enacted stigma is based on a perceived distinction between 'self' and 'other' in which the self is seen as normal and the other as abnormal or defective. As noted by Aitken (2001), the othering of young people is common. However, most literature focuses on ways young people are othered by society at large and ignores processes operating within their peer group. As I have argued elsewhere, in work relating to the performance of young people's health beliefs and issues of embodiment (Beale 2010), processes of stigmatisation and othering are multi-directional. In many instances, both in my previous work and the research used for this thesis, young people who stigmatised or othered certain sections of their peer group were simultaneously themselves stigmatised by others.

As I have discussed elsewhere (Beale 2010), experiences of stigma or othering can have a significant impact upon an individual's ontological security. Put simply, ontological security refers to an individual's sense of being in, or belonging to, the world and underlies their ability to engage in the activities of day to day life. Laing states that an ontologically secure individual

> "may have a sense of his [sic] presence in the world as a real, alive, whole, and, in a temporal sense, continuous person. As such, he can live out into the world and meet others…Such a basically *ontologically* secure person will encounter all the hazards of life, social, ethical, spiritual, biological, from a centrally firm sense of his own and other people's reality and identity." (Laing 1960: 40 emphasis in original)[17].

Felt stigmas and experiences of being 'othered' can challenge an individual's ontological security through undermining their self-esteem, confidence and sense of self-worth and identity. Some of the participants I worked with were reluctant to

[17] Although Laing's initial discussion of ontological security focused on people with schizophrenia, the concept of ontological security has since been widely used to apply to other contexts.

discuss some issues and ideas in the group context, but felt able to do so in the smaller follow-up interviews. For example some of the Year 9 girls at Hillcrest High School mentioned bullying as an issue during the group discussion, but were unwilling to discuss this in any depth. However, in the follow-up interview one of them disclosed her experiences of bullying at primary school and the impacts this had on her mental and physical health and well-being; and was open about the resulting depression, fear of leaving her house and weight-gain associated with low self-esteem and comfort eating.

Overall, Goffman's work is able to make a number of contributions to the theoretical framework I am seeking to develop. His discussions of performance and interaction rituals offer a useful starting point for exploring the ways in which young people relate to each other and to other people, and the ways in which this can be shaped by social and cultural norms and expectations. In a number of the works discussed here, Goffman highlights the importance of individuals presenting an image which will be accepted by others and of being able to employ face-saving tactics or avoid enactments of stigma – all of which can be especially important in the case of young people due to their emergent identities and need to develop or maintain self esteem. It is clear that many of the strategies, rituals and performances discussed by Goffman have spatial dimensions and, as discussed, his work on territories resonates particularly well with the more abstract understanding of space and scale used in this thesis. Nevertheless, there are a number of gaps which remain in terms of the theoretical framework for this thesis, and the next section will address some of these through a discussion of Foucault's work on power, discipline and gaze. In particular Goffman's work does not explicitly address issues of power, discourse, knowledge and gaze, or the ways in which norms and expectations may be controlled or resisted – although I believe such ideas are implicit in Goffman's work even though they are not articulated overtly.

3.5 Michel Foucault: Power, Discipline and Gaze

Although Foucault's primary interest was in history, much of his writing connects with issues of space and place – especially aspects of these which are enmeshed in history (Philo 2000b). The sheer volume of Foucault's work and its diversity make it impossible to provide a comprehensive coverage here, and I am therefore being selective in the aspects I discuss. As was noted earlier in this chapter, the ideas in Foucault's paper *Of Other Spaces* have been used in the recent theoretical re-workings of space. Foucault's geography has an emphasis on dispersion, where things are 'jumbled up' on the same level as each other, but he envisages what has been described as a transient connectedness rather than chaos (Philo 2000b).

Although much of Foucault's work under discussion in this section was written about bodies, I believe that this is of pertinence to work on health and well-being. Philo (1996) suggested that issues relating to the body and embodiment offered considerable possibilities for health geographers to engage more explicitly with theory. This call for geographers to explore the interplay between bodies, embodiment and theory has subsequently been echoed by others, both within and beyond Health Geography (Colls 2007; Longhurst 1997, 2001, 2005; Simonsen 2005). Empirical work I have undertaken suggests that both embodied aspects of gender and identity, and an individual's physique and appearance and its reception are integral components in young people's perceptions of health; and that embodiment involves not only the physical appearances associated with different masculinities and femininities, but also their corporeality and performance. Drawing upon some of Foucault's work, this section will discuss issues relating to power, discipline and gaze and will highlight some of the ways in which this can help inform the ways in which young people's health beliefs and behaviours are shaped and performed.

According to Foucault, the disciplining of bodies, and thereby of people, is intrinsically linked to regimes of power and knowledge. This is particularly apparent in *Discipline and Punish* (1975) where Foucault argues that, through power, discourses and knowledges are deployed on and over bodies establishing certain knowledges and representations of truth regarding the lives and behaviour of individuals and particular bodies. For Foucault, power is a strategy rather than a property or possession and, as summarised by Smart (1985), "a relation of power does not constitute an obligation or prohibition imposed upon the 'powerless', rather it invests them, is transmitted through and by them" (Smart 1985: 77). Foucault identifies what he describes as the productive aspect of power, and argues that:

> "What makes power hold good, what makes it accepted, is simply the fact that it doesn't only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms of knowledge, produces discourse. It needs to be considered as a productive network which runs through the whole social body, much more than as a negative instance whose function is repression" (Foucault 1980: 119).

Thus, for Foucault, the techniques of power are invented to meet the demands of its production (Foucault 1980). Although Foucault does not consider power and knowledge to be the same, he does suggest that each promotes the production of the other (Barker 1998). For Foucault, there is plurality and multiplicity of power, and power relations are interwoven with other kinds of relations such as those involving the family. Both objects of knowledge and the particular subjects to which particular knowledges or objects relate are produced by power.

In *Discipline and Punish*, Foucault discusses changes in the French penal system in which physical punishment (punishment of the body) was being replaced by losses of freedom or finance (correcting of the soul). Early in this book, Foucault poses the question "If the penality in its most severe forms no longer addresses itself to the body, on what does it lay hold?" and states that the answer:

> "seems to be contained in the question itself: since it is not longer the body, it must be the soul. The expiation that once rained down upon the body must be replaced by a punishment that acts in depth on the heart, the thoughts, the will, the inclinations" (Foucault 1975: 16).

For Foucault, this transition in the penal system involves both a substitution of objects and displacements; but he suggests that, at the same time, "the division between the permitted and the forbidden has preserved a certain constancy from one century to another" (Foucault 1975: 17). Foucault argues that physical punishment, especially torture, was strongly embedded in the legal system and suggests that this revealed 'truth' and demonstrated the manifestation of power; stating that "[physical punishment] also made the body of the condemned man the place where the vengeance of the sovereign was applied, the anchoring point for a manifestation of power, an opportunity of affirming the dissymmetry of forces" (Foucault 1975: 55).

Whilst a discussion of penal practices may seem far removed from the interests of this thesis, many of the ideas Foucault introduces in this context can have a wider resonance to more general questions about the ways in which power, discipline and the acceptability of different acts or behaviours can sculpt societal norms, expectations and behaviours. In his discussion of docile bodies Foucault stated that "a body is docile that may be subjected, used, transformed and improved" (Foucault 1975: 136). He draws on a range of examples including schools, hospitals, factories and the army to discuss ways in which bodies were disciplined through the outworking of power and 'subtle coercion' to conform and become more 'useful'. For Foucault, the body is both an object of knowledge and a target for the exercising of power. Foucault's argument was summed up clearly by Smart, who stated that "The body is shown to be located in a political field, invested with power relations which render it docile and productive, and thus politically and economically useful" (Smart 1985: 75). As was noted in Chapter 2, issues relating to young people's health, and therefore their bodies, have become a significant political and policy focus. A number of recent initiatives, such as the weighing of children and young people in schools and changes to policies surrounding school meals, have sought to discipline young people's bodies and encourage them to conform to notions of health and what constitutes a 'healthy' body.

For Foucault, discipline is a technique and a type of power. It provides procedures for the training or coercion of bodies through instruments such as hierarchical observation, normalising judgement and examination. Whilst discipline

may be imposed, for example in the classroom, this is not necessarily the case. Thus Foucault argues that:

> "'Discipline' may be identified neither with an institution nor with an apparatus; it is a type of power, a modality for its exercise, comprising a whole set of instruments, techniques, procedures, levels of application, targets; it is a 'physics' or an 'anatomy' of power, a technology" (Foucault 1975: 215)

Like power, discipline can take a variety of forms. This multiplicity and the interweaving of different relationships is particularly clear in Foucault's statement that:

> "one can speak of the formation of disciplinary society in this movement that stretches from the enclosed disciplines, a sort of social 'quarantine', to an indefinitely generalizable mechanism of 'panopticism'. Not because the disciplinary modality of power has replaced all the others; but because it has infiltrated the others, sometimes undermining them, but serving as an intermediary between them, linking them together, extending them and above all making it possible to bring the effects of power to the most minute and distant elements. It assures an infinitesimal distribution of the power relations" (Foucault 1975: 216).

It is important to recognise that power can be institutionalised, both by institutions, such as schools and prisons, and by organisations such as the state. This is apparent in several aspects of Foucault's writing including that relating to panopticism, the penal system and asylums. However, Foucault makes it clear that relations of power extend beyond the limits of the state and therefore the same has to apply to any analysis of power (Foucault 1980). The state is not able to occupy the entire field of power relations and can only operate within and on the basis of power relations which already exist. Thus it is important to consider the wider power relations which occur. In the context of this work, this includes not only the roles and power relations associated with the state and school, but also those relating to the family, friends, peer group cultures, local social and cultural norms and issues of globalisation; and these issues will be explored further in Chapter 6 of this thesis.

Whilst it is easy to gain an impression from aspects of Foucault's work that he regards power and discipline to be overarching forces, it is important to recognise that Foucault does allow scope for power and discipline to be challenged or resisted; and resistance will be discussed in Chapter 6 in relation to school meals. In *Discipline and Punish* Foucault notes that it was evident that there was a risk of the spectacle of punishment being rejected by those to whom it was addressed. Thus, Foucault observes that "the solidarity of a whole section of the population with those we would call petty offenders…was constantly expressed" and "it was this solidarity much more than sovereign power that was likely to emerge with redoubled strength" (Foucault 1975: 63). In her discussion of working class youth and the New Labour's respect agenda, McDowell (2007) argues that young people's moral agency is complexly enmeshed in discourses of deference and resistance in which the moral basis of respect, and the mutuality of the term, is understood. For Foucault there are many

different kinds of revolution and possible ways of subversively recoding power relations (Foucault 1980). As Smart (1985) discussed, power is accompanied by resistance and depends on the multiplicity of points of resistance. As with power, there is a plurality of resistances and it is not possible to locate a single locus of revolt or rebellion. Power, knowledge, discipline and resistance all operate in a variety of multiple, juxtaposed and intersecting spaces and scales; as does another technique of interest, gaze.

For Foucault, gaze offers an additional dimension to both power and discipline. In *Power/Knowledge* he notes that "gaze has had great importance among techniques of power developed in the modern era, but…it is far from being the only or even the principal system employed" (Foucault 1980: 155). There are a number of aspects to Foucault's work on gaze, but that relating to the medical gaze is of particular pertinence here due to its relevance to medical and health care systems, and thereby to understandings of what health is. Nevertheless, as Philo (2000a) discusses, this aspect of Foucault's work has frequently been overlooked by medical and health geographers (see also Parr 2002).

In *The Birth of the Clinic* Foucault (1989) discusses the rise of clinical, scientific or 'modern' medicine and the associated emergence of what he describes as the medical gaze. This idea is introduced with the observation that:

> "the rejuvenation of medical perception, the way colours and things came to life under the illuminating gaze of the first clinicians is no myth. At the beginning of the nineteenth century, doctors described what had for centuries remained below the threshold of the visible and the expressible, but this did not mean that, after over-indulging in speculation, they had begun to perceive once again, or that they had listened to reason rather than to imagination; it meant that the relation between the visible and invisible – which is necessary to all concrete knowledge – changed its structure, revealing through gaze and language what had previously been below and beyond their domain. A new alliance was forged between words and things, enabling one *to see* and *to say*" (Foucault 1989: xiii emphasis in original).

Thus, the medical gaze produces a more scientific objectivity around which a rational language can be organised and through which power and 'truth' can be manifest. Building on Foucault's arguments in *The Birth of the Clinic*, Armstrong suggests that "the clinical gaze, encompassing all the techniques, languages and assumptions of modern medicine, establishes by its authority and penetration and observable and analysable space in which is crystallized that apparently solid figure of the discrete human body" (Armstrong 2001: 17). Furthermore, Armstrong (2001) also argues that the medical gaze was extended during the twentieth century to include a broader area encompassing issues such as public health and preventative medicine and other non-medical institutions such as schools. This extension of the medical gaze is manifest, for example, in the weighing of children and young people in schools and in the changes to school meal policies which have already been noted.

It is often assumed that the medical gaze is a totalising power which elevates the clinician and relies upon his or her view alone. However, for Foucault, the medical gaze actually requires endless reciprocity because it depends upon a relationship or dialogue between the doctor or clinician and the patient. Thus Foucault argues that "as it moves forward, this gaze is really retreating, since it reaches the truth of the disease only by allowing it to win the struggle and to fulfil, in all its phenomena, its true nature" (Foucault 1989: 9). In the context of this research on young people and health beliefs, gaze is seen as being both reciprocal and multidirectional. Whilst young people are the object of gaze and surveillance from other people and institutions such as the school and health professionals, their own gaze also affects their perception of issues and problems and the ways in which they view policy and resource or service provision.

Drawing on Foucault (1989), Philo (2000a) argues that there are three spatialisations associated with the medical gaze. The first of these is the abstract space of the two-dimensional table where the clinician identifies, learns about and fixes the illness. This table is inextricably linked both to the patient, and the materiality, fleshiness and contours of his or her body, and to the clinician's gaze. The second spatialisation in Foucault's understanding of the medical gaze is the three-dimensional spaces of the body which acts as the space of localisation or seat of the disease through which illnesses are interpreted. The third spatialisation is the landscape of medical practices and institutions, such as hospitals, in which diseased people are located or isolated.

Whilst Foucault himself is reluctant to tie his work to any particular science or academic domain (see Foucault 1980), it is clear that questions relating, or of relevance, to geography are important in much of his work. When questioned about the relationship between his work and geography, Foucault acknowledges others had suggested he was 'obsessed' with space but argues that through considering space he came to what he had been looking for, namely the possible relations between power and knowledge (Foucault 1980). Nevertheless, he does admit that "once knowledge can be analysed in terms of region, domain, implantation, displacement, transposition, one is able to capture the processes by which knowledge functions as a form of power and disseminates the effects of power" (Foucault 1980: 69).

With regard to the issue of agency, which was introduced in Chapter 1 and then discussed more fully in Chapter 2 of this thesis, MacBeath has argued that "in Foucauldian terminology, identity and agency arise through discourses which generate different ways of knowing self and give rise to multiple identities, located in the larger structures of class, race and gender" (MacBeath 2006: 197). MacBeath also discusses issues of power and highlights some of the tensions between the development of individual and group identities. As will be highlighted in Chapter 6,

similar issues are discussed by Liimakka (2008) in relation to young woman's body image, agency and media representations of womanhood; although the author draws primarily upon Merleau-Ponty's phenomenology and a limited discussion of Goffman's staging.

As will be discussed later, questions relating to power, knowledge and the disciplining of beliefs and behaviours are important themes in this thesis. It is clear that Foucault's work is pertinent to these themes. In addition, issues relating to gaze will be discussed on a number of occasions, both in relation to Foucault's medical gaze and to questions of gaze more generally. Finally, Foucault was also interested in how human subjects were produced (Philo 2004) and this retains a pertinence to questions of young people's identity formation. Nevertheless, despite the clear relevance of Foucault's work for the theoretical framework I have developed the work of Foucault and Goffman discussed so far does not offer a fully adequate framework. In this thesis I will also be drawing on the work of Judith Butler in order to complement and flesh out some of the ideas introduced by Goffman and Foucault, and Butler's work will therefore be the focus of the next section.

3.6 Judith Butler: Gender and Performativity

The idea that gender identities are asserted through performance is well documented (e.g. Butler 1996) and this has been apparent in empirical work undertaken to date. During my Masters fieldwork, gender and the ways it was embodied and performed proved pertinent to considerations of young people's perceptions of health and risks to health (Beale 2005, 2010); for example, one of the groups I encountered demonstrated a marked enactment of the white masculinities similar to the 'Geordie' masculinities discussed by Nayak (2003a, 2003b). Issues relating to gender and performativity have remained pertinent during the research undertaken for this thesis and it is important to recognise that such performances help shape research encounters and thus have a significant impact on the data obtained. As with Foucault, the body has been an important theme in Butler's work on both gender and performativity and this is pertinent to issues of health and well-being. However, as Grosz (1994) notes, there is a tacit assumption underlying Foucault's work that all bodies are inscribed in the same way and by the same tools. This reduces the body to a blank and passive page which offers a neutral medium/signifier for the inscription of text, thereby allowing no scope for sexual or other difference. Building on this gap in Foucault's work, this issue of difference is a key contribution of Butler's work.

A significant amount of attention has already been given to ways of theorising masculinity and masculinities (see discussions in Connell 1995; Frosh et al. 2002;

Haywood and Mac an Ghaill 2003; Mac an Ghaill 1994; MacInnes 1998; McRobbie 1991; O'Donnell and Sharpe 2000) and I will not be revisiting this debate in any detail in this thesis. Here, it is sufficient to note that Connell (1995) outlines a number of approaches to masculinity and argues that a key area of debate has related to whether masculinity is predetermined or socially constructed. I am viewing masculinities and femininities as socially constructed identities which relate to and re-inscribe material bodies, but recognise that there is an inherent tension between these two components. Although Butler herself does not tend to explicitly discuss space or place, her work on gender and performativity has been influential for some areas of Human Geography. Butler's work on gender has influenced some geographers' understandings of bodies and identities, and the spatialities of these, and her notion of performativity has been re-worked in relation to space (Mahtani 2004).

In *Gender Trouble*, Butler (1990) challenges the naturalness of sex and gender binaries and argues that the two sexes are actually social constructions. Furthermore, Butler questions the tendency in second-wave feminism to homogenise women through assumptions of a common identity and suggests that "rather than a stable signifier that commands the assent of those whom it purports to describe and represent, *women*, even in the plural, has become a troublesome term, a site of contest, a cause for anxiety" (Butler 1990: 3 emphasis in original). In addition, Butler also questions the associated assumptions that masculine and feminine identities correspond with male and female bodies. In her discussion of "intelligible" genders Butler states that:

> "The notion that there might be a "truth" of sex, as Foucault ironically terms it, is produced precisely through the regulatory practices that generate coherent identities through the matrix of coherent gender norms. The heterosexualization of desire requires and institutes the production of discrete and asymmetrical oppositions between "feminine" and "masculine," where these are understood as expressive attributes of "male" and "female." (Butler 1990: 17).

Thus for Butler, like Foucault, cultural norms and expectations are shaped and produced through regulatory practices and disciplines. However, Butler goes on to argue that gender identities which appear to be developmental failures or logical impossibilities because they do not conform to the norms of cultural intelligibility actually "provide critical opportunities to expose the limits and regulatory aims of that domain of intelligibility" and therefore open the possibility of subversive gender orders (Butler 1990: 17).

In *Bodies that Matter*, Butler (1993) seeks to combine questions about the materiality of the body with discursive practices related to the performativity of gender. To some extent this builds on the work of Foucault, but with a feminist lens. Butler's argument has two key components. Firstly, she suggests that performativity should be

understood as the reiterative and citational practice by which discourse produces the effects that it names, rather than as a singular or deliberate 'act'. Secondly, she maintains that what constitutes the fixity of the body, including its contours and movements, is fully material but that materiality needs to be rethought as the effect of power and viewed as power's most productive effect. Like Longhurst (1997, 2001), Butler recognises the limitations of a purely social constructionist, inscriptive approach and goes beyond this in her discussion of materiality. At the same time she also avoids the descent into using language and metaphor alone which has often dominated poststructuralist work on the body and, unlike Foucault, addresses issues of difference. This middle road between social constructionism and inscription and poststructuralist language and metaphor is particularly apparent in her summary of materiality in which she states that:

> "What I would propose in place of these conceptions of construction is a return to the notion of matter, not as a site or surface, but as *a process of materialization that stabilizes over time to produce the effect of boundary, fixity, and surface we call matter*. That matter is always materialized has, I think, to be thought in relation to the productive and, indeed, materializing effects of regulatory power in the Foucaultian [sic] sense." (Butler 1993: 9-10 emphasis in original)

This thesis recognises that health and well-being are often experienced in and through the body and, as Howson notes, "'Health' is not an abstract concept…but refers to specific *bodily* experiences that are shaped by material circumstances" (Howson 2005: 50 emphasis in original). Whilst geographers have tended to draw a distinction between discursive bodies and material bodies, emphasising the former (see Longhurst 2001, for fuller discussion), I am viewing bodies as both discursive and material. This thesis acknowledges that bodies are physical, fleshy, corporeal entities which take on different shapes and appearances and, whilst bodies and embodiment may be influenced and sculpted by power and discourse, bodies are also material entities in their own right. Like other authors (for example Bordo 1993; Gatens 1996; Grosz 1994; Howson 2005), I reject the idea of a Cartesian mind-body dualism and consider a person's mind and body to be inextricably linked; with physical, mental and emotional health and well-being directly influencing one another.

Performativity is not only important with regard to embodiment and gender identities, it is also important in relation to the spaces and contexts in which research encounters occur. The idea that research encounters are performative has gained increasing currency in Human Geography. Most of this work on performativity has been theoretical, although a few authors (e.g. Gregson and Rose 2000) have discussed its application to empirical research projects. However, whilst literature has begun emerging about ways of diagramming or mapping performance and emotions in research encounters (MacKian 2004; McCormack 2005), performative aspects of methods such as participatory diagramming and focus groups have been largely

neglected, although Kesby (2007) and Allen (2005) touch on these subjects. Building on the work of Butler, Gregson and Rose (2000) tease out what they consider to be the spatialities and subjectivities of performativities and argue that:

> "performance – what individual subjects do, say, 'act-out' – and performativity – the citational practices which reproduce and/or subvert discourse and which enable and discipline subjects and their performances – are intrinsically connected, through the saturation of performers with power. Furthermore…similar arguments need to be extended to space. Space too needs to be thought of as being brought into being through performances and as a performative articulation of power" (Gregson and Rose 2000: 434).

Gregson and Rose (2000) then go on to demonstrate from their own research some of the relations between performativity, space and power, and ways in which their research encounters were performative.

Outside of Geography, Markussen (2005) questions whether performativity can be discussed in the language of methodology. I believe it can, provided the epistemological framework used allows for the fluidity and multiplicity of discourse within each research encounter and recognises that knowledge is both partial and situated. This requires reflexivity and a consideration of power and positionality. My understanding of performance is in some respects closer to Butler's (1990, 1996) performativity than Goffman's staging (Goffman 1959) but this thesis draws on elements of both because, as was noted in Section 3.4 of this chapter, there are a number of ways in which a consideration of Goffman's work can inform understandings of young people's health beliefs and behaviours and the ways these are performed. Building on my Master's fieldwork, I believe it is essential to consider the physical, social and organisational spaces used and their impact upon performances and participation when analysing data and research findings, and this will be discussed in Chapter 4. First, the final section of this chapter will, on the basis of discussions in both this chapter and the previous one, tease out some key ideas which will run through the subsequent chapters in this thesis.

3.7 Towards a Cohesive Framework

It should be apparent from the discussion in this chapter that the theoretical framework I am using will, alongside other aspects of my research, help this thesis to demonstrate an original contribution to scholarship in Children's Geographies and Health Geography in relation to issues of space and scale and the sculpting and performance of young people's health beliefs and behaviours. Issues relating to space and scale will remain a key theme throughout this thesis, as will the ideas of power and performance. Whilst I support much of Butler's theorisation of the body, discussed in Section 3.6 of this chapter, her work cannot alone fully inform the theoretical framework

I am developing. For the purposes of this research, Butler's work needs to be considered alongside that of Foucault and Goffman and the re-workings of space and scale discussed earlier in Section 3.3 of this chapter. Whilst there are suggestions that the three theorists I am drawing upon are incompatible[18], I believe that they draw upon a number of common themes and can complement each other once the productive synergies are teased out and made visible. All three of these theorists place an emphasis on discourse, citational practices and performance, and they all discuss – sometimes indirectly – issues which are pertinent to questions of space and scale.

The main contribution of Goffman to my theoretical framework is his work on performance, staging and stigma. Gregson and Rose (2000) suggest that Goffman's view of performance is that of an active, prior, conscious and performing self, and contrast this with Butler's stance. However, like Butler, Goffman *does* give attention to the ways in which societal norms and expectations shape performances and interactions between people and, as noted in my earlier discussion of Goffman's notion of 'front', Goffman does suggest that performances may be either intentional or unwitting. Goffman's work on stigma resonates with ways in which young people relate to others, both within and beyond their peer group, and issues relating to stigma can potentially affect research encounters. In the context of this thesis, Goffman's work makes a particular contribution to the material which will be discussed in Chapter 6. As was noted in Chapter 1, this will explore the intertwining of global and local and the ways in which young people's health beliefs and behaviours are shaped and performed.

It should be clear from my discussion of Foucault that his work on power, knowledge, discipline and gaze is relevant to a consideration of the ways in which beliefs and behaviours are produced and performed. Foucault's work is particularly relevant in this thesis due to its pertinence to the ways in which beliefs and behaviours are shaped, enacted and challenged or subverted. Issues relating to power and knowledge also connect with the ways in which young people and their beliefs are (not) valued by different parties. Furthermore, Foucault's work on gaze is significant in relation to the ways in which health is understood or promoted. Foucault's work resonates not only with the material that will be discussed in Chapter 6 of this thesis, but also with the representations and discourses surrounding the countryside and health which will be discussed in Chapter 7.

[18] This criticism has come mainly from peers working on non-representational theory who consider Goffman to be outdated and have a more simplistic view of the work of Foucault and Butler which emphasises the differences and does not accommodate the connections between them. On the basis of the performances observed during the empirical phase of this study, I consider that Butler's work provides an extension to Foucault's ideas rather than contradicting them. Aspects of the performances observed resonated both with Goffman's work on staging, role play and stigma and with Butler's work on gender and performativity.

The use of Judith Butler's work on gender and performativity emphasises the ways in which gender identities are shaped through regulatory practices and disciplines, and the ways in which such identities are performed. Her work allows for greater plurality in terms of possible identities and places a greater emphasis on the ways in which dominant discourses can be challenged or subverted. This bears a particular relevance to the evolution and contestations of young people's identities and the ways in which they may challenge or subvert adults' expectations. Again, the work of Butler connects with issues which will be discussed in Chapters 6 and 7 of this thesis.

As already discussed, the understanding of space and scale I am using in this thesis differs from that which has traditionally dominated in Health Geography and Children's Geographies. The plurality, fluidity and multiplicity of space and scale, plus the ways in which these can simultaneously be both connected, intersecting or juxtaposed and distant, is better able to accommodate the complex web of relations and circumstances which influence health beliefs, behaviours and status. The understanding of space and scale used in this thesis also allows for the simultaneous influence of different scales, such as global and local, upon social and spatial relations and phenomena – a theme which will be explored in more depth in Chapter 6.

Many of the tensions in the ideas discussed in this chapter (such as the extent to which performances are deliberate, conscious acts or a more subconscious conformance or subversion of dominant discourses) relate back to the long-standing tension between structure and agency which has troubled theorists over a number of decades. Rather than viewing structure and agency as a binary, I consider that they combine in the production of phenomena, events and actions. I believe that there are structures which influence, discipline and sculpt society, space and relations but that individuals have agency which can be used to change, challenge or subvert such structures.

As was discussed in Chapter 2, there have been debates surrounding the status of children and young people and a key issue here is whether or not they are considered to be competent social actors. Some authors have also raised questions about whether young people can have agency, given that they are not full adults and their behaviour is both disciplined by adults' expectations of the ways in which they will behave and interpreted from an adult standpoint (Hill et al. 2004; Jans 2004; Munford and Sanders 2004; Smith 2009). Like Foucault and Butler, I consider that beliefs and behaviours are shaped by dominant discourses and by societal norms and expectations. Power relations play an integral part in the manifestation of such processes and require consideration. Not only are the power relations between young people and adults, organisations and society more generally important; so are those

operating within youth cultures and peer groups themselves. However, issues relating to power and agency also influence the extent to which individuals and their beliefs, values and viewpoints are respected. As was noted in Chapter 2, there is currently a trend towards policy initiatives relating to children and young people (such as 'Every Child Matters') including rhetoric about listening to children's voices. Yet, questions have been raised about the extent to which such rhetoric has been realised. This thesis will raise questions about the extent to which young people's voices are, or could be, incorporated into research, policy and theory building. These ideas will be explored in the next chapter of this thesis, along with a discussion of the methodology used and ethical considerations.

Chapter 4 Research Methodology and Ethical Considerations

4.1 Chapter Introduction

Building upon the ideas introduced in Chapters 2 and 3, this chapter discusses the approach I have taken in exploring young people's health beliefs and behaviours, and the associated issues of space and scale, power and performance, and will include both epistemological and methodological considerations which underpinned the research. As already noted, the research on which this thesis is based was heavily influenced by the aims and values of participatory research, and these will be discussed in Section 4.2 of this chapter. In addition, whilst the methods used will be discussed later in the chapter, I would like to note at this stage that the research undertaken for this study used a mixed methods approach combing both qualitative and quantitative approaches. Before proceeding to the main part of this chapter, it is necessary to highlight some key issues relating to ontology, epistemology and method which underpin the remainder of my methodological discussion because, as noted by Hoggart et al, "epistemology and method are closely and complexly intertwined" (Hoggart et al. 2002: 1). Ontology and epistemology influence social theory, which in turn shapes methodology and thereby the specific research methods adopted. However, it is important to recognise that this is not always a straightforward linear process and, as noted in Chapter 3, many aspects of my theoretical framework have emerged from the empirical work I undertook.

Ontology refers to assumptions which are made about the nature of reality (Hoggart et al. 2002) or the specific assumptions which underpin a theory or system of ideas (Kitchin and Tate 2000). Ontology is closely related to issues of epistemology. Put simply, epistemology is "how 'we know what we know'" (Allen 2003: 26) and "[An] epistemological issue concerns the question of what is (or should be) regarded as acceptable knowledge in a discipline" (Bryman 2004: 11). Whilst this might sound like a simple statement, there are a range of complexities surrounding epistemology, social theory and methodology which can impact upon the appropriateness of specific research methods. In Human Geography, as with other Social Sciences, it has increasingly been recognised that philosophical and ontological assumptions underpin all research. Social theory involves the application of epistemological positions to views of the social world and is thus dependent on the ontological and epistemological positions adopted, even when a grounded or emergent theoretical framework is used. Methodologies and research methods are often conflated but they are not entirely the same. Methodology refers to a set of methods, rules and procedures based on a

specific view of the nature of reality (ontology) and the basis on which knowledge claims are made (epistemology) whereas methods are the techniques of data collection and analysis (Hoggart et al. 2002; Kitchin and Tate 2000).

There have been debates across the Social Sciences about the value of both quantitative and qualitative research methods and their combination; and these require some discussion due to the mixed methods approach taken in this study. The debate surrounding the value of both quantitative and qualitative methods, and their combination, is in many ways an ontological and epistemological debate about the nature of reality, ways in which social phenomena can be investigated or explained and how cause(s) and meaning(s) are understood (Bryman 1988). There has been a widespread perception that quantitative methods are objective and produce 'hard' reliable data, usually in the form of large data sets, which are extensive and can be generalised and proponents of this view have placed an emphasis on measurement, causality, generalisation and replication (Bryman 2004). In contrast, qualitative methods have traditionally been perceived as 'soft' and subjective and the results obtained less reliable and relevant, due to the more intensive and contextualised nature of the research and use of fewer, albeit more detailed, cases (Bryman 2004). More recently, there has been increased recognition of the rigour involved in many qualitative studies and greater understandings of the strengths and limitations of different qualitative methods in different contexts and types of research. With regard to Human Geography, I agree with Crang's (2002) assessment that qualitative methods have become the new 'norm', but believe quantitative methods can still play a role provided knowledge is recognised as partial and situated. Furthermore, I would suggest that the 'quantitative-qualitative divide' is in fact a continuum along which specific research methods can be adopted, combined or rejected dependent on the aims of the research and the epistemology and values which underpin this. Writing from a generic Social Sciences perspective, Brannen (2004) suggests that the context of the work must be considered when combining methods and interpretation should occur during all stages. Furthermore, I would suggest it is important to ensure that, when qualitative and quantitative methods are combined, the epistemological and theoretical framework is consistent across the different methods used. Nevertheless, like Kwan (2010), I would argue that a geographer's epistemological position cannot be directly equated with certain methods and that it is important to be critical and sensitive when using quantitative methods regardless of whether they are used in conjunction with qualitative methods (see also McKendrick 1999).

The choice of research methods is, in many ways, as much a political decision as an epistemological one. Thus, Smith (2001) argues that undertaking qualitative research implies a political choice to engage marginalised or neglected knowledges

and that researchers have a responsibility to act upon these knowledges and engage with political opportunities. The inclusion of statistics can add weight to arguments and has political power (Dorling 2003). I would also suggest that politics within academia have an impact on how different methods are perceived and valued. Although quantitative methods are not currently as widely implemented as they once were within Human Geography, the UK Economic and Social Research Council (ESRC), which funds many studies within the discipline, is actively promoting and encouraging Quantitative Social Research as a priority area for funding.

Whilst I am not using non-representational theory in this thesis, the theoretical framework which was outlined in Chapter 3 is consistent with a postmodern ontology. As discussed by Graham, "Postmodernism…rejects the notion of a single grand general theory of society and sees social order as much more partial and even contradictory " (Graham 2005: 28) and she goes on to note that postmodernism is both a condition of society and a method for the Social Sciences. Postmodernism allows for multiple voices, rather than seeking to find an overarching metanarrative to explain social phenomena. It is therefore appropriate for research which is seeking to explore different viewpoints and understandings, such as the ways in which young people conceptualise health and the sculpting and performance of their health beliefs and behaviours. Furthermore, postmodernism seeks to avoid privileging particular voices, and is thus compatible with my interest in including the multiple voices of young people, while knowledge is considered to be multiple and situated.

Although, as will be discussed later in this chapter, I would not consider my research to be truly 'participatory' it has been heavily influenced by the aims of participatory research and the value base of this. Therefore, the next section of this chapter will focus on issues relating to participation and participatory research. Areas of particular interest include the aims, values and epistemology which underpin participatory research, issues relating to the level or depth of participation, and some of the common criticisms of participatory research. Following this discussion of participation, I will introduce my study area and the schools I worked with because these also played a significant role in shaping my methodology. The subsequent sections of this chapter will then move on to a discussion of the empirical work I undertook which employed a mixed methodology. The fieldwork involving young people had two phases, the first of which employed qualitative methods and the second quantitative ones. As will be discussed in later sections of this chapter, there are a number of ways which my deployment of methods and interpretation or analysis of the research material generated differs from that which is 'traditional', especially with regard to quantitative techniques which I have not used within the positivist framework with which they are usually associated. Building upon the discussions of participation,

the context of my research, and the research methods used, the final section of this chapter will focus on research ethics and the ethical considerations which were involved in my work. This discussion of ethics has been included as a section in its own right for the purposes of clarity, due to some of the ethical complexities involved in the type of research I have undertaken, and I would like to emphasise that I consider ethics to be an integral part of the research process rather than a separate entity.

4.2 Participation and Participatory Research

The notion of participation encompasses a number of ideas already introduced in this thesis. As I have discussed elsewhere (Beale 2008), understandings of what participation means or entails differ, and my focus here will primarily be upon the understanding of participation which is used in participatory research. As will be discussed in this section the aims and values of participatory research fit well with my stance on young people and the inclusive understanding of health I espouse, both of which were introduced in Chapter 2, and it also relates to several aspects of my theoretical framework which was discussed in Chapter 3. It is important to recognise that participatory research is not 'new' and participatory approaches to research have a long history in fields such as development studies. Nevertheless, as Kesby (2007) notes, the concept of participatory research is relatively new within critical Human Geography, having evolved from the longer standing traditions of activism and action research within the discipline. Like Kesby (2007), I believe there are a number of contributions which participatory research and Human Geography can make to each other and I will point towards some of these in this chapter.

Terms such as 'participatory research' or 'participatory methods' are sometimes mistakenly used as an umbrella term to describe any research involving people[19] and it is therefore important to clarify at the outset what is meant by such terms. In line with Pain and Francis (2003), I believe it is helpful to distinguish between participatory techniques and participatory approaches and recognise that the use of participatory techniques does not necessarily make research 'participatory' (see Kesby et al. 2005 for further discussion of this issue). The term *participatory techniques* refers to a set of research methods and techniques whereas the term *participatory approaches* refers to particular methodologies and epistemological frameworks. Participatory approaches involve participants in all stages of the research process including problem definition,

[19] I have, for example, attended conference papers where presenters have introduced wholly researcher-defined questionnaires or structured interviews as being 'participatory' methods or techniques. I would suggest that, although questionnaires which are designed with participants may be participatory, questionnaires or other research encounters where the content of the research or discussion is wholly pre-defined by the researcher, and there is no scope for participants to influence the research agenda in any way, should not be considered 'participatory'.

the choice of research methods, data analysis and the use of findings, exemplified by Cahill's (2004) work with young women in New York. Somewhat confusingly, both participatory approaches to research and participatory techniques are sometimes referred to as 'participatory research'. Thus there is a tendency for people who are unfamiliar with participatory research to mistakenly assume that participatory techniques and participatory approaches are the same. In this thesis I will be using the term 'participatory techniques' to refer specific research methods such as participatory diagramming and mapping, and will use the term 'participatory research' to refer to the broad set of beliefs and values associated with participatory approaches to research.

It has been suggested that participatory research is underpinned by a specific ontology which views people as dynamic, capable and reflexive agents who have the capacity for self-change (Kindon et al. 2007). Participatory research is also underpinned by a distinct set of ideals and values and "must be guided by an epistemology that conceives the process and purpose of investigation, and your role as the researcher, rather differently from most conventional research" (Kesby et al. 2005: 145-46). Kemmis and McTaggert (2008) identify seven key features of Participatory Action Research (PAR) which are summarised in Box 4.1[20].

Box 4.1 Key features of Participatory Action Research (PAR)

1.	PAR is a social process
2.	PAR is participatory and engages participants in examining and creating knowledge
3.	PAR is practical and collaborative
4.	PAR is emancipatory
5.	PAR is critical
6.	PAR is reflexive
7.	PAR seeks to transform both theory and practice

(Based on Kemmis and McTaggart 2008)

Participatory research places a high value on lay, alternative or non-academic understandings and knowledges about people's lived experiences or the world more generally. There is thus a focus on working *with* people rather than *on* them which parallels the trend within Children's Geographies towards working with children and young people. Like other forms of action research, participatory research is interested

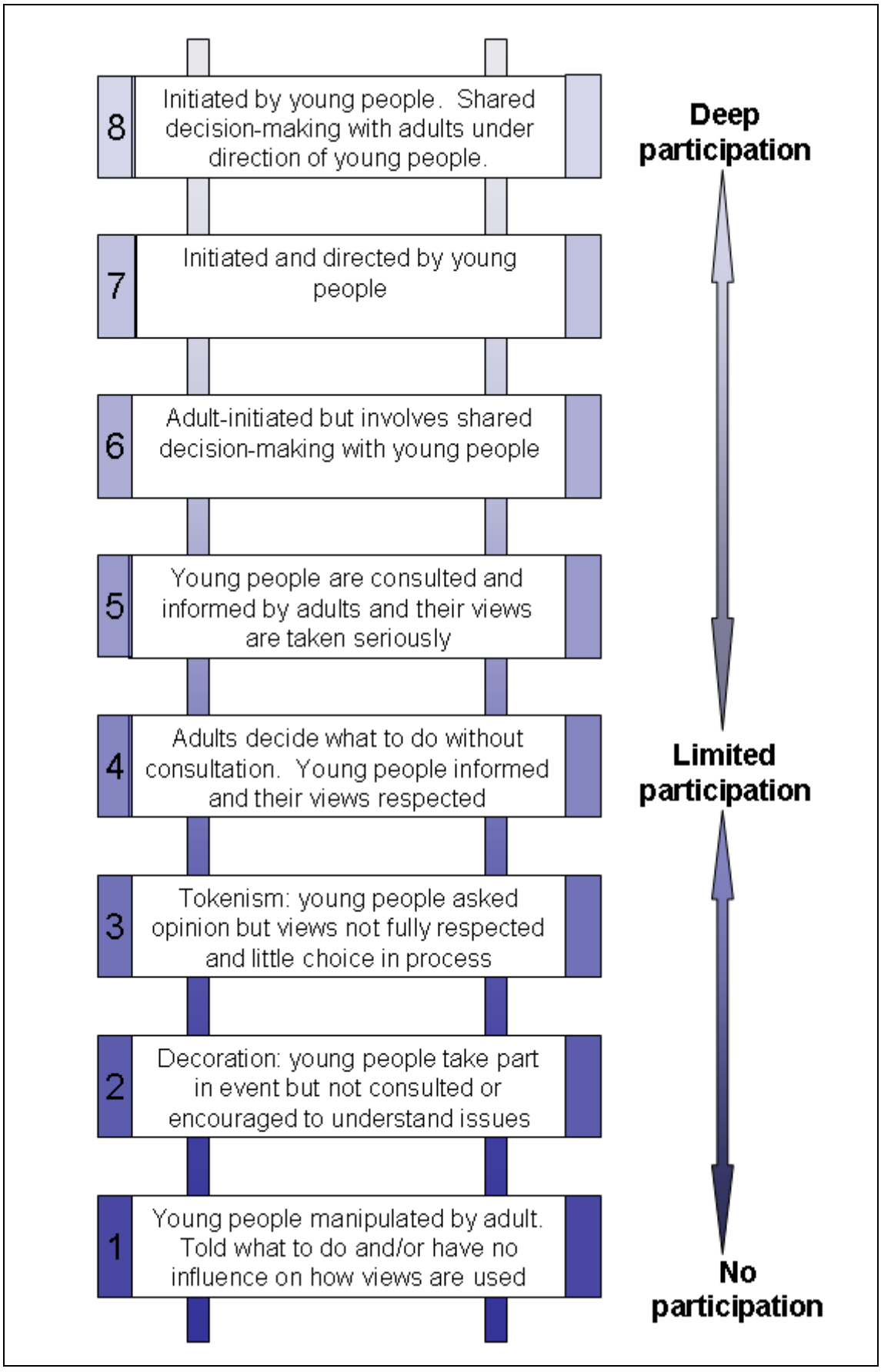
[20] As Kindon et al note, a distinction is sometimes drawn between 'participatory research' and 'action research' and they suggest that "the distinction revolves around the politics of the research process itself…[and] Action Research does not necessarily engage participants directly in the research process" (Kindon et al. 2007: 11). *Participatory* action research is, however, a form of participatory research; and the term 'participatory action research' is sometimes used interchangeably with the term 'participatory research' (see also Breitbart 2003).

in helping to change people's social or material experiences or worlds rather than simply describing or analysing them. Participatory research is collaborative and participants should ideally have as much control over the research process as the researcher, if not more control. Thus participatory research aims to empower those involved and, as Rodríguez and Brown (2009) note, power sharing and agency are significant facets of participatory research with young people. As Kesby et al (2005) discuss, the use of the term 'participant' instead of 'informant', 'respondent' or 'subject' reflects "a shift in understanding about *who* should instigate, conduct, analyse, present, act on and benefit from a research project" (Kesby et al. 2005: 146 emphasis in original). Whilst this project was in some respects pre-defined in that the broad focus on young people and their beliefs about health and risks to health had been identified in the original funding application, I hoped at the beginning of the project that I would be able to involve participants in all the different stages of the project. However, as will be discussed in the course of this chapter, this aim was only partially realised and, as indicated in the chapter introduction, I have serious questions about the extent to which the research can be considered to be 'participatory'.

As noted earlier, there are some important differences between participatory approaches to research and participatory techniques, but these should not in any way be viewed as a binary or dichotomy. Rather, it is important to recognise that the distinction between participatory approaches and techniques is not always clear-cut and may be better viewed as a continuum with different levels, or depths, of participation. This is often described as a 'ladder' of participation (see Figure 4.1)[21]. The ladder of participation can offer a helpful starting point when considering issues of participation, but it should be noted that in reality many projects will not match neatly with a single rung on the ladder. It is possible, for example, to have deep participation (rungs 7 or 8 of ladder) for some aspects of a project, such as planning and conducting the empirical work, but no participation (rung 1 or below the start of the ladder) for other aspects such as data analysis or the dissemination of findings.

[21] The ladder of participation originates from Arnstein (1969). It has been adapted a number of times, including Hart (1992) and Maxey's (2004) versions for children. I have adapted this further for research with young people and incorporated Kesby et al's (2005) concept of 'deep' participation.

Figure 4.1 The Ladder of Participation



(Adapted from Arnstein 1969; Hart 1992; Kesby et al. 2005; Maxey 2004)

It is important to recognise that 'participation' is a contested entity. Just as understandings of what constitutes 'participation' differ (see Beale 2008 for fuller discussion), so do responses towards participatory research. As discussed in Chapter 2, significant attention has been given in recent years to the notion of children or young people's participation, both in the academic and policy arenas, but there is often a lack of clarity regarding what 'participation' means how this might be achieved. Within academia, increasing interest in children's participation has been demonstrated by recent journal articles exploring the idea and its basis (Grover 2004; Jans 2004; Kjorholt 2002). Such literature is often based on an assumption that 'participation' equals citizenship and political participation (Hill et al. 2004) and has concentrated on why children should be allowed to participate in social research and policy-making rather than considering how this can be achieved. As Hill et al (2004) note an adult mould for participation is often imposed, resulting in the formation of youth and school councils, based on the representative democratic principles used in adult political models. This is problematic because it often favours those who are better educated and is vulnerable to adult manipulation.

Participatory research has come under some significant criticism and has been accused of both tokenism and manipulation (Cooke and Kothari 2001). A key problem in untangling the critiques about participatory research is that they do not all draw upon the same understanding of participation and sometimes advocates of participatory research are also among its critics (see, for example, Kesby 2005). As I have noted elsewhere (Beale 2008) there can, in relation to the values which underpin the research process and what is regarded as 'good' research', often be a tension between the views held by the researcher and those of other people, which follow through from general understandings and discourses across theory and policy into specific research encounters and practices. Whilst a researcher may have a preferred model of participation which is underpinned by a distinct set of values and priorities, it is important to recognise that this may not be shared by collaborating agencies and participants. Furthermore, given that one of the principles underlying participatory approaches to research is to include the values and priorities of everyone involved in the project, it can be somewhat contradictory for the researcher to impose a pre-defined value-base or research philosophy. Graham (2005) makes what is, in many respects, a related observation that whilst action research approaches, which include participatory research, have a commitment to helping improve people's lived experiences and social worlds there can be problems in action research with researchers specifying how society 'ought' to be because this runs counter to the idea of multiplicity and inclusion which participatory and action research seek to embrace. As will be discussed in both this section and Section 4.4.3 of this chapter, questions

have also been raised about issues of power and whether participatory research can really address these.

Participatory techniques such as participatory diagramming, which will be discussed later in this chapter, have become increasingly common in research with children and young people and are sometimes referred to as 'adapted' or 'child-friendly' research methods (Punch 2002; Young and Barrett 2001). Nevertheless the idea of adapting research methods to suit children and young people is contested. Supporters of participatory techniques argue it "is important to use language, tools and approaches that reach different groups of children and adults in ways that they can relate to, to make processes intrinsically engaging" (Chawla and Johnson 2004: 68) and that this enables children's views to be articulated and heard (O'Kane 2000). However, Punch suggests "it is somewhat paradoxical that…many of those who call for the use of innovative or adaptive research techniques with children, are also those who emphasize the competence of children" (Punch 2002: 321). This is an interesting point but, in light of these debates about 'participation', it strikes me that the apparent paradox highlighted by Punch (2002) actually misses the point. Discussions about adapted research methods have focused on similarities and differences between children and adults, issues of competency and what should be expected of them in a research context. This has channelled attention towards debates about specific techniques whereas I would suggest that the issues at stake are more about epistemology than method. The crux of the problem is not whether it is right or wrong for researchers to use a particular technique. Instead, the central question is what the philosophical and theoretical assumptions underlying the researcher's epistemology are, and how these can best be translated into methodology. Participatory research is underpinned by a belief that knowledge should be created jointly and processes shared, and techniques such as participatory diagramming have the potential to realise this on a micro scale. As noted, research which uses adapted or 'participatory' techniques does not necessarily take a participatory approach. Similarly it is perfectly feasible for more 'traditional' methods such as questionnaires or interviews to be used within a participatory approach. Whilst I recognise that some researchers who use participatory or adapted techniques with children do so because they view children as less able or less competent, many researchers including myself 'adapt' techniques because we believe this allows richer, more nuanced multiple narratives to emerge rather than because we are working with children or young people per se.

It is important to acknowledge that there is a genuine danger that 'participatory' work may not be empowering or beneficial for those involved. This means that any researcher who is serious about his/her commitment to undertake research *with* rather than *on* children or young people needs to explore reflexively different ways of

engaging them as active participants, both when planning the research design and throughout the research process. The use of participatory techniques alone can achieve limited participation, but 'deep' participation is unrealistic unless a participatory approach is taken due to the sustained collaboration required. As noted by Kesby et al (2005) the 'gold standard' of full, deep participation, equivalent to the highest rung of the ladder, is rarely fully realised and should be viewed as an ideal to aim towards rather than an absolute that successful research must meet. Even if only some aspects of a project are able to promote young people's participation, this may go further towards promoting their autonomy than if no attempt had been made. This is often unrecognised by the critics of participatory research who tend to focus on the 'failure' of researchers to meet the golden ideals of deep participation (see Kesby et al. 2005 for further discussion). The central question is not whether research is 'participatory'. Instead, honest reflexivity and openness on the part of the researcher regarding the depth of participation that can be expected may often be more important than the level of participation achieved.

Although the research undertaken for this study fell a long way below the ideal of deep participation, it did include participatory aspects. The broad topic was defined by myself when the application for ESRC funding was developed and, at this stage, I did not have the local contacts which would have been required to develop the research proposal collaboratively. As will be noted in Section 4.3 of this chapter, the study area was largely researcher defined. Furthermore, I had hoped to develop the methodology collaboratively but, as will be discussed in Section 4.4, this encountered significant resistance from the schools involved; both from staff members and from some of the young people. Nevertheless, limited participation was achieved through the techniques used in the qualitative phase and the subsequent collaborative development of the questionnaire – which was a method selected by many of the young people involved in the qualitative phase.

It is thus clear from the above discussion that participatory research requires reflexivity especially, but not exclusively, on the part of the researcher. Within Human Geography, the idea of reflexivity came to the fore primarily through the work of feminist researchers. This question of reflexivity is not just a case of reflecting upon or evaluating how the research is going, but also requires consideration of issues such as positionality and gaze. Thus, Haraway (1988) argued that it is important to recognise that all knowledge is partial and situated and consider the positioning of the researcher and their gaze. Power can have a major impact on this because the researcher is usually in a privileged position in terms of status, access to resources and knowledge production (Rose 1997). Recognition of issues such as power, positionality and gaze has resulted in the emergence of alternative understandings based around fluidity,

movement and hybridity which, as discussed in Chapter 3, are also a key feature of the recent re-workings of space and scale. In the context of my work, such reflexivity allows for the recognition that representations of, and knowledge about, young people and health will be partial and influenced by the position and gaze of the researcher. Furthermore, reflexivity and a consideration of positionality and gaze can be valuable in exploring the multiple, and sometimes contradictory, narratives which young people construction in relation to health, health beliefs and health behaviours; and Chapters 6 and 7 of this thesis will explore some of these narratives and discourses using material collected during the empirical phase of this study.

One of the criticisms which has been levied against participatory research is that by emphasising empowerment and trying to treat everyone as equals it actually ignores issues of power. For example, Hildyard et al criticise participatory research which "fails to engage with the distribution and operations of power within local communities and the wider society in which they live" (Hildyard et al. 2001: 68-69) and suggest that this will not help marginalised groups because they do not have equal 'bargaining power'. Furthermore, they suggest that participatory research often reinforces the problems which it seeks to solve. This notion that participatory research cannot deal with issues of power is also echoed by Kothari who, drawing on Foucault's understanding of power which was discussed in Chapter 3 of this thesis, states that

> "despite the aims of participatory approaches and the claims made by participatory practitioners, particularly with respect to empowering the disempowered…participative methods of enquiry simplify the nature of power and are thus in danger of encouraging a reassertion of power and social control not only by certain individuals and groups, but also of particular bodies of knowledge" (Kothari 2001: 142).

As Kesby (2005) discusses, the argument that participation imposes power, which is put forward in this edited collection (Cooke and Kothari 2001), is based on an incomplete reading of Foucault and attaches undue emphasis on the idea of resistance. Whilst Kesby agrees that participation is a form of power, he argues that, whilst it can be resisted, power is something which it is possible to work with and that participation can help outmanoeuvre some forms of power. Kesby notes that, in Cooke and Kothari's edited collection, power and resistance are presented as a binary whereas, as I discussed in Chapter 3, Foucault considers them to be mutually constituted and produced. Thus Kesby suggests that

> "If we are to say something more practical than that power is everywhere and must be resisted everywhere, we must read Foucault more closely. While he stressed power's pervasiveness, he also emphasised its instability: assemblages of discourse and practice require constant reproduction and reperformance in order to achieve the appearance of permanence. Yet they continually undergo mutation and, occasionally, transformation." (Kesby 2005: 2045).

Kesby emphasises that a Foucauldian understanding of power can accommodate conscious and reflexive agency and argues that empowerment is entangled with power rather than being distanced from it. Thus, participatory research can simultaneously both embrace and resist or transform power, provided that it is approached reflexively.

Alongside this consideration of power, it is also essential to consider issues of space and scale. Power, space and scale were all discussed in Chapter 3, where I highlighted that they are produced, interwoven and involve plurality and multiplicity. As I have discussed elsewhere (Alexander et al. 2007; Beale 2005), the spaces and contexts in which research encounters occur can have a profound impact on participation. This includes not only the physical spaces used, but also other spaces such as social, organisational or discursive ones. The spatialities of participation have also been recently highlighted by Kesby (2005, 2007) and Klodawsky (2007). Whilst this chapter is primarily focused on my methodology, it will consider issues of participation, power, positionality and gaze which are inherently spatial. Therefore, the next section of this chapter will introduce my study areas and the schools which were involved in the research, in order to provide a foundation for the chapter's later reflection upon issues of space, power, participation and positionality.

4.3 Study Area and Schools: Background, Ethos and Implications for Methodology

As already noted, this thesis maintains that research encounters and process are spatially embedded. Therefore, this section will introduce my study areas and the schools involved in the research. This will enable discussion of the impact of these spaces on the research and, in particular, issues relating to participation.

4.3.1 Selection of Study Area

Whilst I began my PhD with a clear idea of my intended study areas, in practice the selection of study areas has proved to be an evolving process. As was discussed in Chapter 3, previous geographical work on health inequalities and outcomes has suggested that contextual and compositional factors, such as deprivation or high levels of unemployment, in a person's neighbourhood can influence their health status. Therefore I was interested in studying contrasting areas to help explore whether young people's health attitudes and priorities were influenced by contextual or compositional neighbourhood characteristics, or both. I had originally intended to have three study areas including two contrasting rural areas and deprived and affluent districts of an urban area. I initially chose to focus on the Wear Valley, Derwentside and Stockton-on-Tees, and wanted access to one school in each rural area and two in Stockton. Two schools were contacted in the Wear Valley area, two in Derwentside and twelve in

Stockton-on-Tees. Of these, I received positive responses from both Wear Valley schools (Meadowcroft Community College and Riverview High School) and one in Derwentside (Vale End School)[22]. The zero response rate from schools in Stockton-on-Tees led to a reconsideration of my study areas and it was decided that I should concentrate my attention within County Durham.

During the preliminary stage of my fieldwork there was further evolution of my study areas. It became apparent after I started my fieldwork that the area of the Wear Valley covered by my schools actually contained two distinct study areas, which are being referred to as Weardale and the Mid Wear Valley, and these had differing social, cultural and historical backgrounds. In addition, Derwentside was subsequently excluded as a study area for two main reasons. Firstly, from an academic point of view, the market town of Bishop Auckland, which is an area of Wear Valley that was not covered by my two original schools, was mentioned by a number of participants who made references to what it might be like to live in Bishop Auckland and how this might affect health. This initiated an interest in exploring the views of young people who actually lived in Bishop Auckland. Secondly, from a practical point of view, although Vale End School in Derwentside had initially seemed very interested in, and supportive of, my research the school stopped responding to any communications from me regardless of whether I used email, telephone or letters[23]. This meant that it was necessary to find a replacement school. Therefore the inclusion of Bishop Auckland into my study was a logical step. Two schools were contacted in Bishop Auckland, and Hillcrest High School replied positively. Thus my research has focused almost exclusively on the Wear Valley area of County Durham which, as the next section will discuss, contains a number of distinct areas.

4.3.2 Background to Study Area

County Durham is a predominantly rural area in North East England which lies between the river Tees and urban areas of Darlington and Teesside to the south, and the river Tyne and urban areas of Newcastle, Gateshead and Wearside to the north. To the west of the county lie the North Pennines and Cumbria whilst on the east the county is bounded by the North Sea. It is a county of contrasts ranging from the seemingly idyllic valleys of the Durham Dales to the decaying remnants of coalmining

[22] As will be discussed in section 4.6, pseudonyms are being used for the schools and people involved in the study. However, places names have been retained apart from where this would allow individual's to be indentified. The rationale behind this will be outlined in section 4.6.

[23] The reasons behind this are unknown. However, following a meeting with the Deputy Head, Vale End School had offered me the same timetable slot as Meadowcroft Community College. Given that I had already begun work with Meadowcroft, I therefore delayed the start of the work at Vale End and this may have contributed to the school's loss of interest. Alternatively, it is possible that the school decided that they were unable to commit the time required to the project – although there was nothing said in the meeting with the Deputy Head to suggest that this may be the case.

and manufacturing communities. As was noted in Chapter 1, and will be discussed further in Chapters 5, 6 and 7, County Durham includes some of the most affluent electoral wards in England and also some of the most deprived.

In both the academic and policy arenas there has generally been little attention given to County Durham. When the North East is mentioned or discussed, the focus is often on Tyneside and its conurbation of Newcastle-Gateshead or, less frequently, on Teesside and its urban boroughs of Stockton-on-Tees or Middlesbrough. More recently, due to its status as the 'fattest' place in England, media and health policy attention has been attracted to the 'obesity hotspot' of Easington on the Eastern seaboard. Yet, this appears to have done little towards raising the attention given to the county as a whole. Furthermore, the media attention has served to reinforce negative stereotypes about Easington, and County Durham and the North East more generally.

Benneworth argues that the North East is a peripheral region in both economic and European spatial terms. He suggests that there is "a specific regional economic problem composed of several distinct elements, including its domination by mature manufacturing activity and branch plant employment, high levels of unemployment and a poor track record in entrepreneurship and technology development" (Benneworth 2002: 445) and that this situation

> "emerged as a consequence of the North East's early industrialization, initiated in the 18th century by coal, and later through shipbuilding and steel. Although for a time the North East led global markets in these industries, their ownership structure discouraged investment and innovation" (Benneworth 2002: 446).

This quote also connects with a key theme which will be discussed in Chapter 6 of this thesis; namely the intertwining and mutual constitution of 'global' and 'local'. Chapter 6 will also offer some discussion of the ways in which the historical geographies of County Durham have shaped the contemporary situation. As will be argued, issues of space and scale, the mutual production and constitution of global and local and the historical geographies of the area have shaped aspects of the local culture and this has implications for the sculpting and performance of young people's health beliefs and behaviours.

With regard to health, the 2005/06 Annual Report of the Directors of Public Health noted that "County Durham is the most deprived County in England. Over 30% of the population live in wards which are amongst the 10% most deprived in England. This is double the proportion in Northumberland and Lancashire, which are the next most deprived counties." (Crawford et al. 2006: 12). The same report states that "Health in County Durham and Darlington is poor compared with England with extreme poor health in some areas." (Crawford et al. 2006: 5). A year later it is noted that

health inequalities in County Durham "remain persistent and pervasive" (Cresswell 2007: 5).

As has already been noted in Chapters 1 and 2 of this thesis, the research on which this thesis is based focused on the Wear Valley area of County Durham and the area covered by Wear Valley District Council lies in the west of County Durham (see Figure 1.2 in Chapter 1). The Wear Valley is a very diverse area stretching from the Durham Dales Area of Outstanding Natural Beauty (AONB) in the west to the market town of Bishop Auckland in the east, and incorporates a number of former pit-villages in the north-east of the district. Whilst the Wear Valley has not received the same media attention as the Easington area, it does contain areas of marked socio-economic and health deprivation. For example, Woodhouse Close, in the market town of Bishop Auckland, was the most deprived electoral ward in County Durham according to the 2004 Index of Multiple Deprivation (Communities and Local Government 2004). Further information about the Wear Valley's social and cultural environment and histories will be discussed in Chapters 5 and 6. First the next section of this chapter will introduce the schools involved in the study before the remainder of the chapter moves on to a discussion of the research methods used.

4.3.3 The Schools Involved

As was noted in both Chapter 1 and Section 4.3.1 of this chapter, this study involved young people from three secondary schools in the Wear Valley area. All three of the schools fell under the same Local Education Authority (LEA) and some aspects of the curriculum which are of pertinence to this study, such as Personal, Social and Health Education (PSHE), were organised at the LEA level. At the time the fieldwork was undertaken, school meals for the district had recently been contracted out to a private firm who supplied almost all of the secondary schools within the LEA. Whilst individual schools did have some limited input into the menus available, the contracting-out of school meals did reduce the control which individual schools held over both the provision of school meals and of prices.[24]

4.3.3.1 Riverview High School

Riverview High School is a mixed 11-18 comprehensive school in a rural area of the Wear Valley. The school has a large catchment area which includes two small rural market towns, namely Crook and Stanhope, plus rural areas including Weardale and part of the Durham Dales Area of Outstanding Natural Beauty. In the past, Riverview traditionally served a predominantly working-class and agricultural area, but

[24] As will be discussed in Chapter 6, school meals were a recurrent theme in many of the discussion groups and interviews undertaken.

this has been shifting with the increasing in-migration of middle-class and professional families into the area. The school places a strong emphasis on academic achievement and as such also has a tendency to attract middle-class families from outside its traditional catchment area. The percentage of 16 year olds gaining five or more GCSE passes at grades A*-C including English and Mathematics was well above the average for County Durham and broadly in line with the national average at the point when the fieldwork for this study was undertaken. Riverview is a specialist Arts College and had, at the point when the fieldwork was undertaken, also already achieved accreditation under the Healthy Schools initiative. In addition to the compulsory PSHE provision, Health and Social Care was offered as a subject at both GCSE and A-level. The school had a lot of new facilities, especially for sports and arts-based activities such as dance and drama, and these were available to groups out of school hours. At the time the fieldwork was undertaken, the school had around 790 students on its roll, including around 200 Sixth Form and Further Education students, and a very active school council.

4.3.3.2 Meadowcroft Community College

Meadowcroft Community College is a mixed 11-16 comprehensive school in the Mid Wear Valley. Meadowcroft's catchment area partially overlaps with that of Riverview High School, including the market town of Crook and some common villages. However, the majority of students come from former mining villages; many of which have high levels of deprivation and ill health. GCSE results were significantly below average for the county and well below the national average. The school's most recent Ofsted report[25] notes that "The Wear Valley has very few employment opportunities and a significant proportion of pupils come from areas with high levels of deprivation and ill health" and that "Although results in GCSE examinations are below national figures, they represent good achievement for pupils who had well below average standards when they entered the school". The young people attending Meadowcroft Community College are almost exclusively white and few join or leave the school before the end of Year 11. The number of pupils with special needs or statements of special need are well above the national average. Meadowcroft was given specialist Sports College status during the course of this research, but this new status had not yet trickled through to improved facilities at the time the research was undertaken. The provision of after school activities appeared to be restricted both by the limited facilities available and by the numbers of students who were dependent on school busses for transport. The PSHE curriculum was delivered by form tutors

[25] The quotations from the school's Ofsted report have not been referenced fully because to do so would allow the school to be identified.

through the life-skills classes (Years 10 and 11) or tutorial lessons (Years 7-9) and GCSE health and social care was offered. At the time the fieldwork was undertaken the school had around 800 students on its roll.

4.3.3.3 Hillcrest High School

Hillcrest High School is a mixed 11-16 comprehensive school in the market town of Bishop Auckland. The school itself is located in an area which had the highest level of 'overall' deprivation in County Durham, based on the 2004 Index of Multiple Deprivation. However, the school is oversubscribed and does attract some middle class families from more affluent outlying areas. Although GCSE results are slightly higher than at Meadowcroft, they are still significantly below average for the county and well below the national average. Hillcrest's intake is almost exclusively white, but school does have a number of students from travelling communities. The majority of these are from Roma Gypsy or Irish travelling families who are, for the time being, permanently resident in the area. The school has specialist Sports College status. PSHE classes were taught by a specialist PSHE teacher, but these had been changed to fortnightly lessons in order to accommodate a new time-table structure and extra PE lessons. At the time the fieldwork was undertaken the range of after school and lunchtime activities available was increasing, although some students felt that there was a lack of sports opportunities. Whilst the school did have a new sports hall, which had been financed as part of its move to specialist Sports College status, the school's physical environment was generally in poor condition. The school placed a strong emphasis on pastoral support and had a dedicated support centre for students which included workers from external agencies. In addition, the school was very active in the national AIMhigher programme, but it was not clear whether this was impacting equally across the different social groups represented in the school. Socially, there was at times a marked divide between 'Chavs' and 'Posh' students in the school[26]. At the time the fieldwork was undertaken there were around 670 students on the school's roll.

4.4 Identifying Appropriate Research Methods

As the previous sections of this chapter have discussed, the epistemological foundations of my research indicated a participatory approach and, whilst the extent to which the research can be considered 'participatory' was mediated by the spaces and contexts I worked within, the aims and values of participatory research had a significant impact upon my methodology and the research methods used. I wanted to develop a methodology which recognised young people as 'competent', promoted their autonomy

[26] These were labels used by a number of research participants at Hillcrest when describing other groups of young people in their local area. The terms appeared to be used in a derogatory manner.

and would engage and interest them as active participants rather than passive subjects, thereby allowing their views and priorities to be fore-fronted. The original research proposal submitted to the ESRC stated that my PhD was intended to be a participatory research project and that the methods chosen would be decided by the young people involved; but also indicated a number of qualitative methods which I was considering using and suggested the possibility of supplementing these with a small amount of quantitative work or secondary analysis. In practice, whilst some of the methods I suggested in the original proposal were used, many of the methods which I had expected the young people I was working with might chose, such as auto-photography and diaries, were not embraced.

Whilst from an epistemological point of view the research I undertook was underpinned by the aims of participatory research, many of the initial aims and aspirations did not translate into reality. From the outset, a fully participatory project was impossible because the broad topic for the research had been decided upon by myself and, whilst I had hoped to scope the project further with the schools involved, the need to identify a topic for funding purposes, lack of local contacts and time-frame involved in applying for funding ruled out collaboration at this stage. Furthermore, my intention to plan the methodology collaboratively with the schools encountered significant resistance.

The research at both Meadowcroft and Riverview started over a term before that at Hillcrest. In both of these schools I attempted to involve staff in discussions about the design of the project and research methods and asked if there were particular issues or themes they wanted the project to explore, but my key contacts in both schools did not appear interested in pursuing this avenue. This was articulated very clearly by the teacher in charge of the Healthy Schools initiative at Meadowcroft, who made it explicit that the school wanted me to come in with a 'ready made' research project because the staff did not have time to involve themselves in the planning or design of the project. Furthermore, the staff at Meadowcroft and Riverview were not happy for me to undertake work with students outside of school; both citing the time that would be involved and concerns about the potential impact on students' work. At Hillcrest, the PSHE teacher initially appeared to be more accommodating of the idea of collaborative work. However, for the purposes of continuity and comparability it seemed appropriate to begin the work at Hillcrest by using the same methods and structures which had already been used in the other schools, and then develop further work with shared decision making about methods, design and focus. As will be discussed in Section 4.4.2, the work at Hillcrest was seriously affected by substantial periods of absence in relation to my key contact in the school, and the research did not reach the intended collaborative stage. Moreover, in all three schools, the young

people themselves showed some significant reluctance to engage in discussions about the design of the project or the direction it should take. All of the groups involved in the initial group discussions where asked if they felt there were any particular themes or issues which they thought the project should consider, and what activities they thought should be part of this. Ideas suggested by myself, such as diaries, photography, story boards and drama, were not well received. However, a number of groups expressed a clear view that a quiz[27] or survey should be done in their school.

The qualitative approaches used in the project centred around group discussions, participatory diagramming and mapping, and interviews with friendship pairs or small groups. In all instances, the group discussions were undertaken in conjunction with the participatory diagramming. The sessions sought to explore young people's understandings of health and the factors which they thought were the main risks and barriers to health for young people in their area. This was then followed up with interviews, some of which included further participatory diagramming. Participatory mapping was also used in a small number of interviews to try and explore which areas participants thought were healthy or unhealthy but, as will be discussed later, I found that those involved did not have the skills required for this method to be effective.

After the qualitative work was completed, the findings from this were used to help inform the design of questionnaires which were to be distributed among a large proportion of each school. The use of a questionnaire was recommended by several of the groups I worked with during the qualitative phase of the project and the questionnaires were designed in collaboration with school council at Riverview. The main aim of the questionnaires was to provide a broader sweep of opinions across each school which would help, firstly, to provide some context for the more detailed qualitative material collected and, secondly, to provide the schools with some more detailed findings without their being able to trace this back to individuals. Data from the questionnaires were analysed both through statistical procedures and with the use of the GIS package Arc-GIS. Feedback was given to the schools in the form of A0-sized visual summaries of findings which could be displayed by the schools if they desired, and there is an open offer for me to discuss the work with staff or students.

4.4.1 Rationale for Chosen Methods

This section outlines some of the main strengths and limitations of the research methods deployed. It will also highlight the key reasons for their inclusion in the

[27] The term 'quiz' was generally used by participants in the younger year groups. When further questions were asked by myself it appeared in each instance that they were talking about questionnaires aimed at finding out what people did, rather quizzes to test knowledge or understanding.

research. The way in which methods were deployed did not always correspond with what is considered to be standard 'good practice' and the reasons for such deviations, which generally relate to issues of epistemology, methodology or ethics, will be discussed.

4.4.1.1 Focus Groups

As Conradson (2005a) discusses, the use of focus groups has become increasingly popular in Human Geography. In their basic form, focus groups are effectively a group discussion or interview which is focused around a particular theme or topic. Focus groups enable the researcher to access several views from each session and the interaction between participants makes them especially useful for exploratory work (Longhurst 2003). There is also a safety in numbers and their polyvocal nature is more egalitarian and empowering (Wilkinson 2004). Whilst focus groups are often used as a means of harnessing a spectrum of views which are held by individuals in relation to the specific topic, they can also be used as a means of exploring individuals' interactions and the dialogues which occur during the discussion (Conradson 2005a).

Whilst the use of focus groups can been very useful in exploratory research, it is important to recognise that focus groups do have a number of limitations. Firstly, not everyone is comfortable in a group situation and the presence of other group members means that individuals cannot express views in complete confidence (Gibbs 1997). This can therefore exclude some accounts. Furthermore, focus groups can sometimes be difficult to run with certain types of individuals dominating discussions (Bedford and Burgess 2001). There may also be a reluctance for participants to express views which may be perceived as controversial or which differ from those which have been expressed by other group members and, as Conradson (2005a) notes, this is particularly likely if sensitive topics are discussed. As will be discussed later in this chapter, power imbalances between the researcher and participants must be recognised and may be compounded by power dynamics between group members (Hoggart et al. 2002).

Focus groups have been used successfully in research exploring health issues with young people (Robertson 2003; Stanton et al. 2000; Watson et al. 2003). However, these studies had all based discussions on pre-defined topics identified by the researchers and the focus groups therefore acted as fact-finding events for the researchers rather then opportunities for young people's views and agendas to be fore-fronted. My aims were different and I therefore needed to consider the potential limitations of focus groups for my work. I was concerned that participants who were unfamiliar with group settings might feel threatened or lack the confidence required to

discuss issues openly. I also suspected that the use of focus groups on their own would only 'engage' those with the best communication skills, thereby prioritising the views of well-educated participants from middle-class backgrounds.

In this thesis I am using the term 'group discussion' rather than 'focus group' when talking about the research undertaken for this study; partly because this is the term I used when talking to school staff and participants, and partly because I did not use focus groups in their 'traditional' sense. The term 'discussion group' was used when talking to the schools and young people because I felt that this gave those without research experience a more immediate sense of what the method entailed, without the use of unnecessary jargon. I was also concerned that the term 'focus group' might sound more formal than the term 'group discussion', and I wanted the research to be as informal as possible so that the young people involved would feel comfortable with participating. Furthermore, these group discussions also incorporated participatory diagramming exercises, which do not constitute part of a focus group in the traditional sense of this term. Most of the groups were subdivided for at least part of the session – generally whilst participatory diagramming exercises were undertaken – and thus included separate, parallel discussions rather than a single 'focused' group discussion. All of the group discussions were recorded, and a separate recording device was placed with each part of the group whilst they were subdivided for the diagramming exercises. An example session plan is shown in Appendix 3.

4.4.1.2 Participatory Techniques

Whilst participatory techniques can include a variety of media such as video, drama and story boards, my focus here will be on participatory diagramming and mapping techniques. Like focus groups, participatory diagramming is generally a group activity. However, as Kesby et al (2005) discuss, the researcher generally adopts a lower profile during the diagramming as compared to focus group facilitation. In addition, the more tactile and visual nature of the method can encourage contributions from quieter group members and those who are less confident with verbal communication. Participatory diagramming is an iterative process and the initial diagram should be viewed as a work in progress which can be discussed and then modified by participants as desired. Kesby et al (2005) suggest that this can helpful when dealing with sensitive issues because it can allow the issues to be brought into the open allowing scope for reflection and debate. Participatory mapping is often a form of participatory diagramming in which participants draw sketch maps of a particular area. However, participatory mapping may also employ base maps which participants add to or annotate in some way.

Participatory techniques are relatively simple and accessible tools which can be used both within and outside of a participatory approach (Kesby et al. 2005). In addition, the techniques are generally fairly versatile and can be tailored to suit different participants. Further advantages for my work include the way techniques can be used in sequence with discussion moving naturally from one to another and the potential for different data sources to be triangulated (Kesby 2000). Kesby et al (2005) suggest that participatory diagramming should serve two purposes. Firstly, it should help to gain the best impression possible of the topic or issue which is being investigated and, secondly, it should help to promote participants' own learning and ability to reflect upon and analyse ideas or issues including self-reflection.

As Breitbart (2003) notes, it is important to consider how the methods chosen further the goals of participation. In the context of my work, I felt the inclusion of participatory diagramming and mapping would help balance some potential drawbacks of the group discussions by helping create a less threatening environment in which individuals could express views less conspicuously. I used a two-stage diagramming exercise during the initial group discussions in order to help participants think about meanings of health and the main risks to health for people their age in their area. A typical example of one of these diagrams is shown in Figure 4.2[28]. The first stage of the diagram was a brainstorm about what health meant and the second stage used post-it notes to identify key risks or barriers to health for young people their age in their local area. The ideas on the diagram and related issues were discussed after each stage of the diagramming. In most instances, a second moderator was used to help facilitate the group discussions.

In addition, I had also intended, if desired, to use participatory mapping to explore participant's conceptualisations of healthy or unhealthy places. Although participatory mapping has been used successfully in other research projects with young people, the method was not successful in the study this thesis is based upon. Participatory mapping exercises were attempted in the follow-up interviews with Year 10 participants at both Meadowcroft and Riverview, and two versions of the mapping were tried. Firstly, I attempted to get participants to draw me some sketch maps of their local area to highlight places and neighbourhoods which they thought were healthy and unhealthy. In both interviews where this was attempted the young people involved appeared unable to represent their area visually on the flip chart paper. Secondly, having found the sketch map did not work, I tried using base street maps with tracing paper overlays to explore the same issues. However, I found that the

[28] It should be noted that the doodle 'Hya Sue' did not refer to anyone involved in the research. This doodle started as a series of seemingly random dots which the participant then realised could be joined up approximately to make these words.

young people involved had limited spatial literacy and map reading skills and appeared unable to locate on the map places such as their homes, school and local shops.

Figure 4.2 Example of a Two-Stage Participatory Diagram

(Bernadette and Erin, Year 10 group, Hillcrest)

4.4.1.3 Interviews

Whilst interviews may take either structured, semi-structured or unstructured formats, my focus here will be primarily upon semi-structured interviews. As numerous authors have discussed, semi-structured interviews are commonly used to gather detailed qualitative data (see, for example, Dunn 2005; Hoggart et al. 2002; Longhurst 2003; Valentine 2005). In many respects, interviews offer similar advantages to focus groups but involve fewer people in each research encounter. The smaller size can be an advantage for those who are less comfortable offering views in a group context. However, it should not be assumed that a young person who is shy in a group setting will be any more willing to open up in an interview setting as some may find the more personal setting intimidating. Interviews allow an in-depth conversational style of data collection which is fluid, nuanced and can be varied as required to suit different participants (Valentine 2005). In semi-structured and unstructured interviews participants are able to develop their own accounts and descriptions using their own

words, rather than being constrained by rigid questions and possible answers which are often found in questionnaires or structured interviews. These personal accounts can be particularly useful for exploring complexities, contradictions and meanings (Valentine 2005) and this is something which this research has sought to do.

For this study, follow-up interviews were undertaken with many of the young people who had been involved in the group discussions and participatory diagramming exercises. The participants were generally interviewed in friendship pairs, although there were some groups of 3 and one group of 4. This method of interviewing was previously used by Nayak in his work with young males about racism and identity in the West Midlands (Kehily and Nayak 1997). The friendship pair interviews have been used in this study because it offered a more informal and less threatening environment for the participants, which allowing richer and more complex narratives to be constructed and explored. The follow-up interviews offered a way of checking my interpretation of what participants had said in the group discussions. They also allowed me to explore personal issues and experiences, such as bullying and domestic issues, in more depth than had been appropriate in the larger group setting. Furthermore, the interviews also enabled me to explore issues which had been raised by other groups, their views on these issues, and the importance which were attached to them. An example interview schedule is shown in Appendix 4.

4.4.1.4 Observation

Observational methods such as ethnography and participant observation have become extremely common in Human Geography because they can allow a researcher to develop a deep and nuanced understanding of people's everyday lived experiences (Cook 2005). Although I have not used either ethnography or participant observation as methods in this research, the use of observation skills has been an integral part of the methodology. In both the group discussions and diagramming exercises I paid close attention to the ways in which different participants engaged with both each other and the research process, including issues such as the use of body language and participants' use of space. I have also paid careful attention to the spaces used in the research and their impact upon group dynamics and the atmosphere of different research encounters. This has included consideration of the characters and atmospheres of the different schools and their potential impact on the research.

Furthermore, I have visited different locations within my study area during the day and have used local bus services to gain an insight into the 'feel' of different places and the ways in which people use their local environment and interact with each other. This has helped me to understand some of the issues which the young people I worked with have discussed in relation to their neighbourhoods. In each of the schools, I

ensured that at least one of my visits overlapped with the school lunch-break and, whilst I did not formally observe places like the school canteens, this enabled me to get a sense of how many young people were eating in school and how many were leaving to either eat at home or get food from local takeaways. As will be discussed in Chapter 6, policies surrounding school meals were an important issue for many of the young people I worked with. The lunch-time practices observed corresponded with the accounts given by participants, particularly in relation to food practices and the subversion of school policies.

4.4.1.5 Questionnaires

As was noted in the introduction to this section, many of the young people involved in the group discussions and diagramming thought that the research should include a survey or 'quiz' of young people in their school. The questionnaire used was developed in collaboration with the school council at Riverview High School. It was completed by young people in all three schools.

There is a long history of the use of questionnaires and survey methods in Social Science research, and well established ideas of what constitutes 'good practice' in terms of issues such as validity, sampling and questionnaire design; which often assume a positivist epistemology and objective knowledge. Parfitt (2005) argues that it is essential for researchers employing quantitative survey techniques to consider issues of reliability and validity in order to reduce sampling, response and non-response errors. Sampling errors are those which occur as a result of the ways in which respondents have been selected whereas non-sampling errors, such as response and non-response errors, are associated with biases introduced through the questionnaire design (see Parfitt 2005 for fuller discussion). Probability sampling, such as simple random, stratified or multi-stage samples is generally regard as essential for reliability. Where non-probability or purposive samples are used, these most frequently use quota sampling (Parfitt 2005). However, I have used a non-probability sample which aimed to capture as many respondents as possible rather than a quota. The instructions on the questionnaires made it clear that the young people did not have to answer any questions with which they felt uncomfortable, and it was made clear to the schools that I did not wish any of the young people to be forced into completing questionnaires if they did not wish to do so. As will be discussed in Section 4.6 of this chapter, the response rate for the questionnaires is not known because, for reasons of confidentiality and ethics, I did not wish the schools to keep records of which young people had completed questionnaires.

It is often considered a good idea for questionnaires to use a number of different question types (Parfitt 2005) and, as Kitchin and Tate (2000) discuss, the

ways in which questions are worded can be crucial to the success of a questionnaire. The length of a questionnaire can also be important (Kitchin and Tate 2000; Parfitt 2005) and this was a limiting factor in my research. Whilst Riverview and Hillcrest schools were planning to do the questionnaires during PSHE lessons, Meadowcroft wanted students to complete them during a 15-minute registration period. Therefore the questionnaires needed to be concise enough to be completed by mixed-ability groups during this time and yet also needed to cover the key issues identified during the qualitative phase of the research and by the Riverview school council.

Oppenheim (1992) suggests that there are two broad types of surveys or questionnaires: the descriptive, enumerative or census type survey, the purpose of which is to count; and the analytic, relational type of survey which is designed to explore associations between variables. The questionnaire used in this study falls under the second category because in addition to counting phenomena or beliefs it has also sought to explore why certain beliefs were held. As can been seen from the copy of the questionnaire in Appendix 5, a mixture of open and closed questions was used. This also included the use of Likert-style scales to help measure attitudes and behaviours.

Like McLafferty (2003), I believe that there is a need to consider data analysis at the design stage of the questionnaire. This is in order to help ensure that the questions asked are suitable for the purposes of the study and maximise the likelihood of them yielding meaningful data. However, in the context of this study, considering analysis options at the design stage was not as simple as it might sound. Literature on questionnaires and survey methods generally assumes that the researcher will be controlling the design process and deciding what questions to ask and how to word these. The literature also tends to assume a positivist or realist epistemology. Neither of these assumptions apply in the context of my work, due to the collaborative nature of the questionnaire design. There was, unsurprisingly, a trade-off between what I as a trained researcher considered to be a 'good' question and questionnaire design, and the questions and options which the young people wished to include. For example, questions 8 and 10 on the questionnaire include the categories 'occasionally' and 'regularly', which is not generally viewed as good practice by researchers because these terms can mean different things to different people. However, members of the school council at Riverview were convinced that these terms would be understood easily by their peers. On my suggestion, these categories have been qualified with examples of what 'occasionally' and 'regularly' mean; but this has introduced a further complication because the young people in involved in the questionnaire design have used different definitions of 'occasionally'. For question 8, which related to smoking, the consensus amongst members of the school council was that 'occasional' smoking

was something which occurred a couple of times a month, whereas for drug-taking in question 10 'occasional' meant a few times a year. I have respected the views of the school council on such issues, and am not making any claims about the direct comparability of different variables.

4.4.1.6 Secondary Data

Whilst secondary data can form the basis for an entire project, it is often used to provide the researcher with contextual material, for example historical or socio-economic data, to complement the primary data obtained during fieldwork (Clark 2005). In the context of my project, a key advantage to using secondary data was that it provided background information about my study area which would have been difficult for me to obtain through primary fieldwork alone due to time and resource constraints. In this thesis I have used data from both the 2001 census and the Index of Multiple Deprivation in order to glean information about the areas I was working in and, as will be discussed later in this chapter, as part of the analysis of the primary data I collected.

It is important to recognise that there are limitations of secondary data. Firstly, as the researcher, you do not have control over how the data is collected and it is likely that the data was originally collected for a different purpose to that of your research. Therefore the data needs to be viewed as a cultural artefact because it will inevitably have been shaped by the values and priorities of those who collected the data (Clark 2005; Kitchin and Tate 2000; White 2003). Secondly, secondary data is rarely static (Clark 2005) and issues such as changing questions, boundaries or spatial units need to be taken into consideration. In addition there may also be issues of compatibility between different data sources (Clark 2005). For example, in my work, I have had to accommodate the fact that the census and Index of Multiple Deprivation use different spatial units. Finally, Clark (2005) suggests that it is important for the researcher to draw upon the same language as those who compiled the data. This is something which can be difficult because it is not always clear how the original compilers operationalised concepts and what they mean by specific terms.

4.4.2 Discussion of Fieldwork Undertaken

In all three schools I began the fieldwork with group sessions during which I combined group discussions with participatory diagramming activities. All of the groups were mixed gender apart from the Year 12 group at Riverview which contained the students taking the AS-level health and social care course and only included females as a result of which students were studying the subject. These group sessions were intended to provide a starting point for exploring participants' beliefs and priorities in relation both to the substantive theme of health and to the research process. All of the

participants involved in the qualitative work were recruited by the teachers. Whilst I had explained to the teachers that I wanted as broad a cross-section of students as possible, it is not entirely clear how far this request was followed. The numbers of participants involved in the group discussions and interviews in each school, and the distribution of year groups and genders, are summarised in Table 4.1.

Table 4.1 Numbers of Participants Involved in Qualitative Work

School	Activity	Year Group	Number of females	Number of males	Total participants
Riverview	Discussion groups	8	1	2	3
		9	3	2	5
		10	3	1	4
		11	0	2	2
		12	16	0	16
		Total	23	7	30
	Interviews	9	0	2	2
		10	3	1	4
		Total	3	3	6
Meadowcroft	Discussion groups	8	4	3	7
		9	2	6	8
		10	2	4	6
		11	4	1	5
		Total	12	14	26
	Interviews	8	3	3	6
		10	2	3	5
		11	4	0	4
		Total	9	6	15
Hillcrest	Discussion groups	8	4	3	7
		9	4	4	8
		10	3	4	7
		Total	11	11	22
	Interviews	8	3	3	6
		9	3	4	7
		10	3	4	7
		Total	9	6	15
Total	Discussion groups	8	9	8	17
		9	9	12	21
		10	8	9	17
		11	4	3	7
		12	16	0	16
		Total	46	32	78
	Interviews	8	6	6	12
		9	3	6	9
		10	8	8	16
		11	4	0	4
		Total	21	20	41

At Riverview, the teacher informed me that she had 'randomly' stopped students in the corridor and asked if they wanted to be involved. With the exception of the Year 12 Health and Social Care students, it appears that I did get a mix of students, but the numbers were significantly lower than I would have liked and have thus limited the extent to which the participants could be considered to be representative of the student body. I had asked for a group of around eight students from each year group and was actually given two groups in total, each of which had two year groups represented. When I tried pushing for more students from each year group, the teacher made it clear that she felt she had already given me enough students as there had been some from each year and a mixture of genders. My sense at this point was that I was beginning to stretch the limits of the time and energy the teacher was willing to give to the project and, in view of the longer term interests of the research, I did not push the issue further. All of the fieldwork undertaken at Riverview was carried out during the weekly PSHE lessons and the entire school had this lesson during the same timetable slot.

At Meadowcroft the teacher I was liaising with asked for volunteers from specific form groups to participate during either their life-skills classes (Years 10 and 11) or tutorial lessons (Years 8 and 9). These classes were held during a different time-table slot for each group and the groups in Years 7-9 were streamed according to academic ability. The teacher was very keen that she should be available to great me on the days I came into the school, and the classes involved in the project were therefore determined by whether they fitted around our respective teaching timetables and my commitments at Riverview. The participants I worked with a Meadowcroft were drawn from a high ability Year 8 class, a low ability Year 9 class and mixed ability Year 10 and 11 classes. Some of the participants in the Year 8 group had parents working in 'professional' occupations such as teaching; but the majority of Meadowcroft participants did not, with some families dependent on short-term manufacturing posts.

At Hillcrest, the teacher selected willing members of her PSHE classes and actively tried to include young people from a mixture of social and family backgrounds; rather than simply selecting the first students to volunteer. The groups at Hillcrest included young people from a variety of social and cultural backgrounds and a range of academic abilities. Three of the Hillcrest participants were members of the minority travelling community. The research at Hillcrest only included participants from Years 8, 9 and 10, and not Year 11, because the school did not wish those in their final GCSE examination year to be involved. As was noted in Section 4.3.1, the decision to include Hillcrest High School was taken part-way through the empirical phase of the project. The group sessions at both Meadowcroft and Riverview had already been completed before the decision was made to include Hillcrest, and this decision was made partly on

the basis on comments which participants at the other schools, especially Riverview, made about Bishop Auckland – the market town in which Hillcrest High School was situated.

After the group sessions had been completed in all three schools, some of the participants were, as indicated in Section 4.4.1.3, subsequently involved in follow-up interviews in small groups of two or three (or occasionally 4) participants. These interviews were done in single gender pairs or groups, so that participants would be able to raise any issues which they had felt unable to discuss in the mixed gender group. This also eliminated the sexual banter between male and female participants which had dominated some sections of discussion in the Year 8 group at Hillcrest.

Not all of the young people who participated in the group discussions were involved in the follow-up interviews. At the point when the follow-up interviews were undertaken, the two Year 11 participants at Riverview were involved in exam skills and revision techniques sessions during their PSHE lessons and were unable to miss these. Also at Riverview, one of the Year 8 males and one Year 9 female were absent on the day the interviews were scheduled and the other participants who would have been interviewed at the same time did not wish to continue on their own. The Year 8 female participant from Riverview had not been included in the interview schedule because I did not have anyone to pair her with and did not feel it was appropriate to group her with participants she did not know.

At Meadowcroft, two students dropped out of the study before the interviews and one had been placed on a behaviour management scheme which precluded his participation. I took the difficult decision to exclude the Year 9 Meadowcroft participants from the interviews. From the performances during the group discussion it had been clear that the male members of this particular group were in the process of exploring their emergent sexual identities and this appeared to have been aroused by my presence and the topic under discussion. The amount of graphic sexual innuendo from male participants in this group context gave me concerns about whether it would be appropriate for me, as a female researcher, to undertake follow-up interviews with these particular participants. In addition, it felt more appropriate to simply omit all of the Year 9 Meadowcroft participants from the interviews, rather than invite the females back and not the males, because their omission would be less obvious on this basis than if I had invited some members of their group for follow-up interviews without inviting the others.

At Hillcrest, the interviews were delayed by a period of long-term sick leave on the part of the staff member I was liaising with. Dates for the interviews were set up on her return, but she subsequently went back on sick leave before she had spoken to all of the participants. As a result members of the Year 8 and 10 groups had not been

given advance notice of the interviews; although the Year 9 participants had. Two of the participants at Hillcrest were not involved in the follow-up interviews because they were absent on the days these took place. In addition, two of the Year 8 girls, who had not had advanced notice of the interview, decided to return to their lesson before the end. They had a supply teacher for the lesson they were missing and had planned to 'have a laugh' with their friends during this class. Both appeared distracted during the interview and commented that they wondered what was happening in the class. However, the third Year 8 female was very keen to continue with the interview despite the other two returning to class.

As has already been discussed in Sections 4.4 and 4.4.1.5 of this chapter, many of the young people involved in the qualitative phase of this study suggested that a survey or quiz should be undertaken in their school; and the questionnaire used in the quantitative phases of this study was designed in collaboration with the school council at Riverview. I felt that it was important for all of the young people involved in the questionnaire design to be able to meet together at the same time to discuss what this should included, because I was concerned that it would be impossible to reach a firm consensus if the questionnaire was designed separately by different groups. My concerns about reaching consensus on the questionnaire design centred around the aims of participation and the inclusion of young people's views and priorities. As was noted in Section 4.4.1.5 of this chapter, the questionnaires needed to be accessible enough for them to be completed during a fifteen minute registration period. It was likely that having several different groups involved in the questionnaire would generate too many desired questions, and potentially disagreements over wording, which would then have required me as the researcher to exclude material which some participants wished to include. I felt that including only one group in the questionnaire design, and enabling them to collaboratively make decisions and reach a consensus about what should be included, furthered the aims of participation better than including more participants whilst excluding some of their views. The focus on a single group allowed scope for deeper participation, whereas having more participants yet being unable to include all of their view points was more likely to become tokenistic.

A decision was taken to only involve young people from one school in the questionnaire design because of the logistical challenges which would have occurred had I tried to involve young people from all three schools. As my contact at Hillcrest was on sick leave at the point when the questionnaires were designed, and the qualitative phase of the projected had not yet been completed there, I realistically had a choice between Meadowcroft and Riverview. Given that the schools were some distance apart, and staff only had limited time available for the study, arranging a joint meeting during school time with participants from both schools was not a practical

option; especially as the schools held PSHE lessons at different times and did not want participants missing academic lessons. Furthermore, as indicated in Section 4.4, Meadowcroft and Riverview were both unwilling for participants to be involved in activities relating to the study outside of school, and organising an evening or weekend session to design the question was therefore not an option. Riverview was selected because the Deputy Head teacher (whom I worked with for this phase of the study only) was keen for the possible questionnaire to be discussed with the school council; and the fact that the whole school had PSHE lessons in the same timetable slot made it easier to arrange a time without council members needing to miss academic classes. The school council at Meadowcroft was not active and the staggering of tutorial and life-skills classes, in which PSHE was taught, meant that it would not be possible to meet with all the Meadowcroft participants at the same time.

At Meadowcroft and Riverview, the questionnaires were distributed in the second half of the summer term to students in Years 7, 8, 9 and 10. The Year 11 students were not included because they were on study leave for their GCSE exams. After my contact in the school returned from sick leave, Hillcrest agreed to do the questionnaires in July of the same term. Unfortunately the school was flooded at the start of the week when the questionnaires were due to be completed and the school was forced to close for the remainder of the academic year. The questionnaires were re-delivered to the school in late September, but an Ofsted inspection meant that they did not get completed until after the half-term break. At Hillcrest, the questionnaires were distributed to students who were then in Years 8, 9, 10 and 11, and thus covered the same cohort of students as would have been involved had the questionnaires been completed in July 2007. For the purposes of comparison I have, for all schools, recorded the school year which the students were in during July 2007; so the Hillcrest participants have been entered as Years 7, 8, 9 and 10 on the data set.

Table 4.2 shows the number of questionnaires returned from each school. It also shows the percentage of students in the final sample who attended each school. As was indicated in Section 4.4.1.5, and will be discussed further in Section 4.6, the response rate is not known. Table 4.3 shows the questionnaire returns by year group, and Table 4.4 by gender. With regard to gender, the category ‘both’ refers to participants who ticked the boxes for both male and female. The category ‘not specified’ refers to those who answered the first part of question 1, which related to year group, but did not give a gender.

Table 4.2 Questionnaire Returns by School

School	Count	Percent
Hillcrest	395	33.82
Meadowcroft	360	30.82
Riverview	413	35.36
Total	1,168	100

Table 4.3 Questionnaire Returns by Year Group

Year Group	Count	Percent
Year 7	240	20.67
Year 8	312	26.87
Year 9	287	24.72
Year 10	322	27.73
Total	1,161	100

Table 4.4 Questionnaire Returns by Gender

Gender	Freq.	Percent
Female	490	42.2
Male	468	40.31
Both	2	0.17
Not Specified	201	17.31
Total	1,161	100

Figures 4.3a-c show the year group and gender distributions within each school. Some of the variations are a result of which students where available when the questionnaires were completed. At Meadowcroft, students were in and out of school due to work experience and school trips during the period when the questionnaires were completed and some form tutors were unable to fit in time for the questionnaires. At Hillcrest, PSHE lessons were, as was noted in Section 4.3.3.3, only held fortnightly and questionnaires were only completed by those classes which had PSHE lessons during the sampling week. The distribution between year groups and genders was generally more even at Riverview, and the lower number of Year 8 males may simply have been a demographic factor.

Figure 4.3a Gender and Year Group Distribution in Hillcrest Sample

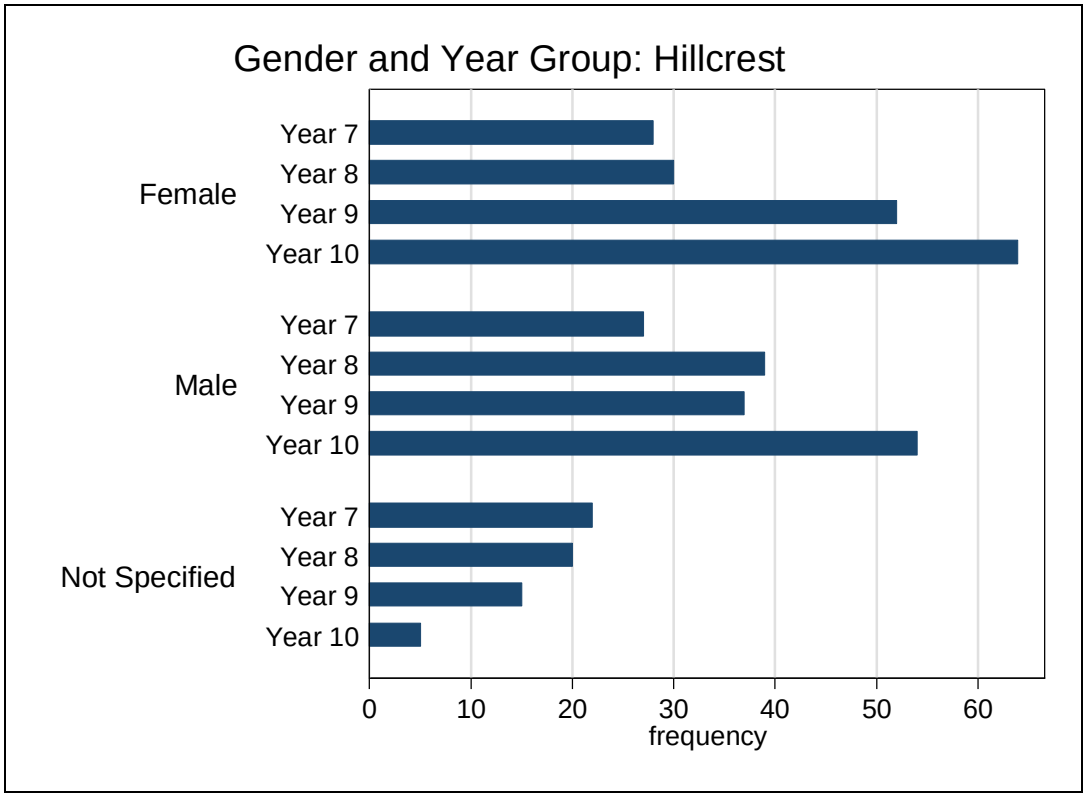


Figure 4.3b Gender and Year Group Distribution in Meadowcroft Sample

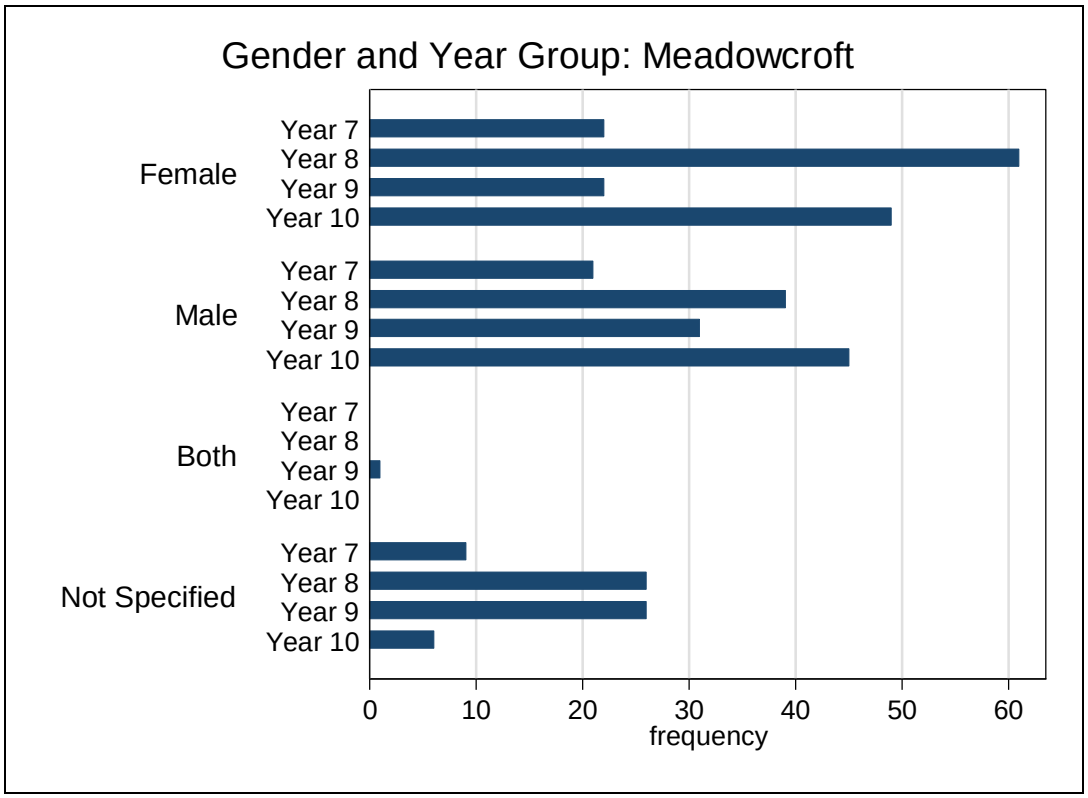
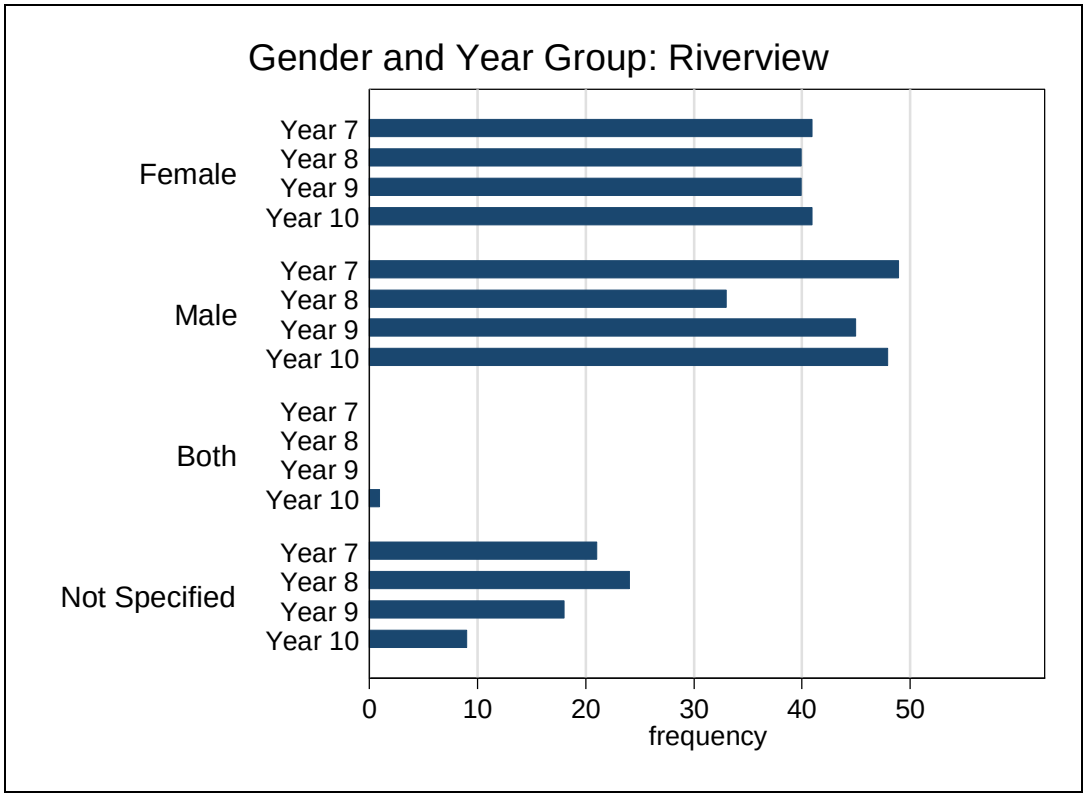


Figure 4.3c Gender and Year Group Distribution in Riverview Sample



4.4.3 Power, Positionality and Gaze

The ways in which the empirical research unfolded were inevitably affected by issues of power, positionality and gaze. Chapter 3 of this thesis has already discussed issues of power and gaze from a theoretical point of view, drawing on the work of Foucault. In addition, the issue of power has also been discussed in Section 4.2 of this chapter in relation to participatory research. This subsection will consider issues of power, positionality and gaze in the research which this thesis is based upon.

It is often argued that power relationships are unequal between the researcher and participants, and that it is important to be sensitive to the power dynamics within research encounters (see, for example, the discussion in McDowell 1992; Valentine 2005). Power can have a major impact on this because the researcher is usually in a privileged position in terms of status, access to resources and knowledge production (Rose 1997) and literature in this area has often assumed that it is the researcher who acts as a conduit for power, with the participants place in a comparatively 'power-less' position. However, as with many issues in social research this is a gross simplification and power dynamics are often complex and multidirectional (Katz 1994), which fits with Foucault's (1980) assertion that there is plurality and multiplicity of power and that power relations are interwoven with other sorts of relations. The increasing awareness of the ways in which power can impact upon research encounters has been associated with a greater awareness of the need for reflexivity and Haraway (1988) argues that it

is important to recognise that all knowledge is partial and situated and consider the positioning of the researcher and their gaze.

When recruiting research participants through gatekeepers there is a danger of being directed to a narrow selection of potential participants (Valentine 2005). In this instance power is manifest through the gatekeepers' control over access, but it should be noted that the researcher is not 'power-less'. Whilst, in this study, the gatekeepers did have control over which participants were involved, especially in the qualitative phase, I was still able to exert some control over this process – albeit with varying degrees of success – by highlighting the mixture of participants I wanted. In addition, the young people themselves also had some power in this process as they were able to either agree or refuse to participate.

In her discussion of interviews, Valentine argues that "it is important to reflect on who you are and how your own identity will shape the interactions that you have with others" (Valentine 2005: 113). This observation also applies equally well to many other methods and throughout the research process I have been mindful of both the impact which my positionality may have and the ways in which my persona and identity may influence research encounters. For the group-based aspects of the research I also gave careful consideration to who I used as a second moderator and the impact which they could have. Similarities in background or identity between the researcher and participants can have both positive benefits and drawbacks. On the positive side, it can help with the establishment of rapport and encourage empathy, mutual respect and understanding (Valentine 2005). One drawback however, is that the researcher may 'miss' things which would have been apparent to a researcher from a different background.

Emotions and emotional judgements can impact upon the ways research encounters unfold and our interpretations of these. As has already been noted in Section 4.4.2, I felt uncomfortable with the amount of sexual innuendo involved in the performances of masculine identity displayed by members of the Year 9 group at Meadowcroft. Here, my feelings about the session influenced the judgement I made about whether it was appropriate to include these participants in the follow-up interviews. Interestingly, although there was some sexual banter in other sessions – especially the Year 8 group at Hillcrest – this stemmed from genuine discussion surrounding issues like teenage pregnancy and did not trigger the same emotions in myself.

A further consideration is the impact of the environments and settings in which research encounters occur, and of any equipment or materials used. This potential impacts of the spaces and setting used has already been highlighted in Section 4.2 of this chapter and in my previous work (Alexander et al. 2007). I was very aware of the

potential impact which the use of the school setting might have and the fact that this might lead some participants to give staged and role played responses based on what they had been taught in school, even if these weren't things they actually believed. All of the group sessions and interviews at Riverview were conducted in classrooms, as were some sessions in the other schools, and these are obviously associated with behavioural norms and expectations. At Meadowcroft, most of the sessions were conducted in the school library. In many respects this provided a less formal space as the room was used for socialising during breaks as well as for study. The office belonging to a Head of Year was accessed through the library and this meant that there were sometimes senior members of staff coming in and out of the room, especially near the start of the school day when they were following up student absences. One of the interviews was also disrupted by the GCSE Health and Social Care teacher who had summoned the Year 11 class to the library in order express her displeasure about their coursework. Interestingly, I was more sensitive than the participants to these disruptions by staff, and most of the participants carried on with discussions regardless when staff entered the room. At Hillcrest, some of the sessions were conducted in a committee room which the students were not normally allowed to access. This space was not associated with behavioural norms and expectations in the same way as the classrooms and the novelty of its use appeared to excite some of the participants and encourage freedom of expression.

The Year 8 participants at Meadowcroft had a tendency to whisper instead of speaking whilst undertaking the participatory diagramming exercises which were used during the group discussion. In this instance, it is not clear whether this behaviour was due to the normal school expectations surrounding quietness during lesson times, or whether it related to either the presence of the recording device or nerves. The potential impact of tape recorders and the power which may be manifest through these has been highlighted (Valentine 2005) but the majority of young people I worked with did not react to the recording devices in an obvious manner. The main exception was the Year 9 group at Meadowcroft where the male participants appeared to perform and 'show off' to the recording devise with exaggerated performances of their masculine identities and with the use of crude language.

The discussion of power, positionality and gaze in this section relates back to the issues surrounding space and scale, power and performance which were discussed in Chapter 3. More specifically, the issues of power discussed relate back to the work of Foucault, which was also discussed in Chapter 3, and the issues surrounding role-playing and performances of gender and identity connected with the work of Goffman and Butler. These issues of power, performance, space and scale will be discussed further in Chapters 6 and 7 of this thesis, in relation to the empirical

material gathered. First, the next section of this chapter will offer a brief discussion of data analysis, followed by a further section on ethics, before the key findings are outlined in Chapter 5.

4.5 Data Analysis

Data analysis is an integral aspect of methodology and, as has already been noted with regard to questionnaire design, needs to be considered when selecting and developing research methods. Although numerous books offer guidance about research methods (for example Hoggart et al. 2002; Limb and Dwyer 2001) the discussion of data analysis tends to be less plentiful. However, methods of analysis are an integral part of methodology which affect outcomes and therefore warrant careful consideration. Using a combination of research methods increases the challenges for analysis. There were two main challenges in the context of my work: firstly, I had different types of data; and, secondly, I wanted to explore both the thematic content of data and the ways it was constructed including, where possible, the performance and negotiation of sessions.

4.5.1 Qualitative Analysis

However, before material could be analysed it needed to be converted into appropriate formats. The flip chart paper from the participatory diagramming was unwieldy and I therefore took digital photographs of each diagram to store the material as JPEG files. This allowed me to condense each diagram into a smaller area and to zoom into particular areas of a diagram to view detail. The recordings were digitalised through the use of the software 'Total Recorder' and stored on a password protected computer drive.

The qualitative material was analysed using the package ATLAS.ti. The recordings were entered into the analysis package as mp3 audio files, because this package had the ability to create short audio quotes which were then transcribed if they were used in writing such as this thesis or in presentations. The audio material was kept in audio format during the data analysis, instead of this all being transcribed, because this allowed nuances such as tone of voice to remain in the data. When transcription was undertaken this was done using dialect. There has been debate about the usefulness of computer software for the analysis of qualitative data (see Crang 2005; Peace and van Hoven 2005 for discussion). A key advantage of such software is the easy sorting and retrieval of sections of coded data according to theme or code. This made it easier to compare what different groups had said regarding particular topics. The JPEG copies of the participatory diagrams were also analysed with the use of ATLAS.ti. I used an open coding method, developing codes based on

ideas and themes in the data, rather than starting with a set of pre-defined codes. Thus the codes used were emergent, which helped to forefront the views of the young people themselves. For the more popular themes there was sometimes considerable diversity in participants' views. For example, from the passages about smoking I could see that although the 'risks' associated with smoking were widely understood attitudes about smoking varied, sometimes quite subtly.

4.5.2 Quantitative Analysis

The questionnaire data were analysed using the statistical packages SPSS and Stata. The data were typed into SPSS manually, and care was taken to ensure that this was done in an accurate manner. The variables were initially explored using basic descriptive procedures to look at frequencies and percentages. Cross-tabulation between variables was undertaken in two-way contingency tables using Stata to identify possible relationships between variables, some of which will be discussed in Chapter 5, and the statistical tests Pearson Chi^2 and Cramér's V were used in conjunction with the cross-tabulations. Chi^2 measures the squared difference between the observed and expected counts, divided by the expected count, for each cell in the contingency table in order to measure how much each of the individual cells contributes to the overall association between the variables. The measure of overall association between the variables is based on the total Chi^2 for all cells, but this is also influenced by the size of the contingency table and therefore the number of degrees of freedom. A higher Chi^2 value for a given number of degrees of freedom suggests a more significant association between the variables and this is indicated by the p-value. If there are more degrees of freedom, then a higher Chi^2 value is required for the association to be significant. In line with many other researchers I have used a p-value of 0.05 or less to indicate statistical significance

The Chi^2 test is only valid if all of the cells in the contingency table have an expected count of at least 1, and no more than 20% of the cells may have an expected count of less than 5. For some of the ordinal variables, such as 'Happiness', I combined adjacent categories with very low counts in order to reduce the number of cells with low expected counts. Chi^2 and the associated p-value test whether there is an association between the variables, but do not test the strength of this association. Therefore it is necessary to also use a contingency coefficient which is not dependent on the size of the table, such as a standardised contingency coefficient or Cramér's V. I have used Cramér's V as this is the most common measure of association for nominal variables provided that the contingency table has more than four cells, and it can also be used when one variable is nominal and the other ordinal. With Cramér's V a value of 0 would indicate no association between the variables and 1 would indicate a perfect

association. It is worth noting that Cramér's V has a tendency to underestimate the strength of associations between variables and I have therefore also considered the standardised Contingency Coefficient, which will be highlight in relation to some of the variables discussed in Chapter 5.

For the questions where participants were asked to tick all of the options which applied, such as the question about what health meant, each possible response was included as a separate variable and coded yes (option ticked) or no (option not ticked). When I was entering this data I noticed that I was entering a number of repeated patterns of yeses/no's and therefore thought that there might be a pattern to which types of young people had given each set of responses. I therefore undertook hierarchical cluster analyses of each set of related variables to see how the response grouped. However, I found that there were too many sets of answers for this procedure to yield useful information.

Some of the questionnaire data was also analysed using the GIS programme Arc-GIS. Shape files for the 2004 Super Output Area (SOA) boundaries were obtained from the Office of National Statistics, and Electoral Ward boundaries were obtained from Edina Digimap; both under educational use agreements. The data I wished to analyse was attached to the associated dbase files and linked to arc-map. This procedure was used when I wanted to explore the spatial distribution of beliefs or behaviours, such as the percentage of young people in each SOA who said that they smoked 'regularly'. Choropleth maps were developed, with the categories used based on natural clusters or breaks in the data.

4.6 Research Ethics

Any research work involving people requires a careful consideration of research ethics, and this is particularly complex when children or young people are involved. Debates about ethics in social research often centre around issues of consent and the protection of research respondents. This applies to both research with adults and that with children. What makes research with children and young people particularly tricky is their legal status as minors and debates about their vulnerability and competence (Morrow and Richards 1996). Ethical debates generally revolve around the idea of non-maleficence, especially in research involving minors. However, regarding participatory research, Pain (2004) suggests that ethics should be about having positive impacts, rather than the traditional maxim of doing no harm. This challenges some of the norms in research with children.

With regard to consent, the status attached to children creates problems for participation. As children and young people are legally considered to be 'minors' they are therefore often constructed as being incompetent and 'unable' to give informed

consent, meaning parental consent is often viewed as a requirement. At the same time, children and young people have the 'right' to be involved in decisions about their lives. There is thus a direct conflict between children and young people's status as minors and the promotion of their rights or autonomy. This is particularly problematic in participatory research where the promotion of young people's autonomy and agency is a central aim and, as Heath et al (2007) discuss, this can create tensions for researchers between their personal aims and commitment to participatory research and the expectations or requirements imposed by others.

Further problems are raised by children and young people's 'vulnerable' status and need for 'protection'. In particular, parent/guardian's responsibilities for maintaining young people's well-being and right to information can conflict with issues of confidentiality. As noted by Christensen and Prout (2002) adult gatekeepers may consider their right to information over-rides any promises of confidentiality. Ethical considerations concerning child protection and safety extend beyond consent and confidentiality, affecting a range of issues such as the conduct of research encounters and the dissemination of results. Other key aspects of participatory research which can conflict with standard ethical conventions include an increased recognition of power, which challenges the usual 'powerlessness' of children and young people, and an increased focus on the outcomes of the research including its impacts for participants as well as empirical 'results'.

For the qualitative phase of this study, parental consent was obtained for those under the age of 16 and informed consent was also obtained from the young people themselves. The information and consent forms used can be found in Appendix 6. For the quantitative phase of the study, the schools sent letters to parents/guardians to say that the research was being done and explaining how to withdraw their child/ward from this process; and examples are again shown in Appendix 7. Assuming that they had not been withdrawn, young people then had the choice of whether they wanted to complete a questionnaire. For reasons of confidentiality I did not ask the schools to keep a record of which students did and did not complete questionnaires, and as a result I do not know what the response rate was. My rationale was that I knew I would be giving the school detailed feedback which would include things like the number of students involved in drug-taking, and I did not want there to be any risk of the schools tracing this kind of information back to individual students.

Issues relating to confidentiality and anonymity are often complex in group situations (Longhurst 2003) because information is being disclosed in front of other people. It was agreed at the start of all group sessions that the participants should respect each other, and should not mention to other people anything which group members said without the permission of the person who made the comment. Some

participants were reluctant to disclose personal information during the discussion groups, and this was respected. For the follow-up interviews, the participant's were paired or grouped with friends and were generally more open about personal issues in this setting. It was recognised that there was a need to identify in advance potential problems such as sensitive issues which might arise (Valentine 2005). Although this was not needed in reality, I had a plan in place that any participant who raised issues which gave me significant concerns for their welfare, or who had appeared distressed by the discussions, would be encouraged to come and discuss this with a teacher at the end of the session.

Longhurst (2003) suggests that researchers also need to be prepared to deal with offensive or racist views. County Durham, like the rest of North East England has an almost exclusively white population and, as Nayak (2003c) discusses, racist attitudes are sometimes articulated as aspects of performances of white working-class male identities. On the occasions when racist comments were made by participants I chose to ignore these rather than challenging them, because I was aware that these were an aspect of the beliefs and performances of identity which I was seeking to unravel. However, had a racist comment been made in front of a member of an ethnic minority group this would have been challenged carefully and sensitively.

Although this thesis is discussing real places, all of the individuals and organisations involved are being referred to under pseudonyms in order to protect their identity. However, place names have been retained, except where I felt the use of a place name could allow an individual participant to be identified – either through the low population in the place or through behaviours or other issues which the participant mentioned. In order to protect confidentiality, all of the questionnaires were anonymous. Where appropriate, data from the questionnaires has been aggregated to Super Output Area (SOA) level, based on postcodes or addresses given by participants, and any SOAs with less than five respondents have not been included in the mapping work I have undertaken.

Chapter 5 Young People's Health Beliefs and Behaviours: An Overview

5.1 Chapter Introduction

This chapter will offer a brief summary of some of the key findings from the empirical work I undertook, covering both the qualitative and quantitative phases of this, and will provide a foundation for the subsequent thematic discussions in Chapters 6 and 7. For the purposes of clarity, this chapter has been split into a series of sections. However, the issues under discussion are interwoven and whilst the sections used provide a loose organising framework for the material included, the boundaries between the different conceptual ideas should be viewed as fluid and permeable rather than fixed and bounded.

Section 5.2 of this chapter will discuss the health beliefs and attitudes expressed by the young people I worked with. This will be followed in Section 5.3 by a summary of the factors which participants felt influenced their health or that of young people their age and a brief discussion of health related behaviours. Following these discussions of health attitudes and behaviours, the focus of this chapter will then shift to issues of place. This will include some discussion of the types of places which participants considered to be healthy or unhealthy before moving onto to an exploration of the relationships between, firstly, residential neighbourhoods and health status and, secondly, residential neighbourhoods and health attitudes. At the end of this chapter I will offer a preliminary discussion of the ways in which young people's health beliefs and attitudes are sculpted and performed, and the ways these relate to issues of space, before pointing towards three ensuing substantive themes which will be discussed in subsequent chapters.

This chapter offers only an overview of the key data and results. The material in this chapter draws on both the qualitative and quantitative phases of the study; although it is weighted slightly towards the latter with the qualitative material being discussed in greater depth in Chapters 6 and 7. The volume and complexity of the data collected during the research means that it is not possible to cover all the different nuances within the space available in this thesis. Therefore, I have chosen to focus on the aspects of the data which underpin the themes discussed in the subsequent thematic chapters, centring around issues relating to health beliefs, attitudes and behaviours, and those areas of data which are not strictly pertinent to the arguments in this thesis have been omitted. As was noted in Chapter 4, areas with fewer than 5 participants have been excluded from the analysis of quantitative data. Furthermore, the maps shown in this chapter are intended only to offer a visual representation of the

data and, in order to improve the clarity these patterns, the names of the SOAs are shown on the series of maps in Appendix 1, rather than on the maps in this section.

5.2 Young People's Health Beliefs and Attitudes

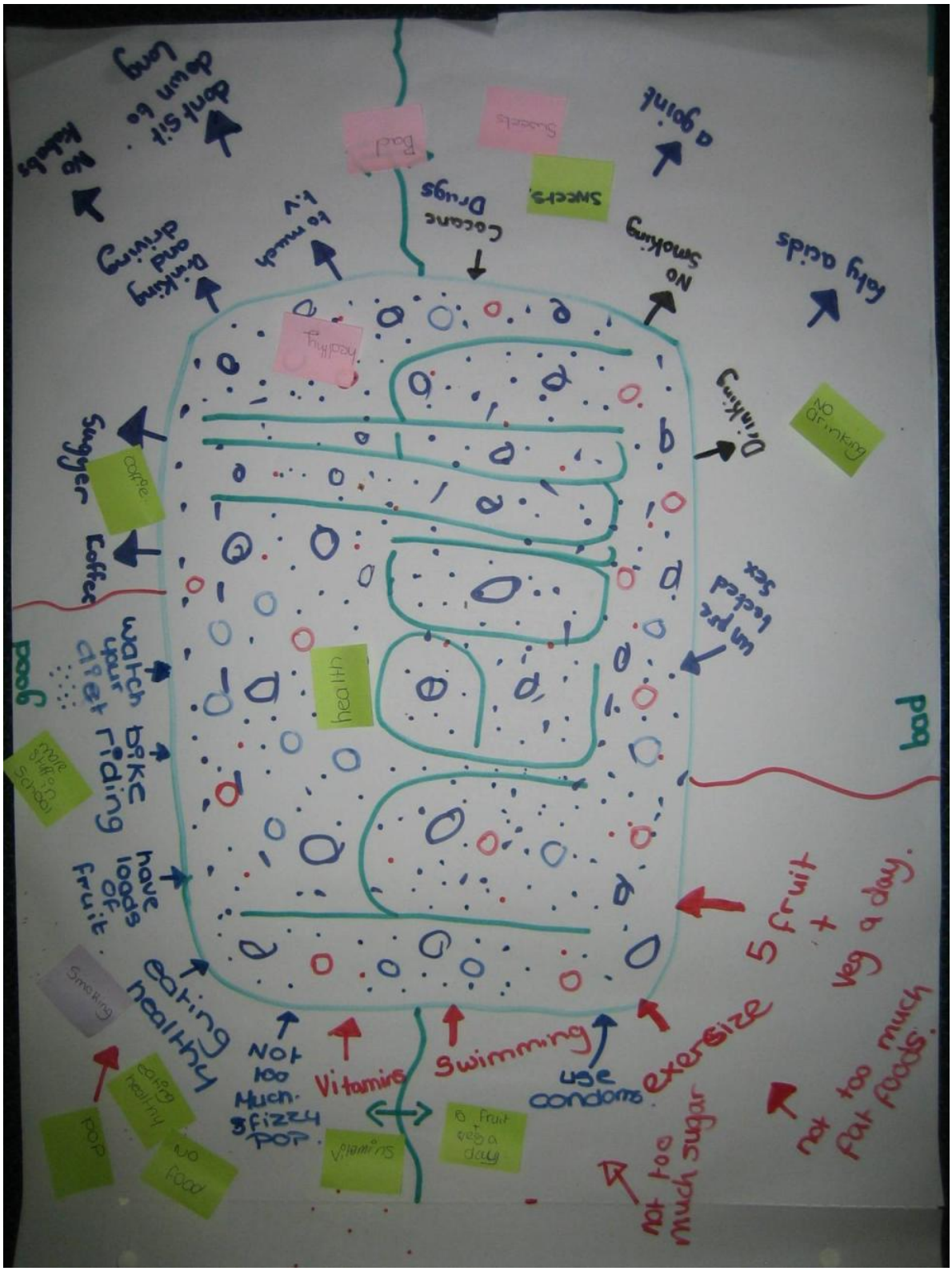
This section will discuss the health beliefs and attitudes held by the young people I worked with. My primary focus here will be upon the beliefs and attitudes which were articulated by participants, in either a verbal or written form. However, there will also be some limited discussion of the ways in which beliefs and attitudes were performed.

During many of the group discussions, participatory diagramming activities and interviews, as well as in the questionnaire responses, participants tended to put a strong emphasis on physical aspects of health, especially issues such as diet and exercise. The points made on the participatory diagrams in Figures 5.1a-c, in response to the question 'what does health mean to you?', were fairly typical of the responses given during group sessions. Whilst there was some significant variation in the content of participants' diagrams, the ideas relating both to diet and/or food and exercise and to fitness and/or sport appeared on virtually all of the diagrams. Whilst, as reflected on the diagrams in Figures 5.1a and 5.1b, the majority of participants tended to place considerable emphasis on physical aspects of health and well-being, such as diet and exercise, some participants did spontaneously discuss social and emotional aspects of health and well-being, as illustrated by some of the points made on the diagram in Figure 5.1c. During the qualitative phase of the research, social and emotional aspects of health were more commonly discussed at Hillcrest and Meadowcroft than at Riverview, possibly reflecting the differing life experiences of participants. As was noted in Chapter 4, Riverview High School served a rural area of the Wear Valley which had become popular with middle-class families and the market town of Crook, Hillcrest served the market town of Bishop Auckland plus some outlying villages and Meadowcroft served a number of former pit villages plus the market town of Crook.

Figures 5.2a-c show the responses given in the questionnaire to the question 'What is health?'. Here, students could select as many categories as they thought necessary and there was the option for them to add extra categories. The bars show the percentage of students in each school who said each category was important. As can be seen from these bar charts, the majority of participants ticked either 'Physical fitness' or 'Eating the right food', or both, when they answered this question. Each of these two categories was selected by broadly the same proportion of students within each school at Meadowcroft and Riverview but 'Physical fitness' attracted a lower percentage at Hillcrest than did 'Eating the right food'. Interestingly, whilst the participants involved in the qualitative aspects of the research at Hillcrest and

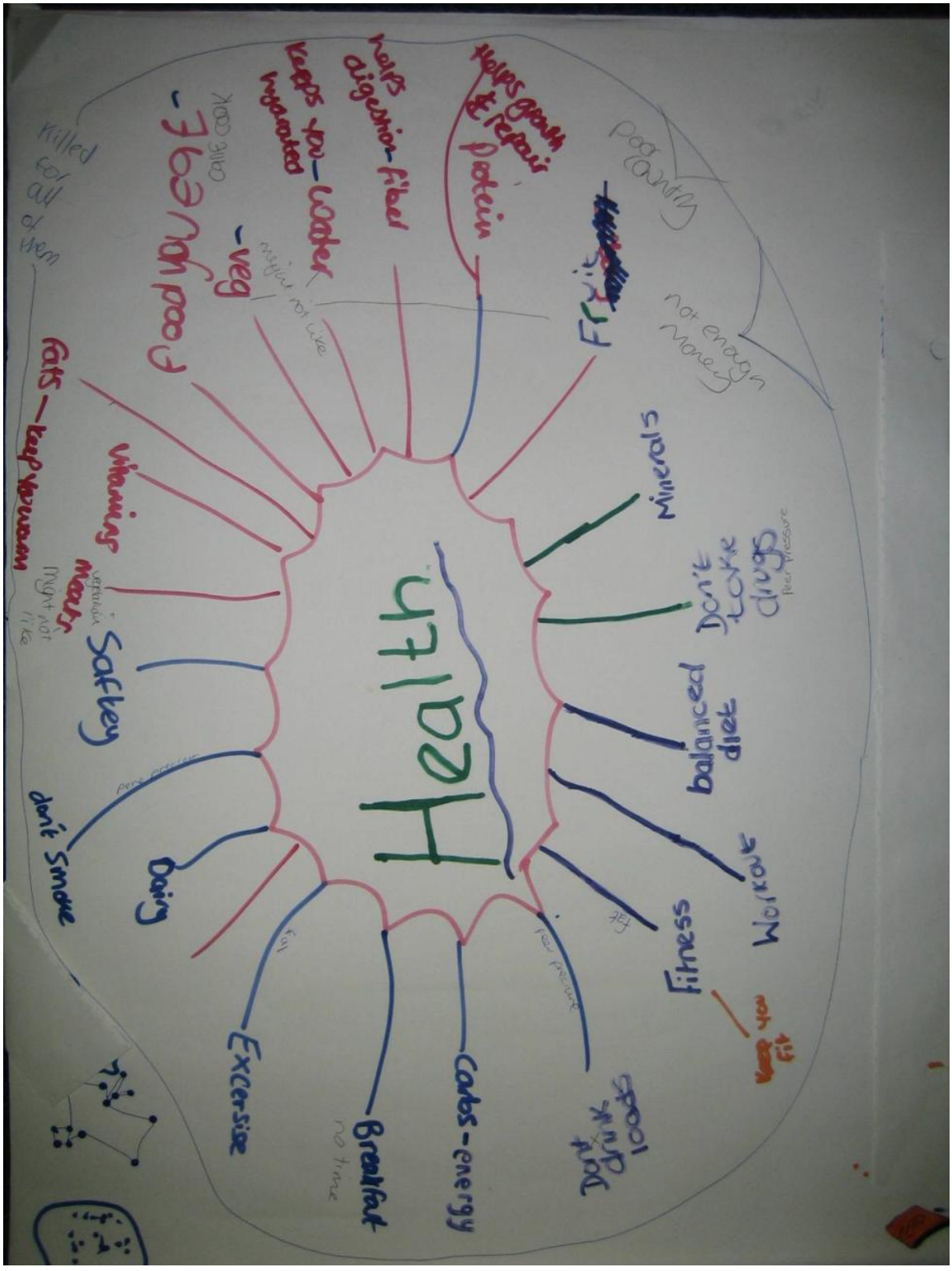
Meadowcroft had tended to place more emphasis on emotional aspects of health and well-being compared to those at Riverview, the category 'Happiness' was selected by a higher percentage of questionnaire participants at Riverview than at Hillcrest or Meadowcroft.

Figure 5.1a Meanings of Health 1



(Year 8 participants, Hillcrest)

Figure 5.1b Meanings of Health 2



(Year 10 participants, Riverview)

Figure 5.1c Meanings of Health 3

(Year 11 participants, Meadowcroft)

Figure 5.2a Meanings of Health: Hillcrest

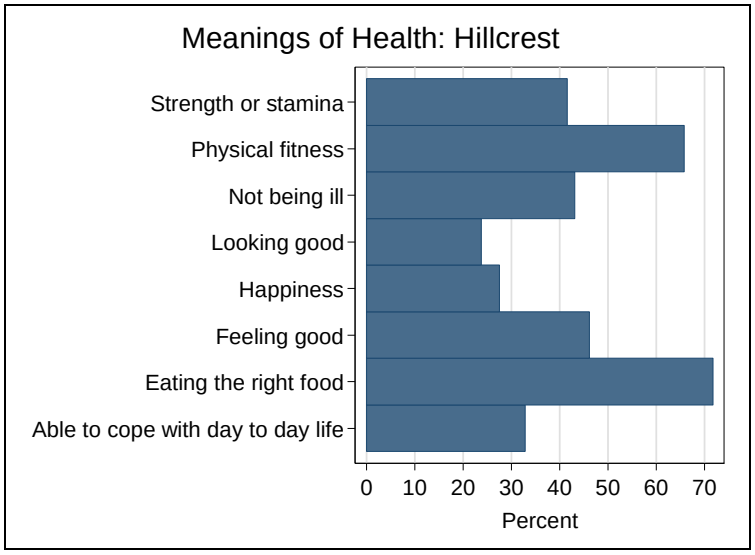


Figure 5.2b Meanings of Health: Meadowcroft

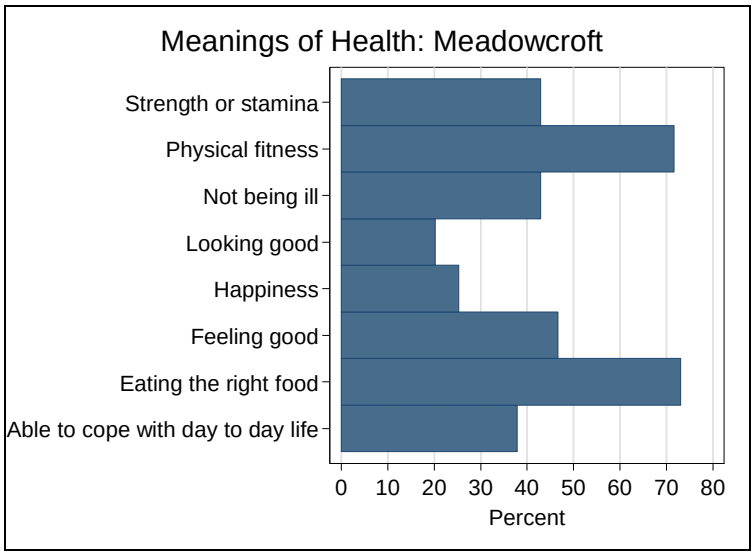
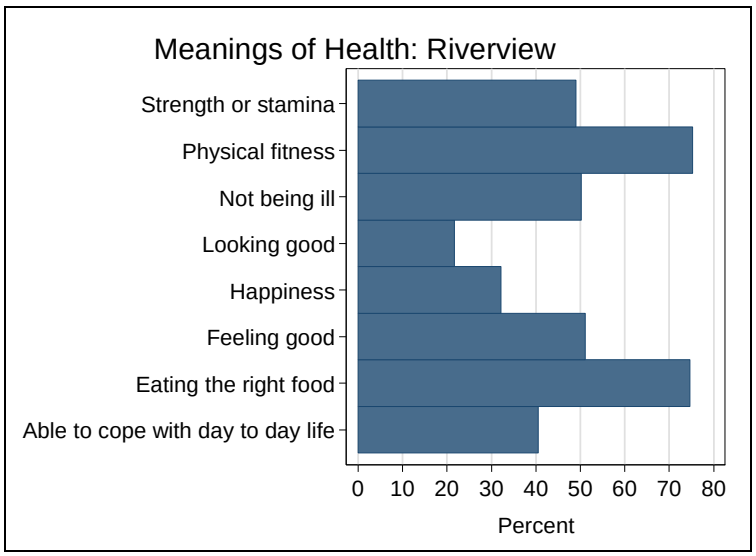
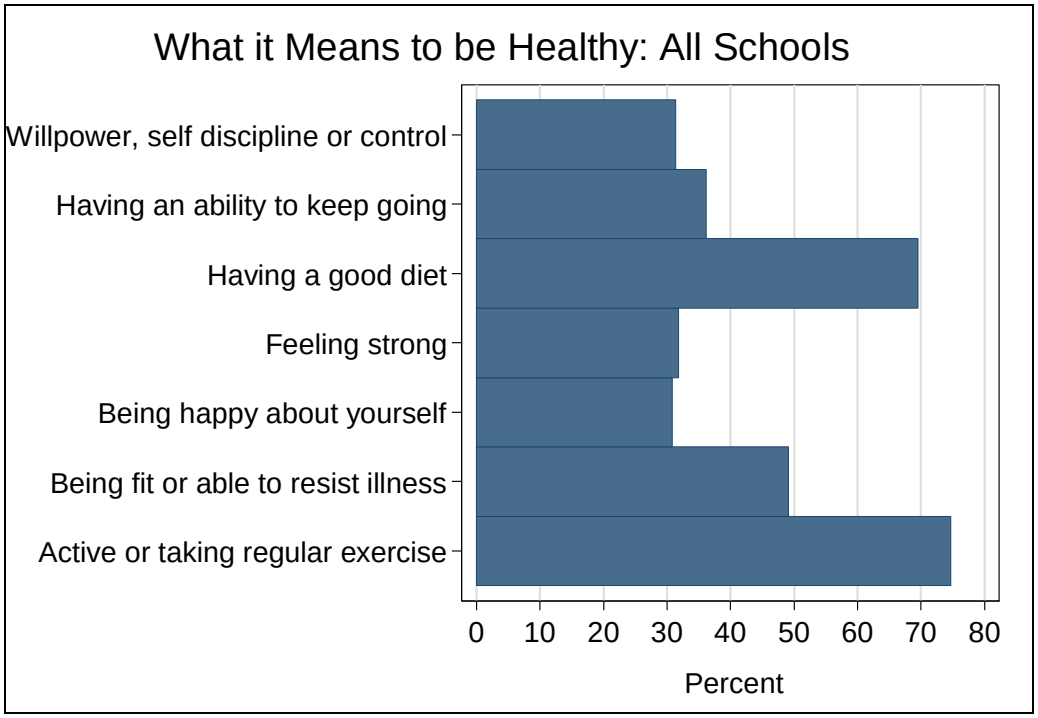


Figure 5.2c Meanings of Health: Riverview



As with the meanings of health discussed already, responses to the question 'what does it mean to be healthy?' emphasised aspects of physical health such as diet and exercise. As can be seen from Figure 5.3, a high percentage of participants selected 'Being active or taking regular exercise' and/or 'Having a good diet' in their response to this part of the questionnaire. The quotation in Box 5.1 shows a fairly typical response from one of the group discussions.

Figure 5.3 What it Means to be Healthy



Box 5.1 What it Means to be Healthy: Discussion

NHB What does health mean to you?
Philip eat healthy
Richard eat healthy
Jon looking after your body
NHB What does it mean to eat healthy?
[pause]
NHB What do you have to do to eat healthy?
Philip like get an apple
NHB How do you look after your body?
Jon drinkin plenty of water eatin healthier foods instead of McDonalds and eat more salad now and then, and just vary your diet, balanced diet
Jane fruit
NHB Anything else that health is?
Richard exercise
Lewis um you should drink like quite a load of milk because it has like calcium in it.
(Year 8 and 11 Participants, Riverview)

In the questionnaires, participants were asked how important they thought health was. The percentage saying 'Very important' was highest at Riverview (Figure 5.4a) and lowest at Hillcrest (Figure 5.4b). There were no statistically significant differences between genders or year groups in any of the schools.

Figure 5.4a Importance of Health: Riverview

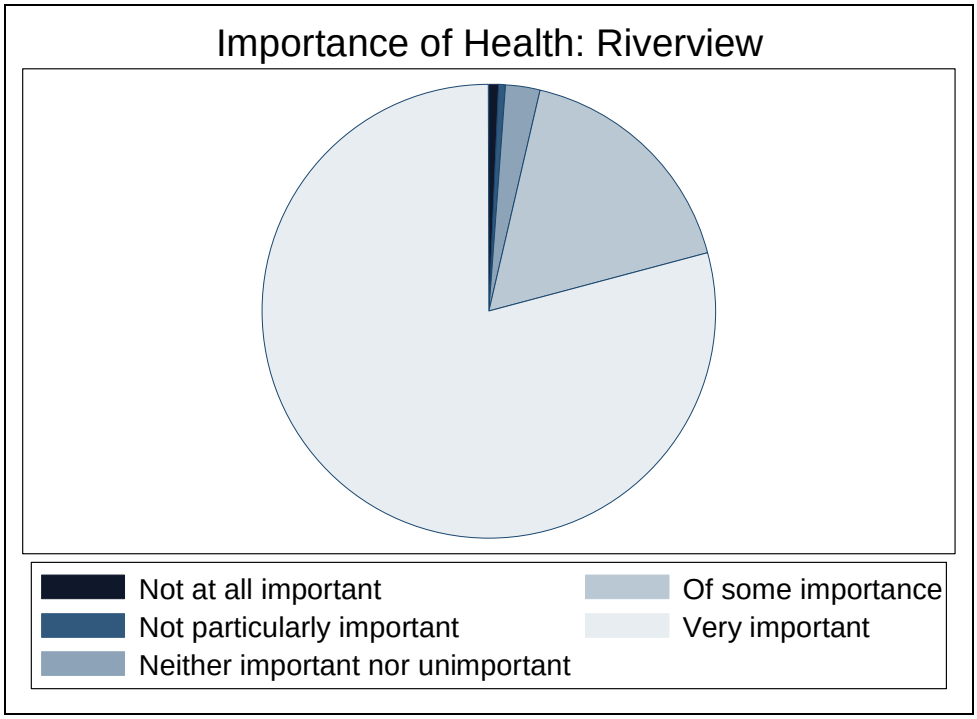
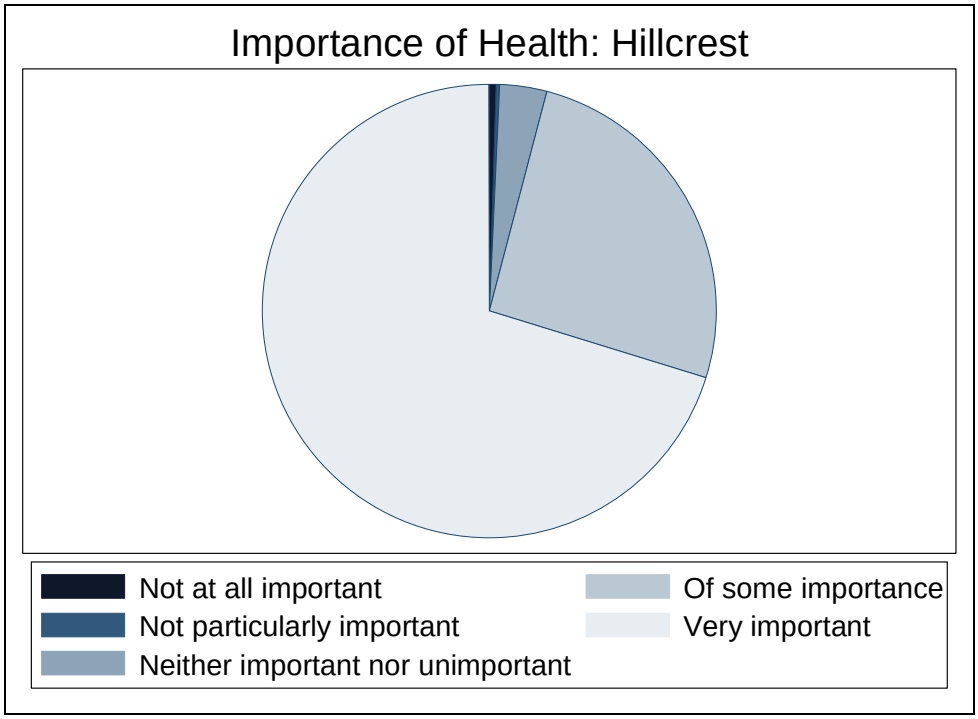


Figure 5.4b Importance of Health: Hillcrest



Similarly, as can be seen from Table 5.1 the percentage of students at Riverview who rated their own health as 'Relatively Healthy' or 'Very Healthy' was higher than the average for all schools, and Hillcrest had the lowest percentage who considered themselves to be 'Very healthy'. When the 'Very unhealthy' and 'Unhealthy' categories were combined into a single category[29] there was a statistically significant relationship between the school attended and self-rated health. However, the association between these variables was weak with a Pearson Chi² value of 20.5820 with 6 degrees of freedom and a Cramér's V of 0.0954 despite the p value of 0.002. There were no clear patterns in terms of possible relationships between self-rated health and age, but there was some association between gender and self-rated health. Table 5.2 shows the counts and expected counts for the cross-tabulation between gender and self-rated health using the combined 'Unhealthy' column. This shows that a higher number of female participants rated themselves as 'Average' than would have been expected if there was no association between the variables. Similarly, the number of males rating themselves as 'Unhealthy', 'Relatively healthy' or 'Very healthy' was higher than would have been expected with no association between the variables. Whilst the association between self-rated health and gender was slightly stronger than that between self-rated health and school, the association was still weak with a Pearson Chi² value of 15.7775 with 3 degrees of freedom, a Cramér's V of 0.1299 and a p value of 0.001.

Table 5.1 Self-rated Health by School

		School			
		Hillcrest	Meadowcroft	Riverview	Total (Average)
Self-rated health					
Very unhealthy	Count	2	4	4	10
	%	0.52	1.15	0.99	0.88
Unhealthy	Count	19	16	14	49
	%	4.99	4.61	3.47	4.33
Average	Count	160	149	123	432
	%	41.99	42.94	30.52	38.2
Relatively healthy	Count	171	143	211	525
	%	44.88	41.21	52.36	46.42
Very healthy	Count	29	35	51	115
	%	7.61	10.09	12.66	10.17
Total	Count	381	347	403	1,131
	%	100	100	100	100

[29] These categories were combined due to the low expected counts which would have invalidated the Chi² test if the original categories had remained.

Table 5.2 Self-rated Health by Gender

Self-rated health		Gender		
		Female	Male	Total
Unhealthy	Count	21	30	51
	Expected	26.2	24.8	51
Average	Count	210	144	354
	Expected	181.7	172.3	354
Relatively Healthy	Count	211	231	442
	Expected	226.9	215.1	442
Very Healthy	Count	38	50	88
	Expected	45.2	42.8	88
Total	Count	480	455	935
	Expected	480	455	935

The self-rated happiness among students was similar across all three schools with only a very small minority rating themselves as 'Unhappy' or 'Very Unhappy'. As Table 5.3 shows, there were some variations between the schools in terms of the level at which students rated their happiness with, for example, a lower percentage of Hillcrest students saying they were 'Very happy'. However, the association between the variables was weak and there were no clear patterns in terms of variation between year groups or genders.

Table 5.3 Self-rated Happiness by School

Happiness		School			
		Hillcrest	Meadowcroft	Riverview	Total (Average)
Very unhappy	Count	1	10	8	19
	%	0.26	2.83	1.99	1.67
Unhappy	Count	20	15	12	47
	%	5.18	4.25	2.99	4.12
Neither happy nor unhappy	Count	60	44	48	152
	%	15.54	12.46	11.94	13.32
Happy	Count	231	187	241	659
	%	59.84	52.97	59.95	57.76
Very happy	Count	74	97	93	264
	%	19.17	27.48	23.13	23.14
Total	Count	386	353	402	1,141
	%	100	100	100	100

Although a comparison of tables 5.2 and 5.3 shows that students have tended to give a higher rating to their happiness compared to health, there is still a statistically significant relationship between self-rated health and happiness among students in all three schools. Table 5.4 shows the counts and expected counts for a cross-tabulation between happiness and self-rated health.[30] This cross-tabulation has given a Pearson Chi² value of 95.0239 with 4 degrees of freedom and a Cramér's V of 0.2173 with a p value of 0.000.

Table 5.4 Self-rated Happiness and Self-rated Health

		How healthy person is			
Happiness		Average	Relatively healthy	Very healthy	Total
	Count	88	39	7	134
Neither happy nor unhappy	Expected	52.6	67	14.4	134
	Count	241	341	44	626
Happy	Expected	245.8	313	67.2	626
	Count	66	123	57	246
Very happy	Expected	96.6	123	26.4	246
	Count	395	503	108	1,006
Total	Expected	395	503	108	1,006

Further patterns were apparent if the data were explored at the level of individual schools. The percentage of young people at Hillcrest who rated their health as 'Very healthy' was similar for different genders, but a higher percentage of males rated themselves as 'Healthy' (50.3% compared with 39.8% for females) and the percentage who thought they were 'Very healthy' decreased with age. The percentage who said they were unhappy increased slightly with age, but the numbers involved were small, and were lower than in the other schools. At Meadowcroft, the percentage of students who rated their heath as 'Relatively healthy' or 'Very healthy' was slightly lower than the average for all schools. However, the percentage of students who said they were 'Very happy' was higher than in the other schools. When the questionnaires were completed a higher percentage of males rated their health as either 'Very healthy' or 'Relatively healthy' (59% compared with 45% for females) and self-rated health was lower in Year 9 than in Years 7, 8 and 10. The percentage rating their happiness as 'Very unhappy' or 'Unhappy' was higher for females, but the numbers involved were small. At Riverview, a higher percentage of males rated their health as 'Very healthy' (16.2% compared with 7.6% for females) and self-rated health was better among Years

[30] In order to reduce the number of cells with an expected count of <5 I have excluded the 'Very unhappy' and 'Unhappy' options from the happiness variable and the 'Very unhealthy' and 'Unhealthy' options from the self-rated health variable.

7 and 9 than Years 8 and 10. The percentage rating their happiness as 'Very unhappy' was higher for females and Year 10, but the numbers involved were small.

Whilst this section has focused primarily on the questionnaire data, it is important to remember that this does not easily accommodate more nuanced understandings of health or their articulation. The questionnaires focused mainly on 'typical' answers given in the qualitative phases of the project and, as was discussed in Chapter 4, were intended to illicit more immediate or instinctive responses rather than carefully constructed, complex arguments or ideas. However, the qualitative phase did allow for the construction of richer and more complex narratives, despite the regular reoccurrence of stereotypical responses. The extract in Box 5.2 offers a glimpse of the ways in which the young people involved in the group discussions and interviews constructed and negotiated more complex narratives surrounding the meaning of health and what it means to be healthy, and these will be discussed in more detail in Chapters 6 and 7.

Box 5.2 Developing Health Narratives

NHB	Some most of you think that you're healthy in some ways and not in others?
Craig	Yeah
Lizzie	Yeah
Louise	Yeah
NHB	so why?
Louise	Like she [Lizzie] said, you could do some more exercise or
Katie	you could eat a bit healthier
Louise	Yeah
Graham	Don't eat as much, sweets and that stuff
Craig	Some people think that like if they're fatter than other people that they're not like healthy, so they'll stop eating that makes them even more unhealthy, you've got to cut down and do exercise as well cos it's a mix of two things that's healthy, cos just eatin healthy isn't enough and just exercising isn't enough, cos if you're exercising a thousand calories off and then eating another thousand calories it's not doing anything, so you need to have like exercise and eating the right stuff
Cathi	and that's what's good
NHB	So you think it's mainly diet and exercise that are the main things in health?
Steven	Yeah
Lizzie	Yeah

(Year 8 group, Meadowcroft)

5.3 Factors Influencing Young People's Health

All of the participants were asked what they thought were the main factors which affected health for young people in their area. This question was asked in both the group discussions and the questionnaires, as well as in some of the interviews. Individuals were also asked about the main things which they felt had influenced their own health. Figure 5.5 shows responses from the questionnaires which suggest that the main factors affecting the health of young people in the study area are smoking,

alcohol and drugs. A relatively high percentage of students also said that poor diet and stress affected health. As can be seen from Table 5.5, the percentage of students from Meadowcroft who said that a lack of money, lack of sports facilities, poor diet or sexual health issues affected the health of young people in the area was higher than in the other schools studied, and a number of the other categories also attracted higher percentages at Meadowcroft. It is not clear from the questionnaire data whether the higher percentages at Meadowcroft resulted from an increased incidence of such issues or a greater awareness of potential problems. However, the qualitative work undertaken suggested a similar awareness of issues and problems in all three schools.

Figure 5.5 Factors Affecting the Health of Young People in Local Area

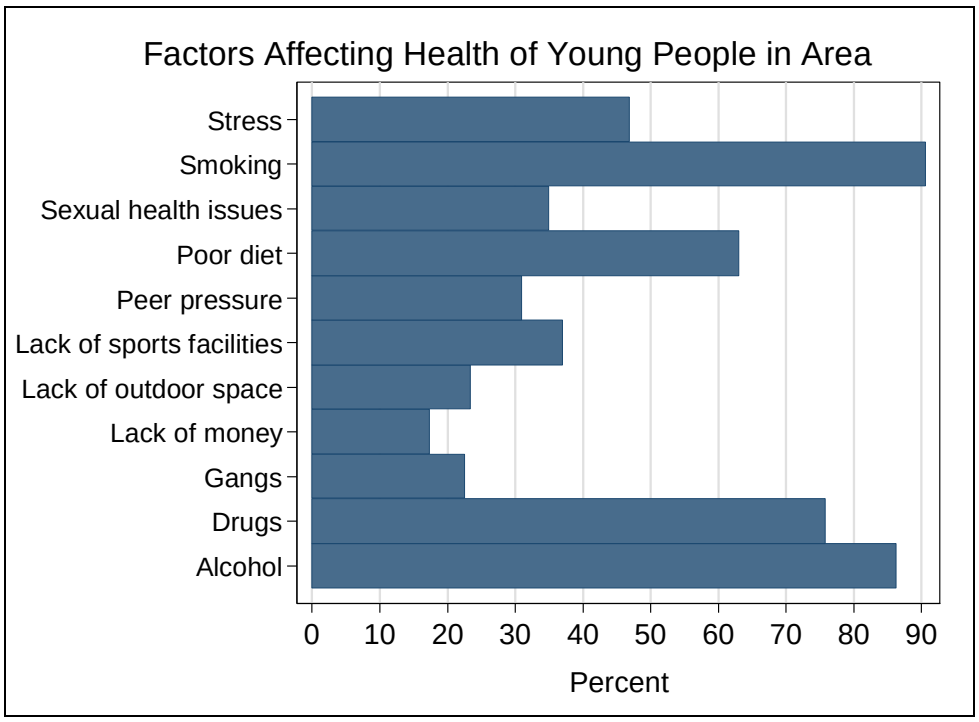


Table 5.5 Factors Affecting the Health of Young People in Local Area

Variable	Hillcrest %	Meadowcroft %	Riverview %	Average %
Alcohol	86.41	91.01	82.11	86.31
Drugs	72.56	83.71	72.06	75.82
Gangs	21.03	24.44	22.55	22.62
Lack of money	14.36	22.19	15.93	17.33
Lack of outdoor space	22.56	26.97	21.08	23.4
Lack of sports facilities	36.15	44.1	31.86	37.09
Peer pressure	20.77	39.04	33.82	31.02
Poor diet	61.79	70.22	58.09	63.08
Sexual health issues	29.23	47.75	29.17	34.92
Smoking	91.54	91.85	88.48	90.55
Stress	45.13	50.28	45.83	46.97

The questionnaires asked students to identify factors which had influenced their own health. As Figure 5.6 shows, 'Hobbies or sport', 'Friends', 'Family or parents' and 'School' were identified as the main influences. Table 5.6 shows that the percentage of students who said that 'Alcohol, drugs or smoking' had influenced their health was substantially higher at Meadowcroft compared to the other schools, and the percentage who cited 'Family or parents', 'Friends' or 'Hobbies or sport' was highest at Riverview.

Figure 5.6 Influences on Participant's Own Health

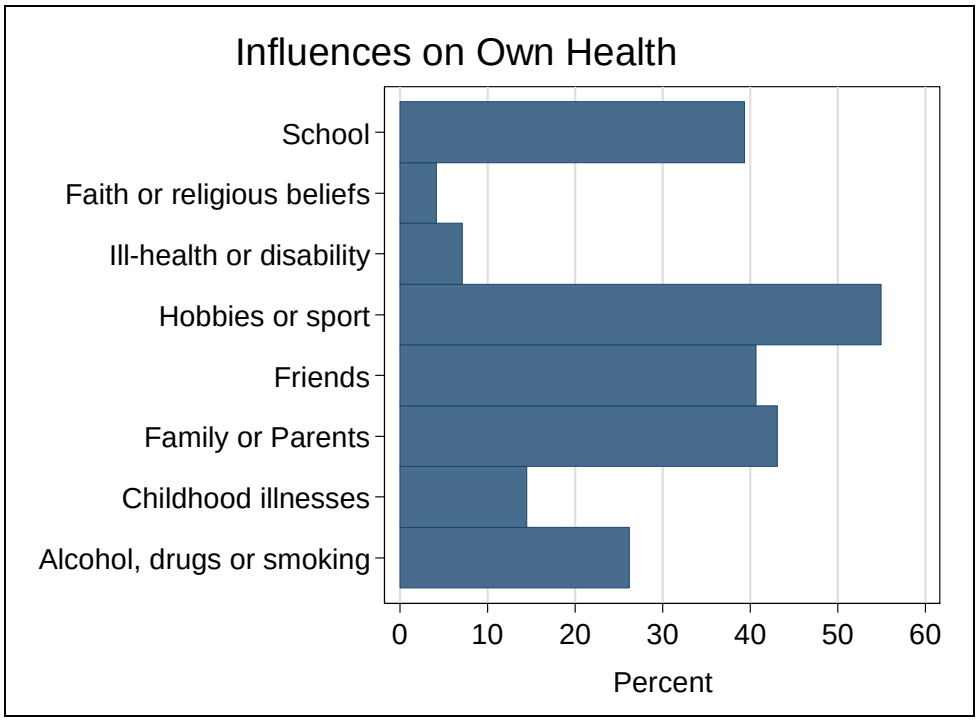


Table 5.6 Influences on Participant's Own Health

Variable	Hillcrest %	Meadowcroft %	Riverview %	Average %
Alcohol, drugs or smoking	21.39	36.36	21.78	26.25
Childhood illnesses	12.5	14.96	16.01	14.51
Family or Parents	38.89	43.11	47.24	43.16
Friends	34.44	41.35	45.93	40.67
Hobbies or sport	53.06	52.79	58.79	54.99
Ill-health or disability	6.11	7.62	7.87	7.21
Faith or religious beliefs	3.33	4.4	4.72	4.16
School	36.94	41.94	39.37	39.37

The factors affecting the health of young people in each area and the influences on individuals' own health were explored in more depth during the group discussions and interviews. There was again a strong emphasis on behavioural factors such as sport or exercise, diet and smoking. A number of students felt very strongly that their family background had made a big difference both to the way they thought about health and the extent to which they engaged with health-enhancing behaviours and avoided potentially damaging ones. At Riverview, participants generally felt that their friends

and parents had a positive impact on their health, but the picture was more mixed in other schools. For example, in the extract in Box 5.3, group members had spontaneously introduced the idea that their families and where they live influenced their health, and these were clearly viewed as negative influences by these participants.

Box 5.3 Influence of Family and Place of Residence

NHB	What difference do you think your family and where you live make?
Lucy	Cos if you've got a poor home then
Clare	you're sad
Emma	Yeah
Lucy	It's like it affects your health
Jess	yeah
Lucy	it affects your health cos of the air an stuff
NHB	And what about family?
Emma	If yous family doesn't show that they care for ya you won't feel loved and wanted so that could affect you because you could be down n that

(Year 11 group, Meadowcroft)

For Karl, at Riverview, family and friends were very clearly a positive influence, as illustrated by the extracts in Box 5.4 which come from the group discussion and interview in which he was involved. Laura, in the first of these quotations also talks about a project organised by the local Primary Care Trust and the ways in which this helped her to get involved in fitness activities. However, Laura was unusual in having such a positive view of local policy initiatives and, as will be discussed in Chapter 6, many participants were resentful of what they perceived to be a gap between what the schools, council and policy makers said they should be doing and the facilities and resources available. Similarly, not all of the participants regard family and friends to be positive influences on their health and well-being. Some of the participants at Hillcrest talked about the negative impact of other family members smoking and the ways in which this had either encouraged them to start or put them off the idea of trying cigarettes. Although most of the data relating to the influence of family and friends was obtained from the group discussions and interviews, some of the responses on the open questions in the questionnaires also offered useful insights. For example, one of the Year 7 females at Riverview, who considered her local area to be unhealthy, wrote that “I am living at my Grandmas at the moment. I hate it.” and this offers a glimpse of the impact which domestic circumstances can have on health and well-being. At both Hillcrest and Meadowcroft a number of participants raised issues relating to the negative impact of peer pressure and the local youth cultures, and the ways in which these influenced health behaviours; a theme which will be explored in the next section of this chapter and then developed further in Chapter 6.

Box 5.4 Influence of Friends and Family

NHB Are there particular things which have happened that have influenced your views?
Karl well ma friends really cos um I do a lot of bikin and ma friend Dean he's a good biker as well as so I'm always trying to be as good as him you see
NHB Um?
Laura Ah went to this project an something ta like help out and they were trying to make a new fitnessy thing for kids to go to after school and stuff called 'Leap' and um some of my friends and me went to that and I got to loads of things that I might not have been able to do if I didn't go like I go to jump off cliffs and toboggan and stuff,
(Year 9/10 group, Riverview)

NHB Thinking about yourselves now, what do you think are the main things that have influenced your health like as you've grown up?
Karl Like, like ma friends because they've got us inta sports and stuff, like different kinds a sports, and so they've like influenced us, n they've like in a way challenged us to get betta as well at the sport Ah'm doin, so it's like theys probably more healthy. Or like when Ah go tos the house or something like ta eat meals.
NHB [to Mike and Simon] What do you two think? What, as you've grown up what do you think's influenced your health, changed your health
Mike nothing
Simon well like what Karl's said and parents cos a bit like what Karl said like they influence you like in different sports or different things, they cook food for you and
Mike stuff
NHB [to Mike] What about you?
Mike what them two said
NHB What was that?
Mike What them two said.
NHB Okay, so as you've grown up um so as you've grown up do you think it's just your parents that have influenced your health and friends, things like that?
Mike Umm.
Karl yeah
Simon yeah
NHB None of you have had experience um experiences that have changed how you thought or anything like that?
Simon no
Karl na
Mike No
(Mike, Year 10 and Simon and Karl, Year 9, Interview, Riverview)

5.4 Young People's Health Behaviours

This section is primarily focused on health-damaging behaviours such as smoking. Nevertheless, it is important to recognise that many of the young people I worked with engaged in health enhancing behaviours such as sports or healthy eating and that these are an equally important aspect of health behaviour. However, given that many examples of health enhancing behaviours have already been highlighted, such as Karl's mountain biking, this section will not revisit this theme in detail.

Table 5.7 shows how common smoking was in the three schools involved in the project. As can be seen from the percentages in the table, smoking was considerably more common among young people attending Meadowcroft compared to those attending Hillcrest and Riverview. The relationship between smoking and school was statistically significant with a Pearson Chi^2 value of 47.5219 with 6 degrees of freedom,

although the strength of the association between these variables was lower than expected with a Cramér's V of 0.1434 and p value of 0.000.

Table 5.7 Smoking by School

		School			
		Hillcrest	Meadowcroft	Riverview	Total (Average)
Smoking					
No	Count	253	200	277	730
	%	64.87	56.34	67.56	63.20
Tried and didn't like	Count	87	54	74	215
	%	22.31	15.21	18.05	18.61
Smoke occasionally	Count	14	26	28	68
	%	3.59	7.32	6.83	5.89
Smoke regularly	Count	36	75	31	142
	%	9.23	21.13	7.56	12.29
Total	Count	390	355	410	1,155
	%	100	100	100	100

There was also a statistically significant relationship between smoking and year group. Unsurprisingly, as Table 5.8 shows, the percentage of young people who said they smoked regularly increased in the older year groups. This cross-tabulation had a Pearson Chi² value of 66.3964 with 9 degrees of freedom and a Cramér's V of 0.1387 with a p value of 0.000. As was noted in Chapter 4, Cramér's V has a tendency to underestimate the strength of the association between variables and the Contingency Coefficient for this cross-tabulation was considerably higher at 0.234 (p value 0.000). However, the pattern was sometimes less clear-cut when the data were viewed at the individual school level, and at Hillcrest the prevalence of smoking was higher in Year 7 than Year 8.

Furthermore, there was also a relationship between smoking and gender and, as the percentages in Table 5.9 show, a higher percentage of females than males said that they smoked occasionally or regularly. When the gender variable was reduced to the two categories of 'Female' and 'Male', the cross-tabulation between these variables gave a Pearson Chi² value of 33.0741 with 3 degrees of freedom and a Cramér's V of 0.1865 with a p value of 0.000. With regard to smoking, the gender patterning was most marked at Meadowcroft where 29.6% of females said that they smoked regularly, compared with only 11.2% of males.

Table 5.8 Smoking by Year Group

Smoking		Year Group				
		Year 7	Year 8	Year 9	Year 10	Total (Average)
No	Count	187	215	156	169	727
	%	78.24	70.03	55.12	52.65	63.22
Tried and didn't like	Count	36	45	66	67	214
	%	15.06	14.66	23.32	20.87	18.61
Smoke occasionally	Count	10	12	23	23	68
	%	4.18	3.91	8.13	7.17	5.91
Smoke regularly	Count	6	35	38	62	141
	%	2.51	11.40	13.43	19.31	12.26
Total	Count	239	307	283	321	1,150
	%	100	100	100	100	100

Table 5.9 Smoking by Gender

Smoking		Gender				
		Female	Male	Both	Not Specified	Total (Average)
No	Count	270	324	1	132	727
	%	55.44	69.83	50.00	67.01	63.22
Tried and didn't like	Count	95	88	1	30	214
	%	19.51	18.97	50.00	15.23	18.61
Smoke occasionally	Count	43	16	0	9	68
	%	8.83	3.45	0.00	4.57	5.91
Smoke regularly	Count	79	36	0	26	141
	%	16.22	7.76	0.00	13.20	12.26
Total	Count	487	464	2	197	1,150
	%	100	100	100	100	100

In some respects, the patterns for alcohol consumption were similar to those for smoking. As the percentages in Table 5.10 show, alcohol consumption was also highest among participants from Meadowcroft. There was a statistically significant, but weak, association between alcohol consumption and school attended, with a Pearson Chi² value of 44.2512 with 6 degrees of freedom, a Cramér's V of 0.1391 and a p value of 0.000. Alcohol consumption generally increased with Year Group, as the figures in Table 5.11 show. The cross-tabulation between alcohol consumption and Year Group had a Pearson Chi² value of 85.0577 with a Cramér's V of 0.1578 and a p value of 0.000. As was the case with smoking and Year Group, the Contingency Coefficient

was considerably higher with a value of 0.264 and a p value of 0.000. Unlike smoking, there was no clear gender patterning overall with regard to alcohol consumption.

Table 5.10 Alcohol Consumption by School

Alcohol consumption in average week		School			
		Hillcrest	Meadowcroft	Riverview	Total (Average)
None	Count	227	136	203	566
	%	58.66	39.19	49.63	49.52
1-2 glasses or small bottles	Count	97	95	120	312
	%	25.06	27.38	29.34	27.30
3-5 glasses or small bottles	Count	32	48	47	127
	%	8.27	13.83	11.49	11.11
More than 5 glasses or more than 1 large bottle	Count	31	68	39	138
	%	8.01	19.60	9.54	12.07
Total	Count	387	347	409	1,143
	%	100	100	100	100

Table 5.11 Alcohol Consumption by Year Group

Alcohol consumption in average week		Year Group				
		Year 7	Year 8	Year 9	Year 10	Total (Average)
None	Count	157	166	125	116	564
	%	65.97	55.33	44.64	36.25	49.56
1-2 glasses or small bottles	Count	61	79	87	84	311
	%	25.63	26.33	31.07	26.25	27.33
3-5 glasses or small bottles	Count	13	26	33	55	127
	%	5.46	8.67	11.79	17.19	11.16
More than 5 glasses or more than 1 large bottle	Count	7	29	35	65	136
	%	2.94	9.67	12.50	20.31	11.95
Total	Count	238	300	280	320	1,138
	%	100	100	100	100	100

As I would have expected, drug use was much lower in all three schools compared to smoking and alcohol consumption. As can be seen from Table 5.12, the percentage of young people at Hillcrest who say they have tried or use drugs is lower than in the other schools. The percentage of young people at Meadowcroft who say they use drugs occasionally or have tried drugs is higher than in the other schools, but the percentage who use drugs regularly was lower at Meadowcroft than at Riverview. The percentage of young people who use drugs regularly is highest at Riverview, but

the numbers involved appear to be small. The relationship between drug use and school attended was statistically significant with a Pearson Chi² value of 39.3459 with 6 degrees of freedom, but the association between the variables was weak with a Cramér's V of 0.1329 (the Contingency Coefficient was 0.185) and a p value of 0.000. There was some increase in drug use with increasing age. However, this was not statistically significant and this is unsurprising given the low numbers involved in drug use (>20% of cells having an expected count of less than 5 for the cross-tabulation between drug use and Year Group). There were also no clear overall gender patterns.

Table 5.12 Drug Use by School

		School			
		Hillcrest	Meadowcroft	Riverview	Total (Average)
Drugs					
	Count	350	267	351	968
No	%	93.09	78.53	88.19	86.89
	Count	14	37	21	72
Tried and didn't like	%	3.72	10.88	5.28	6.46
	Count	9	31	17	57
Use occasionally	%	2.39	9.12	4.27	5.12
	Count	3	5	9	17
Use regularly	%	0.80	1.47	2.26	1.53
	Count	376	340	398	1,114
Total	%	100	100	100	100

Overall, the tables discussed in this section show how common smoking, alcohol consumption and drug use were in the three schools. These suggest that a similar proportion of young people at Hillcrest and Riverview smoke and drink alcohol, and that this is lower than the proportion in Meadowcroft. Unsurprisingly, smoking, alcohol consumption and drug use increase with age and there is a statistically significant relationship between each of these behaviours and the Year Group in all three schools.

At Hillcrest, smoking is more prevalent among females but alcohol consumption and drug use are slightly higher among males. At Meadowcroft, smoking is more prevalent among females (30% smoke regularly compared with 11% of males), alcohol consumption and regular drug use are broadly the same for different genders and occasional drug use is higher among females. At Riverview, smoking is more prevalent among females, alcohol consumption is broadly the same for different genders and drug use is slightly higher among males, but these relationships were not statistically significant. It is possible that all these behaviours were under-reported on

the questionnaires, due to participants' concerns about being caught[31], and the true figures may therefore be higher. Alternatively they could also be over-reported as a means of 'showing off' to peers. However, in the group discussions and interviews, some participants at both Hillcrest and Meadowcroft suggested that the majority of people in their year groups smoked. As the extract in Box 5.5 illustrates, smoking and alcohol consumption were a significant aspect of the local culture in the Meadowcroft area, and this is an issue which will be explored further as part of the discussion in Chapter 6. It also highlights the possible significance of place, which will be explored in the next three sections of this chapter.

Box 5.5 Main Risks to Health

NHB	Generally what do you think are the main risks to your own health?
Clare	drinkin
Jess	Yeah
Mark	yeah
Lucy	Everbody drinks
Emma	Everythin really
Clare	yeah
Emma	like sex n diet
Lucy	Yeah
[discussion of ages and whether they all drink]	
TONY	The amount of alcohol or just that it's available, I mean what you do with it that affects the health or
Emma	you don't think that alcohol affects your health much do yta, ah mean I don'
Clare	When you're
Emma	compare other things it's not that bad really
Jess	then eatin like really bad

(Year 11 group, Meadowcroft)

5.5 Young People's Perceptions of 'Healthy' and 'Unhealthy' Places

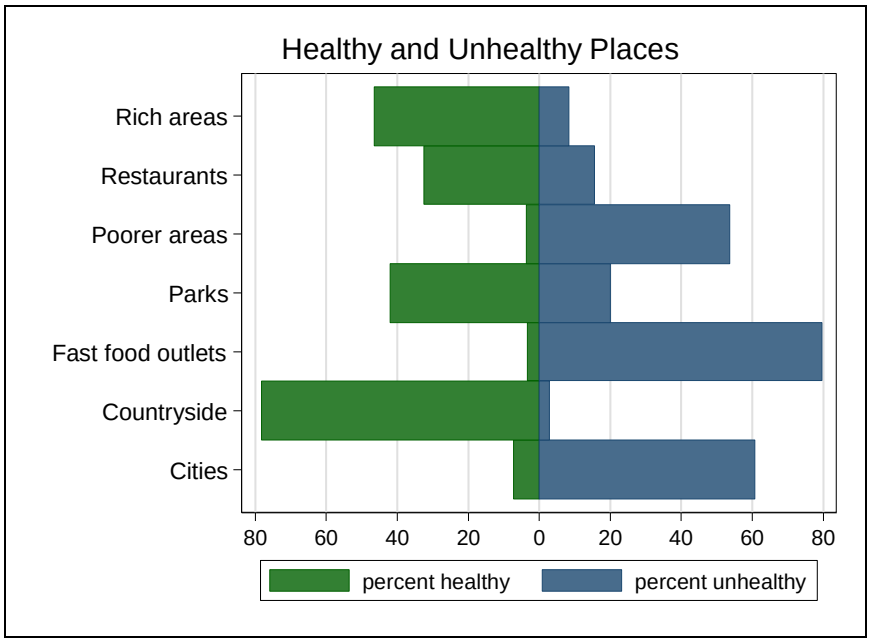
During each phase of the fieldwork participants were asked questions about whether they thought some places were healthier than others, and what kinds of places they thought were healthy. These questions were used in order to offer an alternative way of exploring young people's health beliefs, which I hoped would be less readily associated with 'correct' answers from school PSHE lessons. These questions were also included to give an insight into the extent to which participants considered place-based aspects of health to be important.

The questionnaire responses to the questions about the kinds of places which are healthy and unhealthy are shown in Figure 5.7. In both the questionnaires and group discussions many participants thought that cities or urban areas and industrial areas were unhealthy because of pollution and traffic. In the group discussions most groups immediately mentioned fast food places or takeaways as examples of

[31] Some members of the school council at Riverview had felt that students would not answer these questions honestly due to concerns about teachers finding out or seeing what they wrote.

unhealthy places and this was also a significant theme in the questionnaire responses. The questionnaires included 'Industrial Areas' in the question about unhealthy places and 60% of students selected this as an example of an unhealthy place. In some of the group discussions there was also an emphasis on other countries, especially less economically developed countries in the Global South.

Figure 5.7 Healthy and Unhealthy Places



The questionnaires also included an open-ended question asking why students thought the places they mentioned were healthy. There were several common themes in students' responses, which will be discussed further in Chapter 7. These included open areas, woody areas, fresh air or absence of pollution, fruit and vegetables or organic products, space for exercise, tidiness, presence of sports centres or gyms and an absence of takeaways. In some of the group discussions, participants also focused on an absence of overweight people and an absence of traffic in an area, and the cleanliness of different places. In addition, participants were asked if they thought the area where they lived was healthy. In the questionnaire most of the young people thought their area was either 'Average' or 'Healthy'. Some of the young people involved in the group discussions felt their areas were unhealthy because of the behaviours of others, and this issue is discussed Chapter 7. Figure 5.8 shows the percentage of young people living in each valid Super Output Area who rated their local area as either 'Unhealthy' or 'Very unhealthy' on the questionnaire. The areas with the highest percentage of young people classifying them as 'unhealthy' were in the less rural areas of Crook, Willington, Bishop Auckland and Tow Law (see Appendix 1 for the location of individual SOAs). Figure 5.9 shows the percentage who rated their local

area as either ‘Healthy’ or ‘Very healthy’. The colour ramp for this map runs in the opposite direction to that in Figure 5.8 which means the darkest areas are again those which participants considered less healthy, and areas of Willington, Bishop Auckland and Tow Law again feature in this group.

Figure 5.8 Areas Rated as ‘Unhealthy’

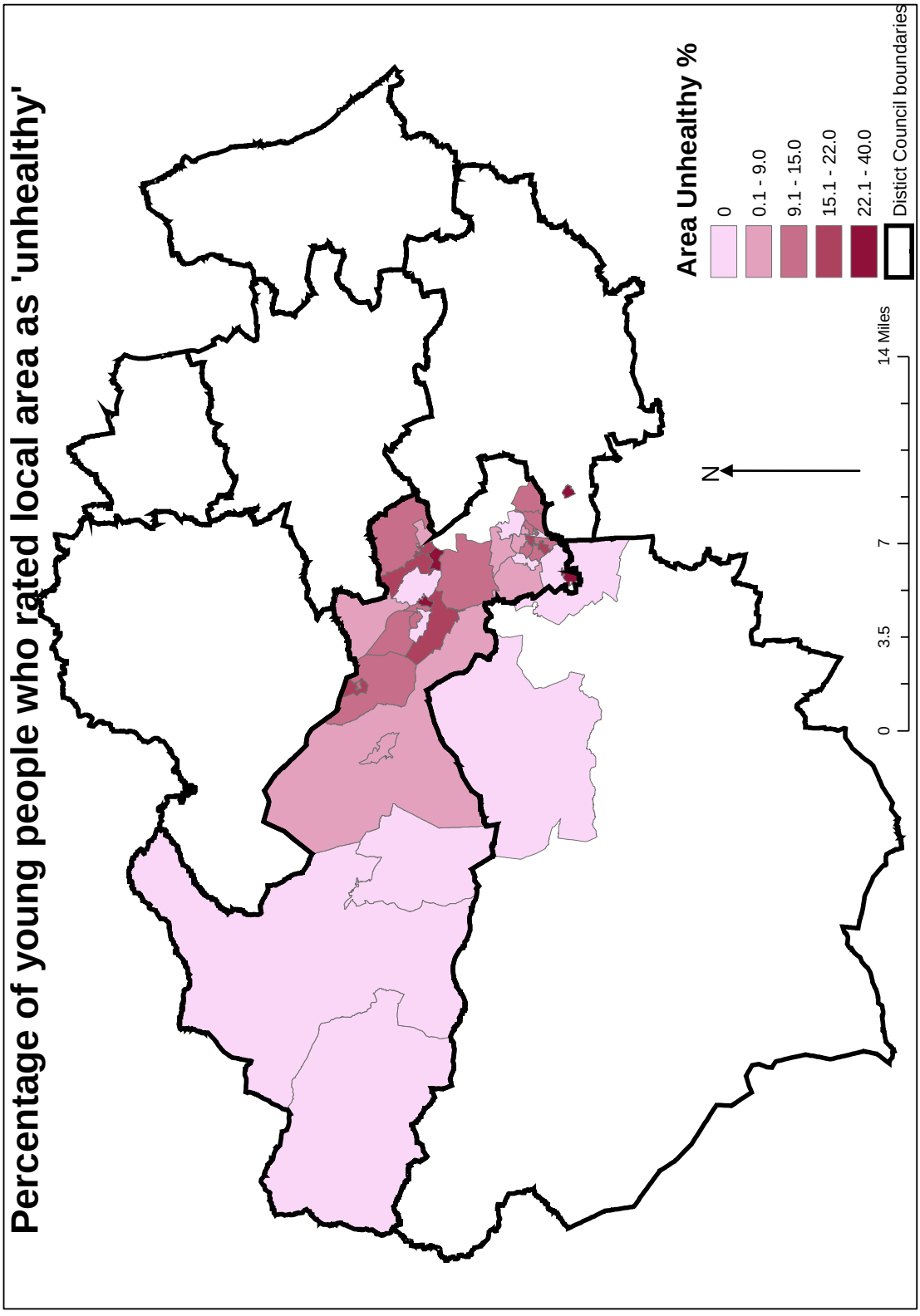
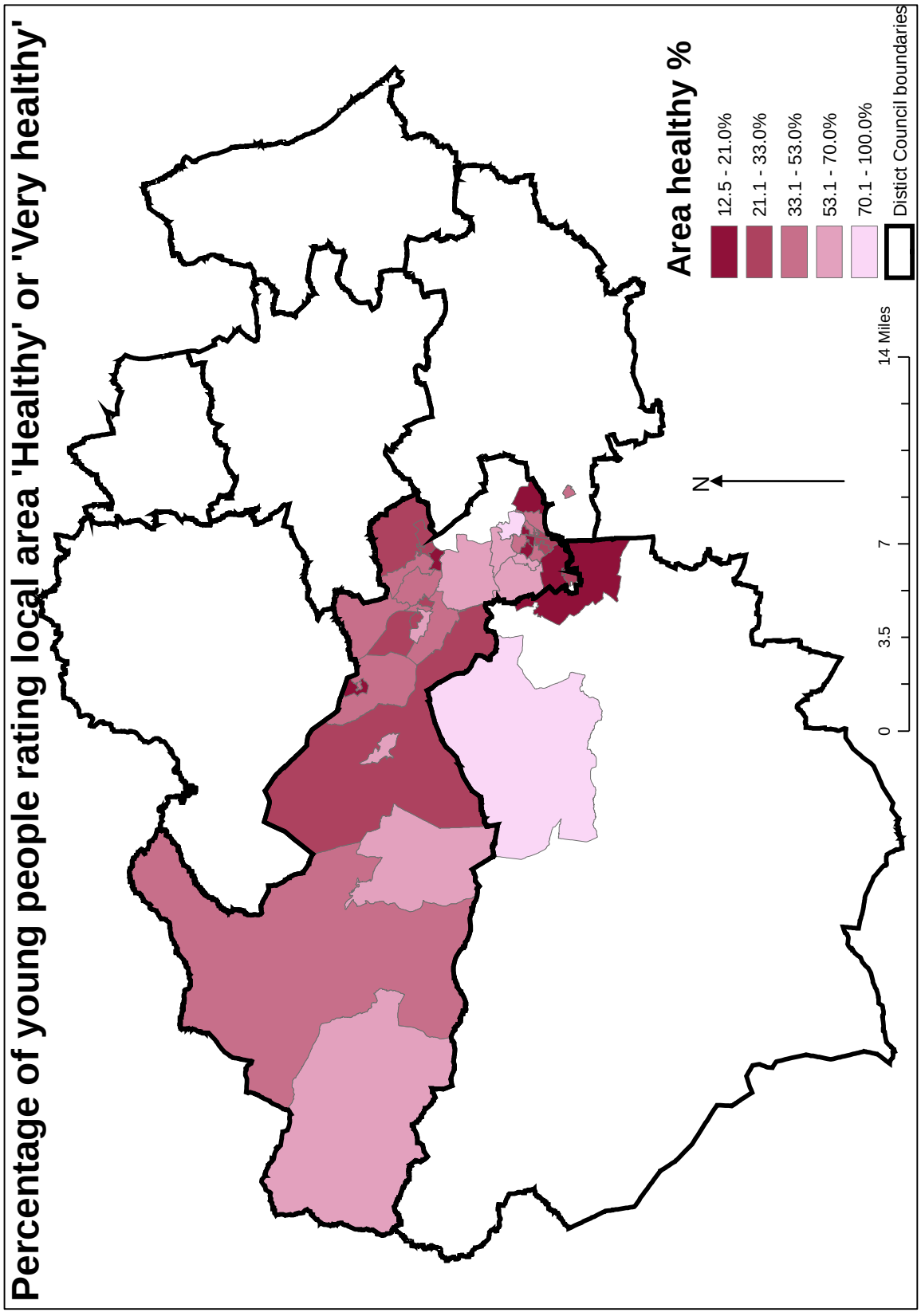


Figure 5.9 Areas Rated as 'Healthy' or 'Very healthy'



As with the questions surrounding health beliefs and behaviours, analysis of material from the questionnaires in isolation does not allow for the complexity and multiplicity of views. The complexities and contestations were more apparent in the qualitative data. The extract in Box 5.6 gives an example of the ways in which

participants negotiated and constructed their views around places and health, and further examples will be discussed in Chapter 7.

Box 5.6 Negotiating Understandings of Health and Place

NHB	There was also, there wasn't um I don't think the two of you talked about it as much but some of the groups here and also in my other, one of my other schools have been talking a lot about Crook
Emma	Uhum
NHB	And about some bits of Crook being healthy and some aren't?
Clare	[to Emma] that's over to you Ah think
NHB	Is it something you would agree with or not?
Emma	Ah don't say, Ah don't know really.
Clare	how does that work?
Emma	Ah kna
Clare	Some bits healthy and some bits aren't
Emma	I don' thin'. Crook's just Crook.
NHB	There's been people who've said kind of 'oh I live in Crook but where I live it's okay'
Emma	I can see what theys mean because there's
NHB	But there's other
Emma	because there's like more posher and newer estates and then there's like old estates, like rough estates
Clare	But that doesn't affect your health though
Emma	But it might do if you like live in the rough estates like an you can' afford things but not really
NHB	So you live in what you think's a nice area of Crook
Emma	Well where Ah live it's alright

(Clare and Emma, Year 11, Interview, Meadowcroft)

As was discussed in Chapter 3, this area of the research is drawing on the understanding of 'place' used in contemporary Human Geography in which places are viewed as the fusion of individual natural and built environments with social and cultural processes and identities, rather than as locations without meaning. It is recognised, however, that not all of the young people involved viewed 'place' in this way, and some suggested that places (i.e. locations) could not be healthy or unhealthy because it was only people who could be. Whilst I respect the view of these participants, I would like to suggest that if places are considered to be a combination of location, environment and people, as is the case in this thesis, then this distinction between places and people is not clear-cut.

In general, Bishop Auckland was viewed negatively by participants in all three schools, many of whom viewed Bishop Auckland town and the surrounding housing estates as unhealthy and drew contrasts with 'healthy' outlying villages and countryside. The reasons given for why Bishop Auckland was considered to be less healthy included issues such as obesity, fast food and takeaways, the lack of open spaces in some areas, crime and vandalism, and problems with dogs/rats and hypodermic needles in specific locations – and some of these ideas are illustrated by the extracts in Box 5.7. However, some of the participants who lived in Bishop Auckland did contest this view quite forcefully.

Box 5.7 Healthy and Unhealthy Places: Some Narratives

NHB In terms of places that were healthy, or not healthy, your group said that restaurants were healthier than McDonald's, cities are less healthy and posh areas are healthier, yeah?
Erin Uhum.
Abi Like countryside and that
NHB And most of you thought that the places where you live aren't particularly healthy?
Bernie Na. Cos there's like a Chinese or a takeaway at every corner
Erin Yeah everywhere you look there'll be like bad things
Abi Like sweet shops and pubs and like bakeries and butchers and like when people go out for dinner there's like butchers, chip shop, chip shop, baker, sweet shop. An in the swimming baths when it's like proper rainin' people are like 'ah I don' want to stay in because I don't like the food' you know the food's kind of naff
Erin I wouldn't say that
Bernie Na. It's quite nice
Abi and then people are like 'Oh let's go down the swimming baths', all in the swimming baths they just sell like beans on toast, chips
Erin jackets
Abi drinks, hotdogs
Bernie then there's a vendin' machine
Abi yeah
(Abi, Bernadette and Erin, Year 10, Interview, Hillcrest)

NHB Do you think the area where you live is healthy?
Grace Na
Jade No
NHB No?
Jade No, because where Ah live they sometimes, what they do right they get couches and they don' want the [word unclear] and they'll get the cushions and they throw them like in this tip and rats'll go there, and plus where I live, me gardens, that's me house there [indicates on imaginary diagram], me garden's just there and there's a pigeon's garden and the rats go under the fence
Helen But that's got nowt to do with being healthy though, has it?
Jade But they like come and
Grace Ah don' like rats
Jade But the other thing is what happens, we have loads of flies because um the other problem is people go huntin' and when the dogs don't eat the bones they throw the bones away and the flies'll go round them, and like
Grace It's just disgustin'
Helen disgusting
///
NHB and what about you, Grace. Do you think the area where you live is healthy?
Grace Just like all drug addicts
Helen Where do you live?
Grace Me?
Helen Yeah
Grace [gives name of area]
NHB So you don't think [*name of place*] is particularly healthy?
Grace no.
NHB Uhum?
Grace And there's needles lyin' about
(Grace, Helen and Jade, Year 8, Interview, Hillcrest)

In contrast, the area around Riverview was widely seen as 'Healthy'; both by a number of participants who lived in Weardale and by many of those who lived elsewhere. As will be discussed in Chapter 7, this area was often viewed as healthy and the reasons given included fresh air, the presence of trees and animals, an absence of cars and pollution, existence of space and places to play outside and the

notion (held by female participants in particular) that the area was friendly with a sense of community. Nevertheless, it should be noted that a small minority of participants living in Weardale did not view their local area as 'countryside' and said that 'wild' or 'open' places should be considered countryside.

As will be discussed in Chapter 7, the discussions with Meadowcroft participants raised some interesting ambiguities surrounding issues of health and place and what was meant by 'countryside'. During the group discussions, there was considerable debate about whether the area was 'healthy' and this generally focused on issues such as the location and image of gyms and the nearest swimming pool, the presence or absence of takeaways, a lack of outdoor space, scruffiness, litter and pollution, and gangs. As will be discussed in Section 5.6, the Mid Wear Valley was also characterised by higher levels of 'health damaging' behaviours, such as smoking, alcohol and drug use and, as will be discussed in Chapter 6, participants placed a greater emphasis on issues of image, identity and belonging. Before discussing the possible relationships between place and health behaviours, the next section of this chapter will offer a brief discussion of residential neighbourhoods and health status.

5.6 Residential Neighbourhoods, Health Status and Health Attitudes

This section of the chapter will focus on the residential neighbourhoods in which participants lived, rather than the schools attended. As the tables in Appendix 9 show, residential neighbourhoods did not always fit neatly into school catchment areas and there were a number of Electoral Wards and Super Output Areas from which young people attended more than one school. Therefore, the discussion of residential neighbourhoods offers a more meaningful insight into the impact of place than would be the case if this thesis only discussed the schools attended. However, for some indicators, such as the categorisation of social class based on questionnaire responses regarding parental occupation shown in Table 5.15, the low numbers represented in individual neighbourhoods would result in large amounts of missing data and in these instances school has been used as a proxy for place. The maps which are shown later in this section are intended only to offer a visual representation of the data. The large variations in the geographic size of the Super Output Areas make it impossible to simultaneously show both the overall pattern of the data and the detail of each individual SOA. Therefore the names of the SOAs are shown on the series of maps in Appendix 1, rather than on the maps in this section.

As has already been noted, many areas of County Durham are characterised by high levels of socio-economic and health deprivation. Figure 1.3 in Chapter 1 of this thesis showed the contrasting levels of overall deprivation in the County Durham. The unemployment level in the Wear Valley is significantly higher than the national average,

and as Table 5.13 shows, this has been the case throughout the duration of this study. Table 5.13 shows the model based overall unemployment only, and the source stated that this cannot be separated into male and female unemployment due to small sample size.

Table 5.13 Wear Valley Unemployment

Unemployed (model based)	Wear Valley Count	Wear Valley %	North East %	Great Britain %
Oct 05-Sep 06	2,100	7.4	6.7	5.4
Jan 06-Dec 06	2,300	7.9	6.9	5.4
Apr 06-Mar 07	2,200	7.1	6.6	5.4
Jul 06-Jun 07	2,100	6.7	6.6	5.3
Oct 06-Sep 07	1,900	6.2	6.4	5.3
Jan 07-Dec 07	1,800	5.9	6.2	5.2
Apr 07-Mar 08	1,900	6.4	6.4	5.2
Jul 07-Jun 08	2,000	6.5	6.6	5.2
Oct 07-Sep 08	2,100	6.6	6.9	5.3
Jan 08-Dec 08	2,100	6.8	7.5	5.7
Apr 08-Mar 09	2,600	8.1	8.2	6.2

Source: ONS Annual Population Survey

Table 5.14 shows the overall unemployment rate for each Electoral Ward in the Wear Valley, the location of which are shown in the maps in Appendix 2. This table is based on data from the 2001 census and, although older, this is the most recent data at this level of analysis. As there table shows, there were marked difference between the unemployment rates in different wards, and it is suspected that this observation is still applicable.

Table 5.14 Wear Valley Unemployment in 2001 by Electoral Ward

Ward	Unemployed Count	Unemployed %	Wear Valley %	Great Britain %
Bishop Auckland Town	92	7.1	8.2	5.8
Cockton Hill	108	5	8.2	5.8
Coundon	168	9.4	8.2	5.8
Crook North	61	8.8	8.2	5.8
Crook South	175	8.4	8.2	5.8
Dene Valley	133	11.2	8.2	5.8
Escomb	77	4.5	8.2	5.8
Henknowle	87	5.5	8.2	5.8
Howden	57	8.9	8.2	5.8
Hunwick	51	7.3	8.2	5.8
St Johns Chapel	69	10.3	8.2	5.8
Stanhope	97	6.3	8.2	5.8
Tow Law and Stanley	164	10.2	8.2	5.8
West Auckland	163	9	8.2	5.8
Wheatbottom and Helmington Row	132	11.5	8.2	5.8
Willington Central	200	9.4	8.2	5.8
Willington West End	21	3.8	8.2	5.8
Wolsingham and Witton-le-Wear	63	4.5	8.2	5.8
Woodhouse Close	247	14.6	8.2	5.8

(Source: National Statistics 2001)

The questionnaires collected data about the occupations of participants' parents or guardians. These were then categorised into the National Statistics Socio-economic Classification (NS-SEC) social class bands, shown in Appendix 8, using the analytic classes derivation table for the NS-SEC (National Statistics 2009)[32]. Where participants listed more than one occupation for their parents or guardians the highest socio-economic class given for each case has been used in the analysis. In Table 5.15, the percentage in band 8 – which is the category for 'unemployed' – is substantially lower at Riverview than in the other schools. In addition, Riverview also has slightly lower percentages for the semi-skilled and unskilled social classes. When social class was analysed at the Ward and SOA levels, based on the data collected in this study, a similar pattern was identified to that in the official data in Table 5.14. However, I am not showing this data here because the low counts in some wards could allow individuals to be identified. Differences in the classification system used mean that my data on social class cannot be compared directly with that from Nomis official labour market statistics.

[32] The NS-SEC is an occupation based government classification which was developed by the ESRC and is one of the more widely-used social class classifications in the UK. It was selected because it is used in many official sources of data such as the census.

Table 5.15 Socio-economic Class of Parents by School

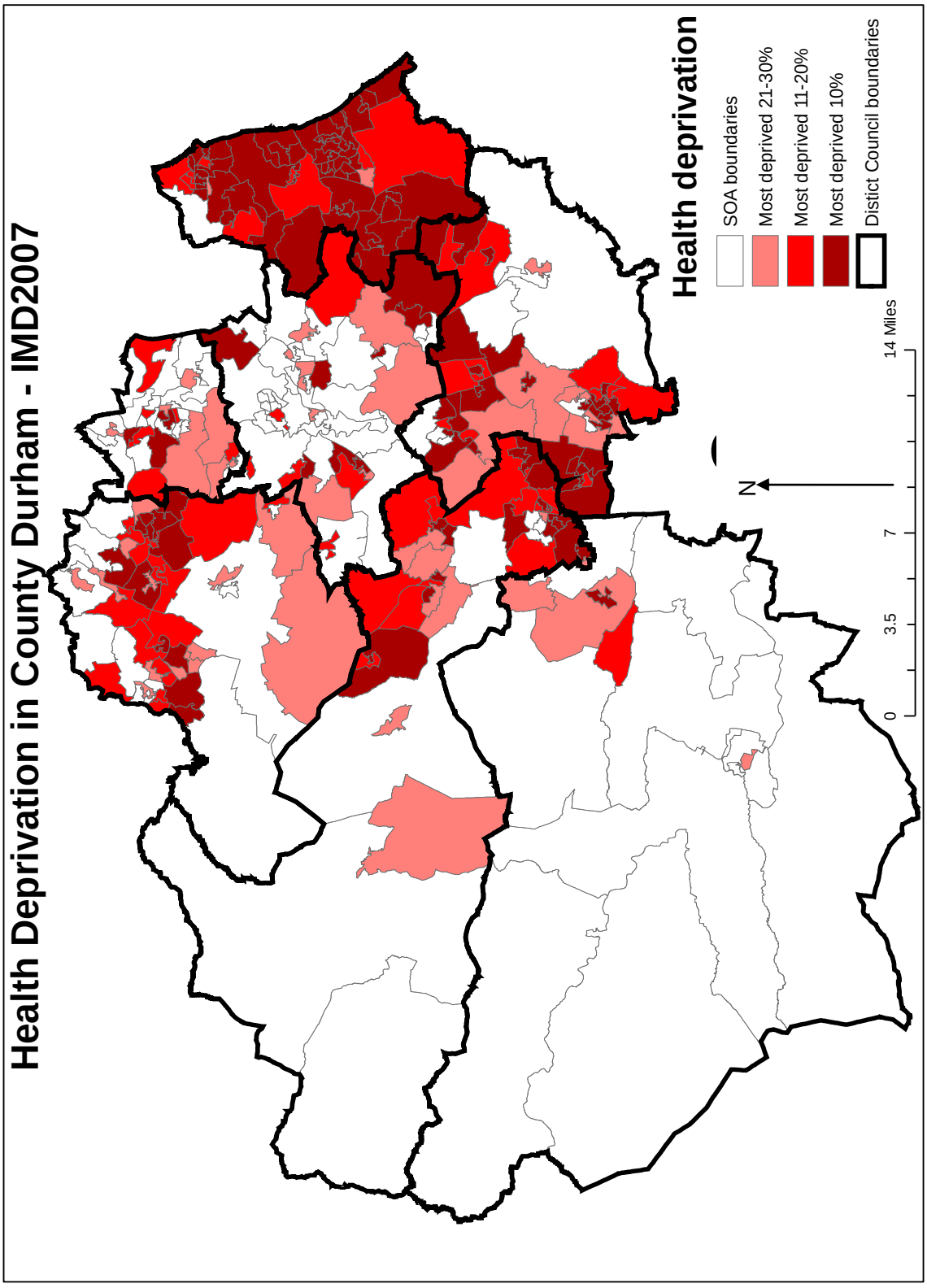
Highest SEC of parents or guardians		School			
		Hillcrest	Meadowcroft	Riverview	Total (Average)
	Count	4	4	2	10
1.1	%	1.45	1.45	0.62	1.15
	Count	18	19	28	65
1.2	%	6.52	6.91	8.72	7.45
	Count	65	73	93	231
2	%	23.55	26.55	28.97	26.49
	Count	25	27	32	84
3	%	9.06	9.82	9.97	9.63
	Count	24	22	48	94
4	%	8.7	8	14.95	10.78
	Count	23	14	23	60
5	%	8.33	5.09	7.17	6.88
	Count	51	53	46	150
6	%	18.48	19.27	14.33	17.2
	Count	33	37	33	103
7	%	11.96	13.45	10.28	11.81
	Count	33	26	16	75
8	%	11.96	9.45	4.98	8.6
	Count	276	275	321	872
Total	%	100	100	100	100

Figure 5.10 shows the levels of health deprivation in County Durham according to the 2007 Index of Multiple Deprivation. This shows a clustering of health deprivation in the Bishop Auckland, Crook, Willington and Tow Law areas of my study area. This shows some similarities to the patterning of unemployment and low social class, and to the overall deprivation which has been discussed earlier. As already noted, the names of each area are shown on the map in Appendix 1.

Figure 5.11 shows the percentage of young people in each valid Super Output Area within my study area who rated their own health as either 'Healthy' or 'Very healthy'. The colour ramp on this map has been reversed so that the darkest areas are those with the lowest levels of self-rated health. This map again shows a clustering of poorer health in the Bishop Auckland, Crook, Willington and Tow Law areas. However, a comparison of Figures 5.10 and 5.11 suggests that there are some individual areas which have a high level of health deprivation according to official statistics, but have

relatively good self-rated health. This fits with the observation in the previous section that some of the young people who lived in areas which others considered to be unhealthy actually viewed their area more positively.

Figure 5.10 Health Deprivation in County Durham (2007)



(Source: Department for Communities and Local Government 2008)

Figure 5.11 Self-rated Health

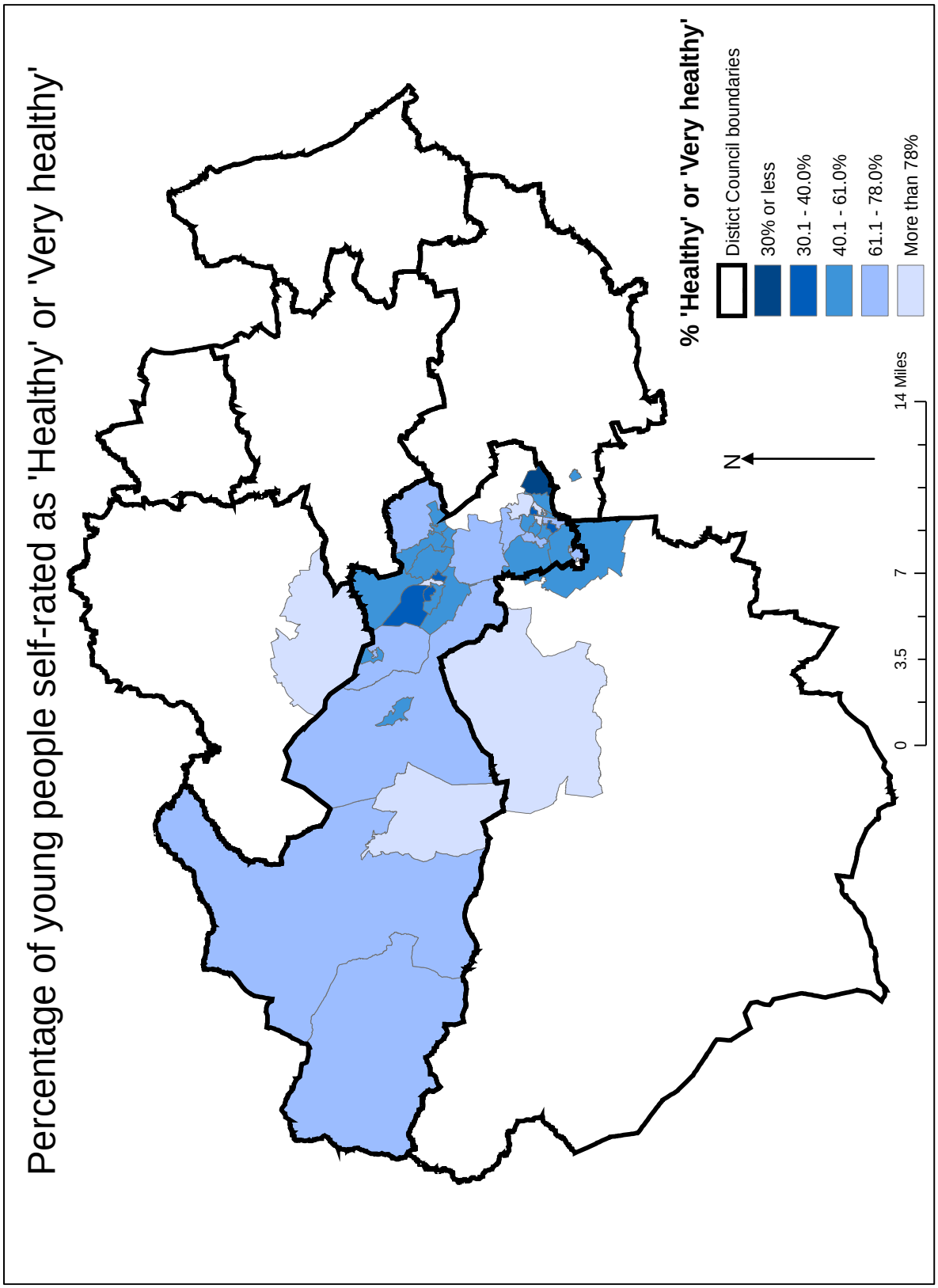


Figure 5.12 shows the percentage of young people in each valid Super Output Area who have tried smoking, including those who currently smoke. This map suggests that more people have tried smoking in the Bishop Auckland, Crook, Willington and Tow Law areas; and this follows the general social class and unemployment patterning discussed earlier in this section. However, there is also a reasonably high percentage of young people in upper Weardale who have tried smoking[33]. Figure 5.13 shows the percentage of young people in each valid Super Output Area who said that they smoke regularly. This follows a different pattern to those who have tried smoking (Figure 5.12). There is again a concentration of the phenomenon in the Crook, Willington and Tow Law areas. However, whilst Figure 5.12 suggested that a high proportion of young people in the Bishop Auckland Area had tried smoking, Figure 5.13 suggests that in this area initial experimentation with smoking has not translated into regular smoking. It was noted in Section 5.4 of this chapter (Table 5.7) that smoking was most prevalent at Meadowcroft Community College where 21.13% of young people smoked regularly. However, when the data is analysed at the Super Output Area level rather than the school level, we find that some areas have a higher percentage and that 30% or more of young people in the Crook South 1 and 3 Super Output Areas said that they smoked regularly. These high levels of smoking in certain Super Output Areas, and the fact that initial experimentation has not translated into regular smoking in some areas, suggests that area of residence may be a significant factor in smoking uptake and continuation and, although not discussed here, the data obtained in this project suggest that the same may apply to other health behaviours. It appears that social class and issues such as unemployment may also be pertinent. As will be discussed in final section of this chapter, these patterns raise some interesting questions about the ways in which young people's health beliefs and behaviours are shaped.

[33] The 'Ever smoked' variable in this map was created by combining the 'Tried and didn't like', 'Smoke occasionally' and 'Smoke regularly' categories on the original smoking variable.

Figure 5.12 Young People who Have Smoked

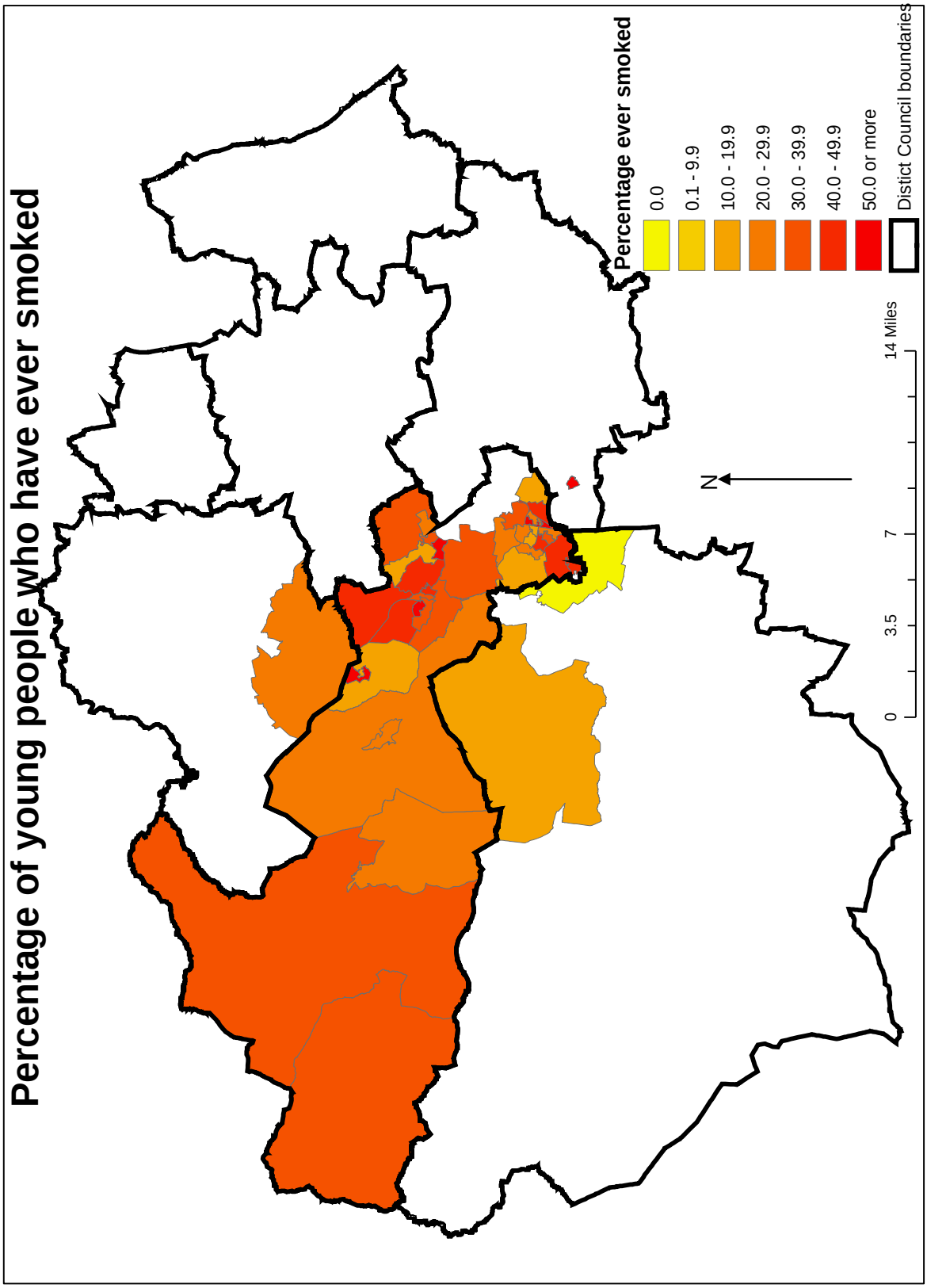
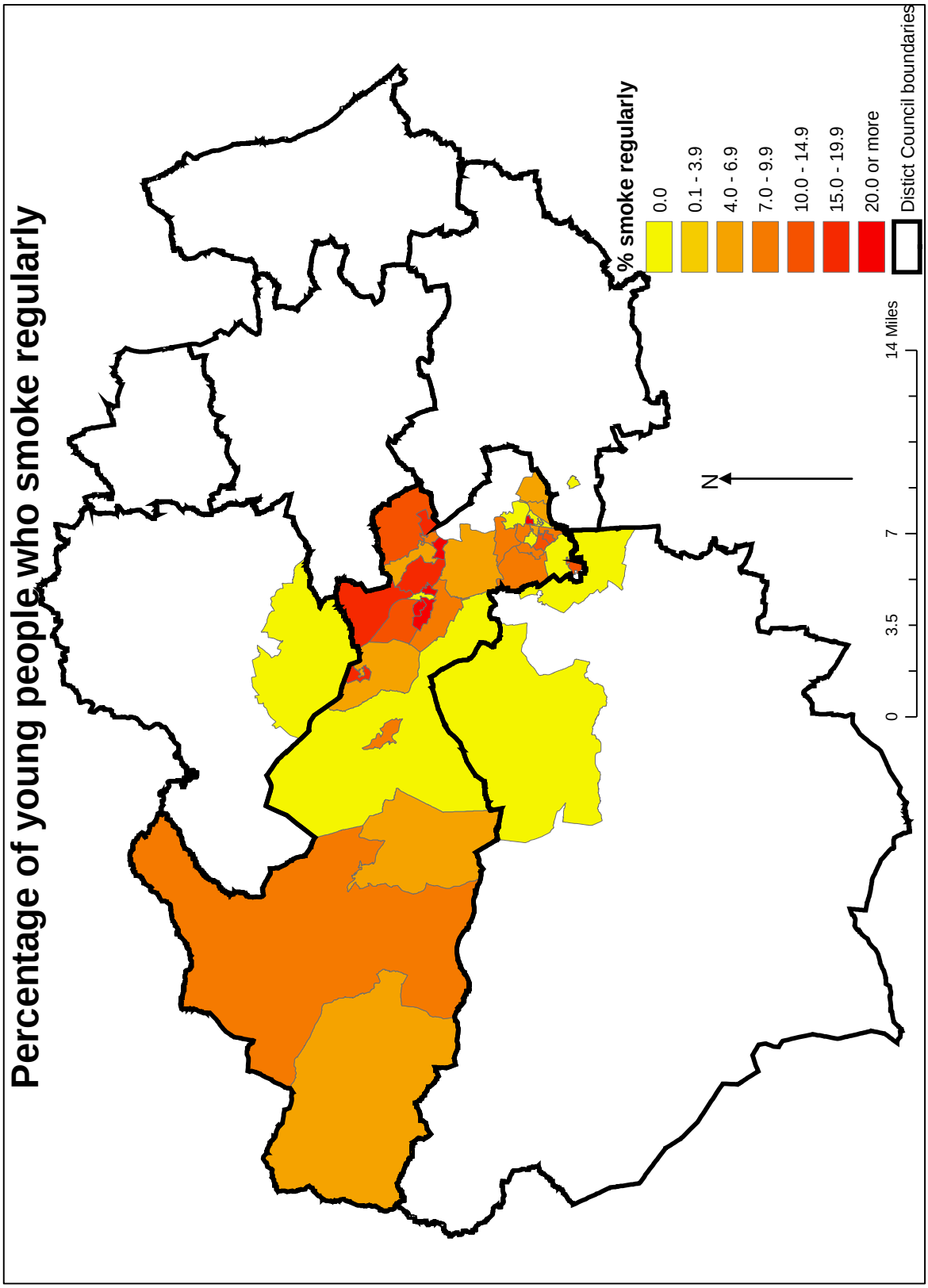


Figure 5.13 Young People who Smoke Regularly



5.7 Issues for Further Discussion

This chapter has offered a brief summary of some of the key findings from the empirical stage of this PhD project. The focus here has been on the health beliefs and attitudes articulated by young people in verbal and written form during the group discussions, interviews and questionnaires. This chapter has also considered the distribution of certain behaviours such as smoking and alcohol consumption among young people in the study area.

In this chapter I have argued that young people's conceptions of 'health', and understandings of what it means to be 'healthy' have generally focused on physical aspects of health and well-being such as diet and exercise although, as was discussed in Section 5.2, some of the young people involved in the qualitative phase of the research did mention social and emotional aspects of health and well-being. This section of the chapter also explored the questionnaire data relating to self-rated health and happiness and the importance which participants attached to health, and the relationships between these and other variables; notably school attended, Year Group and gender. Although there were some statistically significant relationships between these variables, the strength of the associations were generally weak and this suggests that demographic factors or the influence of different schools cannot provide an adequate explanation for the variations in participants' health beliefs and attitudes.

Whilst the majority of participants in the questionnaire survey suggested that smoking, drugs and/or alcohol where the main factors which affected the health of young people in their local area, the percentage who said that these had influenced their own health was substantially lower. As was discussed in Section 5.3, material from the group discussions and interviews suggested that the influences on young people's health were more fluid and complex than could be accommodated in the questionnaire responses. It was noted in Section 5.4 that a higher percentage of young people from Meadowcroft smoke and consume alcohol regularly compared to the other schools in the study, and it was suggested in Section 5.6 that place of residence appeared to be significant in terms of the uptake of health damaging behaviours such as smoking. However, as will be discussed in Chapter 6, I believe that the sculpting and performance of young people's health beliefs and behaviours is more complex still and involves an interaction of global and local processes and cultures, which cannot be reduced simply to issues of place, school or demographics. Furthermore, Chapter 6 will highlight, ways in which issues of space and scale are an integral aspect in such processes.

Nevertheless, as the discussion of countryside and health in Chapter 7 will argue, issues of place are still significant but should not be viewed in isolation. Section 5.5 of this chapter has already highlighted the ways in which participants viewed some

places as being healthier than others; and both the discourses surrounding health and place and the sculpting of young people's perceptions of places as 'healthy' will be explored in more depth in Chapter 7. This chapter will also build on the discussion of global and local interactions, space and scale which will be covered in Chapter 6, and will consider ways in which issues of power and performance are manifest in the sculpting of discourses and the articulations and performances of young people's beliefs about health, place and the countryside.

Chapter 6 Global and Local Interactions: Networks of Power and Influence

6.1 Chapter Introduction

Building on both the empirical material introduced in Chapter 5 and conceptual material from Chapters 2 and 3, this chapter will discuss issues of time, space and scale as they relate to the shaping and performance of young people's health beliefs and behaviours. Particular attention will be given to the mutual constitution of the 'global' and 'local', their fluidity, multiplicity and the networks of power and influence operating alongside and within space and scale. Existing work which discusses issues of space and scale, and the networks of interactions between global and local, generally focuses on the ways such processes and phenomena are manifest in cities (Smith 2003a, 2003b), whereas as the study area I focus upon is predominantly rural. Alongside this discussion of space and scale, I will also explore issues of culture, identity and belonging and the ways these intersect with the performance of health beliefs and behaviours. This chapter will offer a synthesis of both theoretical ideas and empirical material, but remains grounded in the empirical work undertaken.

This chapter will begin with a discussion of the ways in which 'global' and 'local' are being understood in this thesis in the context of a globalised society. As outlined in Chapter 3, the idea of a separate 'global' and 'local' is an artificial binary. However, as an analytic tool, I will look at global and local processes separately in this chapter, but am doing this for the purpose of problematising the binary. Following this general discussion of 'global', 'local' and globalisation, the chapter will focus more exclusively on the County Durham context and will pay particular attention to the Wear Valley area of County Durham. Section 6.3 will discuss pertinent aspects of the historical geographies of County Durham and the ways in which these have shaped the contemporary situation in the Wear Valley. This discussion of the historical geographies of my study area will provide a foundation for the subsequent substantive discussion of young people and health in County Durham and the ways in which these intersect with multiscalar networks and spaces of influence. Particular attention will be given, firstly, to issues of globalisation as they relate to young people's health, health attitudes and behaviours in the County Durham context and, secondly, to the impact of local cultures upon the performance of young people's identities and health beliefs. The final sections of this chapter will bring together these different strands to discuss global-local interactions, multiscalar networks and health, and the ways in which

networks of power and influence contribute to the sculpting and performance of young people's health attitudes and behaviours across time and space.

6.2 Understanding 'Global' and 'Local' in a Globalised Society

This section will discuss the ways in which the terms 'global' and 'local' are commonly used, both within and beyond Human Geography, and the ways in which the terms are being understood here. I will then discuss some key aspects of globalisation as they relate to the themes in this thesis. Particular attention will be given to issues such as space and scale, power, multiplicity, fluidity, and the interplay between globalisation and everyday life. Following this more general discussion of globalisation, I will introduce the concept of cognitive globalisation and its pertinence to understandings of young people's health attitudes and behaviours. The final part of this section will briefly discuss existing research relating to young people and globalisation and will point towards the contributions which the research undertaken for this thesis will make.

As already noted, the 'global' and 'local' are often viewed as separate entities and, whilst I wish to problematise this artificial hierarchical binary, it is nevertheless important to discuss the distinctions which are commonly drawn between global and local scales. The idea of separate hierarchical scales such as local, regional, national and global is both widespread and pervasive, and is frequently used in policy contexts including health policy and promotion (Clancy and Cronin 2005; Weiss et al. 2001). With regard to health, the majority of policy initiatives operate at a national level. Nevertheless, it is important to recognise that the development of Primary Care Trusts has allowed more scope for local initiatives, albeit within the national policy frameworks. In addition, there is also, to a limited extent, some evidence of health planning and policy on a global level especially with regard to issues such as infectious diseases, water safety and non-communicable diseases such as heart disease and oral health problems (Ezzati et al. 2004; Petersen and Yamamoto 2005; Yach et al. 2004). There appears to be a common assumption in many policy contexts that initiatives which operate at a global or national level will have a trickle-down effect until they reach the local and individual levels (see discussion in Marmot 2005). However, this thesis will argue that this hierarchical view of scale is overly simplistic and that policy needs to better recognise and accommodate the multiple and intersecting scales and networks of power and influence which sculpt contemporary societies. Scale can be deployed both to understand health, as is the case in this thesis, and to improve it, for example through policy; and although my main focus is on the former these are closely linked.

The understanding of space and scale being used in this thesis has already been introduced in Chapter 3. As discussed, this thesis is drawing on some of the recent reworkings of relational and abstract understandings of space and scale (Amin 2002; Foucault 1986; Marston et al. 2005; Massey 2005; Swyngedouw 1997) which have not, thus far, been utilised extensively within either Health Geography or Children's Geographies. As highlighted by Lefebvre (1991), space is produced; yet, it is not a finished product and is continually under construction and (re)formation (Massey 2005). Both space and scale are fluid and can take multiple intersecting and juxtaposed forms which are mutually constituted and produced through and alongside practices, performances, interactions and relations (Amin 2002; Massey 2005; Rose 1999). The concomitant networks of power and influence are both products and producers of space and scale; yet, space and scale involve plurality and multiplicity and thus cannot be reduced to simple networks or hierarchies.

As already noted, this thesis is moving away from the hierarchical understanding of scale, which is dominant in policy contexts and remains pervasive in many areas of Human Geography despite recent developments in spatial thought. Like Marston et al (2005), I am also seeking to acknowledge the importance both of flows and fluidities and of materialities. Marston et al suggest that a coherent ontology needs to consider:

> "analytics of composition that resist the increasingly popular practice of representing the world as strictly a jumble of unfettered flows, attention to differential relations that constitute the driving forces of material composition and that problematize axiomatic tendencies to stratify and classify geographic objects; and a focus on localized and non-localized emergent events of differential relations actualized as temporary – often mobile – 'sites' in which the 'social' unfolds." (Marston et al. 2005: 423)

Swyngedouw (1997) and Marston et al (2005) emphasise the role of processes, relations and practices in the production of scale and, as noted in Chapter 3, Swyngedouw suggests that 'process' is a more appropriate starting point than 'scale' for socio-spatial theory. In line with Sywngedouw's observation, this chapter will focus on a number of processes which have influenced interactions between 'global' and 'local' in relation, firstly, to the evolution of my study area, secondly, the production of 'health' as it relates to young people and County Durham and, thirdly, the sculpting and performance of young people's health beliefs and behaviours.

The idea that we are living in an increasingly globalised world is widely recognised both within and beyond Human Geography (see, for example, Flint 2002; Johnston et al. 2002; Massey 2002). A vast body of literature already exists in relation to this theme, and I will not be revisiting this in detail here. Instead, I will briefly focus on ways in which the global and local have interacted across time and space, with a particular emphasis on the implications for ideas about the production of space and

scale, and on issues of multiplicity, plurality and power, as they relate to the substantive issues in this thesis. Globalisation has many forms and facets, and my primary interest here is in the economic aspects of globalisation which have shaped the historical and contemporary geographies of the Wear Valley, and in the globalisation of culture and identity.

Building on the work of authors such as Smith (2003a), human geographers often discuss globalisation in relation to cities and networks. Yet, the processes and effects of globalisation are not confined to urban areas. Few authors have sought to explore the ways in which globalisation has impacted upon rural areas in the developed world, and the notable attempts to do so have generally focused either on the leisure, tourism or hospitality industries (Fisher 2006; McCarthy 2008), or on economic development and issues such as settlement expansion and urban sprawl (Hamin and Marcucci 2008; Markey et al. 2008). As such, there is a lack of extensive general discussion of the interplay between globalisation and everyday life for other sections of rural society. Woods suggests that the 'globalised countryside' should be viewed "as a hypothetical space, corresponding to a condition of the global interconnectivity and interdependency of rural localities" (Woods 2007: 492), but also maintains that:

> "Such a space does not currently exist (and may never exist), and there are no rural localities that can be labelled at present as 'global countryside' in quite the same way as London and New York are described as 'global cities'." (Woods 2007: 492).

Nevertheless, whilst I agree in principle with Woods' view that the 'global countryside' does not exist to the same extent as global cities, it is important to recognise that globalisation has had profound effects on many rural areas. As will be discussed later in this chapter and also in Chapter 7, some rural areas have become more homogenous due to the impacts of globalisation and related trends but others, such as County Durham, have become more 'global' whilst also retaining their local identities. This intermingling of global and local in rural areas challenges the more traditional hierarchical understandings of space and scale and the binary which is often imposed between the 'global' and 'local'.

Another challenge to the notion of a global-local binary comes from work on de-territorialisation and denationalisation. Sassen (2000, 2003) argues that the global institutions and economic trends, such as global financial markets and multinational companies are only one aspect of globalisation and that it is important to consider other processes, such as 'cross-border networks of activists' and the role of politics, which do not always scale at the 'global' level. Referring to these additional aspects of globalisation, Sassen notes that, although the territorial and institutional domains within which processes of globalisation occur have largely been constructed in national terms,

> "What makes these processes part of globalization even though localized in national, indeed subnational settings, is that they involve transboundary networks and formations connecting multiple local or 'national' processes and actors, or involve the recurrence of particular issues or dynamics in a growing number of countries" (Sassen 2003: 2).

Sassen's discussion of the subnational as a site for globalisation resonates with issues of governance, which were discussed in Chapter 2. Her work also has a number of implications for discussions of the interplay between globalisation and everyday life, which will be explored later in this chapter. In the context of my work, the spaces and channels through which young people's health beliefs and behaviours are shaped and performed frequently cross and transcend traditionally bounded scales, settings and contexts. As will be discussed, some behaviours and attitudes clearly had localised elements, yet cannot be fully isolated from wider networks of power and influence.

Another important aspect of my thinking in relation to space and scale comes from Foucault's work on power and knowledge. The contribution which Foucault's work has made to made my understanding of space and scale has already been outlined in Chapter 3, and I will not be revisiting this discussion here. Instead, I wish to briefly highlight the specific contributions of Foucault's work to my rejection of the traditional global-local binary and my focus on issues of power and performance. Firstly, it has already been noted in Chapter 3 that Foucault placed a clear emphasis on the simultaneity and multiplicity of dispersion, juxtaposition and connectedness, in which differing facets were considered to be on the same level as each other rather than hierarchical. This is conducive to my understanding of global and local as being interwoven, juxtaposed and yet not fully synonymous. Secondly, Foucault has a particular interest in issues of power, knowledge and discipline and the ways in which discourses are produced and established. These ideas, which were discussed in Chapter 3, are pertinent both to this chapter's discussion of the sculpting and performance of young people's health beliefs and behaviours and to the subsequent exploration of intersections between globalisation, local cultures and young people's identities. Thirdly, although the connections are yet to be explored, I believe that Foucault's ideas about power and discourse intersect with recent work pertaining to the idea of cognitive globalisation.

Although the concept of cognitive globalisation has not been engaged with extensively by human geographers it is of particular pertinence to some of the themes discussed later in this chapter. Put simply, the term 'cognitive globalisation' refers to aspects of globalisation which directly relate to the ways in which people think and then behave. In relation to health, this concept of cognitive globalisation has primarily been developed by Lee (2004) who suggested in a previous work that:

> "The cognitive dimension of globalisation concerns changes to the creation and exchange of knowledge, ideas, norms, beliefs, values cultural identities, and other thought processes. How we think about ourselves and the world around us is being changed by globalisation. The causes of this are varied including the mass media educational institutions, think tanks, scientists, consultancy forms and 'spin doctors'." (Lee, 2000, quoted in Collin 2003: 62).

This idea of cognitive globalisation resonates with the discussion in Chapter 3 surrounding Foucault's work on power, discipline and gaze. In addition, the cognitive aspects of globalisation can also sculpt performances in relation both to the social norms, staging and role-playing discussed by Goffman (1959, 1972) and to the issues of gender and performativity discussed by Butler (1990, 1993). As will be discussed later in this chapter, the media played a significant role in the sculpting of young people's health beliefs and behaviours, as did the absorption of ideas from settings such as the school, family and peer group. Although I largely agree with Lee's suggestion that "our cultures, wants or perceived needs, values, beliefs, knowledge and aspirations are being changed" by the cognitive dimensions of globalisation (Lee 2004: 157), it is important to also recognise the ways in which strong local cultures and identities can interact with, and sometimes counteract, more global trends. Robinson explores ways in which globalisation has included "the increasing acceleration in both concrete global interdependence and consciousness of the global whole" (Robinson 1992: 8) and some of the participants in the research undertaken for this thesis demonstrated a clear awareness of health issues in other countries, such as problems with access to clean water in many Global South contexts. In addition, Robinson highlights the ways in which discourses and power are deployed in and through globalisation, influencing issues such as identity and self-identity, and argues that this "proceeds in various parts of the world and within various societies in terms of *globally diffused ideas* concerning tradition, identity, home, indigeneity, locality, community and so on" (Robinson 1992: 166 emphasis in original).

With regard to young people and globalisation, there is already a small but significant emerging body of work; especially in relation to the North American context, youth identities or cultures and young people in the Global South (Cahill and Katz 2008; Driskell et al. 2008; Katz 2004). Within Human Geography, Katz (2004) offers a detailed discussion, based on ethnographic fieldwork, of the ways in which globalisation and economic restructuring have impacted upon young people's everyday lives in Sudan and New York City and emphasises "the myriad ways global capitalism and other large-scale processes ricochet through and between disparate places" (Katz 2004: 259). Nayak (2003c) discusses the impact of globalisation upon young male identities amongst different neighbourhoods in Newcastle-upon-Tyne. In particular, as will be discussed later in this chapter, Nayak's (2003a, 2003b, 2003c) work on white

working-class masculinities in Newcastle-upon-Tyne resonates with some of my research – especially that undertaken with the young people at Meadowcroft Community College. Furthermore, despite the differing contexts, there are also connections with Horschelmann and Shafer's (2005) discussion of globalisation and the performance of youth identities in the former German Democratic Republic. Alongside this chapter's interest in young people, globalisation and identity, it is also important to bear in mind the specificity of the County Durham context and the ways in which this is enmeshed and enfolded with globalisation and global trends. Therefore, the next section of this chapter will discuss the historical geographies of County Durham and the ways in which the global and local have intertwined in the creation of the contemporary context.

6.3 Historical Geographies of County Durham: Creating the Global-Local Spaces of Today

In their discussion of North East English culture, Colls and Lancaster suggest that "The 'North-East' is essentially a state of mind to do with histories and feelings about itself." (Colls and Lancaster 1992: xii). As this quotation suggests, The North East has a distinct regional identity which has been shaped by its history and identity. Whilst the significance and purpose of this regional identity has been debated (see Lanigan 1996: for discussion of this issue) it is generally accepted that the term 'the North East' cannot be reduced purely to a geographical location and Purdue (2005) argues that it carries both political and historical 'baggage'. A distinction has sometimes been drawn between 'Englishness' and 'Northerness' and Taylor (1993) thus suggested that the North of England, and the North East in particular, has sometimes been viewed as an 'other', or a 'foreign country' within, when compared to stereotypical views of 'Englishness' which are based on idealised images of southern or 'middle-class' England, and the Home Counties in particular (see also Colls 1992). More recently, in his discussion of young people in Tyneside, Nayak notes that

> "the Tyneside conurbation epitomises a region that has strong local roots but an uncertain relationship to nationhood. The distinctive regional identity of Tyneside…has seen a greater emphasis given to Northern peculiarities by locals at the expense of a homogeneous 'Englishness'" (Nayak 2003c: 36).

However, Nayak goes on to argue that "the local and national are not entirely exclusive categories, but co-exist in a complex inter-dependent relationship with one another" (Nayak 2003c: 37) and, as noted earlier, the co-existence and mutual construction of scales such as local, national and global is an important idea in this chapter. Furthermore, the evolution of the local cultures and identities in the North East and County Durham did not occur in a vacuum and has been juxtaposed with a myriad of

processes occurring within and across different spaces and scales. Thus, any discussion of contemporary County Durham, or the North East more generally, requires some consideration of the historical geographies of the area.

Alongside this regionalism in the North East as a whole there are also strong local identities within the North East, and it is important to recognise that County Durham cannot simply be equated with Newcastle, Tyneside, Teesside or Northumberland. This poses some challenges in the context of this thesis, because much of the existing literature is either focused on the North East in general or on Tyneside or Teesside in particular. Therefore, this thesis will draw on literature relating to other areas of North East England where the ideas discussed are pertinent to my work and, where necessary, any significant differences will be highlighted. This section will build upon the more theoretical discussion in Section 6.2 and relate the ideas it contained to the context of County Durham (and these ideas will then be discussed in relation to young people and health in County Durham in Sections 6.4 and 6.5).

In many respects, the recent history of County Durham is synonymous with that of the rise and decline of heavy industries and, in particular, the coal mining industry. However, coal was not the first industry to dominate in the county and the view that County Durham can be equated purely with coal mining is somewhat simplistic. It is important to note that the historical geographies of County Durham as a whole are very different to those of Durham City itself. Durham City has, for a long time, been an enclave of privilege and affluence which is socially and culturally distinct from surrounding areas.

Whilst the coal industry has generally dominated discussions about County Durham's industrial legacy, the Pennine area in the west of the county was historically a lead mining area. There are suggestions that lead was mined in the upper Wear and Tees valleys during the Roman occupation, and that Weardale and Teesdale were the world's leading producers of lead ore during the first half of the 19th Century, before the industry's rapid decline in the 1870s (see Pocock and Norris 1990 for discussion). As will be discussed in Chapter 7, there are still visible signs of this industry's previous activity in the Upper Weardale area. It is also worth noting that much of the county was historically an agricultural area and the agricultural industry retained its importance in Weardale throughout much of the twentieth century.

County Durham was a key player in the industrial revolution and was, at the peak of its prosperity, one of the lynchpins of the global economy. The nineteenth and early twentieth centuries were characterised by the dominance of heavy industry, especially coal-mining and steel. The coal industry in County Durham was initially focused on the western area of the county, including the Mid Wear Valley, because the proximity of the coal seams to the surface made the area amenable to large scale

mineral extraction and, as technology improved, the industry gradually shifted eastwards to utilise the deeper and richer coal seams around the eastern seaboard (Strangleman 2001). Thus the former mining communities within my study area were among the first to form, but were also, in general, among the first to encounter pit closures and large-scale job losses. Whilst the closure of the last mine in County Durham in 1993[34] did, in some respects, mark the end of an era, the influence of the area's industrial heritage remains and Strangleman et al's assertion that "while the industry has collapsed, or completely disappeared there is a sense in which these are *still* mining areas" (Strangleman et al. 1999: section 5.6) still resonates in many areas of contemporary County Durham.

County Durham's industrial history has had a significant impact on the social and cultural geographies of the area. During the coal mining era, large-scale in-migration into the area (especially from Ireland and the West of Scotland) for employment in individual coal mines lead to formation of pit villages each of which had their own distinct social mix and culture. Whilst the transient nature of employment meant that mining families often moved en-masse from employment in one pit to another, individual communities were further cemented by a tendency for the off-spring of mineworkers to marry within their own community (Smith and Fletcher-Jones 2003).

The collapse of the coal-mining industry in the second half of the twentieth Century had a profound impact on County Durham which, as was discussed in Chapters 2 and 5, is now frequently characterised by high levels of deprivation and stark inequalities. However, as will be highlighted later in this chapter, the strong local identities and loyalties which developed through the mixing of immigrant groups in pit villages are still evident in many areas of the county today. Nevertheless, writing in the late 1970s, Bulmer suggested that whilst "County Durham is [sic] the nineteenth-century was a melting pot for immigrants…In the twentieth century, in total contrast, its most striking characteristic is immobility" (Bulmer 1978: 13). Today, a lack of social mobility is apparent in many communities and this is maintained through the high levels of socio-economic and health deprivation and through local cultures, norms and practices. As will be discussed in the following sections, the discourses and power dynamics surrounding this blending of global, local, culture and identity plays a significant role in shaping young people's health beliefs and behaviours, and performances of identity.

[34] The last coal mines in County Durham were Easington Colliery (closed in April 1993) and the Vane Tempest mine in Seaham (closed in June 1993). Whilst the Wearmouth Colliery in Sunderland (closed in June 1994) was the last mine to close on the County Durham Coalfield, this was situated within the administrative district of Sunderland and not County Durham.

6.4 Globalisation and Health in the County Durham Context

This section will discuss the interplay between globalisation and health, with particular reference to young people in my study area. Much of the existing work on globalisation and health has been epidemiological in nature, with a particular emphasis on global health pandemics and infectious diseases (see discussion in Brown and Bell 2008), or has focused on population health at a national or international level (Huynen et al. 2005). There has also been a strong emphasis on globalisation and health in Global South contexts (Timimi 2005), environmental health (Martens 2002; McMichael and Beaglehole 2000) and on the globalisation of healthcare (Koivusalo 2006; Milio 2001; Reznik et al. 2007). Whilst I do not wish to deny the importance of such work, my discussion of globalisation and health will have a rather different focus and, as highlighted earlier, will move away from the traditional understanding of hierarchical or nested scales and levels towards a more fluid conception which emphasises plurality, multiplicity and juxtaposition. Thus, rather than seeking to formulate an overarching narrative of global health, I am interested in the ways in which globalisation has intertwined with local cultures in the sculpting and performance of young people's health beliefs and behaviours and the ways in which power is manifest in and through these processes.

Writing about the South African context, Gilbert and Gilbert (2004) suggest that globalisation and its influence on health issues is intertwined with local power dynamics and domestic circumstances, but place a strong emphasis on the power held by different actors. In their response to Gilbert and Gilbert's paper, Thomas and Thiede (2005) argue that the effects of globalisation upon health cannot be understood without considering the ways in which power is manifest and exercised, and suggest that "power can be exercised through direct conflict, through keeping off limits certain discussions and through the moulding of beliefs" (Thomas and Thiede 2005: 261). They further argue that any such exploration of power needs to consider the pervasive nature of globalisation. The interplay between power, globalisation and local culture will be a significant theme in the remainder of this chapter.

Building upon previous discussion this section will highlight some of the specificities of globalisation and health in the context of County Durham as they relate to young people and health. This will be explored through two sub-themes which arose from the empirical research undertaken. Firstly, issues relating to the media and technology and, secondly, those relating to diet and food practices. These two subsections will draw extensively on material from the qualitative phase of the fieldwork and, although the young people involved did not refer to globalisation per se, many of the issues participants raised were related to ideas which are widely associated with

the concept of globalisation and these led me to identify globalisation as a significant process in the sculpting of young people's health beliefs and behaviours.

6.4.1 Globalisation, the Media, Technology and Young People's Health

This section will draw upon fieldwork data to discuss general relationships between globalisation, the media, new technologies and young people's health with specific reference to my study area. The discussion in this section will focus on the themes which participants thought were important, particularly issues relating to television (TV), magazines, 'celebrities' and new technology including games consoles and computers; all of which are aspects of the globalisation of culture and technology. This section will also briefly discuss issues relating to identity and performance, with some reference to cognitive globalisation and power.

Almost all of the groups involved in the project talked about the role which the media, especially TV and magazines, played in shaping young people's beliefs and understandings about health. The media is often criticised in public and health discourses for the portrayal and glamorisation of super-thin models and celebrities, and this theme was brought up in many of the groups. Although, as was discussed in Chapter 5, many of the young people involved placed a strong emphasis on physical aspects of health there was still a widespread view that people who "looked better" – i.e. were physically attractive or pretty – were also healthier. This connection between a person's appearance and their health was articulated particularly clearly in the following extract from the Year 11 focus group discussion at Meadowcroft (Box 6.1).

Box 6.1 Personal Appearance and Health

NHB	What do you think's influenced your own health?
Jess	Ah think how ya look, like, I think
NHB	How you look?
Jess	Yeah
NHB	So what impact do you think that has?
Jess	I dunno
Emma	We I think if yer like have a balanced diet n all, if yer have a balanced diet and that then yous look nicer, don ya?
Jess	You feel
Emma	Ya feel better because you know ya lookin betta.
NHB	so it makes you feel better about yourself?
Jess	Yeah
Emma	Yeah
Clare	Like you'll have better self esteem
Lucy	Yeah
Emma	I was tryin ta think of that word

(Year 11 group, Meadowcroft)

There were a number of instances when appearances were used as a basis for judging a person's health. For example, in the Year 9 Meadowcroft group, participants included some discussion of a particular estate on which they said that the residents were all overweight and just spent all their time watching TV and eating[35]. None of the participants had any significant contact with residents on this estate, and the judgements they were making appeared to be based on a combination of hearsay and the physical appearance of residents they had noticed. Thus, in this example, it appears that stigma was enacted on the basis on residents' appearance by those living in other areas, and assumptions made about their lifestyles and health. This enactment of stigma resonates both with the work of Goffman, which was discussed in Chapter 3, and with Foucault's work on power, knowledge and gaze. Furthermore, this example also demonstrates the ways in which phenomena can simultaneously scale in intersecting and multiple ways because it juxtaposes more global discourses surrounding obesity and health with local ideas about people and place.

This link between perceived deficiencies in physical appearance and poor health is also illustrated in the extract in Box 6.2 where Karl compares people who have been portrayed negatively on TV with dogs in a manner which makes them appear to be almost sub-human in his eyes. The extract also points towards another significant theme, namely the influence of models and celebrity culture.

Box 6.2 Deficiencies in Physical Appearance and Poor Health

NHB	So what else do people think might be risks or barriers for people your age?
[pause]	
Karl	Um on ours it says don't abuse your body and whereas on like on the telly it shows you the effects and you think 'ah I don't want to look like a dog' like or something
Dawn	Peer pressure
NHB	Peer pressure.
Penny	seeing models an stuff and stop eating cos you think you should be like that.

(Year 9/10 group, Riverview)

As highlighted in Box 6.3, many of the young people were extremely aware of the potential impact of TV, magazines and celebrity culture upon health and well-being, whilst having no direct experience of it affecting people they knew. However, some participants had encountered more personal experiences of this process, as illustrated in the extract in Box 6.4. With regard to agency and images of the 'ideal' woman, Liimakka similarly notes that "young women in general seemed to pose contradictory opinions about whether media images of the ideal woman have an influence on them or not" (Liimakka 2008: 137). Similar contradictions were apparent in the narratives of the young people I worked with. Whilst all of the participants who raised issues relating

[35] It was not possible to transcribe this discussion accurately due to the number of participants who were talking at the same time and problems with noise from the adjacent classroom.

to the media or TV and body image where aware of the discourses which suggest that such images influence young people's body image, self-image and perceptions of what they 'should' look like, many were unsure about whether or not these had influenced them personally.

Box 6.3 TV, Magazines and Celebrity Culture: General Impact

NHB There was a very brief mention in your group about people who don't eat and like people on telly and stuff, you didn't talk about it as much as some of the other groups, but how widespread is it, does it happen around here?
Sarah Where in our school?
NHB This area. The school or the area where you live
Sarah Um. Well Ah s'pose, a lot of the girls look at the magazines n think 'yeah I want to be like that, I want to be like that', but I suppose they don't take it on board, and go like 'Oh I'm goin ta go on a crash diet' or anything like that
[giggles from Penny]
NHB So you don't think it influences how people act?
Sarah Pardon?
NHB You don't think it influences how people act?
Sarah No, not really…I s'pose in other parts of the country it could, but not 'ere I don't think.
(Penny and Sarah, Interview, Year 10, Riverview)

Box 6.4 TV, Magazines and Celebrity Culture: Direct Experience of Impact

NHB So what do you think are the main risks and barriers to health for people your age?
Kim the people around you like they can influence ya and things
Julia and like when you see things you want to like follow that and be like them um and it's just getting you unhealthy to try to be fashionable
Amber And some people go to like go to as far as like being anorexic just to be seen to be as thin as the celebrities you see on telly and that
NHB Do you know people who have done that?
Amber well, one of them yeah, but she's alright now, she had to be in [name of hospital] n that but she's now.
(Year 9 group, Hillcrest)

It was also clear from the discussions that the media such as TV programmes also influenced participants' views in less stereotypical ways. For some participants, the TV was actually regarded as a positive influence which raised awareness of issues such as diet and exercise. The extract in Box 6.5 is illustrative of this trend and highlights the positive influence of programmes which showed examples of good health and fitness programmes or regimes.

Box 6.5 TV as a Positive Influence: Fitness Trainers

NHB What things do you think have influenced your own health?
Dawn pardon?
NHB What sorts of things do you think have influenced your own health?
Laura parents
Penny TV
Sarah Yeah
(laughter and agreement)
NHB In what way TV?
Sarah Cos you see all these people on a TV, all these famous people and that they have their own fitness trainers and view that they use them
NHB So you think that TV is a positive thing?
Sarah Yeah
Dawn Uhum
Karl I reckon it's a positive things as long as you don't like
Penny watch it 24/7
Karl stay like watchin' it for ages an that
Sarah Thing is that you don't become obsessed like with models and things and see that how skinny they are an think 'Ah've got be like them'
(Year 9/10 group, Riverview)

Along similar lines, a number of groups discussed the ways in which examples of poor health or the dangers of particular behaviours were portrayed on the TV and in other media. Many of the young people appeared to be affected both by the images they were presented with and by the portrayal of negative outcomes such as long-term debilitating illnesses and death. The extract quoted in Box 6.6 is typical of many of the discussions in this vein, and highlights the ways in which the images young people see on the TV and in other media interweave with examples they see in real life.

Box 6.6 TV as a Positive Influence: Examples of Poor Health

NHB What do you think it is that makes you able to stand up to the peer pressure?
Craig Cos we know what they'll do, cos you know the risks and everything, and people who've started they'll know the risks now and some of them won't stop cos it's hard
Lizzie Like knowing people that actually smoke and that want to quit and everything, but can't
Katie Yeah
Lizzie and like it's people that you know that started an things
Louise and like you always see things on TV like of people who have died of cancer and stuff.
(Year 8 group, Meadowcroft)

The young people involved in the research gleaned information and examples from a range of media sources, not just from health-related TV programmes or those involving celebrities. During my fieldwork, a clinically obese primary school pupil in another area of County Durham, who had reportedly refused to cooperate with professional and parental attempts to encourage healthy eating and exercise, was featured heavily in the news and documentary programmes. The prominence of his case arose due to a debate over whether he should be taken into care to ensure that he had a healthy diet and fitness programme. This example appeared to have shocked some of the participants, as illustrated in the discussion in Box 6.7. In addition, the

subsequent discussion also shows the way in which some participants gleaned information from unexpected media sources; in this instance the Guinness Book of Records, as well as from TV programmes and magazines.

Box 6.7 TV News and Guinness Book of Records

NHB Do any of you have any particular experiences which have influenced your views on what health is?
Greg Watchin Trevor McDonald about the 8 year old 14.5 stone kid
[Giggles from Kim, Amber, Julia and Sophie]
NHB Yesterday?
Greg Yes, I'd really not like to be him right now, and what was it, the 83 stone man
Shane yeah
Dean He's not 83 stone now
Greg no
Dean or he'd be dead
[laughter]
NHB Anything less recent?
Dean No
Amber No
Greg Well yeah, not recent but Ah saw in the Guinness Book of Records 2004 that a lass was so skinny she had the smallest ah
Dean waist
Greg yeah waist size and she was so skinny and she'd never ate.
Shane that's urgh
Jacob strange
Shane Horrible that
Greg and she's just like [demonstrates with hands] that
Julia that thin
(Year 9 group, Hillcrest)

There have been suggestions in the media and elsewhere, that new media technologies such as computers and playstations, which are an aspect of the globalisation of information, communication and leisure technologies, have encouraged an increase in sedentary leisure activities and unhealthy eating coupled with a decreased energy expenditure (see Smith and Green 2005 for further discussion). This idea was reflected in some of the group discussions and is illustrated clearly in the extract in Box 6.8. However, as illustrated by the extract in Box 6.9, there was also a significant counter-narrative which suggested that new games and technologies such as the Wii could play a role in promoting physical health through exercise.

Box 6.8 Gifts and Sedentary Activities

NHB Are there other things that you think are important for health that we've not talked about so far?
[pause]
Emily No
[Karen and Louise shake heads]
Karl Well the stuff you get because um if say ya get a playstation game or somthin you might want to just play on that for ages n then you'll just sit there for ages an just play with it an eat crisps or summat an then you'll get fatter whereas then say you get an new football or something then you'll want to go and play with your football or use your football boots and then you'll go outside for ages and get like exercise
(Year 9/10 group, Riverview)

Box 6.9 Health-Promoting Technologies: The Wii

NHB Is there anything else that we've not talked about which you think is important
Dean Games consoles
Greg Electronic devices
Shane Cos of staying inside on them all day like I do
Greg I suppose the Wii, you know the W I I [word spelt out], cos you can do golf and so you're practising your swinging and there's some times what you have to do like that [demonstrates] to churn the butter
Jacob Cos like
Dean When ya box
Greg Like it's mental
[further discussion]
Amber I think the Nintendo Wiis are good cos you can like exercise
Julia You run about n that
Kim and there's a little stick thing
Shane You can do badminton on it
NHB Do you actually physically run about with it?
Amber Yeah you have to run around on it and do like everything for it
Sophie And I've got like the Olympics one for the Playstation 2 and you have to like get on a dance mat and you've got to like run on the dance mat and stuff like that
(Year 9 Group, Hillcrest)

Amongst some of the older participants in particular, oblique references were also made to ideas and information which they had learnt about that related to health in other places, such as countries in the Global South. Whilst I did not explore the ways in which participants had learnt about other places, such references to health in other places highlight another aspect of the interplay between health, globalisation, the media and technology. Trends such as time-space compression and convergence have, through material aspects of globalisation such as information and communication technologies and the media, increased links between different places and different parts of the world and raised awareness of differences in people's lived experiences. Thus, for participants like Sarah and Dawn, in Box 6.10, poor health was something which generally affected other people in other places, and discussions around the factors which affected people's health had a more abstract nature when compared to those in groups which drew more directly upon personal experience or images which they could relate to on a more personal level.

Box 6.10 'Poor' Countries

NHB So what do people think are the main barriers or risks to your health?
Karl If your friend like if for food if your friend doesn't eat it or like he thinks it's disgusting and goes on about it then you start thinking 'oh I'm not going to eat this' you'll have more one on these [indistinct] so you'll stop
[pause]
[laughter]
Sarah Don all look at me!
[Sarah laughs]
Sarah You might live in a poor country so you canna afford any of these whatsoever.
NHB Does it just have to be a
Karl How can you not afford fitness though? you can like
[laughter]
Louise you can't possibly
Dawn like if you live in a place which has no walks and no way of getting exercise
Sarah Or if you do fitness then you have nothing to drink and like so therefore you die.
Penny Yeah
[laughter]
Simon Yeah, but that's not very likely.
(Year 9/10 group, Riverview)

The young people involved in this research generally considered the media to be one of a number of influences upon their beliefs and understandings about health. As the two extracts in Box 6.11 demonstrate, the young people involved in the research drew on a range of sources and narratives when discussing health, and this complexity was evident when attempts were made to articulate where they had learnt things and how they had formed the views they held. The images and ideas presented on the TV and in magazines were held broadly on a par with other factors such as family, friends and school in terms of the extent to which they influenced young people's beliefs and behaviours.

As the next sub-section will discuss, the media also had some impact upon young people's diets and food practices. However, the relationship between globalisation, food and young people's health cannot be reduced to the impact of the media on its own. The next sub-section will therefore explore the complex interplay between globalisation, food practices and young people's health.

Box 6.11 Influences on Individual's Health and Health Narratives

NHB Thinking about yourselves now, what do you think are the main things that have influenced your health as you've grown up?
Penny Umm, Ma parents, friends.
NHB How and why?
Sarah Um me parents have always taught me not to smoke and things and the same with me friends. Ma mums obs, um my brother's diabetic and so she always has to put a good meal on the table like, she canna just be giving him fatty chips and like every day, and so she's helped a lot.
Penny My mum and dad eat healthy so, like, I dunno really.
NHB So do you think your parents have influenced your health, in terms of what they do and what they've taught you?
Penny Pardon?
NHB So do you think that your parents are the main thing that have helped you to be healthy now?
Sarah Yeah
Penny Yeah
NHB How do you think you have come to have the views you have about health; where have you got your ideas from?
Sarah TV, magazines, parents,
Penny Friends
Sarah friends, family. Um, school teachers, um my dance instructor, that's about it really
NHB Um, do you get different types of information from different places do you think?
Sarah Um.
Penny Yeah. Like we took food for GCSE
Sarah and our food teacher like she goes through everything with us like what's healthy and what's not
Penny but if we went out with our friends like then we wouldn't be like 'Ooh that's got 150 calories in.

(Penny and Sarah, Interview, Year 10, Riverview)

NHB How do you think you've come to hold the views you have?
Karl Probably jus like from like seein it on the telly or from peop from people tellin us abaat what bein healthy is and from like experience as well, cos like say like I hurt myself or something and I could like go outside or sumthing I stayed in an jus eat, was eating instead I'd go back, like when I was alright I'd go back an do what Ah was doin but I'd find it much harder because Ah hadn't like had any training of it.
NHB Uhum.
[brief pause]
NHB What about you, where do you, how do you think you've come to have the view that you do now?
Mike I dunno
NHB You don't know?
[pause]
NHB Is there particular places or people you've got ideas from?
Mike No
[pause]
Simon No not really, jus, naa.
[brief pause]
NHB How, where and when have you learnt about health?
Mike School
Simon TV
Karl I've learnt jus from everywhere really, like from self experience, like from watchin other people and like and people tellin us and then like Ah've learnt it from school n like in science n something
Simon Learning off other people as well
NHB So in terms of, um do you think that most of it's learnt in school rather than at home?
Karl Say it's about a third of it's learnt at school or sumthin like n then there's like another third learnt like at home and like off seein other people health gettin down n it's like your own experience is like the other third.

(Interview with Mike, Year 10 and Karl and Simon, Year 9, Riverview)

6.4.2 Globalisation, Food and Health

Existing literature relating to globalisation and food has tended to focus on either the supply of items to supermarkets or Western countries and impacts on producers (Barrett et al. 1999; Echanove 2005; Gwynne 1999; Humphrey 2007), or on the partially related issue of ethical and fair trade movements (Clarke et al. 2007; Freidberg 2003, 2004; Hughes et al. 2007; McEwan and Bek 2009). Within Geography, there has also been a significant focus on alternative food production and practices[36] (Goodman 2003; Guthman 2008a; Little et al. 2009; Slocum 2007; Sonnino and Marsden 2006; Watts et al. 2005) which emphasise the role of local actors and networks.

This section will discuss the relationships between globalisation, food, diet and eating practices, and health, with particular reference to young people in my study area. This discussion will draw extensively upon fieldwork data and will focus on issues raised by participants including fast food, pizza, family eating practices, school eating arrangements and the social consumption of food and drink. In addition, this section will discuss the diversity of food products available and ways in which these have influenced young people's eating practices, health beliefs and health behaviours, drawing links with issues such as globalisation, time-space convergence and time-space compression. Drawing on this discussion, I will explore questions surrounding the extent to which such diversity has increased young people's day to day food options and choices, with particular reference to participants' own accounts.

The final part of this section will explore issues relating to health promotion and education, especially with regard to young people's awareness of healthy eating and school strategies surrounding eating and health promotion. This will be discussed with brief reference to the so-called 'globesity' pandemic (Bifulco and Caruso 2007; Kline 2005) and obesogenic environments (Delormier et al. 2009; Harrington and Elliott 2009; Nelson and Woods 2009; Procter et al. 2008; Swinburn et al. 1999) and links will also be drawn with health policy, the media and cognitive aspects of globalisation. I will explore the impact of healthy eating messages upon young people's eating habits, with particular reference to participants' own accounts. This will include some brief discussion of issues relating to sport and exercise, although the main focus of this section will be on eating and food practices.

Globalisation and neoliberal market policies have increased the power of multinational companies with regard to food, and it has been suggested that their power is likely to increase further compared to that of national and supranational

[36] Alternative food practices seek to change the ways in which people produce, purchase and consume food. They emphasise the development and role of local food systems and producers alongside issues of social justice, human and non-human well-being, and education. Examples include organic produce and Farmer's Markets.

governments (Watts et al. 2005). Despite the increased success of alternative food practices, there have been suggestions that these have made little progress in terms of challenging neoliberal policies or shifting power balances (McCarthy 2006) and Guthman (2008b) suggests that such practices may themselves reflect aspects of neoliberal strategies and politics. Furthermore, whilst increasing attention has been given to local food systems and alternative practices, it is important to recognise that the binary which such discourses commonly construct between the local and the global is problematic because local food systems are inescapably tied to global systems (Feagan 2007). To add further complexity, alternative food practices are becoming more of a global phenomenon and thus cannot be separated fully from processes of globalisation.

In their discussion of apple production in Washington, USA, Jarosz and Qazi conclude that

> "the local is global. Local landscapes are invariably situated within global processed…Thus, the conceptual boundaries and divisions between the local and the global as oppositional or as cause-effect relations are artificial and false…the global does not exist externally to the local, but the global is realised locally through social structures and agency as it unfolds within and is shaped by particular landscapes." (Jarosz and Qazi 2000: 9)

This comment, in many ways, epitomises my thinking on the ways in which the global and local are interwoven and mutually constituted, and the ways in which seemingly local practices have global scope and vice versa.

In their discussion of transnationalism and commodity culture, Crang et al (2000) highlight the cultural commodification of ethnic products, particularly in relation to food and fashion, and the circuits and networks through which these are incorporated into other cultures. Whilst I did not engage in detailed discussions about participants' eating practices, drawing only upon information which was offered spontaneously, it was clear from the general discussion that many participants regularly consumed food types which had originated in other cultures. For example, pasta was a significant component of many participants' diets; yet, as Alexander (2000) discusses, was originally a culturally specific regional commodity within Italy before its spread within and beyond Italy.

There have been suggestions that food practices offer spaces both for negotiating the meanings of home, ethnicity and belonging and for tracing facets of identity and that familiarity can help promote feelings of belonging and attachment Collins (2008). Yet, at the same time, food practices can also blur traditional boundaries surrounding culture and ethnicity (see, for example, Duruz 2005). In addition, some authors have recently highlighted a gendering of food practices which sometimes connects to the negotiations surrounding home, ethnicity and belonging.

For example, it has been suggested that females are more inclined to engage in alternative food practices such as the consumption of local or organic produce (Little et al. 2009). In their discussion of gender, migration and food, Dyck and Dossa (2007) argued that women generally emphasised the importance of fresh ingredients and that food was an important element in negotiations of cultural belonging. Moreover, there have been suggestions that middle-class mothers place more emphasis on healthy eating and are less permissive of offspring's preferences (Hupkens et al. 2000). These observations regarding the gendering and classing of food practices were partially reflected in discussions with the young people with whom I worked.

It is clear that the media can play a role in shaping people's food practices, especially through advertising. Thus Lang (1998) suggested that marketing and branding can change food cultures over a relatively short period and that young people are particularly influenced by these strategies. In addition, periodic food scares, for example during the 2001 Foot and Mouth outbreak, have highlighted debates about food safety and policy (Goodman 2003) and involvement of the media in these scares highlights the complex interplay between globalisation, food and health.

Alongside the advertising are marketing strategies involving the media, there was also some evidence of local marketing strategies which influenced young people's behaviour in my study area. Participants at both Hillcrest High School and Meadowcroft Community College highlighted the ways in which the attitudes of local shops towards pricing and identity checks contributed to underage drinking, and binge drinking in particular. These factors are illustrated clearly in the discussion in Box 6.12.

Box 6.12 Alcohol Pricing and Identity Checks

Amber	All them new fatty food places and like all o them things what's coming out, like sweets and stuff like that, and takeaways. More's comin out and so more people's getting them
Sophie	Alcohol
Julia	like at [name of shop]
Amber	I mean you go in the shop like and they don't even ask you for ID, check if yous the right age. If you look old enough, right
Kim	If you look 18 then you might not be 18 and they just hand it out ta you
Julia	the price as well
Amber	It eats all of your insides
Greg	I haven't got a clue
Julia	the price is like not high so you can jus buy it
Kim	Yeah, do you know what I mean, if the prices are really low then people will think, well I'll get that, I can get more for my money.

(Year 9 Group, Hillcrest)

Whilst many food products which originally emerged from other cultures have been incorporated into mainstream British food cultures, some participants had disparaging attitudes towards things like Chinese and Indian takeaways which they clearly regarded as 'other'. This was illustrated particularly well by discussions in the

Year 9 group at Meadowcroft. Participants in this group made a number of jokes about such products, and the participatory diagram they produced included reference to 'Chinki's' and 'Russians' (see Figure 6.1). As noted in Chapter 4, all of the discussions during the diagramming were recorded and the tones of voice on the recording suggested that these comments had been made in a derogatory manner. It seems that this rejection of food products which the young people could easily identify as part of another, 'non-white' culture was one aspect of the performance of their emergent white masculine identities which will be discussed more fully in Section 6.5 of this chapter. Furthermore, these discourses and performance surrounding food again resonate with issues relating to stigma and othering, which have already been discussed in relation to the work of Goffman, and to questions bout gender and performativity which relate to the work of Judith Butler. Some authors have suggested that food cultures reflect cultural histories and can contribute to the production and reproduction of whiteness. However, within Geography, the main focus has been on alternative food practices and the ways in which institutions such as farmers markets and organic vegetable boxes have created a space for the performance of middle-class white identities (Guthman 2008a; Slocum 2007). In contrast, these participants' rejection of ethnic foods appeared to be one aspect of the performance of emergent white working-class identities; especially amongst male participants. Issues surrounding the performances of gender, identity and belonging will be discussed more fully in Section 6.5 of this chapter.

Figure 6.1 'Chinkies' and 'Russians'

(Year 9 Males, Meadowcroft)

With regard to food and health, many of the participants placed a strong emphasis on diet as one of the key components of health. As Box 6.13 shows, the

Year 10 girls at Riverview placed considerable emphasis on healthy eating which was reflected in their descriptions of their own behaviours. These views were echoed by a number of other participants, particularly the older females at Meadowcroft and Abi (Year 10) at Hillcrest.

Box 6.13 Healthy Eating

NHB So what do you do yourselves?
Sarah in terms of what?
NHB Eating, exercise.
Penny I eat beans
[rustling]
Sarah An I eat eggs, an I have a diet that's low on calories n low on fat an I also do dancing twice a week n we also have PE in school don we?
Penny Yeah
Sarah Um what else, Ah out of school um I just pickin around
Penny Walkin, we walk our little cousins all the time um
Sarah Yeah
Penny We walk them around
Sarah And our dogs, so
[brief pause]
Sarah We do quite well really
[slight giggle from Penny]
(Penny and Sarah, Interview, Year 10, Riverview)

NHB So do you think that physical aspects of health such as diet and exercise are the most important?
S/P Yeah
NHB Why?
Sarah Cos that's what health is really, isn't it, what you're putting in to what yer gainin from it. If you're putting in good food you like get good health out.
Penny You canna like eat Chinese takeaways and pizza an that like everyday
Sarah You'd just run out of energy. You want a balanced diet.
Penny and not do exercise
Sarah You're gonna end up daft
Penny Obese
Sarah It's not good for your health
(Penny and Sarah, Interview, Year 10, Riverview)

It has been suggested that family eating practices and obesogenic environments may be linked and both impact upon the healthiness of individuals' diets and engagements with physical activities (Delormier et al. 2009). As Valentine (1999) notes, Western discourses about eating practices have tended to emphasise individual responsibility and issues such as self-control and this was reflected in the attitudes of many participants towards issues such as diet, as illustrated by the extracts in Box 6.14. Like Frobisher et al (2005), I found that most of the young people I worked with appeared to feel that they understood the key elements of a healthy diet, even if they did not put this into practice. The extract in Box 6.15 shows some of the negative attitudes expressed towards fast food, although it should be noted that Mike still expresses a liking of McDonald's food despite the strong views other participants expressed to the contrary. The role of McDonald's is significant because it epitomises

several aspects of the interplay between globalisation and health. It is a transnational company with a global reach, which has marketed itself as a provider of fast, convenient food. McDonalds' has come under heavy criticism for the poor nutritional value and high fat content of its food, and like other fast food outlets, is seen to be a significant factor in the 'globesity' crisis and obesogenic environments (Hemphill et al. 2008; Pearce et al. 2007). Yet, it remains a significant aspect of youth cultures, especially in regard to having space for socialisation, and is often frequented on trips into town by young people who are not yet old enough to socialise in pubs.

Box 6.14 Sport, Diet and Self-Control

NHB	what things do you think have influenced or affected your own health?
Lewis	I play sport
John	has affected, what in a good way or a bad way?
NHB	either
John	either? I dunno. Well, in a good way I do a lot of running, I do play quite a bit of sport so I keep myself quite physically fit, I go to the gym once a week - well I used to sometimes depending what kind of a mood I was in - I don't eat loads of fatty foods, I have quite a good balanced diet, I do like the occasional McDonald's, but just not enough.
[brief pause]	
John	So that probably just it.

(Year 8/11 group, Riverview)

Box 6.15 Negative Attitudes towards Fast Food

NHB	Are some places healthier than others?
Louise	Yeah cos some places have got pollution
Emily	And things like that.
NHB	What do other people think?
Penny	McDonald's.
Karl	yeah
Mike	I like McDonald's
Dawn	they're horrible
Sarah	they're rank
Karl	I don really like Macdonald's
Penny	Ah don't
Karl	I like KFC though, but that's worse for you.
Dawn	McDonald's give me food poisoning
Karl	In KFC they found a deep fried mouse, n that still taste nice.

(Year 9/10 group, Riverview)

In both of the above extracts, there is some acknowledgement that participants do partake in unhealthy options such as McDonald's even though they are aware that the food is unhealthy. In some instances, participants were less sure whether or not certain foods were healthy and, for example, the Year 9 Meadowcroft group engaged in a relatively heated debate about the status of pizzas. For many participants, the

consumption of things like crisps, keks[37] and chocolate appeared to be a pleasure-fulfilling activity, a way of relieving boredom, or a means of obtaining comfort, and this is illustrated by the extract in Box 6.16. A number of groups at Hillcrest and Meadowcroft also suggested that bullying and depression encouraged comfort eating.

Box 6.16 'Keks'

NHB	Do you think you're healthy?
Karl	Yes
Louise	No
Sarah	kind of
Penny	sometimes
[laughter]	
NHB	So what do you think stops you being healthy?
Dawn	All the keks
[laughter]	
NHB	what do people think kind of stops them being healthy or makes them less healthy than they might be?
Karl	Uhm keks.
Simon	When Ah'm bored I just kind of feel like eating because it's free.
Penny	comfort eating.

(Year 9/10 group, Riverview)

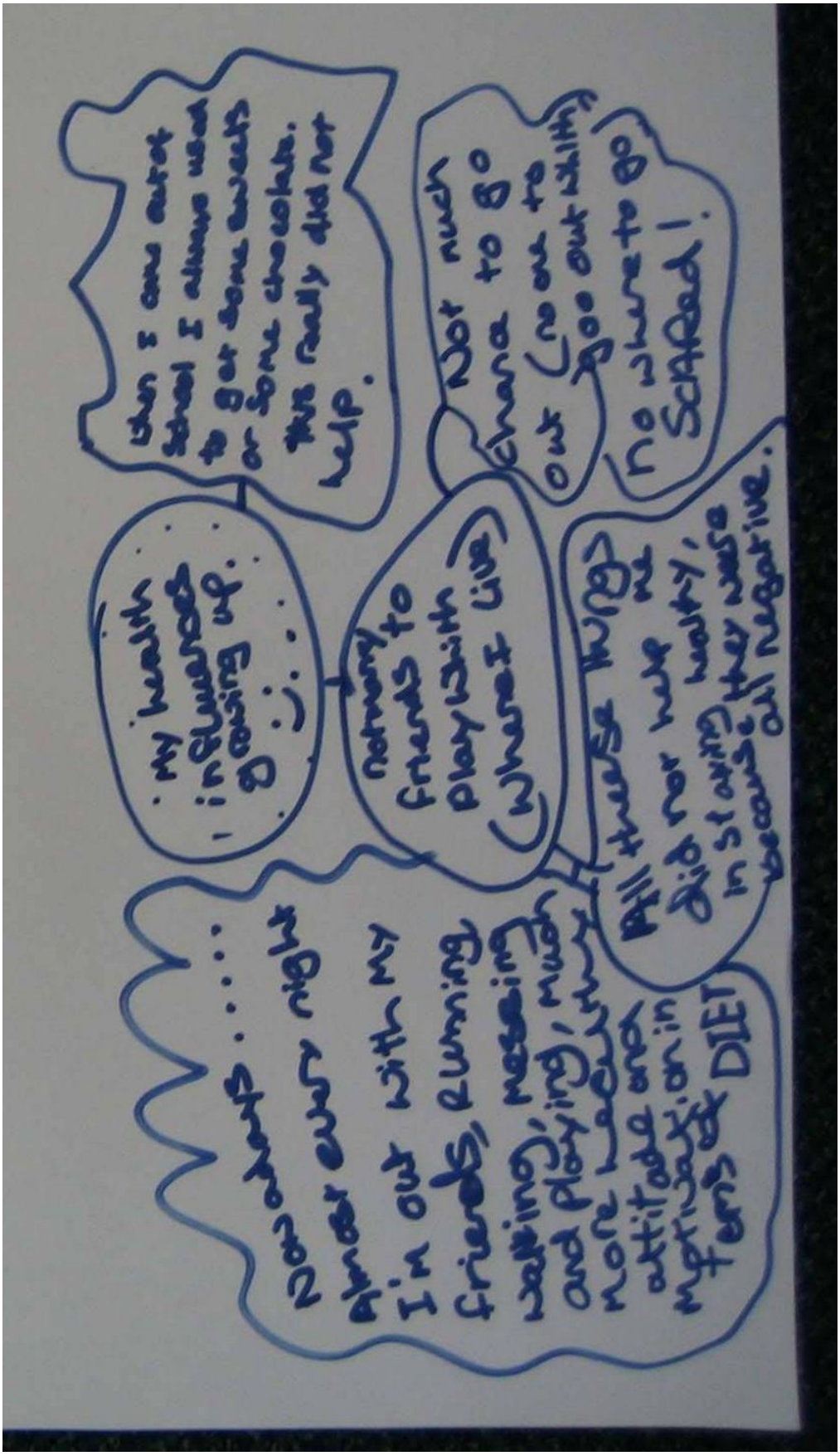
The idea that parents, and in particular mothers, can be an important source of health-related information is highlighted by Ackard and Neumark-Sztainer (2001) who suggest that this is particularly pertinent to the discussion of potentially embarrassing or sensitive issues. Furthermore, Eldridge and Murcott (2000) have discussed the impact of parental influence upon young people's eating practices and suggest that parental influence is complexly interwoven with young people's desire for independence and bids for autonomy. Many of the groups I worked with engaged in extensive discussion around family eating practices and the extent to which they were able to dictate what they ate. Whilst some participants, especially those in younger year groups, appeared to have little control over the food they ate at home, many played an active role in negotiating family eating practices and a number of Hillcrest participants talked about the ways in which they had been teaching their families about healthy eating. This discussion of eating practices demonstrates some examples of the ways in which young people are able to display their agency, for example through choices about what they eat or through the education of other family members, but also acknowledges that such agency may also be bounded, for example in the instances where participants where unable to influence family eating practices. Furthermore, it is impossible to separate young people's active attempts to influence family eating practices, which might be viewed as an enactment of their agency, from the impact of

[37] 'Keks' was a local term used by the vast majority of participants to refer to sweets or candy, but not chocolate.

power, discourse and knowledges deployed in and through mechanisms such as the school PSHE curriculum and health education or promotion campaigns and strategies.

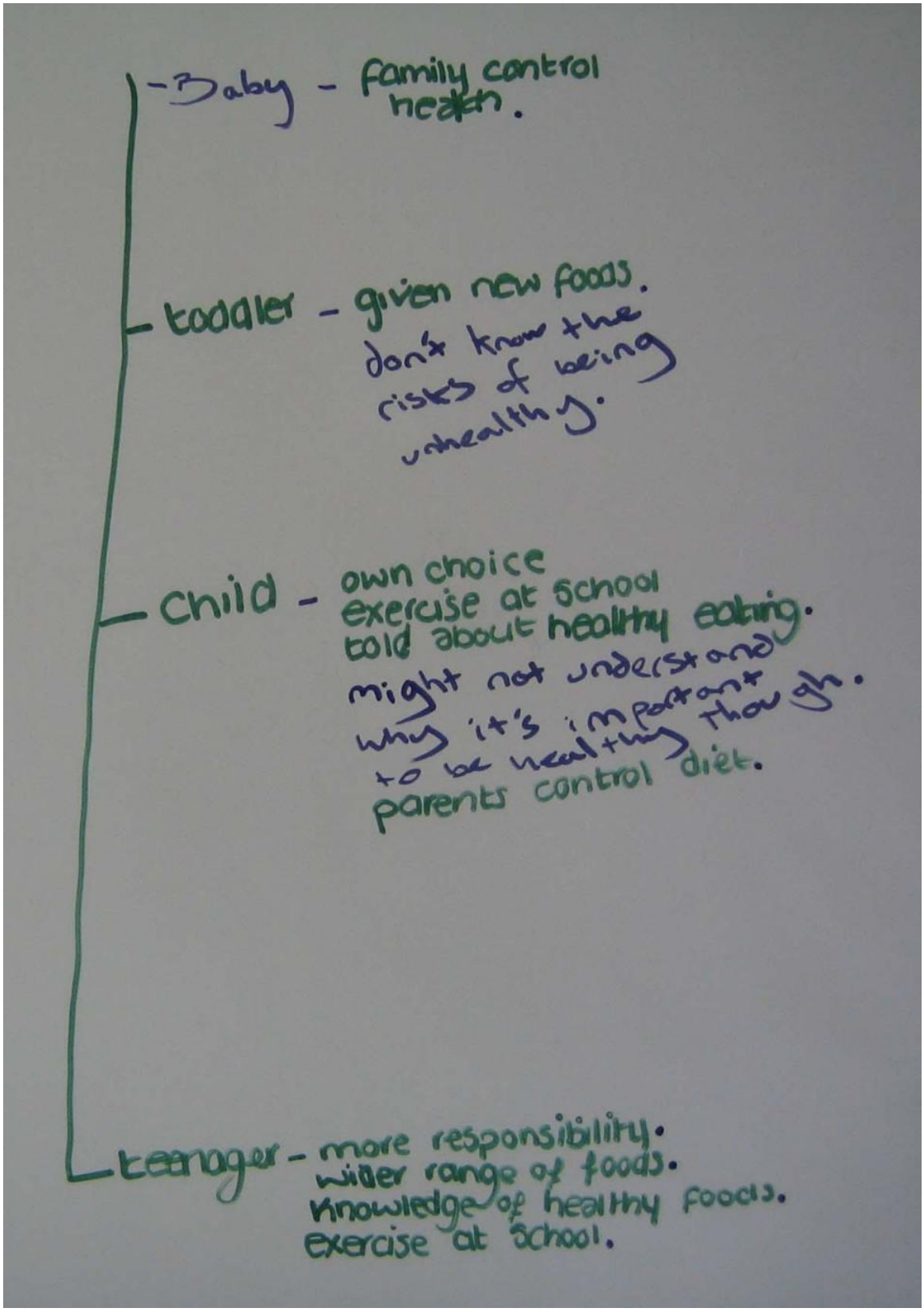
Figure 6.2 shows a diagram produced by Craig (Year 8, Meadowcroft) during an interview. His narrative weaves together issues relating to control and autonomy and the influence of family, friends and other people on his health and food practices. He describes how, when he was at primary school, he used to go to the village shop after school and that the things he bought there (sweets or chocolate) did not help his health. He also describes how his village is spread out along a hill and that whilst he lived at the top of the hill, all the other children lived at the bottom, which meant that there was nobody to play with where he lived because, when he was at primary school, he was not allowed to go down the hill on his own. His friends did not like to come up the hill because this meant going past the recreation ground, which they were scared of due to the behaviour of older groups of young people; and, besides this, the only place they could go was the recreation ground of which they were scared. Craig contrasts this with his current situation, following the arrival of a new family near his house and the fact that since starting Year 8 his parents have given him more freedom. He says that now he is out almost every night, that he has a healthier attitude and that this has given him more motivation with his diet. Furthermore, a number of participants highlighted a transition which had been between their health and diet being controlled by others when they were younger and the increased autonomy which many of them now had. This transition, and an associated increase in understanding about healthy eating and exercise, is shown on the timeline in Figure 6.3.

Figure 6.2 Craig's Narrative



(Craig, Year 8, Meadowcroft)

Figure 6.3 Health Behaviours and Autonomy: Dave, Luke and Nick's Narrative



(Interview with Dave, Luke and Nick, Year 10, Meadowcroft)

Another issue which participants emphasised was the impact of school policies and initiatives. There have been suggestions that school policies and the built environment of a school can create obesogenic environments (Carter and Swinburn

2004) and, whilst I would not suggest that the schools involved in this research were obesogenic, it was clear that some aspects of the schools' practices and initiatives served to discourage some young people from healthy eating. One of the schools (Riverview) had attained Healthy Schools Status and the other schools were seeking accreditation. As part of this, all three schools had recently changed their menus for school meals and this trend is illustrated by the extracts in Box 6.17.

Box 6.17 Changes to School Meals

Dawn	Our school right we used to have chips and like
Penny	big chips
Dawn	like everythin and
Mike	they were nice
Penny	Yeah
Sarah	they were nice
Dawn	Yeah, listen. Then one day we came back ta school and everything was gone an we had like potato
Penny	We were in the paper this week
Dawn	and cabbage
Sarah	We were in the paper this week for being like the most healthiest school.
Dawn	But that isn't good
Mike	On 'Ready, steady, cook' it is[38]
Sarah	No just about all the food that were eating like they changed all the fats
Dawn	They should have like,
Penny	Acted on what people wanted
Dawn	should have like minimised it instead of like cuttin it all out.

(Year 9/10 group, Riverview)

Jess	At school they push health as well don they, so that influences what you think, they take chips off at the dinner hall, don't they like a few days a week
Lucy	n take the salt out
Jess	an the salt and like there's load of like healthy things
NHB	Did that change this year?
Jess	Yeah
Emma	Wha last year wasn it?
Mark	Yeah an last year wunt it?
Jess	Yes, an it's even more like this year to what it was, so
Lucy	Um
Clare	um
NHB	Do you think that makes much of a difference or not?
Emma	Not really cos people are jus going to go home and like
Jess	no
Mark	Aye they jus go ta their houses
Emma	and just go home
Clare	an get whatever they want
NHB	So is there a lot of people who go home for lunch?
Emma	It increased a lot didn't it like when that started
Clare	but they don't do chips n that cos
Jess	they do once a week
Clare	yeah it's chips once a week, but they still do curly chips n that because they're not really chips or something they jus
Emma	and wedges as well
Lucy	Yeah and wedges
Clare	because they're not chips [half laughs]

(Year 11 group, Meadowcroft)

[38] Ready, steady, cook is a popular TV programme.

It was clear from the group discussions and interviews that there was considerable resentment towards the new school menus, and this is highlighted by the discussions in Box 6.18. The issue of school meals was particularly heated in the Hillcrest groups. Here, the young people were annoyed about the high cost of healthy options, which many of them could not afford. They also resented the contradictory messages which they felt the school was giving through its emphasis on healthy eating and failure to ensure that this was a viable option for students.

Box 6.18 Resentment towards School Meals

NHB And so for things like school meals, we've already talked about them a bit, do you think it's up to you to decide rather than for the school to
Penny Well yeah, but sometimes there's nothing there that you like and so you end up starving yourself all day
NHB So you don't think the school should be trying to impose its healthy stuff on you, or do you?
Sarah Well they can put the healthy stuff in as long as they make it right really, um how we like it, umm I mean they're obsessed with peppers, I swear know they put it in the pasta n everythin you come across, peppers, pepper bloomin lasagne-y stuff n quiche and pasta and it's all plastered in pepper. They jus
Penny put pepper in everythin
Sarah load everythin together n they haven't really much idea.
NHB Peppers aren't even particularly cheap.
Penny They're just horrible
Sarah I like pick all the peppers out but it all just has that horrible peppery taste.
(Penny and Sarah, Interview, Year 10, Riverview)

Rachel In the dinner hall they have like all the food and it's like dear an that.
Jason The hall's starving us so that we like go for the cheap stuff
Helen Salad
Daniel Yeah that's actually true because like a healthy sandwich which has like one lettuce n all that, £1.75, but then a pizza or sumthin is like
Helen 90p
Daniel a quid or something.
Jade No, it's 90 [pence]
Jason And a hotdog £1.50
Daniel A hotdog like that big [demonstrates] is like £1.50 but then a nice sandwich which is healthier for you is dearer.
Niall And a burger is 65 pence
Jason and the drinks are like 80 pence and I don't think that's right
Daniel and a bacon sandwich
Grace If you want a bottle of water you have to pay 80 pence for it.
[further discussion]
Jason And if the school acts so like it's brilliant, then why doesn't it actually be brilliant.
(Year 8 group, Hillcrest)

There was some evidence of a subversion of school initiatives by young people, which was either deliberate or indirect, and this resonates with the discussion in Section 3.5 of Chapter 3 where I explored ways in which Foucault's work on power, discipline and gaze also incorporates scope for power and discipline to be challenged or resisted. For example, as highlighted in Box 6.19, Penny and Sarah discussed how many of them liked to spend time outside during the lunch break and the ways in which this, combined with a general dislike of the food available, meant that students found

ways of evading the school's healthy eating initiative. At Hillcrest, the size of the dinner hall meant that those having school meals were separated from those who brought packed lunches. This separation of friendship groups, combined with the prohibitive cost of the food in the school, meant that many of the Year 10 and 11 students went into the town centre for lunch. At Meadowcroft, participants indicated that many of the students who lived in the village where the school was situated had passes to go home for lunch and I also observed a significant number of students procuring food from a local chip shop during the lunch break.

Box 6.19 Subversion of School Policies

Sarah The school's tryin to like do the healthy foods and that but
Penny It's horrible
Sarah Yeah it's not that nice n they're making a poor job of it
[pause]
[giggles]
NHB Do most people eat here or do they go home?
Penny Um no, most people sneak down [*name of village where school is located*]
Sarah Um well there's a few groups what sneak down [*name of village where school is located*] and there's some people with passes so you're allowed to go down n then a lot of people do eat here but they um get things like to take with them because you're not allowed to eat outside
Penny Ahum
Sarah like so they just get things that you can shove in your bag so the teachers can't see so like sandwiches and all that so instead of like getting a cooked meal and veg and like proper food they just get hotdogs
Penny Or sandwiches or pasta pots or things like that.
NHB Do a lot bring packed lunches?
Sarah I don't really know, there's
Penny A few people do
Sarah yeah
Penny The younger ones, the younger ones just bring sandwiches n stuff like that
Sarah Yeah, the younger ones tend to bring a packed lunch.
[interruption]
Penny Yeah and I think they should, like year 10s and 11s should be allowed to go down because like we're mature n like we always come back to school.
Sarah We've been here like four year, just getting the same foods all the time because they like serve it up every week and if you don't like anything else then you're just eating the same rubbish.
Penny Umm.
[pause]
NHB Well what do you think, um what do you think practically they could do differently?
Sarah Get a better chef.
[Penny laughs in agreement]
Penny Have more variety
Sarah Yeah.
Penny It's horrible food.
(Penny and Sarah, Interview, Year 10, Riverview)

It is important to recognise that food practices and the performances of identity they are associated with can be influenced by the power dynamics and discourses surrounding food; which are, in turn, shaped by the cognitive and cultural aspects of globalisation. Thus, Hayes-Conroy and Hayes-Conroy (2008) argue that power and knowledge can play a significant role in shaping food practices and associated beliefs. Supermarkets and advertising – both of which are features of globalisation and increased digital and technological connectivity – can also influence the discourses surrounding food, and this was acknowledged by a number of the young people I worked with. At the same time, Hayes-Conroy and Hayes-Conroy (2008) also suggest that local and lay knowledges can play a role in the evolution of food practices, especially in rural areas. In the next section I will explore the interplay between local cultures, young people's identities and health beliefs and behaviours. This will include some discussion of the operation of power and discourse and the ways in which 'local' practices simultaneously scope as 'global'.

6.5 Local Cultures and Young People's Health: County Durham Today

This section will discuss ways in which local social and cultural norms have impacted upon young people's health beliefs, attitudes and behaviours, with particular reference to my study area. Drawing upon both academic literature and examples from fieldwork data, I will explore issues relating to power, performance and identity. This will include a significant focus on North Eastern youth identities in general, and issues such as smoking and binge-drinking.

As Wills (2008) discusses, the issue of social class has generally not been prioritised within Human Geography, even during the height of Marxist geography, despite some interest in labour market and economic issues. Although social class often appears to be a 'taboo' subject within Human Geography, possibly due to assumed associations with structuralism and structuration theory, class identities are apparent in many sections of youth culture. Just as Nayak (2003a, 2003b, 2003c) found with his work in Newcastle-upon-Tyne, I encountered a number of performances of white working-class youth identities and some of these appeared to have implications for the performance of some participants' health beliefs and behaviours.

In her discussion of Geography and 'New Working Class Studies', Stenning suggests that:

> "At the heart of the new working class studies is geography – a recognition of the mutual constitution of class and place through the everyday and more extraordinary events of working class lives…Working classness is placed. It is performed and constructed within communities and, in turn, shapes the spaces of community, economy, politics and much more. It is often within the spaces of community – local and not so local – and the spatial practices of work and life that subjectivities and materialities intersect. Practices, strategic or otherwise, enacted within homes, workplaces, communities and the myriad other spaces of everyday life reflect the articulation of gender, generation and race, in particular, and the employment of resources – economic, social, cultural; tangible and embodied – in the negotiation of economic, political and social lives" (Stenning 2008: 10).

Whilst Stenning focuses her argument upon working-class sections of society, the observations made about the mutual constitution of place and class, and the shaping, construction and performance of communities and practices, are also applicable to other sections of the population including middle class neighbourhoods. The communities, identities and practices which emerge may differ, both within and between 'classes' and neighbourhoods, but they still evolve through a complex interweaving of place, space, norms, expectations and performed identities. This complexity is also highlighted by McDowell who criticises the ungendered nature of many class studies and seeks to promote scholarship which "sees class through the lens of gender and race relations, that constructs class not as categorical positions but as active, ongoing and negotiable sets of practices that vary across time and space…" (McDowell 2008: 21).

In his discussion of white hip hop culture in Newcastle-upon-Tyne, Bennett (1999) highlights a blending of global and local similar to that discussed here. Whilst hip hop culture originated as part of New York's Afro-American culture, it formed a small but significant white working-class subculture in the areas discussed by Bennett. Referring specifically to Newcastle-upon-Tyne, Bennett suggests that "the localisation of hip hop, rather than being a smooth and consensual transition, is fraught with tensions and contradictions as young people attempt to reconcile issues of musical and stylistic authenticity with those of locality, identity and everyday life" (Bennett 1999: 6). Another significant theme which Bennett touches on, but does not discuss in detail, is the ways in which other people in the area respond to youth identities which are seen to differ or deviate from those which are dominant in a given area. This theme will be explored later in this section.

The performances of identity which were observed in the Year 9 Meadowcroft and Year 8 Hillcrest groups centred around aspects of the local white working-class identities; and included extensive discussion of issues such as sexuality and pregnancy in an identity exploring manner, as the young people explored boundaries and grappled with their emergent adolescent identities. With the exception of Rachel at Hillcrest,

most of the sexual banter and innuendo came from male participants. This fits with Haywood and Mac an Ghaill's observation that the development of young male identities is bound up with an exploration and rejection of other forms of sexuality, and associated characteristics such as femininity, and that "in structuring the attributes of maleness, the various forms of masculinity which are hegemonic in English schools can all be argued to be crucially involved in policing the boundaries of heterosexuality as much as the boundaries of 'proper' masculinity" (Haywood and Mac an Ghaill 2003: 78; see also Connell 2000).

Amongst some young people, it appeared that involvement in sport and other physical activity was a key element in their emergent identities. In a study undertaken by Bromnick and Swallow at a North of England comprehensive school, sporting success was the second most common response when young people were asked about the best thing that could happen to them – with winning the lottery the most common response (Bromnick and Swallow 2001). The importance of sport, and football in particular, for many North East identities has been discussed extensively by Taylor who argues that:

> "The working man's belief in the strength and skill of his own type has been given popular expression in a sporting hero with whom he can identify…The creation of a particular type of sporting hero, representing male skills and male interests, has been consistent with the region's labour tradition." (Taylor 1992: 128).

Nayak (2003b) argues that, in the post-industrial era, Geordie identities were being refashioned around activities relating to football and going out drinking and, whilst the young people I worked with were not Geordies, these were still important aspects of their identities, especially among male participants. Whilst the research participants did not engage in the hegemonic support of Newcastle United football club, as described by Taylor (1992) and Nayak (2003b), items of football memorabilia such as pencil cases were observed in relation to a number of North Eastern and northern Premier League teams; notably Sunderland, Middlesbrough, Manchester United and Liverpool.

Football offers a good example of the ways in which global and local intertwine in the construction of youth identities. Like many sports, football has been heavily affected by globalisation. For example, despite the strong Youth Football Academy set up at Middlesbrough and Darlington football clubs, few of the football players in the regular first teams were local and many came from other countries. In addition, football is heavily involved in global media and TV broadcasting and branding – with Newcastle United in particular being keen to promote itself as a 'global brand'. Yet, for many young people in my study area, and the North East as a whole, the support of the globalised local football team was an important aspect of their 'local' identity.

As was noted in Chapter 5, alcohol consumption and smoking were significant activities amongst some groups of young people, and this is illustrated by the extract in Box 6.20. It is well recognised that tobacco smoking and excessive alcohol consumption are a noteworthy characteristic of many male, white working-class identities and are sometimes considered to be ingrained behaviours in many working-class cultures and communities (Amos and Bostock 2007; Haines et al. 2009; Hunt et al. 2004; Wiltshire et al. 2005). However, there have been suggestions that higher levels of smoking and alcohol consumption among young females are a more recent phenomenon and that these have now overtaken the rates for males in some groups (Amos and Bostock 2007; Sweeting and West 2003). Whilst the cross-sectional nature of my data makes it impossible to comment on longer-term trends in my study area, it is clear that all three schools had a higher prevalence of smoking among females than males. This pattern was particularly marked among students attending Meadowcroft Community College where 30% of female students who responded to the questionnaire survey said that they smoked regularly compared to 11% of males. Existing literature has suggested that children whose parents smoke are more likely to becomes smokers themselves and that those living in deprived neighbourhoods are likely to find it harder to quit smoking (see, for example, Copeland 2003).

Box 6.20 Smoking and Drinking

NHB	What do you think are the main risks and barriers to health for people your age?
Isabel	smoking
Ruth	smoking
Will	smoking
Dave	drugs
Ruth	It's like a thing at our age, you have to drink, you have to drink, you have to drink a lot
Luke	No you don't
Isabel	You know what it's like, if all yas mates does and then they think ah but she din't
Will	If they did then I'd just walk away from it and get around it.
Dave	Yeah

(Year 10 group, Meadowcroft)

The majority of participants involved in the discussion groups and interviews said that they did not smoke, although many admitted to alcohol consumption. When asked why they didn't smoke, many of the participants offered fairly graphic accounts of the damage smoking could do. As the extract in Box 6.21 highlights, these accounts often blended the reasons given in health promotion strategies and the PSHE curriculum with less standard ideas – in this instance the notion of yellow hair. Many of the young people who did smoke and drink alcohol were clearly aware of the risks as illustrated in Figure 6.4 which shows an extract from the diagram produced by the Year 9 males at Meadowcroft, all of whom reported that they smoked and engaged in alcohol consumption. In contrast to Sigelman et al (2000), the young people I worked

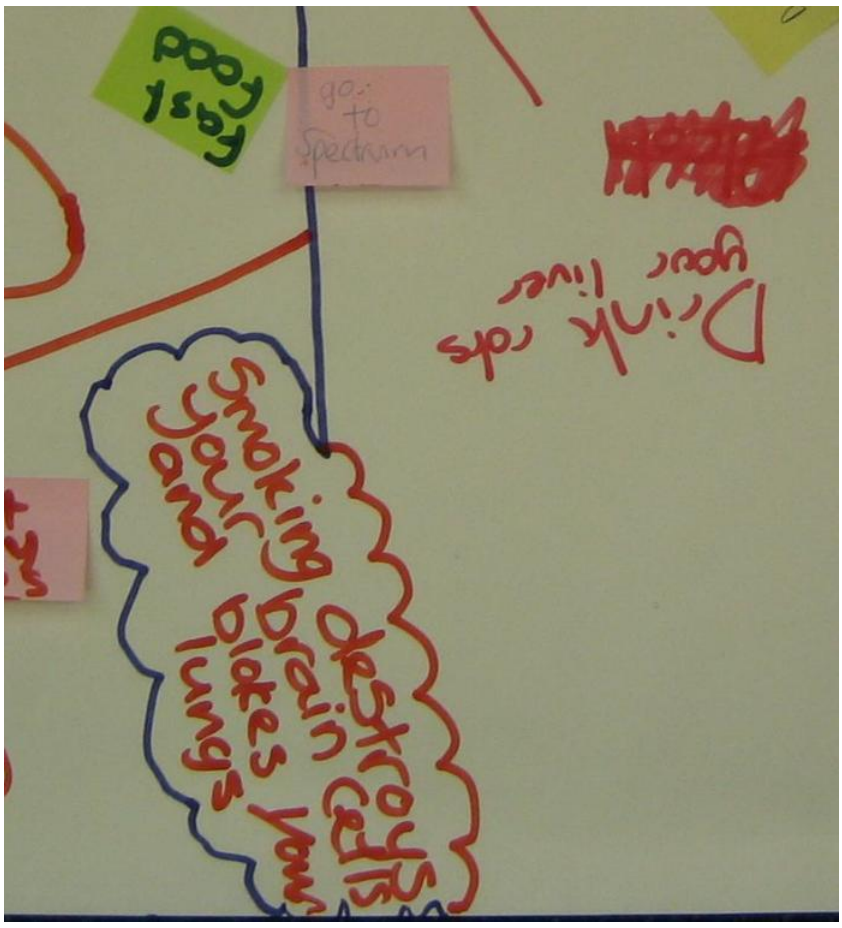
with were very aware of the long-term health problems such as liver damage which could arise from alcohol consumption, as well as the shorter term impacts which such behaviours could have.

Box 6.21 Reasons for not Smoking

NHB	okay... So, why don't you [smoke]?
James	Why don't we what?
Lizzie	Cos it's stu
Louise	It's stupid.
Steven	It's stupid
Louise	It damages your health
Craig	seriously
Katie	You get addicted
Steven	It will kill you faster, no point, gives you yellow hair, gives you yellow teeth, makes your lungs.
Craig	Yellow hair?
Louise	Yellow hair?
Katie	Yellow hair?
[laughter]	

(Year 8 group, Meadowcroft)

Figure 6.4 Impacts of Alcohol and Smoking



(Year 9 Males, Meadowcroft)

The non-smokers in the groups I worked with generally had very clear ideas regarding the reasons why many of their peers did smoke and consume alcohol. Although an aspect of 'local' culture, smoking is also a globalised phenomenon which is associated with large multinational companies and advertising and marketing strategies. Whilst, in the UK, tobacco advertising has been banned on the TV, young people are still able to access images of smoking through the TV and media and these images can offer an indirect advertisement for the activity. As the quotes in Box 6.22 show, issues relating to image and identity were important influences on smoking behaviours, and a desire to be happy or popular was often cited as a reason for young people to start smoking or drinking. Existing literature has suggested that smoking may be seen as an aid to social relations (Wiltshire et al. 2005) and can act as a mechanism in defining social groups (Stewart-Knox et al. 2005). Smoking is an important vehicle in young people's self-definition and negotiation of identity, especially among females, rather than a simple act of experimentation or rebellion (Haines et al. 2009). In the case of drinking, a perceived lack of alternative activities was also influential, especially for some of the Hillcrest participants, as highlighted by Rachel in Box 6.23.

Box 6.22 Suggested Reasons for Peer's Smoking and Drinking

NHB so why do other people do it?
Louise to look cool
Cathi yeah
Craig to follow their friends
Lizzie yeah
James that's peer pressure
NHB So what do you think's the difference between you in terms of you not doing it, how you manage not to get influenced by it and the others do?
Katie Cos like other people might give into their friends more, like even if
Lizzie they care more about their friends than the school
Katie Ah don't know, some people might
Louise They care more about being popular with their friends than school
Lizzie they just do it to look cool and we can kind of, can see past that, it's not cool at all, it's just stupid.
Craig Everybody thinks it's just a few years and it's like 40 years away
Lizzie they say it's just out of stress, but
Craig It'll affect you, but yous could just keel over next week
Louise An then you get addicted and then you can't stop
James It'll kill you
NHB So do you think that the only difference is that they want to be kind of in the popular group or do you think there's other differences as well?
Katie Mostly cos they want to be popular
Lizzie Maybe like their parents do it and they don't really care
Louise I dunno
Lizzie and so they think it's okay for them to do it
Louise Cos some people
Lizzie i know some people, people that
Louise I know some people like that, like their parents actually let them
Craig and their parents they give them cigarettes and stuff and then they don't think it's wrong because of that.
James that's stupid.
(Year 8 group, Meadowcroft)

NHB So why do other people?
Isabel Cos they can, that's why
Luke Cos their friends do
Ruth Some people drink, smoke because it's there, they don't do it because
Dave They get it like over and done with
Nick Some people think they do it to look cool, but they don't, they look hard
Will they drink to make themselves happy, if they're unhappy some people do it to make them happy
(Year 10 group, Meadowcroft)

Box 6.23 'Hanging Around' Streets

Rachel Teenagers now all wes do is hang around the streets and we can't do nothing else than hang around the street smoking drinkin n that because there's nothing else for us to do
Daniel they should
Jason Most of us want attention, that's why we do it.
Niall They should make a house right where you're allowed to smash everythin in it. That would be fun.
Jason Yeah right you know when you're like sayin there's the only place you can go is like on the street and you get wronged off the police for knockin about on the street.
Year 8 group, Hillcrest

Some authors have suggested that smoking is an important aspect of young femininities in areas where educational attainment carries little prestige (see, for

example, Archer et al. 2007b; Plumridge et al. 2002; Rugkasa et al. 2003). However, whilst Archer et al (2007a) argue that a disengagement from education is often a characteristic of heterosexual working-class femininities, few of the young females I worked with fitted this mould. Whilst the culture in my study area had traditionally attached little importance to education, the vast majority of female participants I worked with appeared keen to do well at school and many had clear plans for further education. Thus it seems likely that the association between femininities and smoking was imbedded in local cultures rather than being an artefact of low educational aspirations. As the extracts in Box 6.24 show, this view is supported by the ways in which many groups described the peer pressure surrounding smoking and alcohol consumption, and the problems which some young people encountered in standing up to such pressure.

Box 6.24 Peer Pressure, Smoking and Alcohol Consumption

NHB	Do you think that there's things you can do about like the things you've said are bad, or not?
Dawn	no.
Sarah	not really
NHB	What about peer pressure, is there anything you can do about that?
Penny	not really
Emily	No
Karen	No
Sarah	Ignore it
Dawn	you can't really
NHB	I was going to say can you ignore it?
Dawn	not really
Louise	no
Sarah	Rise above it
Karl	depends how strong your willpower is
Simon	yeah it does
Karl	like if you really like something an your friend's like peer pressurin you ta do summat else then you say 'no Ah don't want to do it'

(year 9/10 group, Riverview)

Dean	pressure
Greg	Peer pressure
NHB	In what way?
Greg	Well someone tells ya to do summat and you're scared so you do it.
Jacob	That's bullying really
Shane	Or everyone else is doing it
Dean	Fast food
NHB	okay, so hang on, you
Amber	Everyone else does it so say like loads of people
Kim	Smoke
Amber	like loads of people smoke and
Kim	to look hard
Amber	and like you're the only one the only person that doesn't and then everyone says like oh ah just go on
Julia	just have one like
Amber	just have one and so and then like you have one and you could get addicted, so.

(Year 9 group, Hillcrest)

In his discussion of actor-networks and young people's alcohol consumption, Demant (2009) suggests that networks shape young people's agency in a variety of ways. He also notes that drinking can constitute a mechanism for gaining control and agency and states that "Alcohol can, in a bewitching way, destablilize [sic] one form of agency (the virtuous girl) and in this way make way for another form of agency by transforming the network" (Demant 2009: 42). Demant also argues that young women's bodies are produced as sexualised objects in relation to alcohol and that an exploration of the complexity surrounding the ways young people become drinkers needs to consider the relationship between alcohol, bodies, normative expectations and materiality. It is clear that, in the work undertaken for this thesis, young people's (non)-engagement with smoking and alcohol consumption was governed by a complex and fluid mixture of individual action or agency, peer group identities and expectations, social and cultural norms and practices and the social, cultural and structural environments in which the young people were situated. Such processes and practices operate in multiple and juxtaposed ways, and cannot be fully separated into discrete spaces or scales.

Jess, at Meadowcroft, was unusual in that she had begun smoking in Year 8, along with many of her classmates, and then successfully quit 18 months later. In Jess's case, the desire to quit smoking came from a realisation that it didn't meet the expectations she had previously had; rather than her decision being shaped through social and cultural expectations or discourses in the media. Furthermore, as highlighted in Box 6.25, she disliked the effects of smoking such as the smell. This extract also highlights the influence of the GCSE Health and Social Care course which Clare and Emma were taking – a theme echoed by Sarah and Penny at Riverview. Whilst Jess's decision to stop smoking was, at least superficially, an active decision which displays her agency, it is still questionable whether it can be attributed to agency alone, or whether her agency has been bounded and the decision influenced (either consciously or subconsciously) by the discourses and panopticism associated with school health education. In addition, although Jess articulates the view that her initial smoking was not related to peer pressure, it is also possible that her subsequent decision to stop smoking was a subconscious form of resistance to peer pressure and the power associated with it.

Box 6.25 Smoking Cessation: Jess's Narrative

NHB	You seem to have done something interesting in terms of gone with the peer pressure an then gone against it?
Jess	Um. It wasnae really peer pressure either it was jus kinda to know wha it was
Clare	What it was like
Jess	like, yeah and it wasn't really all it was cracked up ta be.
Clare	Um.
NHB	Did you do the same?
Clare	Ah've tried it n it's, horrible
Jess	Yeah
Clare	I've tried it, yeah, but like I think it's like it's your skin goes spotty
Jess	an it smells like smoke which puts me off
Clare	An it's like, I dunno, I reckon half the peoples smokes just ta make themselves look good
Jess	Look good, to look hard.
Clare	Yeah to look hard, but it's like what ya have to realise is it's not goin ta make you look any better.
NHB	So what do you think it is which has allowed you to look at it this way and not them?
Clare	Ah do health and social
NHB	You do health and social?
Clare	Yeah
Emma	Yeah
Jess	I don't
Lucy	No

(Year 11 group, Meadowcroft)

As noted earlier, bullying was a significant theme at both Hillcrest and Meadowcroft, and this was often discussed in relation to peer pressure. In general, participants felt that there was little they could do about bullying. As illustrated by the discussions in Box 6.26, female participants tended to favour talking to friends as a strategy for coping with bullying whereas some of the male participants favoured more confrontational methods. Fighting was an issue which came up among the older male participants as a means for dealing with disputes (see Pellegrini 2003 for wider discussion of related issues). The Year 11 males at both Meadowcroft and Riverview cited fighting as a key risk to their health, and existing literature has suggested that physical fighting is an element of masculinity which impacts on male health over and above the influence of the socio-economic and cultural factors which sometimes shape such behaviour (Mahalik et al. 2007). It is likely that this emphasis on fighting was one mechanism through which these males explored and negotiated their emergent identities, and existing literature suggests that fighting and violence are often considered to be an aspect of white working-class male identities (Bosson et al. 2009; Nayak 2003c; Pellegrini 2003; Robertson 2003). In the work undertaken for my Master's, issues such as fighting were part of the mechanisms deployed by young people to promote their own status and ontological security through the othering or stigmatisation of different members of their peer group (see discussion in Beale

2010)[39]. However, it is not clear whether this also applies to the young people I worked with during the research undertaken for this thesis. Whilst, during my Master's work, fighting was a method used to manage or resist other young people whom participant's viewed unfavourably and considered to be different to themselves, in this PhD work participants talked about fighting as a mechanism for settling disputes. The extent to which these two ideas might be synonymous is not clear.

Box 6.26 Bullying and Coping Mechanisms

Jess	If it happens to you ya cannae do anything about it really. Well we cannot anyway
NHB	What kind of things?
Jess	Like if you're being bullied then you canna stop yourself being bullied really, an peer pressure, you canna stop people tellin ya ta do things
Clare	yeah
Jess	so
NHB	But are there people who you can approach about that kind of thing, and does that make any difference?
Emma	There are here, but like I wouldna talk to anyone in school
Jess	Ah'd tell friends
Emma	But no I wouldn't tell here, at least I don't think I would
Jess	Na.
Emma	unless it got that bad
Clare	I don't know
Emma	I mean it's never got that bad so I don't know
Lucy	na
Emma	I don't think I would.
NHB	so do you just kind of have a small group of friend that you would
Jess	We have different friends, cos like you knock about with them in school don ya, and then we're kindy like all friends really, I mean that not like definite
Emma	I don't think there's much bully in our year really
Lucy	Na
Jess	No not in our year, but like in the younger years I think there's like
Clare	Cos some of them think they're good and some of them jus
[brief pause]	
NHB	And what about you, Mark, is it different for kind of blokes?
Mark	No it's just the same really
NHB	cos you were talking about like there being more fighting?
Mark	Well that's just the way we sort stuff in't it.
NHB	yeah?
Mark	Ah mean they jus bitch abaat each other and we jus fight.
(Year 11 group, Meadowcroft)	
NHB	What about you, Mark, what do you think are the main risks and barriers for people your age?
Mark	Jus the smokin, drugs n sex
NHB	So do you think it's the same for you as it is for the lasses?
Mark	Aye, but we fight a lot more
NHB	You fight a lot more?
Mark	Uhum
NHB	So what do you think is significant about that?
Mark	I dunno it just knacks your health, dun it?
(Year 11 group, Meadowcroft)	

[39] It should be noted that although this material comes from the fieldwork which was associated with my Master's degree, the ideas and material were not included in my Master's dissertation or in any other work previously submitted for examination, and from a conceptual point of view this material was developed during the first 18 months of my PhD.

Whilst the vast majority of participants came from white English backgrounds, there was a small but significant Irish travelling community, especially in the Bishop Auckland Area. Three of the participants at Hillcrest (Niall, in Year 8, and Bernadette and Erin, in Year 10) were open about their membership of this community and were not afraid to articulate views which went against those expressed by other participants. Counter to the rest of their group, Bernadette and Erin did not attach any real importance to physical aspects of health or to issues such as diet. There have been suggestions that members of travelling communities in the UK have poorer health outcomes than those from white British backgrounds and other ethnic minorities (Peters et al. 2009) and that those from travelling communities often have very negative experiences of encounters with health services (Van Cleemput 2000). It has been suggested that there is a tendency among male members of travelling communities to boast about conquests and place an emphasis on survival (Levinson and Sparkes 2003) and this was evident in some of Niall's accounts of activities such as stealing eggs to eat from nests in trees.

In their discussion of adolescent males and schooling, Haywood and Mac an Ghaill (2003) suggest that in order to understand young males' identity formation an inclusive account is needed of the multiple forms of social power and the dynamics of this within different institutional settings – and, like Nayak and Kehily (2008), I believe that the same also applies to femininities. The expressions of masculinity, femininity and identity I encountered were varied, but there was a tendency for some groups to present a more hegemonic image which varied between groups and, in particular, between different areas of residence. The identities presented by many of the Riverview participants were closer to resembling middle-class stereotypes of educated and health enhancing behaviour, and a number of participants here contrasted themselves against perceived deficiencies of those living in Bishop Auckland[40].

In the work undertaken for my Master's[41], which involved young people in a different area of County Durham, some participants had displayed a marked enactment of white working-class masculinities, similar to the 'Geordie'[42] masculinities discussed by Nayak (2003a, 2003b). For these young people, the maintenance of a 'macho' or 'hard' image had been an essential survival strategy in an environment where physical and emotional bullying was commonplace and this gave the young people a 'status' in

[40] These comparisons were offered spontaneously without me making any references to the town.

[41] This material again has not previously been submitted for examination. From a conceptual point of view, this material was developed alongside the theoretical framework for this PhD and, as such, cannot be fully separated from my PhD work.

[42] The term 'Geordie' refers to people from the Tyneside area of North-East England (particularly the city of Newcastle-upon-Tyne) and to their culture. This area is adjacent to County Durham and, whilst County Durham was formerly a coal-mining area and Tyneside combined this with ship-building, the two areas have similar cultures and histories.

the eyes of peers. Elements of macho behaviour had been observed among male participants in several of the sessions undertaken for my Master's fieldwork, especially in relation to risk-taking behaviours, and there was a certain kudos associated with domestic problems. Furthermore, these participants promoted their status by contrasting themselves with 'softies' or 'swots' (see Beale 2010 for discussion). Thus, in my Master's work, issues of identity and stigma appeared to underpin the cultures and practices associated with bullying and such process fitted with the work of Goffman, discussed in Chapter 3 of this thesis in relation to identity, role play, staging and stigma, and also to Foucault's work on power and discourse and Butler's work on gender and performativity. As has been discussed in this section, performances of identity have also been apparent in the research undertaken for this thesis – and this was particularly clear in the white working-class identities performed by a number of participants at Hillcrest and Meadowcroft. It should however be noted that such performances were not limited to those relating to white working-class masculinities or femininities. For example, Karl and Daniel, both of whom will be discussed in Sections 7.4 and 7.5 of Chapter 7, performed different identities; with Karl emphasising issues such as fitness and outdoor activities and Daniel contrasting his middle-class identity with those of other (non-middle-class) young people in his area.

In most instances, both during my Master's fieldwork and during the work undertaken for this thesis, the performances observed were not single, calculated or deliberate acts. Rather, they were a repetition and reiteration of practices which structured the individual peer group and local cultures and their place in wider society. Beliefs and discourses surrounding how bodies or people should look or behave were enacted by the young people I worked with in a variety of ways, as they sought to negotiate and establish their emergent identities. This process was complexly interwoven both with local social and cultural norms and with the ensuing networks of prejudice and stigmatisation. It was clear that many of the young people I worked with during my Master's fieldwork had carved out their identities along social-class and gender lines, associating primarily with other young people from a similar background to themselves, and this pattern was also apparent amongst many of the young people I worked with during my PhD research. These negotiations and performances of identity lead to the enactment of stigmas by the different groups based on the social or friendship groups individuals belonged to, or where the lived, in a similar manner to the tribal stigma discussed by Goffman (1963). Enactments of tribal stigma were an important means by which many of the young people encountered during my Master's fieldwork maintained their ontological security through constructing themselves as 'normal' and the beliefs, behaviours or appearances of different groups as 'other' and, whilst some of these issues where less clear-cut in my PhD work, it appears that these

same issues are also relevant to the work undertaken for this thesis. In turn, these processes of stigmatisation and othering served to reinforce, both positively and negatively, the different identities which the young people were developing.

Academic literature has generally focussed on specific groups or types of people who are stigmatised by wider society; even when authors are seeking to unpick or challenge such stigmatisation. Notable examples include homeless people (Cloke et al. 2000; Johnsen et al. 2005; May 2000), prostitutes and homosexuals (Scambler 2007; Vescio and Biernat 2003), HIV/AIDS sufferers (Cullinane 2007; Robertson 2007; Tempalski et al. 2007) and 'deviant' youth (Jones 2002; Kraack and Kenway 2002). In the research undertaken for my Master's it appeared there was also a more complex process of stigmatisation at the local level, through which different sections of the peer group were othered. As this section has discussed, similar trends have also been apparent in my PhD research. At Hillcrest the power dynamics surrounding social class identity were clearly volatile, with participants tending to associate themselves clearly with one social group and speak negatively of the behaviours and attitudes of other such groups. Whilst such identities were seen as being 'local', it is important to recognise that they have not evolved in a vacuum and have been shaped by cognitive and cultural aspects of globalisation, through mechanisms such as the media and TV, and by the socio-economic environment in which the young people live; which have been influenced by economic aspects of globalisation. As such, these identities, and the knowledges, discourses and performances on which they were based, were multifaceted and multiscalar because they were simultaneously constructed and produced through both 'local' and 'global' and encompassed a multiplicity of intersecting and juxtaposed spaces.

As I have discussed elsewhere (Beale 2010), it appears that stigmatised places and stigmatised people were related in the eyes of the young people I worked with previously, often being discussed interchangeably. The concomitant stigmatisation of people and places has also been apparent in my PhD work, and section 6.4.1 has discussed this with regard to one of the housing estates in the Meadowcroft area. These issues relating to the stigmatisation of places will be discussed further in Chapter 7 in relation to young people's understandings and experiences of the countryside.

6.6 Global-Local Interactions and Networks of Power and Influence: Shaping Young People's Health Attitudes across Time and Space

This chapter has highlighted the intertwining, and mutual constitution and production, of global and local in relation to young people's health beliefs and behaviours and their identities. The issues relating to globalisation, which were

discussed in Section 6.4, were inseparable from the 'local' issues discussed in Sections 6.3 and 6.5. The discussion of space and scale in Section 6.2 of this chapter (plus that in Chapter 3) highlighted the importance of flows and networks in the juxtaposition and co-construction of global and local. Cognitive aspects of globalisation, such as marketing and the media, have been shown to play a role in the shaping of young people's health beliefs and behaviours, and this process has been illustrated through the discussion of the media and technology, food practices, smoking and alcohol consumption. The sculpting and performances of young people's health beliefs and behaviours were related to negotiations of their emergent identities and were shaped by complex power dynamics and discourses surrounding social norms, expectations, culture and identity which operated through, and in, a range of spaces and scales.

In this chapter, I have also argued that aspects of the 'local' cultures and identities were juxtaposed with aspects of globalisation. This can be illustrated particularly clearly through smoking and football cultures. Smoking cultures, such as those discussed in this chapter, are frequently viewed to be an aspect of white working-class female identities and, yet, have been heavily shaped by cultural and cognitive aspects of globalisation through the portrayal of smoking in the media and on TV. As discussed in Section 6.5 of this chapter, football is often viewed as a key facet of North East identity and yet the 'local' professional teams are very much globalised entities.

This chapter has also highlighted the significance of media discourses and representations, and the role of information and communication technologies. As was discussed in Section 6.4.1, the media, TV and new technologies such as computer game consoles were seen to have both positive and negative impacts upon health. Media discourses, and mechanisms such as advertising, are a key facet of cognitive globalisation; and the power which may be manifest through these can shape beliefs and behaviours and discipline social and cultural norms and expectations. Some of the ideas introduced in this chapter regarding discourse and representation will be explored further in the next Chapter, which will discuss relationships between the countryside and rural living and health; and the discourses surrounding these themes.

Chapter 7 Young People, Countryside and Health: Beliefs and Experiences

7.1 Chapter Introduction

This chapter will deal with questions relating to how 'the countryside' is viewed and understood and will consider ways in which dominant stereotypes and representations of the countryside, and rural living more generally, impact upon health beliefs and policy. Drawing upon the empirical work undertaken, this chapter will discuss young people's views on the relationships between countryside and health, with particular reference to the Weardale and Mid Wear Valley areas of the Wear Valley. This chapter will also explore how young people's experiences of the countryside and rural living affect their views about the countryside and health, and what happens when the countryside is, in some way, 'not quite' countryside.

Writing nearly fifteen years ago, Cloke et al (1995) argued that rural poverty remained a problem in some areas of the UK, despite a range of discursive strategies which sought to obscure such problems through the construction of idyllised rural life. As has already been discussed in Chapters 2, 5 and 6, County Durham is an area with above average levels of deprivation according to indicators such as the Index of Multiple Deprivation and was, at the time the fieldwork for this PhD work was undertaken, the most deprived shire county in England[43] (Communities and Local Government 2004; Crawford et al. 2006). As Philo et al (2003) note, health policy and literature about rural health often treats rural areas as a homogeneous entity. Furthermore, there have been suggestions that policies such as economic restructuring have limited the choices available to rural youth (McGrath 2001) and, in the County Durham context, the collapse of the coal and steel industries had a significant impact upon employment options for young people.

As this chapter will discuss, the representations of idyllic rurality remain powerful and there has, if anything, been a further obscuring of rural deprivation through a dominant ideology of a healthy, wealthy countryside. Yet, as will be discussed in this chapter, the 'rural' areas within my study area did not always fit neatly with stereotypes of 'countryside' and many of the young people I worked with did not feel that they lived in the countryside despite the presence of features such as fields, trees and animals which are strongly associated with stereotypes and representations of the countryside. Towards the end of this chapter I suggest that the industrial

[43] The shire counties are all predominantly rural and this category excludes urban and metropolitan boroughs.

heritage of the area, which has already been discussed in Chapter 6, has influenced the ways in which the area is perceived both by the young people I worked with and by others. As has already been noted in previous chapters, Riverview High School drew its students primarily from the rural area of Weardale, although some came from the rural market town of Crook; Meadowcroft Community College drew its students primarily from former mining villages in the Mid Wear Valley and from the rural market town of Crook; and Hillcrest High School served the market town of Bishop Auckland and some outlying villages.

This chapter will begin with a general discussion of the ways in which the countryside has been understood and represented, including both academic and popular discourses, and the pervasive, but problematic, notion of the rural idyll. I will then introduce the concept of therapeutic landscapes which has developed within Health Geography and discuss its synergies with representations of the countryside and work in Rural Geography. Building on the more conceptual discussion in these two sections, Sections 7.4 and 7.5 will draw on empirical material to explore young people's beliefs about, and representations of, the countryside and their experiences of the countryside and rural living more generally. This discussion of empirical material will also be used to explore the ways in which some participants did not consider their local areas to be 'countryside' despite the presence of features they had identified as being part of the countryside and ways in which this appeared to be related to the industrial heritage of the area.

7.2 Understandings of the 'Countryside' in Academic and Popular Discourses

This section will discuss some of the dominant representations of rurality and their construction, plus some alternative discourses which have been presented more recently. It will explore representations of the countryside and rurality both in academic literature and beyond, including some discussion of popular literature and media discourses. This will include an exploration of the pervasive, but problematic, idea of the rural idyll (Bunce 1994; Mingay 1989), and contestations of this (Bell 2006; Short 2006).

The idea of an idyllic rurality which can be equated with notions of 'the English Countryside' remains pervasive in both academic and popular discourses and, for example, Wallwork and Dixon (2004) argue that this rhetorical construction is interwoven with the construction of national identity and 'Englishness' or 'Britishness' (see also Matless 1992). Yet, as was discussed in Chapter 6, questions have been raised about the extent to which North East England and its regional identity fit with stereotypes of 'Englishness' and thus it is questionable how well notions of 'the English

Countryside' can be reconciled with this regional identity. Questions have also been raised about the inclusiveness of discourses surrounding the notion of the English countryside and a number of authors have highlighted the presence of rural 'others' who do not conform to such stereotypes (see, for example, Cloke 2006b). In a different vein, Bell and Evans (1997) discussed the relationships between environmental concern and citizenship with specific reference to the National Forest in the East Midlands of England. Whilst they primarily discussed issues relating to planning, participation and professional knowledge, the authors noted that the initiative drew on a notion of an "authentic natural and cultural environment" associated with the idea of 'middle England' and suggested that the approach taken "[implied] 'proper' taste about what the landscape should look like and [suggested] appropriate ways of behaving and accessing the countryside" (Bell and Evans 1997: 274 and 76). As was noted in Chapter 6, Northern areas such as North East England have sometimes been represented as an alien or 'other' landscape and culture, in contrast to the wealthier pastoral rural landscape of much of southern England, with some representations drawing on the negative impacts of heavy industry (Bush et al. 2001; Howel et al. 2002; Nayak 2003c; Taylor 1993).

The representations and images of rural areas portrayed for industries such as tourism can have a significant impact on the ways in which such areas are viewed, as can images presented through the media and TV programmes. Mordue (1999) discussed the ways in which the filming of the TV series Heartbeat, and associated increases in tourism in Goathland, North Yorkshire, impacted upon the village and the ways it was represented. Whilst this is, in many respects, a more extreme example than those which will be discussed in relation to my study area, it does highlight the power and symbolism entailed in representations of rural areas. Similarly, Phillips et al (2001) trace the dominance of idyllic representations of rurality in the British mass media and Yarwood (2005) discusses the ways in which the Devon and Cornwall Rail Partnership has sought to promote tourism using connections to the novel *Tarka the Otter* and the romanticised notions of countryside depicted therein. Bell (2006) suggests that rural tourism offers opportunities to consider what he terms "the global idyll" – the widespread practice of providing experiences of the countryside (whether pastoral or wilderness) through the production of various culturally inscribed and legible idylls which involve and facilitate a range of tourism practices and performances.

As a number of authors discuss, this idea of the rural idyll has been contested (Short 2006; Yarwood 2005). The rural idyll is a social construction rather than a purely 'natural' entity, and, as Bell (2006) discusses, it is important to ask questions about who the rural idyll is for and what its purpose is. Building on existing work about the rural idyll and representations of rurality, Horton (2008b) raises an important

question regarding the ways in which the rural idyll comes to be constructed in the first place, and suggests that this has been lacking in many previous discussions. Earlier chapters of this thesis have already highlighted the interplay between issues of power, performance and voice with the construction of social and cultural beliefs, norms and expectations. This theme is again significant with regard to constructions of rurality and rural living and whilst Horton does not fully explore issues of performance he does note that "'rural idylls' are made, by particular people, at particular times, in particular places, for particular reasons" (Horton 2008b: 396). In this chapter I will also explore ways in which the rural idyll is represented and performed, and the ways in which power, knowledge and discourse contribute to its production and performance. It is often assumed, especially in popular discourses, that rural areas are a good place for young people to grow up (see Matthews et al. 2000 for discussion and critique). However, Glendinning et al (2003) highlighted a more complex picture in which rural living both enhanced young people's general health and well-being and also restricted emotional well-being, especially among females, through a lack of amenities and transport limitations. Some of the criticisms of the rural idyll have also come from empirical research involving young people. For example, Watkins and Jacoby (2007) raise questions about the assumption that living in the countryside means that young people have a healthier existence, highlighting issues relating to exclusion and stigma. Similarly Meek (2008) argues that the notions of idyllic rurality can be detrimental to children and young people due the social exclusion they can experience and inter-generational tensions.

The more recent work on rural hybridities (Murdoch 2003; Whatmore 2002) has argued for understanding in which rurality can be expressed in folded relations between rural reference, such as representations of the rural idyll, and rural experience. Later in this chapter, I will explore young people's beliefs and understandings about the countryside and then discuss these in relation to participants' experiences of the countryside and rural living – which incorporates both rural reference and rural experience. In his discussion of rural hybridities, Cloke argues that rurality "can thus be envisaged as a complex interweaving of power relations, social conventions, discursive practices and institutional forces which are constantly combining and recombining" (Cloke 2006a: 26). This conceptualisation of rurality resonates with the discussions of space and scale in Chapters 3 and 6 of this thesis and the work of Foucault and Butler discussed in Chapter 3.

A further small, but expanding, theme in Rural Geography has been research about young people's rural lives in developed countries such as the UK. In her 2002 editorial about young rural lives, Panelli sought to encourage "accounts of how rural lives are negotiated by active, opinionated young people who engage with diverse

social (including economic, political and cultural) relations in particular places that are materially and/or culturally constructed as rural" (Panelli 2002: 121). Two strands of work on rural youth are of particular pertinence to this chapter. Firstly, a number of authors have explored the performances of identity enacted by rural youth (Kraack and Kenway 2002; Saugeres 2002) and their use of public space including behaviours which others construct as 'deviant' (Jones 2002; Kraack and Kenway 2002; Nairn et al. 2003). Secondly, a few authors have begun to explore young people's own constructions and understanding of rurality and rural environments. McCormack (2002) suggests that young people's understandings of rurality are developed through a negotiation of their experiences of agriculture, nature and recreation and the understandings of rurality gained from peers and adults. A recent Norwegian study exploring young people's images of the rural suggested that the majority of young people viewed the countryside as both idyllic and dull (Rye 2006). However, as will be discussed later in this chapter, the young people I worked with tended to hold more romantic idyllic notions of the countryside which a number of participants struggled to reconcile with the areas where they lived.

Another area of interest to this thesis is the existing work on rural natures (Buller 2004; Jones 2006) and Rural Geography's increasing focus on 'non-human' rural studies. The debates surrounding culture-nature are widely understood within Geography and it is not necessary to revisit these debates here, other than to highlight that I consider culture and nature to be interwoven and mutually produced rather than viewing them as a dichotomy. Although aspects of nature such as animals and trees are material entities in their own right, which have varying degrees of autonomy and agency, the meanings which we as humans attach to different aspects of nature are socially and culturally constructed and inscribed. Whilst Castree and Braun (2006) suggest that most rural researchers have focused on discourse alone in their explorations of the construction of nature, there has been increasing interest in relational approaches to non-human rural studies (Enticott 2008; Johnston 2008).

Alongside Rural Geography's interest in representations and understandings of rurality and expanding interest in rural natures, health geographers have increasingly been engaging with the idea of therapeutic landscapes. Whilst these two bodies of work have tended to remain separate I believe there are a number of synergies between them, especially with regard to the ways in which rural areas are represented and understood, and the implications for health and well-being, and health policy. The next section of this chapter will therefore outline the existing understanding of therapeutic landscapes, and the ideas presented in these two sections will be brought together through discussion of the empirical work undertaken for this thesis.

7.3 Therapeutic Landscapes and Health

This section will introduce the concept of therapeutic landscapes, which has been explored by a number of health geographers, and will briefly outline the existing work in this area. It will highlight the ways in which certain types of landscapes, such as wilderness areas, and specific places are seen to be therapeutic. In addition, this section will consider the general lack of engagement with 'unhealthy' or 'non-therapeutic' places or landscapes, and point towards the contributions which a fuller understanding could make. Later in the chapter, I will then link this discussion of therapeutic landscapes back to the previous discussion about understandings of the countryside.

Although it has often received little attention outside of Health Geography, Gesler's seminal work on therapeutic landscapes (Gesler 1992) transformed the approach of many health geographers and, although written over 15 years ago, remains pertinent to much 'cutting-edge' work in the sub-discipline. Several authors (Curtis and Taket 1996; Kearns and Moon 2002; Parr 2004) have outlined the rapid change experienced within the sub-discipline of Medical/Health Geography in the years after the introduction of this concept, and the evolution of the so-called 'new' Health Geographies which I have already outlined in Chapter 2 of this thesis. A key feature of Gesler's 1992 paper was his attempt to bridge the gulf between Medical Geography and the 'new' Cultural Geography. By drawing on aspects of landscape work associated with the 'cultural turn', such as Cultural Geography's theorising of landscapes of despair (Dear and Wolch 1987) and symbolic landscapes (Cosgrove 1984), Gesler highlights ways in which the concept of landscape might help inform understandings of the therapeutic nature of certain places and situations (Gesler 1992). This was a major break from the positivist and Marxist approaches which had hitherto dominated *Medical* Geography and, I would suggest, provided a cornerstone for the 'new' *Health* Geographies which have reinvigorated the sub-discipline. Furthermore, Gesler's recognition that environmental and cultural components of health and health care are inseparable broke the mind-body dualism and helped pave the way for much of the early work on embodied geographies (Longhurst 1997; MacKian 2000). From a theoretical point of view, another key facet of Gesler's (1992) 'Therapeutic Landscapes' is his exploration of the interplay between structure and agency. Thus, he argues that structure and agency are merged in the creation of therapeutic landscapes and that the therapeutic landscape becomes a useful metaphor in developing understandings of the ways healing processes work themselves out in specific places and situations.

Building on the work of Gesler (1992), there has been increasing interest in therapeutic landscapes within Health Geography. As a number of commentators have noted (Gesler 2005; Smyth 2005), initial interest was generally centred around the

themes of healing and places associated with healing, with interest subsequently shifting to incorporate spaces associated with both formal and informal care settings or networks, therapeutic aspects of wilderness spaces and later non-western and minority groups. For example, Gesler (1998) expands his earlier ideas through a discussion of Bath's reputation as a healing place and Geores (1998) highlights the role which metaphors about health and healing played in the establishment of Hot Springs, South Dakota. There has also been interest in therapeutic aspects of everyday places, for example Williams (1999) discusses therapeutic aspects of place identity. The concept of therapeutic landscapes also initially influenced work relating to disability and mental health (Parr 2000). Slightly more recently, Wilson critiqued therapeutic landscapes' emphasis on physical and symbolic sites of healing and highlighted culturally specific dimensions of the links between health and place (Wilson 2003).

Despite the strengths and influence of Gesler's work, there are key areas which have not been fully addressed by the work on therapeutic landscapes. The drive within Health Geography to distance itself from the 'old' Medical Geography has emphasised health and healing, with a general lack of discussion of how this contributes to ill-health or constructions of unhealthy places. Two notable exceptions are Curtis (2004), who discusses therapeutic landscapes and health inequalities, and Kearns and Barnett (1999) who discuss the design and organisation of a children's hospital. Furthermore, within Cultural Geography, the focus on aesthetic and symbolic aspects of landscape has reduced the scope for such work and has borne little relevance for policies or practices which might impact upon people's everyday lives. Thus Mitchell (2003) calls for a reformulation of landscape which includes the social and political and creates justice and Olwig (2005) suggests such representations of landscape create alienation and social injustice through the recognition that landscape is more than representation. Such an approach offers new opportunities for exploring the influence of landscapes and the built environment on health and well-being, and the construction of 'healthy' and 'unhealthy' places.

More recently, therapeutic landscapes work has often focused on care spaces such as hospitals and hospital design (Curtis et al. 2007; Evans et al. 2009; Gesler et al. 2004; Kearns 2005; Moon et al. 2006) or, as noted in the previous section, on nature and wilderness areas (Milligan and Bingley 2007). Other themes of recent interest have included gardening (Gross and Lane 2007; Milligan et al. 2004; Parr 2007), healing and wholeness (English et al. 2008) and complementary and alternative medicine (Doel and Segrott 2003; Hoyez 2005; Lea 2008; see also the older piece by Williams 1998). The issue of power, which is an important consideration for this thesis, has rarely been explored in relation to therapeutic landscapes. A notable exception is the work of Wilton and DeVerteuil (2006) who explore the issue of power and

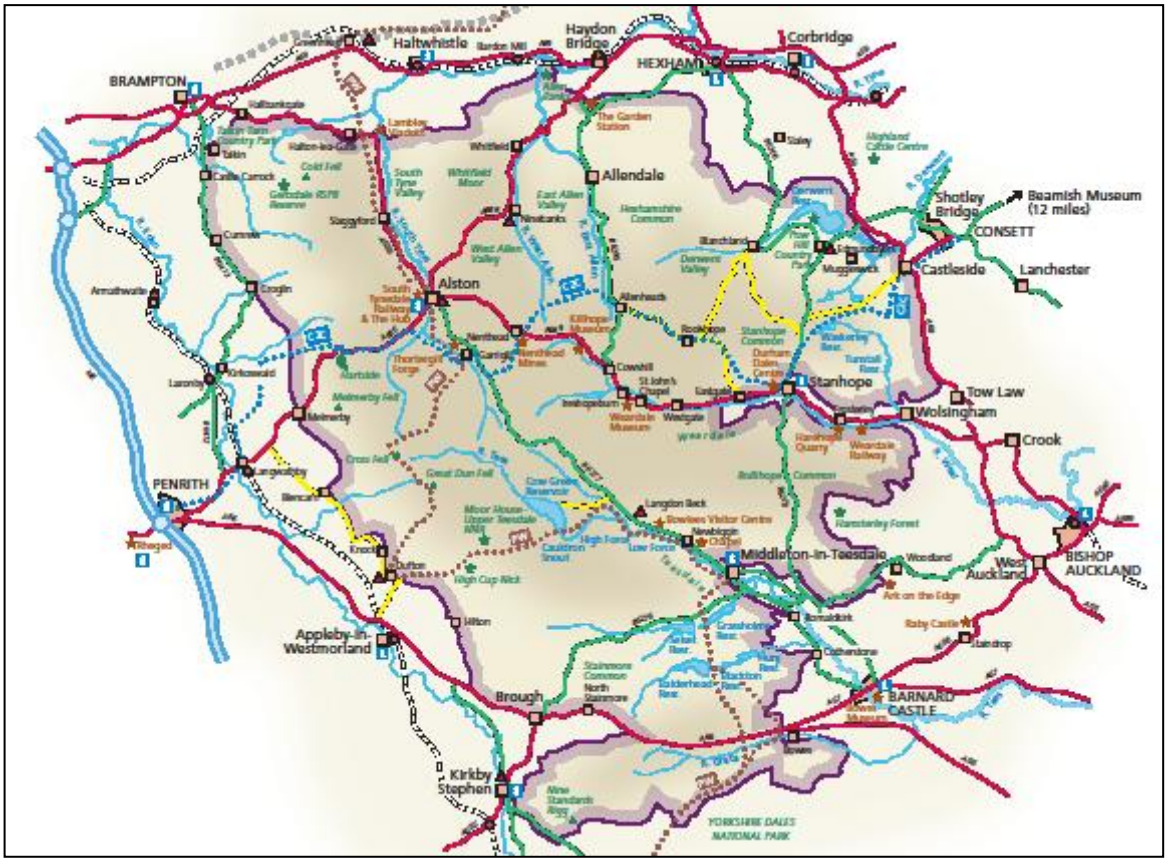
therapeutic landscapes in relation to alcohol recovery programmes. Whilst this is a very different context to that in my work, they similarly draw on the work of Foucault in their discussion of power. Although Wilton and DeVerteuil (2006) draw mainly on Foucault's notion of governmentality, this still has a number of connections with Foucault's earlier work on the issues of power, knowledge and discipline which was outlined in Chapter 3 of this thesis. Furthermore, there has also been a general lack of work on young people and therapeutic landscapes, and that which exists tends to focus on phenomena such as holiday camps (Dunkley 2009; Kearns and Collins 2000; Kiernan et al. 2004) which differ from the context of this thesis. Although the term 'therapeutic landscape' has not been used in popular literature, some academic authors have traced the role of therapeutic landscapes in novels such as *The Catcher in the Rye* (Baer and Gesler 2004) and *The Country Doctor* (Tonnellier and Curtis 2003) and this parallels some of the literature about the rural idyll and which was discussed in the previous section. Conradson (2005b) suggests that therapeutic landscapes should be viewed as relational and, whilst the connections between the two areas have not been explored, this mirrors Rural Geography's recent interest in relational and hybrid geographies; thereby providing a further point for synergy between the two fields. Writing after the fieldwork for this thesis was completed, Leyshon (2008a) explores the ways in which rural young people create and produce discourses of the countryside and their strategies for negotiating such spaces. The remainder of this chapter will explore the beliefs and understandings about the countryside and health which were held by the young people with whom I worked, which were a significant theme throughout the fieldwork undertaken. Whilst I agree with many of the ideas in Leyshon's (2008a) paper, this chapter will diverge significantly from his work through its pre-existing consideration of health and well-being and the integration of ideas relating to health geographies' notion of therapeutic landscapes.

7.4 The Countryside and Health in County Durham: Images and 'Realities'

Drawing on the empirical work undertaken, this section will discuss the different views held by research participants regarding countryside, health and rural living. I will begin by outlining some promotional representations of the area and then explore young people's own beliefs and understandings about the countryside. In particular, I will explore participants' stereotypes of what the countryside 'is' and some of the ambiguities associated with this. A large area of the Wear Valley falls into the North Pennines Area of Outstanding Natural Beauty (AONB), which is also a UNESCO European Geopark. The North Pennines AONB includes a large part of Weardale,

which runs westwards roughly from Wolsingham in the East towards Nenthead near the centre of the AONB. The area covered by the AONB falls within the purple line on Figure 7.1.

Figure 7.1 The Area Covered by the North Pennines AONB



(Source: North Pennines Website 2009, used with permission)

Promotional literature about the Durham Dales and North Pennines AONB tends to emphasise the more idyllic aspects of the rural setting. Typical examples include:

> "This is one of England's most special places - a stunning landscape of open heather moors and peatlands, attractive dales and hay meadows, tumbling upland rivers, wonderful woods, welcoming communities, intriguing imprints of a mining and industrial past, distinctive birds, animals and plants and much, much more…" (North Pennines Website 2009)

> "High moorland expanses, cut through by green, peaceful dales, where tumbling rivers and waterfalls, exciting wildlife, dramatic history and vibrant communities await those who come to explore this area of special and outstanding scenery – this is the North Pennines. The Durham Dales sit within this spectacular area of countryside - a fine example of what makes the North Pennines such a priceless national asset." (Durham Dales Website 2009)

> "Set in the beautiful landscape of the Northern Pennines, and sitting at the confluence of the river Wear and Waskerley Beck, Wolsingham is the Gateway to Weardale. A pleasant Market Place (with Town Hall/Library), and quaint streets full of architecture and history…Wolsingham is an ideal place from which to discover the North Pennines Area of Outstanding Natural Beauty (AONB). This is one of the finest landscapes in the country…" (Ridley et al. No date: 7 and 37)

Similar themes are incorporated into the Durham Dales 'brand' image which is used in promotional literature by both the Wear Valley District Council and the Market Towns Initiative as well as by local tourism groups. As shown by the image in Figure 7.2, this brand image draws on ideas such as nature (natural), authenticity (genuine, sincere and tradition) and recreation (passion and endurance) and related pictures to make the area appear particularly attractive and market the area to different types of people. However, underneath this gloss of depictions of idyllic rurality, lie questions about the representations presented and the extent to which these reflect young people's lived experiences of the area.

Figure 7.2 The Durham Dales Brand Image

(Source: Durham Dales Website 2009, used with permission)

Before further unpicking some of the discourses and representations of the countryside, it is important to acknowledge that the countryside, in general terms, was widely seen as health enhancing by the young people I worked with. As an example, this notion of healthy countryside is evident in the extract in Box 7.1.

Box 7.1 Notions of Healthy Countryside

SM Would you be as healthy if you were picked up and thrown into a big city tomorrow?
John Yeah pollution is one, yeah.
NHB Yes, you've got pollution on your thing [diagram]
John you get a lot of carbon, carbon dioxide, a lot more and there's like smog and you're breathin that in. Um like here it's a lot more sparse, it's not very build up, there's not that much traffic, there's lots of trees and stuff like that n so it keeps the air cleaner than it would be if you went to Newcastle or especially London
[brief pause]
John Compared to places like that you've got like um a longer life expectancy livin here than you would if you lived in London.
[pause]
NHB [to Year 8 participants) And what about you three, do you think some places are healthier than others?
Richard Yeah
Lewis Yeah
NHB What makes places healthy or not healthy?
Lewis If you're in the countryside there's a lot of trees around you, and there's like a lot of air and there's fruit like grows on the trees.
(Year 8/11 group, Riverview)

However, what was considered 'countryside' was not always clear-cut. This ambiguity initially arose during a discussion with a Year 11 group at Meadowcroft who did not think that they lived in the countryside despite the fact that most of them lived in small villages in what I had expected would be considered a rural area. The ensuing discussion lead me to explore the different ways in which countryside is represented and understood and the features which young people associated with countryside or which appeared to prevent them from classing places as countryside. In Box 7.2 participants in the Year 10 group at Meadowcroft focus on industry and pollution as a cause of places being unhealthy and Dave uses pollution as an indicator to contrast the 'countryside' where he lives with other places. The participants in this group locate their areas of residence on a continuum where they suggest that their area is healthier than places like London, which they considered to have a lot of pollution, but feel that they could be healthier. Whilst Ruth is keen to disassociate herself away from the area which the others suggested was polluted she does not really consider the area to be healthy.

Box 7.2 Industry and Pollution

NHB	Do you think the areas where you live are healthy?
Dave	Yeah I'd say that
Ruth	No
Nick	Pollution and that
Dave	So if you lived like near an industrial estate then there'd be like loads of pollution
Will	Factories and stuff can cause that place to be unhealthy
NHB	[to Ruth] you're saying no?
Ruth	No
NHB	Where do people live?
[places mentioned]	
Dave	We live in the countryside don't we and all the pollution's like at the top of Crook
Ruth	I live like the other end of the top of Crook
Isabel	Um
Ruth	and if you go like down to London then it's really seen as there's a lot of pollution and that and so I'd say that we like live in a healthier area here than they do there, but it could be healthier.

(Year 10 group, Meadowcroft)

In their discussion of air pollution and neighbourhood stigma in Teesside, North-East England, Bush et al (2001) identify a hierarchy of stigma in which residents frequently differentiated between their own neighbourhoods and other areas which they considered to be more polluted, thereby distancing themselves from the perceived stigma. Alongside environmental stigma associated with the place, the authors identify social stigmas associated with the residents due to, for example, high crime levels and unemployment. They argue that the interweaving of these different stigmas is used to discredit both Teesside as a place and the people who live there (see also Howel et al. 2002; Phillimore and Moffatt 2004). Like Wakefield and McMullan (2005), I found in my Master's research that some places were simultaneously stigmatised by some people and viewed more favourably by others, and it appears that similar issues were apparent in the research undertaken for this PhD. For example, a number of participants made very negative comments about the Woodhouse Close area of Bishop Auckland, but the two participants who lived in this area defended it quite vehemently when I mentioned that others had suggested that it was an unhealthy area[44]. There were also a number of instances where participants articulated contradictory views about their areas. As noted above, Ruth was quick to distance herself from the area of Crook which the other group members were stigmatising, and identify herself with a slightly different area that could be presented more favourably. Yet, she was also critical of her local area at other points especially, as will be discussed later in this section, in relation to notions of peace and tranquillity. In addition to the ways in which these examples speak back to the issues surrounding stigma discussed in Chapters 3

[44] I have not included an extract from this discussion because the small number of participants from Woodhouse Close (both in the qualitative work and in the questionnaire responses) means that the participants could potentially be identified – especially if the relevant extracts were read in conjunction with other quotations from the two participants concerned.

and 6, they also offer an illustration of the ways in which discourses and knowledge can be simultaneously both deployed and resisted in relation to places. These examples also speak back to the discussion of Foucault in Chapter 3, especially is relation to issues of power, knowledge, discourse and resistance.

The ambiguity surrounding what participants considered to be 'countryside' was explored further in the follow-up interviews. In Box 7.3 Clare and Emma, who had both been members of the group where this theme initially emerged, again drew on a continuum in a similar manner to the Year 10 Meadowcroft group. They feel that their area is more like countryside than cities such as Newcastle, but they still do not consider it to be countryside. Whilst Clare and Emma have a clear view of the main features which they think countryside areas have, such as farms, animals and fields, there is a tension between this view of the countryside and their view that their local area is not countryside. The village where they live had the features which they associated with countryside, yet they did not regard it as such.

Box 7.3 Living 'More' in the Countryside

NHB There was a lot of discussion last time both in your group and the other groups about living in the countryside, and living in the countryside being good for health?
Emma Um.
Clare Yeah
NHB It's something that's come up again and again in lots of different groups, but you were saying that you actually that you didn't feel you lived in the countryside here, and I was wondering what do you think the countryside actually is?
Emma We live more in the countryside rather than like Newcastle
Clare like a big city or
Emma but not, like not compared to like Wolsingham and that it's not really is it
NHB Uha?
Emma in the middle of nowhere
NHB So what is the difference?
[brief pause]
NHB If you had to kind of do a stereotype of the countryside what would it be?
Emma farms
Clare yeah
Emma Quiet houses, a little village
Clare Animals
Emma In the middle of nowhere like
Clare Fields, just loads of fields
NHB Animals, what kind of animals?
Emma Like cows
Clare farm animals
Emma Aha.
(Clare and Emma, Year 11, Interview, Meadowcroft)

A similar tension between notions of countryside and perceptions of their local area was also apparent in the interview with Dave, Luke and Nick at Meadowcroft. As the extract in Box 7.4 shows, these participants were clear that they would not class their local area as countryside despite the presence of features which were generally associated with countryside. There is an interesting tension here between Dave's

responses in this interview, where he really did not appear to feel his area of residence was 'countryside', and his earlier comments in the group discussion when (as was discussed in relation to Box 7.2) he contrasted the 'countryside' where he lived with the pollution where Ruth lived. This tension highlights the contested nature of the notion of 'countryside' and the complexities and ambiguities encountered when trying to unpick what participants viewed as countryside; and there was a recurring image in many of the groups of their local areas being non-urban but, in some way, not really quite meeting their ideas of countryside. In the questionnaire responses to the question about whether the area where they lived was healthy and why, a number of young people made comments about their neighbourhood being 'sort of' in the countryside; as reflected in responses such as "because it is in the country sort of there is no factories and lots of fresh air" (Year 8 female, Riverview, area rated as 'healthy'). This reasonably pervasive idea of their local area being in some way not quite countryside will be unpicked further in later sections of this chapter.

Box 7.4 Fields and Villages: Not Countryside

NHB	Do you think you live in the countryside?
Luke	Na
Dave	I live in a place with no shops
Nick	I live in a place with fields
NHB	Are you [*name of village 1*]?
Dave	yeah
Nick	I live in a place which is like the top near [*name of village 2*] but it's in Crook but there's like loads of fields there but it's not
Dave	it's just one row of houses really isn't it with a road next to it
Nick	yeah
Luke	I live like in the middle of Crook
[pause]	
NHB	okay, so my sense here is generally from people that even in those of you living in some of the villages round here don't seem to think you live in the countryside?
Luke	no
Nick	I'd say it's more countryside or it is in some parts of Crook, but like I wouldn't class it as countryside.

(Dave, Luke and Nick, Year 10, Interview, Meadowcroft)

Across all three schools there was considerable uniformity in terms of the features which participants associated with countryside. The views expressed in Boxes 7.3 and 7.4, which I have already discussed above, were fairly typical amongst Meadowcroft participants and, as the extracts in Box 7.5 show, similar features were highlighted by the participants in other schools. As will be discussed later in this chapter, there were some significant differences with regard to participants' actual experience of countryside and rural areas; but this uniformity in the stereotypes associated with the countryside points towards questions about the ways in which such stereotypes and representation are constructed, produced and performed.

Box 7.5 Key Features of Countryside

NHB What do you think are kind of key features of countryside?
Sarah Water
Penny Trees
Sarah Sheep
(Penny and Sarah, Year 10, Interview, Riverview)

NHB What do you think are key features of countryside?
Niall Wood
Daniel Open fields and just like
Jason farmers
Niall And trees
Daniel yeah and cattle and different things like that
Niall Dogs an
Jason Sheep
Niall Animals!
Daniel yeah and like crops
(Daniel, Jason and Niall, Year 8, Interview, Hillcrest)

NHB What do you think are key features of countryside?
Erin fields
Bernie fields
Abi cows
Bernie animals
Erin no shops
Abi And like out of the way houses and like villages and stuff
(Abi, Bernadette and Erin, Year 10, Interview, Hillcrest)

Almost all of the groups involved in discussions about countryside identified woods or trees, fields and animals (particularly sheep or other farm animals) as key features of countryside. There have been suggestions (Milligan and Bingley 2007) that, for many young people, areas of woodland have therapeutic qualities which can enhance mental health and well-being – although it should be noted that these authors state that this did not generally apply to those who had negative experiences of woodland as younger children. Interestingly, in the research undertaken for this PhD, the participants with the least personal experience of the countryside (such as Grace and Jade who will be discussed later in Section 7.5) often placed a particular emphasis on trees.

Whilst there was considerable uniformity in the responses given to questions about the key features of countryside, a number of interwoven images of the countryside can be identified within this. For many participants, the countryside was conceptualised, at least in part, as a non built-up area, as illustrated by the quotations in Box 7.6.

Box 7.6 The Countryside as a Non Built-up Area

NHB You were talking a lot about the countryside, as did a number of the other groups, both here and in one of my other schools, and you were saying that you didn't feel you lived in the countryside. What do you think are key features of countryside?
Jess Um
Lucy What so you mean key features?
NHB What, what do you think kind of, um what would you I suppose almost stereotypically think of the countryside as being like?
Lucy Oh. Ah eh. Like not many people livin there, like not many houses but like more farms and lots of fields and stuff like that
Jess Yeah, and no factories. Like the air would be fresh air
Lucy and no shopping centres and things like that like big places
NHB Um. And why is it that you think countryside is healthier?
Lucy Because they haven't got like takeaways and stuff n like
Jess Like not cafes but like restaurants
Lucy where people can go if they like
Jess And gyms and things
(Jess and Lucy, Year 11, Interview, Meadowcroft)

NHB So what do you think are the key features of countryside?
Nick I'd say that the countryside is generally there's a lot more land then there is houses and things like that
Luke All open really
Dave Just there's loads of fields and no cars really
Nick Like just a house, or two, and then loads of fields around them
Dave that's like [*name of village*], all fields, trees
NHB And do you think that makes any difference in reality?
Dave no cos there's no shops so you can't go and buy sweets and that
NHB So you don't think that living where you do makes you healthier than people living in Crook for example?
Dave No.
(Dave, Luke and Nick, Year 10, Interview, Meadowcroft)

This notion that the countryside could be contrasted to built-up areas appeared also to be related to discourses surrounding fresh air and the countryside. As will be apparent in the quotations discussed so far in this section, many groups drew distinctions between industrial areas, which they viewed as polluted and therefore unhealthy, and the non-polluted countryside. In addition, as illustrated in Box 7.7, some participants also made comparisons between the South of England, which they considered to be built-up and therefore more polluted and less healthy, and their local areas which they considered to have less fumes and better air – even when these local areas were not quite considered to be countryside.

Box 7.7 Comparison with South of England

NHB One thing which came up in your group quite a lot and some of the others was about living in the countryside and people were saying that living in the countryside was better than living down South? What do you think it is about countryside that makes it healthier? Do you think it's healthier?
Luke Yeah
Nick There's less fumes
Dave Like less traffic and things like that so there won' be like breathin in as much bad air really
[pause]
NHB Anything else?
Luke Na.
NHB just mainly cars and pollution?
Nick probably you'd tend to eat more because if you're in the countryside there's more like
Dave Not as many shops
Nick And more like healthy food, like vegetables where they actually grow them.
(Dave, Luke and Nick, Year 10, Interview, Meadowcroft)

There is already an established body of literature relating to air quality and health and various authors have discussed perceptions of air quality and their relationship to place or perceptions of different places (see, for example, Bush et al. 2001; Day 2007). As has been noted in Chapters 4 and 5, the questionnaires included a question about whether participants thought their local area was healthy and this gave space for them to explain why they thought this. Many of the young people involved mentioned issues relating to pollution or air quality when making judgements about whether the area where they lived was healthy, and the quotations in Box 7.8 are typical of responses in this vein.

Box 7.8 Questionnaire Responses: Healthy Places

"because there are lots of places you can go and play football at that arnt near roads so you dont get that much bad air"
(Year 8 female, Meadowcroft, area rated as 'healthy')

"clean air, country area, little pollution"
(Year 10 female, Meadowcroft, area rated as 'healthy')

"in the environment there are different things going on eg near my house there is a factory therefore there will be some pollution"
(Year 10 female, Meadowcroft, area rated as 'average')

"because it is in the country and there is fresh air"
(Year 7 Female, Riverview, area rated as 'healthy')

"There is lots of fresh countryside and fresh air"
(Year 7 male, Riverview, area rated as 'healthy')

"it is in the countryside with fresh air and space, public footpaths to take walks and no huge fast food outlets eg mcDonalds."
(Year 8 female, area rated as 'very healthy')

"Because there isn't alot of pollution and it is a small quiet village."
(Year 9 Male, Riverview, area rated as 'very healthy')

Based on the responses given in the group discussions, interviews and questionnaires, it appears that fields and fresh produce where viewed as another key feature of countryside. As the quotations in Box 7.9 illustrate, many participants held the view that people living in the countryside were healthier because of food which was grown in rural areas; both commercially through fields and farms and through activities such as gardening and allotment keeping. Many of the participants from Meadowcroft and Hillcrest, in particular, held a fairly romantic view of rural living in which everyone grew and ate their own food rather than buying it, although a small number of participants (such as Jess in the extract below) did note that some people might choose to go elsewhere to get food or to eat.

Box 7.9 Food in Rural Areas

NHB What do you think are key features of countryside?
Karl Ah like sheep, ah and farms, like lots of land. Like cos you wouldn't really see like a potato field or something like in the middle of a city, cos it's like they wouldn't be very good either because all of the pollutions'ud probably affect 'em or something. Bu then you see them in the countryside where there's like no pollution like just to get the air, and theys probably'ud get acid rain on 'em or somethings in cities
NHB [to Mike and Simon] and what about you two, what do you think are key features of countryside?
Mike Just like what 'e said.
NHB And what about you, Simon?
Simon yeah there's like no, there's like a good amount of people but there's not like millions of people into like one big thingy
(Mike, Year 10 and Simon and Karl, Year 9, Interview, Riverview)

NHB What do you think are key features of countryside?
James lots of grass, trees
Steven trees, yeah.
Craig yeah and like nicer scenery that hasn't been
Steven than a town
Craig built on
James and like farm animals, n fields where corn and vegetables n wheat are being grown
Steven an there isn't like big massive buildings
Craig And allotments. Cos if like in a city you look for allotments then there'll probably jus be a couple and they'll be bang in together won't they, but if you look in the countryside then
James they'll be spread out
Craig yeah if you have a few of them here and there they'll be more spread out then, an lots of open space
(James, Steven and Craig, Year 8, Interview, Meadowcroft)

NHB If you instead of like living in Crook and [*name of village*] you lived in say Weardale or Teesdale do you think it would actually make any difference?
Lucy I think, I don' know, it could because there's not so much, ah don' know, really.
Jess People could still travel like to other places if they wanted to, like they could travel somewhere and eat there instead of in the countryside so it would depend on the person really I think
Lucy But you'd have been brought up like, Ah think you would have been brought up like with more healthy foods around you like
Jess yeah, if you live on a farm as well
Lucy Then you're growin stuff
Jess yeah
Lucy And you're not buying all this stuff that like full of bad
(Jess and Lucy, Year 11, Interview, Meadowcroft)

A closely related theme was the notion of the countryside being more traditional than other areas. In Box 7.10, Daniel says that Weardale is traditional and he, like other participants who mentioned this idea, appears to view the countryside as a more romanticised or idyllised area which has not been tainted by modern human practices. Whilst Daniel does not expand on what he means by 'traditional', and the pace of the conversation meant that the discussion had moved away before I had time to unpick the idea, it was clear from his tone of voice and body language that he considered this to be a positive attribute.

Box 7.10 'Traditional' Countryside

NHB	So do you, if you yourselves lived say in Weardale or in Teesdale do you actually think it would make any difference to you?
Daniel	yeah
Niall	Where's Weardale?
Daniel	because
NHB	the other side of Crook
Daniel	Um. It's where the mining used to be, the Lead Mine
Niall	okay [sounds unsure]
NHB	And then Weardale goes, do you know Stanhope?
Jason	Is it like is it posh?
Daniel	It's like country, just it's traditional.
NHB	Do you think it would actually make any difference to you though?
Daniel	yeah because if you're breathin better air and because Ah live just off a main road it's just like you get fresh air and you breathe better
Jason	It's not exactly your fault if like a car goes past though, is it, it's like you're not goin ta die if a car goes past would ya, unless it hits ya

(Daniel, Jason and Niall, Year 8, Interview, Hillcrest)

It is worth noting that my attempts to gather information about my study area from local public libraries drew up a selection of historical books discussing rural traditions and lifestyles in Weardale, plus a few tourist brochures describing the history of Weardale and more traditional events such as local fetes and sheep fayres. These notions surrounding the countryside and tradition fit with the tendency for historical accounts of nineteenth and twentieth century rural England to treat the countryside and agriculture synonymously (see Burchardt 2007 for discussion).

For some participants, the countryside was viewed as a place for 'other' people. As will be discussed later in this chapter, this view of the countryside being for 'other' people may link to participants' notions of their *not* living in the countryside, and to issues of social class. In Box 7.11 specific mention was made of particular groups such as older people and travelling communities which are often considered to be marginalised in rural contexts.

Box 7.11 'Old People' and 'Gypsies'

NHB Some of the other groups, particularly in some of the other schools have been talking about living in the countryside being good for health
Iain yeah
Ryan Yeah. No pollution
NHB so it's something you'd agree with, or not?
Joseph yeah
Wayne yeah
NHB why?
Ryan Cos there's no pollution
Wayne No pollution, no like restaurants, McDonalds
Iain All the food will be like grown on the farms
Joseph They're all old people and stuff in the countryside
Ryan gypsies
NHB Old people did you say?
Joseph yeah. There's only old people that live in the countryside anyway
(Iain, Joseph, Ryan and Wayne, Year 10, Interview, Hillcrest)

This emphasis on 'others' in the countryside contrasts with the discourses surrounding rural others highlighted by Cloke (2006b) and associations between whiteness and the rural idyll (Holloway 2007), both of which suggest that 'others' are generally excluded or considered 'out of place' in discourses surrounding the countryside. It is not clear from Ryan's tone of voice whether the reference to 'gypsies' was intended to be derogatory, reflecting views of gypsies being out of place or other (Holloway 2005; Vanderbeck 2003), or whether it reflected a more romantic view of gypsies and nature (Holloway 2007).

A further significant theme in the group discussions and interviews was the idea of the countryside being peaceful, tranquil or relaxing. Whilst a number of groups talked about this theme, the interview with Isabel and Ruth has offered a particularly rich narrative in relation to this issue. In Box 7.12 Isabel introduces the idea of the countryside being peaceful and relaxing and Ruth goes on to contrast this with the stressful, busy city.

Box 7.12 Peaceful and Relaxing Countryside

NHB So what do you think are like key features of countryside?
Isabel like, like if it's jus like you and no-one else, it's more like peaceful and relaxin and less stressful and you don't have people around you and you can walk around and relax whereas if you're in the city then you're stressed…
[recording obscured by teacher shouting at other students]
Ruth So if you're in the city
[teacher shouting]
Ruth if you're in the city you get stressed easier if you're late for work or something, you have to rush food and that which is like unhealthy and there's like no exercise and stuff because everything's like really busy.
(Isabel and Ruth, Year 10, Interview, Meadowcroft)

This idea of a tranquil and relaxing countryside was developed further by Isabel and Ruth through comparisons with the area where they lived which, as illustrated by the quotation in Box 7.13, they felt was too noisy and had "no peace". They also highlighted issues with the behaviour of other people in the area which they felt prevented them from having any peace.

Box 7.13 Lack of 'Peace' in Local Area

NHB Now if you lived somewhere different like in Weardale or Teesdale do you think that would make a difference compared to here?
Isabel I hate it here, I really do. It's just like too noisy and it's too scruffy and there's like just no peace at all.
Ruth I wouldn't say it's scruffy but I wouldn't say it's like one of the best places to live.
[disruption whilst moving away from noisy teacher]
NHB Anyway, difference between here and Weardale?
Ruth here is like really noisy
[laughs]
Isabel Yeah, it's like no peace at all really. You'll like walk down the street and there'll be loads of like teenagers drinking and like they're always pestering you for drink or they're like 'go in and get us some drink from the shop' and you get a smack or something like for being cheeky. Whereas if you're in the countryside you're like can walk down to the shop without being pestered at all or being scared of getting beaten up or something
(Isabel and Ruth, Year 10, Interview, Meadowcroft)

Yet, as the extract in Box 7.14 shows, Isabel and Ruth also viewed the countryside as active and cities as lazy. At first sight this might appear to contradict their earlier comments, but it appeared that in this section of the discussion they had made a shift away from the notions of peace, tranquillity and stress and the use of the term 'lazy' was used to refer to a lack of health-enhancing physical activity rather than to refer to the idea of relaxation. Thus, for Isabel and Ruth, cities were seen as being lazy because they thought the residents engaged in less physical activity than their rural counterparts who did more walking.

Box 7.14 Countryside as Active, Cities as Lazy

NHB Another thing which you talked about a bit was living in the countryside and you were saying that countryside is better than living in the South.
[nods from Isabel and Ruth]
NHB What is it about the countryside that you think is better?
Ruth There's more physical activities to do and walking and like if you're in a city then you'll just get a taxi or something
Isabel It's like being in a city is lazy whereas being in the countryside is more physical because you've got to walk more and stuff
NHB Do you think you live in the countryside?
Ruth no
Isabel no
Ruth Well kind of but not. Like we're surrounded by countryside but like, like in towns
[interruption from school bell]
(Isabel and Ruth, Year 10, Interview, Meadowcroft)

This idea of urban dwellers relying more heavily on vehicles for transport was reflected in some of the other groups and is an interesting perception which again connects back to romanticised notions of a traditional, untainted and self-sufficient countryside. In reality, I would anticipate that urban dwellers are more likely to be able to walk to work than their rural counterparts. Given that the majority of the working population living in the Wear Valley is no longer engaged in the 'traditional' rural industries of agriculture, forestry and horticulture (Nomis 2009), I would expect rural dwellers to be more reliant on the use of cars for commuting to work compared to those living in cities.

Many of the groups involved in this project highlighted a related idea of the countryside being better for fitness, sports and exercise compared to urban areas. There was a widespread view, amongst Meadowcroft and Hillcrest participants in particular, that people living in the countryside would be healthier because they could engage in physical and outdoor activities more readily and would be able to walk more. Whilst many of the participants talked about these ideas in a fairly unequivocal manner, like Isabel and Ruth in Box 7.14, a few participants did begin to question the assumptions they were making. This is illustrated by the extract in Box 7.15 where Clare initially suggests that people who lived in the countryside would be physically fitter, but then comments in a more reflective tone of voice that perhaps people in the countryside would not actually chose to walk.

Box 7.15 Questioning of Assumptions

NHB	If you lived in a different area, say if you lived up in Weardale or Teesdale do you think you'd actually be any different?
Clare	probablys cos
Emma	I dunno. You'd be able to walk there like
Clare	You'd probably be like more fit because you'd walk everywhere, wouldn't you like.
Emma	if you lived on a farm you'd be more fit, maybe
Clare	but maybes you wudna want a walk, wouldn't ya if there was jus fields an like you kna
Emma	There wouldn't be as many people like influencing you to do bad things
Clare	Uhum
Emma	Um Ah'm guessing, ah don' know. Probably different but I don't know how really.

(Clare and Emma, Year 11, Interview, Meadowcroft)

This idea that the countryside or access to open space can promote health through enabling exercise and physical activity is also apparent in existing literature. A number of authors have already highlighted the idea that open or green space can influence health and well-being (Maas et al. 2006; Tzoulas et al. 2007) and it has been suggested that rural areas are healthier than urban ones because they have more green space (Verheij et al. 2006). A significant number of studies have explored green space or proximity to parks in urban areas and issues such as physical activity (Giles-Corti et al. 2005; Jackson 2003; Maroko et al. 2009; Witten et al. 2008). There has also been some discussion of possible links between the socio-economic status of

neighbourhoods and health-promoting features of open spaces (Crawford et al. 2008), although such studies do not agree on whether access to parks, socio-economic status and physical activity are in fact linked (Abercrombie et al. 2008; Ball et al. 2007). Whilst much of the work in this field has focused on issues such as physical activity, exercise and obesity, there have also been suggestions that exercise in green areas, and the countryside in particular, can promote mental health and well-being and self-esteem (Pretty et al. 2007).

In general, the young people living in Weardale itself felt that they had plenty of space, as illustrated by the discussion in Box 7.16. However, the picture was more mixed among participants who lived elsewhere and opinions were more divided at Meadowcroft, in particular.

Box 7.16 Plenty of Space

NHB	Some of the people here in this group were talking last time about playing outside being important for health, do you agree with this?
Simon	Um. N'yeah
NHB	All of you?
Mike	yeah
Karl	yeah
NHB	Is it something that you're able to do?
Simon	pardon?
NHB	Is it something that you're able to do, do you think?
Simon	yeah
Mike	Mmm
NHB	And do you? [to Karl] I know you do
Simon	yeah
Mike	Mmm.
NHB	[to Mike] you do stuff outside?
Mike	Mmm.
NHB	do you feel safe outside, such as if you're playing around outside?
Simon	Yeah
Karl	in [*name of village*], yeah
NHB	Kind of all the time
Karl	yeah
Mike	I do
NHB	so you don't, so there aren't any problems here of older groups, um older groups of kids?
Karl	Na
Simon	no
NHB	And do you think you have all the kind of space and facilities you need to lead a healthy lifestyle here?
Karl	yeah
Mike	yeah
Simon	yeah

(Mike, Year 10 and Simon and Karl, Year 9, Interview, Riverview)

When asked about the main things which stopped young people in their area from being healthy, a number of participants at both Meadowcroft and Hillcrest mentioned problems such as not having anywhere to play football or run around. Yet, there were other groups in the same schools (such as Craig, James and Steven in Box 7.17) who

felt that they had sufficient space to use if they so wished. A key issue is perhaps the ways in which public and open spaces are used and appropriated, even in the more urban areas, and Cattell et al (2008) suggest that everyday public spaces can play a significant role in promoting well-being through their function as places of memory, places of escape and places of social interaction.

Box 7.17 Access to Outdoor Spaces

NHB A lot of other groups here talked about being told off by older people for playing football and about changes to parks in the area and there being a general lack of opportunities to play outside and on your diagram you've all talked about it kind of being important to have places to play outside. Do you, do you think you actually have places to play outside?
James yeah
NHB You do?
Steven Yeah cos there's some areas around which they've built like special areas where you can go and play football like in a sort of cage like but it doesn't cost it and so it makes the environment more healthy and it's got like built-in cricket area and football and basketball all in one
NHB Where is this?
Steven [*name of village 1*]
James near [*name of village 2*]
Craig Well there's not that many places where I live in [*name of village 3*], but you know how you just go over the hill and then there's [*name of village 4*]
NHB yeah
Craig cos all my friends live there and so I just go up over the bank and there's you know the massive green hill when you get to the top and there's like a junction there, yeah?
NHB yeah
Craig Well there's a big green hill and there's always let someone you can just go on there but when you go intos [*name of village 4*] yous well you can always go on the street but there's like the whole wood, well it's not a wood but there's loads of trees where you can climb and do anything and there's a park and there's a big empty field where you can play football and everythin.
James There's some place in Crook like say [*name of Estate*] where most old people live you're not allowed to play football on them fields because like
Steven You disturb them and they complain
James Yeah you disturb them
[brief pause]
NHB but you think that you've got plenty of space?
James Um
Craig Yeah
Steven yeah cos I've got a massive field outside ma house and a football pitch right down next to it
Craig [to James] And you live right next to a big park don't you
James yeah. You can do a lot of things on a big field like you can play golf, cricket, football, a lot of different sport
NHB And you feel that you can use these places when you want to
Craig yeah.
Steven sometimes they have signs up but most places they just let you play and do whatever you want really
NHB and you feel safe in these areas?
James um
Steven yeah cos there's lots of houses sort of around securing the place
NHB so you've obviously found places you can go where you're not because some of the groups have had have said that there's problems with old, older groups of young people
Steven yeah there is like the skate park if you go down there there's a lot of people who smoke and drink and it's not very safe. I wouldn't really want to go down there on a night.

(Craig, James and Steven, Year 8, Interview, Meadowcroft)

Whilst Craig, James and Steven felt that they had sufficient access to open space to meet their needs, Steven points at the end of the extract towards an issue which was more problematic for some of the other participants. At both Hillcrest and Meadowcroft some participants felt uncomfortable using areas such as parks due to the behaviour of other young people, including activities such as alcohol consumption and drug taking. Such concerns about the behaviour of others are apparent in the extract in Box 7.18, where the discussion between group members also highlights differences in the importance which participants attached to such problems. Whilst media attention has often focused on young people and alcohol in urban areas, it has been recognised that this can also be a problem in rural areas (Leyshon 2008b; Valentine et al. 2008). A number of groups, which included participants who *did* consider themselves to live in the countryside, highlighted problems with a lack of open space in their local area. Many of these participants felt excluded from such spaces due to the behaviour of other people; which, as will be discussed later in this section, did not exclusively mean other young people.

Box 7.18 Concerns about Behaviour of Other People

NHB	In terms of things that stop people being healthy, the things that were mentioned by this groups last time were smoking, a lack of parks in the area and there being nothing to do.
Daniel	yeah because a lack of parks is like a lack of exercise because
Jason	Not if you do it
Daniel	But the lack of parks is through due to vandalism because all the Chavs go there and start ridin their bikes around
Niall	Not all the Chavs. Not all the Chavs
Daniel	Yeah. They've had to take the swings down
Jason	I'm a Chav!
Daniel	because every day Chavs from after school go an swing the swings over and over the bars continuously until they get stuck
Niall	Then you just pull it down with a stick don't you… it's easily solved
Daniel	but like if there's a place right where there's no parks at all people will be bored just sittin down and doin nowt
Niall	But that's what wes always do.
Daniel	cos there no place to go is there, we canna exactly play football in the park like
Jason	You just stay in the house on the computer and eat a packet of crisps
Niall	exactly
NHB	So do you think that's a problem round here?
Jason	yeah
Niall	yeah
Daniel	If you've got a park somewhere then you're more likely to go to it and you're more likely to run about.

(Daniel, Jason and Niall, Year 8, Interview, Hillcrest)

At Meadowcroft, a number of participants talked about the impacts of changes to public and open space in their local area and the ways in which this had restricted their options for exercise and outdoor play. The extract in Box 7.19 offers an account of the way in which the council's attempt to regenerate one area and encourage investment and development had lead to the loss of appropriate space for young

people, and it was clear from the discussion that this change was resented by participants. Concern and resentment about the mixed messages received from the perceived gap between policy makers' advice and the space, services and facilities provided was also apparent amongst a number of the Hillcrest participants.

Box 7.19 Loss of Space through Council Policy

NHB	Are there other things that you think are important for health that we've not talked about?
Ruth	Like the people like within the society I suppose. If you want to go and play football then some older people might come and shout at you and say that you can't play football ere and that might be the only place in your area that you can go to and go and do stuff an they're not allowing you to
Dave	And there's like limited play areas and then so if you go to somewhere else then it's like no ball games and so they'll kick you off and you'll get into trouble and then you'll just think well there's nowhere we can go so you probably won't play.
Luke	the Council, they're not doing anything, they like take all the greens away and put all these stupid little ornaments in the middle and all that.
NHB	Have they done that round here?
Luke	yeah, in Crook
Nick	and [*name of village*]
Dave	Down the street like two seconds from where I am there used to be a massive green with a park and swings. They took the swings down and put like a stone tree in the middle and then paths all around it
Luke	so you can't use it
Nick	it's stupid
Will	it's stupid
Ruth	and if there isn't any, like we live in Crook, and we used to go there to play football and that and there's nowhere else
Will	there's nowt at all
Ruth	there's like a little youth centre near like Glenholme swimming baths, but
Isabel	we don't go there
Ruth	I think that's like
Dave	Where all the smokers go
Ruth	yeah, and there's like a skate park as well, but I've heard that that's where they do drugs an all.
Nick	Where we live, there's a lot of space where we live to play football
Will	yeah
Nick	so there is fields
Will	there's like loads of fields an that

(Year 10 group, Meadowcroft)

However, as I have already mentioned, some participants expressed a clear reluctance to use facilities in their local area when these were available. Whilst many of the young people in this category cited concerns about the safety of the areas, issues of antisocial behaviour or tensions with other members of the community as their reasons for not using facilities, some had reservations about how they would be viewed by their peers. In Box 7.20, some members of the Year 11 group at Meadowcroft highlight a reluctance to use the facilities in their area, such as the swimming baths, and their concerns appear to centre around a fear of being seen by people they knew. This issue was explored further in the follow-up interviews and, whilst these participants had problems articulating their exact concerns, issues of

identity and belonging and a desire to fit in with local social and cultural norms appeared to be significant. These trends regarding the use of specific spaces and places again connect with issues discussed in this thesis surrounding performance and performativity, identity, stigma, power, discourse and resistance.

Box 7.20 Reluctance to use Local Facilities

NHB Do you think the areas where you live are healthy?
Jess I don't think, not really
Clare No
Emma no
Jess There's like the school gym isn't there and the one above the chemists
NHB uhum?
Clare There's gyms like around [*name of village*]
Jess Yeah there's two
Lucy two
Jess But it's your own choice if you use them
Emma Yeah
Clare I wouldn't go I don't think
NHB Do you all live in [*name of village*]?
Emma Na Crook
Lucy Crook
Jess Us three do, don't we?
NHB Okay, so three [*name of village*], two Crook
NHB [to Emma and Lucy] So what about the two of you, do you think Crook is healthy?
Emma There's loads of places for sport if you wanna, cos like there's the swimming baths and there's a gym there but like not anything else really
Jess Um.
Lucy and like you wouldn't dare go an use them though
Emma Ah know
[giggles]
NHB you wouldn't dare go and what?
Emma You wouldn't use them. Ah don know, I wouldn't
[agreement from others]
Emma If you didn't know anybody you might, but.
(Year 11 group, Meadowcroft)

As was highlighted earlier in this section, many of the young people I worked with felt that living in the countryside was, or would be, good for health. In addition, they generally had clear ideas of what they considered to be key features of countryside. However, there were ambiguities surrounding whether their local areas fitted with their understandings of countryside. Similarly, whilst may of the participants felt that access to outdoor space was important for health, there were ambiguities surrounding the ways in which this did (not) translate across to their lived experiences.

Whilst access to outdoor space was an important theme in many of the groups, it did not appear to be a priority for all participants. The reluctance of some participants to use the spaces and facilities which were available in their area, which was noted in relation to Box 7.20, does point towards the possible suggestion that these participants did not attach a high level of importance to such spaces. The extract from the follow-up interview with Jess and Lucy shown in Box 7.21 similarly raises questions about the

importance which they attach to outdoor space. Whilst they initially say that they would use outdoor spaces if there were more available, it is clear from the development of the conversation that they are more interested in entertainment than spaces for physical activity. In addition, it is important to recognise that, as the extract in Box 7.22 demonstrates, not all of the participants thought that the countryside or open space would have any impact on health, and some participants did not feel it mattered where people lived. Furthermore, some participants felt that the people living in an area influenced health rather than the place being an influence, as highlighted by Philip in Box 7.23. This links back to the discussion in Chapter 3 about contextual and compositional understandings of health inequalities; and the range and complexity of views expressed by the young people I worked with, as outlined both in this Chapter and in Chapter 5, fit with my earlier argument towards a relational understanding of health and health inequalities.

Box 7.21 Questions about the Importance Attached to Outdoor Space

NHB If there were more places to kinda do stuff outside would you actually use them?
Lucy Yeah. I think so, if it was like something different instead of like, like something that does actually attract people of our age group
Jess yeah
Lucy And so it could be more like, more exciting instead of jus havin stu's and stuff if there was actually events and stuff held
NHB Such as?
Lucy Um Ah dunno.
Jess Um like um they do do discos
Lucy Yeah
Jess But if they had like groups performing or sumthing like that then people might go. Um
NHB so more on the entertainment side of it?
Jess Yeah
(Jess and Lucy, Year 11, Interview, Meadowcroft)

Box 7.22 Space does not Matter for Health

NHB A lot of groups that I've worked with have talked about living in the countryside being good for health, do you think that that's something that makes any difference or not?
[pause]
NHB Because it wasn't something that you talked about at all
[pause]
Katie I dunno
NHB you dunno, um, do you think that people are equally healthy whatever kind of area they live in?
Louise Cos it's down to them really what they do and it doesna really matter I don't think
NHB Okay. So you don't think that for example someone who lived in like Teesdale or Weardale would be any different to someone who lived somewhere like Bishop Auckland
Katie I don't think it matters
Lizzie Na
Louise It doesna matter
(Katie, Lizzie and Louise, Year 8, Interview, Meadowcroft)

Box 7.23 People more Important than Place

NHB Do you think the area where you live is healthy?
John Yeah but there will be prob more like there will be healthier areas but it is quite a I would say it's a healthy area, like pollution wise it's not as bad as like cities, I mean yous could go to Bishop Auckland and compared to here now, Bishop Auckland you'd be probably less healthy than here because it's a main town and so there's a lot of traffic going through and all the stuff like that.
NHB Uhum?
[pause]
NHB Is it, is it just the environment which makes places healthy or unhealthy or are there other things as well?
Philip Uh it's also um the people um who um who's in the area. Could be lots of um ahh other um like mm not clean like um dog, who um jus, jus um, jus not respect that um they live in the environment.
(Year 8/11 group, Riverview)

When thinking about the ambiguities surrounding perceptions and representations of the countryside, open space and health it is worth noting that 'countryside', as identified by the young people I worked with, was not always confined purely to more remote areas. For example Jacob, in Box 7.24, lived in an area just outside the town of Bishop Auckland and both he and the other participants in the same interview felt that Jacob lived in the countryside. Yet the area where Jacob lived was less remote and more built-up than many of the areas where the Meadowcroft participants lived, or Penny and Sarah's local area, and none of these other areas was really viewed as 'countryside' by the participants who lived in them. This raises questions about the ways in which young people's understandings of the countryside evolve and the possible impact which personal experiences and exposure may have upon this process.

Box 7.24 Living in the Countryside

Jacob I live in [*name of village*]. That is kind of healthy because it's got like lots of trees
Greg you live in the middle of nowhere
Shane nature stuff
Jacob yeah, Naturey stuff.
(Dean, Greg, Jacob and Shane, Year 9, Interview, Hillcrest)

In addition, Chapter 6 has already highlighted the role of media representations in sculpting young people's health beliefs and behaviours, and Section 7.2 of this chapter has included a brief discussion of media representations of the countryside and the impact which such representations may have. Writing in the Global South context, MacKian (2008) discusses the role of the media in the construction of therapeutic landscapes through the ways in which the media represents health and health debates, and I would suggest that the media does play some role in sculpting young people's views about the countryside and health. Whilst I did not explicitly discuss with participants the ways in which representations in the media and literature had

influenced their views about the countryside and health, it is clear from some of the discussions (such as the extract in Box 7.25) that participants were absorbing ideas and representations from books and the media into their frameworks of rural reference and experience. In this example, Lucy draws on an international example when trying to articulate ideas relating to her local area and the reasons why she doesn't consider her local area to be either countryside or healthy. This illustrates the juxtaposition and mutual constitution of global and local, and scalar interconnectivity and multiplicity, in the frameworks of reference deployed by these participants.

Box 7.25 Amish People

NHB	that's interesting because you were saying a little while ago that you thought living in the countryside was healthy, but you kind of live in the countryside here.
Clare	Um
NHB	Don't you?
Lucy	Um
Jess	Ah s'pose so.
NHB	So um I'm just wondering what you think the difference is, or what kind of countryside would be healthy?
Jess	A don't know
Emma	it depends
Clare	Like if you have little villages and things and like that are no-where near big places where have like restaurants and things like that
Jess	Cos even Willington the gym right
Lucy	Them Amish people, I bet they're healthy
Emma	which people?
NHB	I'm sorry, what was that?
Lucy	Um them Amish people, I bet they're healthy
Clare	Why?
Lucy	Because they don't, um, I can't remember, I read it in a magazine

(Year 11 group, Meadowcroft)

This section of the chapter has outlined some of the ways in which the countryside in County Durham has been represented through promotional literature and has discussed participants' own understandings of 'countryside' and their local area. It has suggested that idyllised and romantic notions of rurality are pervasive, both in the ways the area is marketed and in young people's perceptions of what does (or does not) constitute 'countryside'. As I have discussed, there was considerable uniformity with regard to the key features participants associated with countryside. However, a number of related conceptualisations of the countryside were apparent within this; including ideas relating to the countryside as an open or non-built up area, freshness (of both air and produce), the countryside as 'traditional' and the countryside as a peaceful, tranquil or relaxing place. The majority of the participants involved in the qualitative phase of the work believed that living in the countryside was beneficial for health; often citing the availability of open space for exercise or a romanticised notion of residents eating self-grown and healthier produce. An interesting discrepancy has been noted in this section between some participants' understandings of 'countryside'

and their perceptions of their local area, with a number of participants living in areas containing what they considered to be key features of 'countryside' without feeling that they lived in the countryside. This theme will be explored further in the next section which will consider participants' experiences of and access to the countryside, and the ways in which this appears to have shaped some of their views.

7.5 Young People's Experiences of and Access to the Countryside

As was noted in Section 7.2 the conceptualisation of rurality used in this thesis draws on existing work on rural hybridities, which emphasises the importance of both rural reference and rural experience. So far, the discussion in this chapter has focused primarily upon issues relating to rural reference, such as ways in which the countryside is represented and young people's stereotypes about the countryside and health. However, such representations form only part of the current picture in terms of the sculpting of young people's beliefs about the countryside and health, and this section will explore participants' experiences of the countryside and the ways in which such experiences intersect with frameworks of rural reference.

As this section will discuss, there was considerable variation in participants' experiences of and access to the countryside and rural areas. Whilst their areas of residence inevitably influenced young people's exposure to rural areas, with some living in more urban environments, this cannot on its own explain such variations in participants' experiences of countryside and it is therefore important to look to social and cultural factors as well. Many of the participants, especially at Riverview, did have direct experience of day to day life in countryside areas, as illustrated by the discussion in Box 7.26.

Box 7.26 Direct Experience of Countryside

NHB	A lot of the groups that I worked with talked about living in the countryside being healthy,
Simon	Um
NHB	is that something you would agree with?
Karl	Probablys, yeah, because all the pollution like in the cities like is bad for ya, whereas in the countryside there's like more trees and more oxygen and less pollution
NHB	[to Mike] What about you?
Mike	I agree
NHB	Do you think that you live in the countryside?
Karl	Yeah
NHB	where do you live?
Karl	On the hill over there [indicates]
NHB	Which is where?
Karl	[*name given*], on a farm
NHB	[to Mike/Simon] What about the two of you, do you think you live in the countryside?
Simon	yeah
NHB	And where are you?
Simon	literally here, in [*name of village*]
Mike	and I'm the same…[pause]…it's sort of countryside but, ah, yeah
NHB	In what way is it sort of countryside and sort of not?
Mike	Cos the whole of Weardale is countryside
NHB	um?
Mike	Just you get the little villages

(Mike, Year 10 and Simon and Karl, Year 9, Interview, Riverview)

Karl, who lived on a farm in Weardale, was able to give tangible examples of how living in the countryside helped him to be healthy. His account, in Box 7.27, picks up on some of the themes identified in the previous section such as the impact of farm activities. On numerous occasions during the group discussion and interview in which he participated, Karl talked about his involvement on the farm and with outdoor activities such as mountain biking, and his implicit assumptions about the normalcy of his experiences and views resonate with Convery et al's suggestion that

> "whilst livestock–farming relations may be socially constructed and dynamic, thus engendering particular sets of farming practices at particular times and places, they nevertheless form *lifescapes* of 'taken for granted' social, cultural and economic interactions between humans, livestock and landscapes" (Convery et al. 2005: 100 emphasis in original).

Furthermore, Karl's intimacy with farm life and outdoor activities, and discussion of these, also appeared to provide a vehicle for the performance of his identity as a young rural male (see Matless 2000 for discussion of corporeality and countryside; Saugeres 2002 for further discussion of relationships between farming, land and masculinities). For Karl, this involvement in outdoor activities the maintenance of his physical prowess appeared to be fundamental to his identity and self-esteem.

Box 7.27 Farm Activities and Health: Karl's Narrative

NHB Do you think it would actually make any difference to your health, kind of for yourselves, if you lived somewhere else?
[brief pause]
Simon Depends where else it is
NHB If you lived in say Bishop Auckland
Karl Ah reckon, Ah'd probablys like not be as healthy, because when Ah'm on the farm am like have to go and check on the animals or somethings and just see like how many we've got and if I lived in Bishop or something it would just be like running to the fish and chip shop
[brief pause]
NHB what do you think?
Mike um
NHB do you think you'd be the same if you lived somewhere else? Different?
Mike yeah
NHB Which?
Mike Newcastle you'd have all the more like pollution, but I don't think Bishop would be as bad and [*name of village*] isn't that bad
(Mike, Year 10 and Simon and Karl, Year 9, Interview, Riverview)

Similarly Craig, who lived in a small village outside of Weardale drew on personal experiences of his father's vegetable growing, as illustrated by the extract in Box 7.28. His association between plant cultivation and health resonates with some of the existing therapeutic landscapes literature which explores therapeutic aspects of gardening and horticulture (Milligan et al. 2004; Parr 2007), although these authors did not consider young people.

Box 7.28 Plant Cultivation and Health

NHB A lot of the groups, um this wasn't something that your group discussed at all, but a lot of groups I've worked with have talk, have said that they think living in the countryside is good for health. Would you agree with that or not?
Craig Yes because if you live in a city then you've got less access to fruit and vegetables unless you can shops but if you live in the countryside
Steven you can grow your own
Craig then, yeah then lots of people have allotments so you can grow your own like me Dad's got tons of leeks here n there, and carrots and stuff like that and you've got access to them resources to make healthy stuff instead of havin to go out an buy it so whereas you could buy a carrot for what 50 pence or 10 pence or something but then you can get seeds for five pence and grow your own so it's cheaper and so families with less income can be healthier as well, or jus stuff like that.
NHB Uhum? [to James] What do you think?
Steven I think that you are more healthy in the countryside because ya if you're like a farmer then you can grow all the all them vegetables and means that you must eat like less of the unhealthy foods.
NHB Uhum.
[pause]
NHB Do you think that you live in the countryside where you live?
Craig uhum
Steven Na
James yeah
(Craig, James and Steven, Year 8, Interview, Meadowcroft)

These same themes surrounding farming and cultivation were sometimes identified by participants with less personal experience of the countryside. Although

Bernadette and Erin, in Box 7.29, came from travelling families, they had been settled for a number of years in a permanent traveller's site on the edge of the town and did not ordinarily travel far from their immediate neighbourhood. They both appeared to hold a fairly romanticised understanding of the countryside which incorporated ideas around freshness, cultivation and animals – a theme which has already been introduced in the previous section in relation to some of the Meadowcroft participants.

In contrast to participants such as Karl, some of the young people I worked with appeared to have virtually no personal experience of the countryside or rural areas. For example, Grace and Jade, who attended Hillcrest, lived less than ten miles from the edge of the North Pennines AONB but they had never heard of Weardale and Teesdale, which were their nearest valleys. Yet, as illustrated in Box 7.30, they were familiar with Teesside Park – a large retail and leisure complex adjacent to an urban park – over twenty miles from where they lived. Given that some of the participants had little exposure to countryside areas in everyday life, it is possibly not surprising that the discussions surrounding key features of countryside, which were outlined in the previous section, appeared to draw heavily on rural reference and tended to mirror idyllic constructions of rurality. As Horton (2008a) highlights in his discussion of the TV programme *Postman Pat*, children are generally exposed to representations of idyllic rurality from an early age. The same also applies to a number of children's books including classics such as *The Secret Garden* and many of the Enid Blyton books such as *The Magic Faraway Tree* and the *Famous Five* series. Thus it is not surprising that such representations are incorporated into young people's frameworks of rural reference, especially when they have limited rural experience to draw upon.

Box 7.29 Romanticised Notions of Countryside

NHB	a lot of the groups, not so much in this school but in the other schools, have been talking about living in the countryside being good for health
Abi	yeah because you get fresh stuff like from the farms
Bernie	But you're not exactly going to want to go and live in the countryside just for healthy food
Abi	some people might
Bernie	Or ah wouldn't
NHB	so you don't think the countryside is healthier?
Bernie	it is healthier but you're going
Erin	You can buy stuff fresher
Bernie	To move just for healthy food
NHB	do you think if you lived in the countryside that you'd actually be any different?
Abi	yeah
Bernie	Because you could walk around the fields to check on the animals and things like that so you're losin weight
Abi	and there's not as much pollution so for your health and everything like getting into you and there's not like
Erin	So you'd have to like
Abi	MacDonald's and everything like that just round the corner
Erin	Yeah

(Abi, Bernadette and Erin, Year 10, Interview, Hillcrest)

Box 7.30 Lack of Experience of Local Rural Areas

NHB	So if you lived like in Weardale or Teesdale do you think you'd be any healthier than you are now?
Jade	Ah don' know where Weardale or Teesdale is
NHB	okay.
Helen	Teesdale's like more countryside isn't it?
Grace	Teesside Park?
Helen	Cos you see like loads of fields and that
Jade	Ah go to Teesside Park all the time
Grace	But Teesside Park's where all the shops and that are
Jade	yeah
Grace	You don't see trees
Jade	You do on the way though
Grace	yeah, you do on the way but not like
Jade	an then Piercebridge on the way off the motorway like that's got trees and that

(Helen, Grace and Jade, Year 8, Interview, Hillcrest)

Whilst Grace and Jade had virtually no meaningful exposure to rural areas, some of the other Hillcrest participants did go into the countryside regularly despite living in a more urban environment. For example Daniel, in Box 7.31, went to help on a farm every week. However, it should be noted that, unlike many of the other Hillcrest participants, Daniel lived in a wealthier, middle class area and was from a middle class family. It was clear from the discussion groups and interviews that Daniel was accustomed to a different social and cultural environment compared to some of the other Hillcrest participants, and he held a negative image of both his local environment and the behaviours of other sections of his community. As the extract reveals, for Daniel and his family, the countryside was a form of escape from the pressures and non-therapeutic aspects of their everyday landscape and this echoes some of the ideas in the therapeutic landscapes literature surrounding the notion of retreat (Lea 2008). However, for some other participants the countryside was regarded as an area where 'other' and wealthier people lived or visited. These examples illustrate the ways in which certain places and people were simultaneously both stigmatised and esteemed by different participants, often reflecting social-class or gender identities. Throughout the discussions in which he was involved, Daniel made a number of disparaging remarks about 'Chavs' and the areas in which they lived. The stigma which Daniel attached to these people and places was enacted clearly through performances of his middle class identity and the ways he contrasted himself to other people. At the same time, a number of other participants at Hillcrest enacted stigmas towards 'posh' children and young people such as Daniel.

Box 7.31 The Countryside as a means of Escape: Daniel's Narrative

NHB	Some of the groups I've worked with have talked about living in the countryside being good for health
Daniel	yeah
Jason	yes
Niall	yes!
Daniel	Yes that's why I
Niall	That's not really you don't see Chavs like with jewellery and make up
Jason	there's less pollution
Niall	And you don't go around smoking dope and that and you don't like breathe in the air fumes
Daniel	Me and me mam and ma sisters go to a farm to help out every week and because we want to get rid like get away from the parks and the kids playing football outside because like they've smashed the window once. It's shocking.

(Daniel, Jason and Niall, Year 8, Interview, Hillcrest)

As noted earlier in this thesis, many areas of County Durham are characterised by low social and spatial mobility. A number of the young people I worked with had only limited experience of places outside their immediate neighbourhoods, as illustrated by Lucy's comments in Box 7.32. In general, there appeared to be less spatial mobility among Hillcrest and Meadowcroft participants compared to those at Riverview.

Box 7.32 Limited Experience of other Neighbourhoods

NHB	Do both of you live in Crook?
Lucy	Yeah
Jess	No. Ah don'
NHB	Um because a lot of people here have been talking about some bits of Crook being healthy and others aren't. Is that something you would agree with?
Lucy	I don' kna cos I live like in the middle of Crook where like the main street um I wouldn't, because there's lots of takeaways and like pizza places and Italians an things like that so Ah would say that it is healthy, but there's like the takeaways as well. It jus depends really I think.
Jess	um.
Lucy	I've never been to any other part of it really, just the main part, like the middle.

(Jess and Lucy, Year 11, Interview, Meadowcroft)

Some of the participants with lower spatial mobility and limited experience of other areas had problems dealing with questions about whether living in a different place would affect their health. Many of these participants struggled to deal with the more abstract ideas surrounding what different places might be like and the ways this might impact on health and well-being. This difficulty is illustrated by Sarah's comments in Box 7.33, and it is worth noting that Sarah had generally offered very clear and articulate answers during other sections of the group discussion and interview.

Box 7.33 Problems Dealing with Abstract Questions about Different Places

NHB Do you think it would make any difference to your health if you lived somewhere else, so instead of living in Tow Law you lived in say Bishop Auckland or you lived in Crook or somewhere like that?
Sarah I think it would be worse livin somewhere like that cos like Tow Law's really not that busy whereas if you go ta Bishop ah mean it's a town, there's all the shops, there's nothing a really in Tow Law so Ah s'pose. Car fumes could damage your health a bit more. [brief pause] Ah don know.
NHB what if you lived in say Teesdale or somewhere like that? Would it make any difference to your health?
Sarah Same again, ah don' know really
(Penny and Sarah, Year 10, Interview, Riverview)

A further insight can be gained from the extract in Box 7.34, which came from the discussion group in which Sarah was involved. Whilst Sarah had problems imagining what other places in the local area might be like and how this could impact upon health and well-being, she made a number of references to problems in 'poor' countries. Here, it appears that the comparisons were being drawn with places these participants had learned about in school and seen on TV and some of the participants, such as Sarah, had a greater understanding of 'poor' or less developed countries than they did of other areas of their own country or neighbourhood.

Box 7.34 Awareness of 'Poor' Countries

Sarah You might live in a poor country so you canna afford any of these whatsoever.
NHB Does it just have to be a
Karl How can you not afford fitness though? you can like
[laughter]
Louise you can't possibly
Dawn like if you live in a place which has no walks and no way of getting exercise
Sarah Or if you do fitness then you have nothing to drink and like so therefore you die.
Penny Yeah
[laughter]
Simon Yeah, but that's not very likely.
(Year 9/10 group, Riverview)

I would like to suggest that discrepancies between the idyllised notions of rurality presented in young people's sources of rural reference, such as books, magazines and TV, and their personal experiences of their local area and or other rural areas they have visited have contributed to some of the ambiguities surrounding 'countryside' which have been discussed in this chapter. As the discussion in this chapter has already illustrated, there were a number of participants (such as Dave and Nick who were discussed in Section 7.4) who felt that their local area was in some way not quite countryside. In Box 7.35, the participants describe one of the villages on the edge of Bishop Auckland as being 'sort of' countryside. In this instance, the ambiguity appeared to centre around the village's proximity to both 'countryside' and the town.

However, this reason did not apply to some of the other areas which participants felt were 'sort of' or 'not quite' countryside.

Box 7.35 'Sort of' Countryside

NHB	In [*name of village*], do you think you live in the countryside or not
Niall	Near. It's like more in the countryside than where they live but it's not like
Daniel	five minutes and you'll be there
Jason	Yeah cos like trees and stuff
NHB	So what do you, is it countryside or isn't it?
Niall	What?
NHB	do you think it's countryside or not?
Daniel	no
Niall	Not, not totally countryside
Jason	but sort of

(Daniel, Jason and Niall, Year 8, Interview, Hillcrest)

The ambiguity surrounding countryside was also apparent in discussions with Sarah and Penny at Riverview who, like many of the Meadowcroft participants, did not consider the area they lived in to be countryside despite the presence of features which they had elsewhere in the discussion identified as being key features of the countryside. The 'small town' where Penny and Sarah lived was actually smaller than many of the villages in Weardale, which participants almost universally did view as countryside. Yet, as the extract in Box 7.36 illustrates, Sarah in particular was adamant that the area where they lived was not countryside. This raises the obvious question of why an area which had the features she associated with 'countryside' and was smaller in size than Wolsingham, which she uses as a comparison, was not considered to be 'countryside', and this issue will be explored further Section 7.6.

Whilst the concept of therapeutic landscapes was not discussed with participants during the empirical phases of this PhD, there are a number of connections between the discussions and debates surrounding the countryside and health and the notion of therapeutic landscapes. In both this section and Section 7.4 of this chapter, I have argued that the vast majority of young people I worked with considered the countryside to be a healthy place to live and all associated similar features (such as trees, animals, fields, open space and fresh produce) with countryside. This idyllised representation of the countryside, which the majority of participants implicitly drew upon, could be considered a therapeutic landscape due to the health benefits it was perceived to promote. At the same time, as this chapter has discussed, some rural areas within the study area contained the key features participants associated with 'countryside' but were not viewed as either healthy places to live or as countryside. Therefore, these areas which are in some way considered to be 'not quite' countryside cannot be seen to offer a therapeutic landscape in the same way as those which were considered to be both 'healthy' and 'countryside'. The final section of this chapter will

explore some possible reasons why the areas in question did not fit with representations of therapeutic or healthy countryside and related issues of power and performance.

Box 7.36 Ambiguity Surrounding Countryside

NHB	A lot of the other groups I've worked with have talked about living in the countryside being good for health. Is that something you would agree with, or does it not make much difference?
Sarah	It doesn't really make much difference ta me.
Penny	Na. nor me.
Sarah	ah mean you're still getting the same foods but Ah s'pose in the countryside you can jus go out an pick them, then
Penny	yeah I suppose,
Sarah	I mean you're still getting the exercise at the same time
Penny	it's like if you go on holiday to Spain or sumthin then you're not goin to turn round and say 'ah no I'm not in the countryside I'm not going ta eat anythin'.
NHB	Yeah, um some of the groups I've worked with, I mean particularly down in Bishop Auckland have been saying 'oh the people who live in the countryside are healthier'.
Sarah	Well I s'pose there's a lot more places ta walk because if you're in a city then like you've just the same shops and you're surrounded by car fumes all the time and you're surrounded by all these fast food places, Ah mean if you've got a busy job then you're just goin ta go into a fast food place aren't ya. Whereas if you've got in the countryside and you've got time then yes Ah s'pose, but that's like anywhere.
NHB	Do you consider yourselves to live in the countryside?
Sarah	Naaoo.
Penny	No
NHB	Where do you live?
Sarah	Ah live in Tow Law, bu there's nothing really around is there?
Penny	Na
NHB	[to Penny] Would you consider yourself to live in the countryside?
Penny	I'm not sure actually. Me mam an dad want ta move to Spain when I leave school, but Ah'm not sure if I want to go
NHB	But where you live now, do you think it's country, in a countryside area?
Penny	I don't know
NHB	do you think it's kind of
Sarah	It's a small town, surrounded by fields
NHB	Are you both in Tow Law?
Penny	yeah
Sarah	yeah
Penny	it's just like a small, a little town with lots of fields and sheep
Sarah	It's not like Wolsingham really, it's got a few more shops than here but there isn't no bakeries or things like that

(Penny and Sarah, Year 10, Interview, Riverview)

7.6 The Industrial Legacy in Rural County Durham and its Implications

This chapter has explored the ways in which the 'countryside' has been represented in academic and popular discourses, ideas surrounding the countryside and health and the notion of therapeutic landscapes. Furthermore Sections 7.4 and 7.5 of this chapter have also discussed the views and beliefs held by the young people I worked with regarding the countryside, health and their local areas, and the ways in which some of the 'rural' areas where participants lived were not considered to be 'countryside' despite the presence of features which participants considered to be key

aspects of countryside. It has been noted that the distinctions which were drawn between areas which were considered to be countryside and those which were only 'sort of' or 'not quite' countryside could not be attributed simply to the size of the residential areas, their proximity to urban areas or key features of their landscape.

During the fieldwork it became very noticeable that all of the areas which appeared to be 'rural' but were not considered to be 'countryside' fell within former coal-mining areas or, as was the case with Tow Law, near former steel works. Therefore, they were areas which has previously been involved in heavy industry and, as noted in Chapter 5, many of the participants involved in the project (both in the qualitative phase of the research and in the questionnaires) considered industrial areas to be 'unhealthy'. Whilst none of the participants cited the industrial heritage of the area as an explicit reason for not considering it to be countryside, I would suggest that this has had a profound impact on the areas in question; both in socio-economic and cultural terms, which have already been discussed in Chapter 6, and in terms of the ways the areas are perceived both by locals and by outsiders. Although dated, I believe that Benney's description of rural County Durham still hits at the crux of the problem; namely the tension between the area's ruralness and its industrial heritage:

> "There are a hundred and ten villages and towns with a predominantly mining population scattered fairly equally over the five hundred square miles of this county. Although many of these villages are set in the heart of some of the loveliest country, they represent and [sic] extraordinarily uniform picture of bleak ugliness to the stranger with standards set by South of England villages" (Benney 1978: 51)

Whilst the miners Benney describes have gone, or are no longer employed as miners, the legacies of the coal-mining and steel industries continue to shape the socio-economic and cultural geographies of the area. Despite the glossy promotional images of idyllic rurality discussed earlier in this chapter, County Durham remains the most deprived rural area in England – with the Wear Valley being the second most deprived area of County Durham.

For some of the participants, such as Karl and Daniel, the discussions around the countryside and health provided a vehicle for articulations and performances of identity. As was discussed in Section 7.5, Karl's identity as a young rural male was asserted through the frequent references to his farming involvement and participation in outdoor activities such as mountain-biking. At the same time, Daniel used references to his weekly farm visits as a mechanism for asserting his suburban 'middle class' identity and contrasting this to those of 'Chavs' in his local area. Like Leyshon, I believe that "the lives of young people in the countryside are multi-dimensional, complex and textured in ways that demand further analysis", that the performances involved "[expose] the fluid, inclusionary and exclusionary lifestyles they lead" (Leyshon

2008a: 2-3) and that these cannot be separated from either the social and cultural relations in which their lives are embedded or the discourses surrounding notions and representations of rurality. Yet, whilst Leyshon suggests that "rural young people's identities…are produced through an infusion of locally (rural) and globally (urban) mediated culture(s)" (Leyshon 2008a: 22) I would argue that the rural and urban are simultaneously both global and local.

Whilst the literature on therapeutic landscapes has generally sought to separate differing cultural constructions, Brown and Bell (2007) suggest the focus on nature as a setting for health-enhancing physical activity is becoming increasingly global. The role of globalisation is also highlighted in Hoyez's (2005) discussion of yoga and therapeutic landscapes which traces the interplay between local and global phenomena. In the context of this chapter, the discourses and beliefs surrounding the countryside and health – and thereby the extent to which different rural areas fit with the idea of a therapeutic landscape – have been shaped through the intertwining and mutual production of global and local discourses and representations, in which local beliefs and realities cannot be fully separated from global trends or phenomena. The interweaving of representations of rurality with local ideas and global phenomena discussed in this chapter fit with Little and Austin's suggestion that:

> "While there is clearly an important *national* construction of the rural, it is at the local level that the dominant meanings are negotiated and that the particular variations in individual factors and localised constructs are played out (often in a complicated and multifaceted way)." (Little and Austin 1996: 103).

However, I would go further than Little and Austin and suggest that, as with the issues such as food and technology discussed in Chapter 6, the global and local are mutually constituted and produced in relation to frameworks of rural reference and rural experience. At the same time, representations of, and discourses surrounding, the countryside from sources such as the media, TV and literature remain powerful and pervasive; helping to shape young people's frameworks of rural reference and the ways these intersect with rural experience. Thus, the ways in which power and discourse are deployed and manifest in relation both to frameworks of rural reference and to participants' perceptions of different people and places do not scale discretely at either the local or global level, and operate through and within a multiplicity of juxtaposed spaces and contexts.

This chapter has highlighted the power and pervasiveness representations of idyllised rurality. It has also discussed the importance of open space and the ways in which young people's use and experiences of the countryside intermingle with issues of identity and the performance of these. Chapter 6 had previously discussed issues of power, performance, space and scale in relation to the sculpting and performance of young people's health beliefs and behaviours and the intertwining and mutual

constitution of ‘global’ and ‘local’. The final concluding chapter of this thesis will examine these issues in relation to the research questions which were outlined in Chapter 1 and will offer and overview of the key issues discussed in this thesis.

Chapter 8 Conclusion

8.1 Chapter Introduction

The purpose of this final chapter is to draw together some of the key ideas and themes in this thesis and highlight the contributions they can make to work both within and beyond Children's Geographies. This chapter will begin with a summary of the study undertaken before moving on to an analysis of the findings chapters. Building on this, Section 8.4 will discuss the ways in which the material and ideas in the thesis can help in addressing the research questions which were introduced in Chapter 1. The penultimate section of this chapter will highlight the main contributions which this thesis can make to work on Children's Geographies, based on the four key themes outlined in Kesby et al (2009), and will discuss possible future research directions for work within Children's Geographies. However, I believe that the main contributions of this thesis, and opportunities for further research, lie beyond Children's Geographies and these issues and possibilities will be outlined in Section 8.6.

8.2 Summary of Study

As was stated in Chapter 1, the main aim of this thesis was to explore the ways in which young people's health beliefs, attitudes and behaviours are constructed, mediated, and performed. The empirical work undertaken explored what young people considered 'health' to mean, what it means to be 'healthy', the key issues which they believed had influenced their own health and the main risks to health for young people in their local area. Alongside this, this study has also explored whether young people considered some places to be healthier than others, the kinds of places which they thought were healthy and unhealthy and the reasons behind this. As has been discussed in both the introduction to this thesis and the substantive chapters, the research undertaken for this study has focused on the Wear Valley area of County Durham, North East England, and involved young people of secondary school age. Three of the secondary schools in the area were involved in the study, as was outlined in Chapter 4.

From a conceptual point of view, this thesis sits at the interface between Social Geography and Cultural Geography, and also draws on discourses from Health Geography, Children's Geographies, Rural Geography and Participatory Geographies. Additionally, the thesis also builds upon interdisciplinary work relating to children and young people and to health and well-being. As Chapter 2 noted, young people often occupy a liminal zone in which they are seen as being neither fully child nor fully adult

and, as has been discussed in Chapters 2 and 4, this has implications for both health and social policy and for research involving young people. Within both policy and research contexts there has been an increased focus of 'listening' to young people and on 'hearing their voices'. As was noted in Chapter 2, this focus on listening to young people has, within policy contexts, centred mainly around the notion of 'consultation', which is frequently adult defined and often imposes adult models or structures upon young people. In research contexts, there has been increasing recognition that the consultative approach to 'listening' to young people is often exclusionary rather than inclusive, and this has lead to an expansion of interest in 'participatory' research methods and approaches which was discussed in Chapter 4 of this thesis.

As has often been the case with research relating to Health Geography or Children's Geographies, this thesis has drawn on a number of different areas in the development of its theoretical framework. In contrast to many studies within Human Geography, this study has taken a more grounded approach to the development of it's theoretical framework. A number of the theories used were identified after the empirical stages of the project had been completed and were based on the themes which had emerged during the fieldwork; rather than my setting out with a defined theoretical framework which informed both the topic and the methodology. The theoretical framework used incorporated three main strands relating, firstly, to issues of space and scale, secondly, to issues of power and, thirdly, to ideas surrounding performance.

Chapter 3 of this thesis has highlighted the importance of place and space for health, but noted that issues of space and scale frequently remain under-theorised within both Health Geography and Children's Geographies, and that the understandings of space and scale used are often implicitly assumed rather than explicitly discussed. In this thesis, I have drawn on some of the recent re-workings of space and scale, which have been based primarily on the work of Foucault and Lefebvre, and these ideas were discussed extensively in both Chapter 3 and Chapter 6. Space and scale are viewed as being produced and yet are continually under construction and (re)formation, they are fluid and involve plurality, multiplicity and juxtaposition and thus cannot be reduced to simple networks or hierarchies.

The examination of issues of power in this study has drawn upon Foucault's work on power, discipline and gaze. As was discussed in Chapter 3, Foucault argues that the disciplining of bodies (and thereby of people) is intrinsically linked to regimes of power and knowledge. Power is a strategy rather than a property or possession. Like space and scale, power involves plurality and multiplicity; it is produced and at the same time is also a producer. Power and knowledge are not fully synonymous, but are mutually constituted and produced. Discipline can take a variety of forms and is both a

technique and a type of power. Gaze offers an additional dimension to both power and discipline and is significant in both the production of discourse and the construction of regimes of power and knowledge. In relation to health and medicine, Foucault's notion of the medical or clinical gaze is similarly both a technique of power and a producer of power and knowledge.

This study has utilised two different theorisations of performance, which I suggested could be viewed as complementary rather than contradictory. Chapter 3 of this thesis noted that Goffman's work on performance is focused largely around questions of how people relate to, and interact with, each other. He discusses the ways in which people present themselves and the staging, performances and role-play involved. In addition, Goffman discusses the stigma which may be attached to those people or performances which are seen to differ from social norms or expectations. In her work on gender and performativity, Butler argues that gender identities are asserted through performances. Like Foucault, Butler maintains that cultural norms and expectations are constructed through regulatory practices and disciplines. She argues that performativity should be understood as the reiterative and citational practice by which discourse produces the effects that it names, and that what constitutes the fixidity of the body is fully material but that materiality needs to be rethought as the effect of power and power's most productive effect. In this thesis the work of both Goffman and Butler has been used to inform discussions surrounding both the performance of health beliefs and attitudes and the construction and performance of identity.

From a methodological point of view this study was, as was discussed in Chapter 4, heavily influenced by the aims and values of participatory research, although it did not achieve the depth of participation I had hoped for because the schools and young people involved were reluctant to engage with the process of research design. The qualitative phase of the study involved groups of young people in group discussions and participatory diagramming activities. Follow up interviews were used both to check that participants were happy with the ways I was interpreting and representing the views they had articulated in the group discussions and diagramming exercises and to follow up significant themes in more depth. These interviews also allowed the study to explore ideas and issues which participants had been reluctant or unwilling to discuss in the larger group context. As was noted in Chapter 4, when asked about appropriate activities for further development of the study, many of the participants felt that the research should involve a survey in their respective schools. Questionnaires were therefore distributed in all three of the schools. The themes covered in the questionnaire drew on ideas which had been important to participants

during the qualitative phase of the project and the questionnaire was designed in conjunction with young people from Riverview High School.

8.3 Summary of Key Issues and Findings

The key results from both the qualitative and quantitative phases of the study were outlined in Chapter 5 of this thesis. As was discussed, participants involved in both the qualitative and quantitative phases of the study generally emphasised physical aspects of health and well-being such as diet and exercise. The questionnaire explored the importance which young people attached to health and the vast majority of respondents said that they thought health was either 'Of some importance' or 'Very important'. Participant's self rated heath was explored in both phases of the study. As discussed in Chapter 5, responses in the group discussions varied with some participants saying they were healthy, some saying they were not healthy and some saying that they were healthy in some respects but not in others. In the questionnaire, the majority of participants rated their health as either 'Average' or 'Relatively healthy'. Self-rated happiness was generally higher than self-rated health in the questionnaire responses. Chapter 5 also offered a brief overview of the factors which participants thought had influenced their own health and the factors which they cited as the main risks to health for young people in their local areas. It was noted that many of the participants highlighted issues such as smoking, alcohol consumption and diet, plus the roles of family, friends and sporting activities. This chapter also offered an initial exploration of participants' conceptions of 'healthy' and 'unhealthy' places – a theme which was developed further in Chapter 7 in relation to countryside and health.

Issues of space and scale have been a significant theme throughout much of this thesis. The idea that we are living in an increasingly globalised world is widely recognised both within and beyond Human Geography. Yet, local social and cultural norms can have a profound impact upon both young people's every day lived experiences and their health and well-being, as can the socio-economic and material environments in which young people live. Drawing on both empirical and theoretical material, Chapter 6 of this thesis built upon some of the recent re-workings of space and scale to discuss the sculpting and performance of young people's health beliefs and behaviours as they relate to both globalisation and everyday life. Particular attention was given to the mutual constitution of the 'global' and 'local', their fluidity, multiplicity and the networks of power and influence which operate alongside and within space and scale. The interweaving of global trends and local cultures was discussed in relation to two key themes. Firstly, young people, food and health and, secondly, the media, technology and young people's health. The chapter argued that a

more nuanced consideration of space and scale can aid understandings of young people's health beliefs and behaviours, and the geographies of these.

Chapter 7 of this thesis focused primarily on representations of the countryside and young people's beliefs about and experiences of the countryside and rural living. This theme emerged from a specific research encounter with a group of young people at Meadowcroft Community College who lived in small villages surrounded by fields and hills but did not consider their local area to be 'countryside'. This encounter led to obvious questions about how 'the countryside' is viewed and understood, and what happens when the countryside is in some way 'not quite' countryside. This chapter therefore considered ways in which dominant stereotypes and representations of the countryside, rurality, health and young people are shaped and expressed. The notion, dominant in the health sector, of a 'healthy', 'wealthy' rurality was also contested.

8.4 Addressing the Research Questions

This section will highlight the ways in which the material in this thesis has addressed the research questions which were outlined in Chapter 1.

8.4.1 Young People's Conceptions of 'Health'

- How do young people conceptualise 'health'?

The first of the research questions addressed by this study explored what participants thought 'health' meant. There are two facets to this question. Firstly, the research has considered what young people think 'health' means and what it means to be 'healthy'. Secondly, some aspects of the research have explored the sources which young people have used in the construction of their health beliefs.

As has been discussed in this thesis, participants placed considerable emphasis on physical aspects of health and well-being. During the qualitative phase of the study almost all of the groups mentioned issues relating to diet and exercise during the participatory diagramming exercises, and this focus was also reflected in the questionnaire responses. Some participants did also discuss social and emotional aspects of health and well-being, especially those attending Meadowcroft Community College or Hillcrest High School.

The discussion in this thesis, and Chapter 6 in particular, has shown that young people draw on a variety of sources in the construction of their health beliefs and attitudes. During the group discussions and interviews, some of the young people involved in the study talked about the media and TV and the impacts – both positive and negative – that these had on the ways in which they thought about issues of health

and well-being. The other main sources which young people used in the formulation of their health beliefs were family and friends, school and personal experience.

8.4.2 Life Experiences, Health Beliefs and Health Behaviours

- What is the impact of differing life experiences on young people's health beliefs and behaviours?

As was discussed in Chapters 6 and 7 in particular, the young people involved in this study drew upon different life experiences in the construction of their health beliefs, attitudes and behaviours, and culture played a significant role in this process. Issues of social class and their impact were highlighted in Chapters 5, 6 and 7, firstly, in relation to possible relationships between unemployment, lower social class and health deprivation; secondly, regarding smoking and drinking cultures and associated performances of white working-class masculine and feminine identities; and thirdly in relation to participants' use of the countryside and attitudes towards this.

A number of participants highlighted the role of family members in shaping their health beliefs and behaviours. For example, as was discussed in Section 6.4.1, Sarah highlighted that her mother was careful to ensure that she and her brother had healthy meals when they were at home. Often, as was the case with Sarah, family members were seen as a positive influence. However, there were some participants who felt that family practices in relation to food and issues such as smoking had impacted negatively on themselves and, as indicated in Section 6.4.2 some of the participants at Hillcrest highlighted that their parents had control over what they ate and that they had been trying to teach their parents about healthy eating.

Friends also had a significant influence on participants' beliefs and behaviours. Both Chapters 5 and 6 have highlighted the significance of drinking cultures in the area and the ways in which these were interwoven with performance of white working-class identities. Many of the participants at Hillcrest and Meadowcroft described the peer pressure surrounding issues such as alcohol consumption and the difficulties in going against this pressure. A number of the female participants at Hillcrest talked about their experiences of bullying and the impact this had on their health and well-being. However, it is important to recognise that friends can also have a positive influence on young people's health beliefs and behaviours and, in Section 5.3, Karl discussed the ways how his friends helped inspire his interest in sport.

As was indicated in Chapter 5 the majority of participants who responded to the questionnaire survey said that they thought health was 'Very important', although some participants questioned the importance of health during the group discussions. Self-

reported health was better at Riverview High School than in the other two schools, which mainly served less affluent areas. In the questionnaire survey, the majority of participants in all three schools said that they were either 'Happy' or 'Very happy', despite the attention which Hillcrest participants had given during the group discussions and interviews to bullying and its impact on health and well-being.

Many of the young people actively engaged in health-enhancing behaviours such as sporting and outdoor activities, and participants like Karl at Riverview attached considerable importance to such activities. As was discussed in Chapter 6, some participants gave careful consideration to their diet and eating practices, and some of the Hillcrest participants had taken an active role in educating their families about healthy eating. However, many of the participants did engage in health-damaging behaviours such as smoking and drinking. Regular smoking was higher among females than males, and was more prevalent at Meadowcroft than the other schools. In addition there was a spatial clustering of smoking in the Crook area.

8.4.3 The Role of Place and Conceptions of 'Healthy' and 'Unhealthy' Places

- What influence does place have upon young people's perceptions and experiences of health, and how can young people's conceptions of 'healthy' and 'unhealthy' places inform our understanding of their perceptions of health and risks to health?

As has been noted in Chapters 1, 2, 4 and 5, County Durham is characterised by marked inequalities in relation to indices of both overall deprivation and health deprivation. A spatial patterning of behaviours such as smoking has also been discussed in Chapter 5, based on data from the questionnaire survey in this study. As was discussed in Chapter 3, there has been considerable debate within Health Geography regarding the roles of contextual and compositional factors with regard to the ways in which place affects health, plus recent calls for a relational understanding of these. Whilst I initially intended to explore the ways in which place, and more specifically area of residence, impacted on young people's health beliefs and experiences of health and well-being, I have realised that this question is as much about the related issue of culture as it is about place.

Young people's conceptions of 'healthy' and 'unhealthy' places generally centred around features or behaviours associated with the places. Places which were seen as healthy included the countryside, parks and wealthier areas; whereas unhealthy places included, pubs, fast food outlets such as McDonald's, cities, industrial areas and poorer areas. As was discussed in Chapter 7, some of the rural areas within

the study area were not considered to be countryside despite the presence of features which participants associated with countryside and, in general, these places also were not considered to be healthy. Those rural areas which were not considered to be either countryside or healthy were all former coal-mining or steel areas; and this highlights the importance of industry and pollution both in terms of conceptions of 'unhealthy' places, and in terms of the ways in which some seemingly rural areas were not considered to be 'countryside'.

The discussions surrounding healthy and unhealthy places often explored issues relating to diet, as was seen in relation to pubs and McDonald's, or to exercise. Issues such as access to recreational areas and facilities were highlighted by many of the participants and, as discussed in Chapter 7, many participants felt that access to open space or countryside promotes exercise and physical or sporting activities. This confirms the emphasis which young people placed on physical aspects of health and issues such as diet during the discussions surrounding the meanings of health; but also brings in some other issues relating to the characteristics of places and their histories.

In general, participants considered that cities and industrial areas were unhealthy due to issues such as pollution and a lack of open space. Fast food outlets such as McDonald's were also viewed as unhealthy places and many participants also thought that 'Poorer areas' were unhealthy. The majority of participants thought that the countryside was healthy, although some participants who lived in seemingly rural areas did not consider their local area to be either 'countryside' or 'healthy'. Other places which a number of participants considered as healthy included 'Parks', 'Rich areas' and 'Restaurants'. The discourses surrounding healthy places tended to emphasis issues such as access to space for exercise and sporting or outdoor activities and issues such as clean air and peace or tranquillity.

As was highlighted in Chapters 6 and 7 in particular, discussions of places and health sometimes acted as a vehicle for enactments of stigma, both in relation to places and to people. This has, for example, been illustrated through the discussions of Crook, Woodhouse Close and one of the estates in the Meadowcroft area. In each of these examples whilst some participants stigmatised these areas, others resisted this stigma. As the example of Ruth in Chapter 7 illustrated, participants sometimes held contradictory views about their local areas.

8.4.4 Issues of Space and Scale

- How are issues of space and scale implicated in the sculpting and performance of young people's health beliefs and behaviours?

There are a number of ways in which issues of space and scale are implicated in the sculpting and performance of young people's health beliefs and behaviours. As discussed in Chapter 5, the analysis which was undertaken using GIS showed a clear spatial distribution of health beliefs and behaviours in relation to issues such as self-rated health and smoking. Family and school spaces both played an important role in shaping the narratives which young people constructed surrounding health, through the role models young people encountered and the ideas and beliefs they were taught. Both of these spaces also influenced young people's health behaviours, especially in relation to issues such as diet and food practices. The role of virtual spaces was also significant; firstly, with regard to the ways in which young people drew upon on the media and information technologies in the construction of their health beliefs and; secondly, in relation to health-enhancing or damaging behaviours including the use of computers games and television, and the procurement of items such as games or new sweets which had been advertised. The importance of social and recreational spaces was highlighted by many participants in relation to issues such as exercise and open space and in relation to issues such as alcohol consumption or unhealthy food. As discussed in Chapters 3 and 6, this thesis has drawn upon some of the more recent re-workings of space and scale which view these in a non-hierarchical manner and recognise the mutual production and constitution of 'global' and 'local'.

From a theoretical point of view, a key theme in this thesis has been issues of space and scale and the ways in which these are conceptualised. Drawing on the work of theorists such as Foucault, Lefebvre and Swyngedouw, this thesis has highlighted the production and mutual constitution of space and scale. The thesis has viewed space and scale as multiple, fluid, juxtaposed and intersecting, rather than hierarchical, linear or discrete. This thesis has sought to explicitly explore and highlight issues of space and scale, and the ways in which these are understood; whereas previous work in Health Geography and Children's Geographies has generally left such considerations implicit. Furthermore, as highlighted in Chapter 3, work in Children's Geographies and Health Geography has tended to draw upon absolute or relative conceptions of space. The use of the more recent re-workings of space and scale, which view these concepts in a more complex and abstract manner, has allowed for the development of a more nuanced understanding of the ways in which issues of

space and scale are involved in the sculpting and performance of young people's health beliefs and behaviours.

Building on this conceptual discussion of space and scale, Chapter 6 of this thesis has problematised the artificial binary which is often constructed between the 'global' and the 'local'. This thesis has argued that, like space and scale, the global and local are intertwined and mutually constituted and produced; involving plurality, multiplicity and juxtaposition. The ways in which the global and local have been co-produced and manifested has been discussed in relation to both the historical and the contemporary geographies of County Durham, with particular reference to the Wear Valley area.

8.4.5 Manifestations of Power

- In what ways are issues of power manifest in the sculpting and performance of young people's health beliefs and behaviours?

There are a number of ways in which issues of power have been implicated in the discussion in this thesis. As outlined by Foucault, regimes of power are closely related to those of knowledge; and discourse, discipline and gaze are important mechanisms for, and producers of, power. Official health discourses and the policies surrounding health promotion and education, including the school PSHE curriculum and provision of school meals, were one mechanism through which attempts were made to shape young people's health beliefs and behaviours; and this encountered varying degrees of influence and resistance.

As has been discussed in Chapters 5, 6 and 7, social and cultural norms and expectations were an important influence on young people's health beliefs and behaviours. Such expectations were produced through a variety of networks and intersecting spaces and scales; and included both 'local' and 'global' influences, and social formations such as families and friendship groups. Peer group cultures, and the identities and behaviours which these esteemed, impacted upon young people's alcohol and smoking cultures; especially amongst young people attending Hillcrest High School and Meadowcroft Community College. Furthermore, peer group cultures also influenced issues such as the (non)-use of local sports facilities and swimming baths, and engagements with outdoor and sporting activities. Whilst there was often considerable social pressure for young people to conform to aspects of the peer culture, such as smoking and drinking, resistance to these discourses and the associated social disciplining was possible for some participants.

Issues relating to identity and belonging were a recurring theme in participants' discussions of their beliefs and behaviours. Role-played performances, similar to those discussed by Goffman, were used by some participants as a mechanism for promoting their beliefs and identity over those of other people; through drawing comparisons with others or highlighting the supposed faults or deficiencies of certain behaviours or identities. This can be illustrated by the example of Daniel from Hillcrest who, as was discussed in Sections 7.4 and 7.5, contrasted himself and his family's middle class identity with 'Chavs' and their behaviours. Moreover, other performances of identity, and associated citational practices, were also a manifestation of power and discipline which served both to reinforce, and re-inscribe, local cultures and social norms and to resist aspects of the official policies and discourses surrounding health; especially in relation to issues such as food practices, smoking, and performances of white working-class masculinities and femininities.

Drawing on the work of Foucault, manifestations of power, discipline and discourse have been discussed in relation to a number of issues. Chapter 4 highlighted the significance of power, positionality and reflexivity in relation both to participatory research and to research encounters in general, and has highlighted the complexity and multidirectionality of power relations in research contexts. The discussion in Chapters 6 and 7 has illustrated the significance of discourse and discipline, which are both mechanisms and producers of power; and the ways in which these helped shape social and cultural norms and expectations surrounding health beliefs and behaviours, and resistance to these.

Performances of identity and belonging have been a significant means through which health beliefs and attitudes were articulated. Drawing on the work of Goffman, I have discussed the ways in which some such performances were staged and role-played to conform to social norms and expectations, local peer group cultures and official or school discourses surrounding health, well-being and behaviour. Through the incorporation of Butler's work on gender and performativity, this discussion of performance and identity has been complimented by a discussion of the citational practices which served to reinforce and re-inscribe the notions and performances surrounding white working-class masculinities and femininities and local identities.

8.5 Children's Geographies: Present and Future

The discussion in this section has been focused around the ideas and issues which Kesby et al (2009) highlight as key themes in Children's Geographies. Therefore, Section 8.5.1 will outline the four issues which Kesby et al explore. These are, firstly, issues relating to method and ethics; secondly, the importance of capturing ontological complexity; thirdly, the orthodoxy of flexible, child-centred and participatory

research and, fourthly, issues relating to queering adulthood, exploring ~~childishness~~[45], and developing research methods that are resources for agency. Section 8.5.1 will also discuss the contributions of this thesis to Children's Geographies, in relation to these themes. Building on this discussion, Section 8.5.2 will suggest some possibilities for future research within Children's Geographies.

8.5.1 Children's Geographies and the Contributions of this Thesis

This section will outline the four themes which Kesby et al (2009) suggest are key issues in Children's Geographies, and will discuss the contributions of this thesis in relation to these issues. The first of the issues discussed by Kesby et al is 'method and ethics'. With regard to method and ethics, Kesby et al state that:

> "Children's geographers are not unique in appreciating the symbiotic relationship between method and ethics, and while their efforts to recognise the agency of children are often frustrated by a normative ethics that defines children as 'vulnerable', the measured sensitivity they have developed toward their research subjects offers many insights relevant to wider debate on research ethics." (Kesby et al. 2009: 213)

Kesby et al identify the issue of 'informed consent', the role of gatekeepers and confidentiality as key issues relating to method and ethics in Children's Geographies and suggest that the efforts made by Children's Geographers "to ensure that ethical procedures are explained in '*person* friendly' language" (Kesby et al. 2009: 213) can be translated into other areas of research and practice. The discussion in Kesby et al also explores researchers' interactions with parents and concerned others, and suggests that it is important to work *with* parents and other adults to ensure support for child-centred approaches. However, the authors also note that "Striking the right balance between meeting the concerns of parents and securing children's rights as competent respondents, while also leaving the research context untroubled, is no easy matter" (Kesby et al. 2009: 214). In Chapter 4, I have discussed a number of issues relating to method and ethics. In particular, I have explored issues of autonomy, competency and consent, the status of children and young people and the ways in which this can impact upon method and ethics, and confidentiality and anonymity.

In their discussion of method and ethics, Kesby et al also note that research encounters with children and young people can sometimes raise questions regarding the researcher's role in (not) policing interactions between research participants and resolving conflicts. As was discussed in Chapter 4, I encountered some sessions which included significant elements of sexual innuendo, particularly from certain male

[45] Kesby et al state that they "have used the stylistic qualification of a strikethrough through the term childishness here to signify [their] resistance to the work that this word normally does. As with the word 'queering' (now increasingly just queering), repeated use of alternate, positive meanings may eventually remove the need for such a qualification" (Kesby et al. 2009: 221).

participants at Meadowcroft, and I took the difficult decision to exclude the Year 9 Meadowcroft students from the follow-on interviews. From the performances during the group discussion it had been clear that the male members of this particular group were in the process of exploring their emergent sexual identities, which appeared to have been aroused by my presence and the topic under discussion, and the amount of graphic sexual innuendo gave me concerns about whether it would be appropriate for me, as a female researcher, to undertake follow-on interviews with these particular participants. Furthermore, Section 4.6 of Chapter 4 has highlighted the issue of racist language, which was encountered with some participants. It was noted that whilst for the purposes of this work I chose to ignore such comments rather than challenging them, because these were an aspect of the beliefs and performances I was seeking to unravel, a different approach would have been required if such comments had been made in front of a member of an ethnic minority group.

With regard to their second issue, 'capturing ontological complexity', Kesby et al highlight the transitional character and liminality of childhood and youth, which has been discussed in Chapter 2 of this thesis, and argue that this can be used "to increase awareness of the multiple experiences, dynamism and incompleteness that characterize [sic] the human condition more generally" (Kesby et al. 2009: 216). Responses to such complexity include the adoption of multiple methods, particularly the combination of cross-sectional methods such as participant observation, group interviews, diaries and photo-diaries with longitudinal methods such as life histories and life lines or projections; but it should be noted that mixed methods are seen as being qualitative only in the work discussed by Kesby et al. As will be discussed presently, the research undertaken for this thesis differed to that normally undertaken within Children's Geographies due to its combination of qualitative and quantitative research techniques. Chapter 4 of this thesis noted that questions have been raised in the past about the combination of qualitative and quantitative research methods, due to perceived differences in their underlying ontology and epistemology. It was suggested, firstly, that the 'quantitative-qualitative divide' is in fact a continuum along which specific research methods can be adopted, combined or rejected dependent on the aims of the research and the epistemology and values which underpin this and, secondly, that it is important to ensure the epistemological and theoretical framework is consistent across the different methods used.

The third issue in Children's Geographies which is highlighted by Kesby et al, namely the adoption of flexible, child-centred and participatory research, has been an important theme in this thesis. It is suggested that Children's Geographers should pay closer attention to issues of power, and this theme has already been discussed extensively throughout this thesis, especially in Chapters 3, 4, 6 and 7, and the

contributions to this area were summed up in Section 8.4.5 of this Chapter. As was discussed in Chapter 4, although the research undertaken cannot be considered to be truly 'participatory', the methodology used in this study was underpinned by the aims and values of participatory research. Young people were viewed as competent social actors and the research sought to respect and forefront their beliefs and values. However, the depth of participation was limited by the spaces and settings used, and the ways in which both staff and young people resisted the idea of collaborative research design. Interestingly, whilst participatory research projects usually draw almost exclusively upon qualitative research methods, frequently including 'non-traditional' methods such as participatory diagramming, photography, drama and story boards, the young people I worked with were not interested in developing the study along these lines. Instead, many of the groups wanted a survey or 'quiz' to be undertaken in their school.

The research which this thesis is based upon is unusual in that it has used a combination of both qualitative and quantitative research methods, whilst seeking to be 'participatory'. With regard to research design, the quantitative phase of the project was, if anything, more 'participatory' than the qualitative phase, due to the collaborative nature of the questionnaire design. This suggests that whilst participatory research is, understandably, overwhelmingly focused on qualitative research methods – which allow for the development of rich and nuanced narrative and understandings – quantitative methods can play a role in participatory research provided that they further the aims of collaboration and participation and the data obtained are recognised to be of young people's health beliefs and behaviours and both partial and situated.

The final issue discussed by Kesby et al relates to queering adulthood, exploring ~~childishness~~, and developing research methods that are resources for agency. The approach taken to 'health' in this thesis has sought to put aside adult or professionally defined understandings of health in order to explore young people's own perceptions, beliefs and priorities. Furthermore, this work has sought to promote young people's agency and competence in relation to both the research epistemology and methods. With regard to young people's health beliefs and behaviours, it has been recognised in this thesis that young people sometimes engage in actions or choices which display their agency, but that such agency may also be bounded by dominant discourses, social processes and practices, and cultural norms and expectations.

This thesis has discussed a number of sources and resources for empowerment and resistance. As was discussed in Chapter 4, the epistemology and methodology both sought to promote participant's autonomy and prioritise their views and perspectives. With regard to young people's health beliefs and behaviours, and the performances of these, I have both discussed ways in which these were influenced

through the deployment and manifestations of power, discourse and knowledge and have highlighted ways in which discourses and expectations were subverted or resisted. This has, for example, been illustrated through the discussions of school meals, family eating practices and smoking.

It is clear from the discussions in this thesis that participatory approaches to research have the potential play a significant role in developing research and knowledge which forefronts young people's beliefs, priorities and knowledges. However, as was discussed in Chapter 4, it is important that researchers who seek to engage young people through participatory research approaches or methods should be honest and reflexive about the level of participation which is achieved. Whilst the research undertaken for this PhD was not as 'participatory' as I would have liked, I believe that participatory research can be successful in research relating to young people and health.

As was discussed in Chapter 4, my desire to pursue a participatory approach encountered resistance from both school staff and the young people I worked with. In this instance, the school settings limited the depth of participation achieved due to the reluctance to engage with discussions of decisions about the format the research should take, and the restrictions imposed by the fact that the work was carried out on school premises during the school day. However, it is important to recognise that these issues can be school and context specific and, as demonstrated by the work of McMillan (2009), it is possible for deep participation to be achieved in school settings. Thus, it is important that researchers working with young people in school settings are flexible in terms of the methods and techniques used because such research can be context specific and what works well in one school does not necessarily translate successfully to work in a different school.

8.5.2 Future Research Directions in Children's Geographies

There are many different opportunities for further work in Children's Geographies, and I do not wish to be prescriptive about the issues or topics which future Children's Geographers should pursue. However, it is worth noting that Children's Geographies has, to date, been largely urban focused. Whilst, as noted in Sections 7.2 and 7.3 of Chapter 7, other disciplines and sub-disciplines have given some attention to young people in rural areas, and there is a lack of research about young people in rural areas which views issues through the lens of Children's Geographies. In addition, there is also further scope for research relating to Children's Geographies and issues of health and well-being.

The methodological mechanisms which might be used to explore these two themes, or to further pursue the investigation of young people's perceptions of health,

are similarly varied. As was argued in Chapter 4, I would suggest that questions of epistemology, and the philosophy and value base which underpin the research, are more significant than the methods per se and considerations about ontology and epistemology should inform the methodology and choice of research methods. In addition, I would suggest that whilst there has been a tendency for a dichotomy to be drawn between qualitative and quantitative methods, their combination can offer rich data, which incorporates both detailed narrative and contextual breadth, provided that the epistemological framework remains consistent across the different methods used. As this thesis have demonstrated, whilst previous studies which used a participatory approach to research have focused on qualitative research methods and techniques, quantitative methodologies can be used successfully within a broader participatory epistemology.

8.6 Final Remarks

The interdisciplinary nature of the work undertaken means that this thesis is not primarily about Children's Geographies, and that the main contributions of the work and possibilities for future research lie beyond the boundaries of Children's Geographies. From an academic point of view, the trans- and interdisciplinary nature of this thesis has allowed for the development of a more nuanced understanding the ways in which these are shaped and performed. In contrast to much of the existing work within Health Geography and Children's Geographies, this thesis has explicitly discussed issues and conceptualisations of space and scale and, in so doing, has also problematised the artificial binary which is often drawn between 'global' and 'local'. Furthermore, through its consideration of young people's experiences and understanding of the countryside, this thesis has explored the frameworks of rural reference and experience which young people constructed and ways in which these connected with Health Geography's concept of 'therapeutic landscapes'. This discussion of the countryside and health highlighted tensions which occurred when young people's perceptions of their local areas deviated from dominant discourses and representations surrounding the countryside, rurality and rural living and thus from their frameworks of rural reference.

This thesis has also made contributions to discussions relating to young people's health as a social issue. It has explored the ways in which young people's health beliefs, and the performances of these, are intertwined both with issues of place, culture and identity and with policy discourses and initiatives. In addition, this thesis has also highlighted the significance of social formations, such as the family and peer groups, in the construction and performance of health beliefs and behaviours and has,

in contrast to the majority of studies which focus on urban areas, placed an emphasis on rural youth and their health and well-being.

From a policy point of view, this thesis has highlighted the influence of school, council and national policies and initiatives, has explored ways in which such policies may be resisted or subverted by young people, and has illuminated tensions which may occur when young people feel there is a gap between the rhetoric of policy initiatives and their day to day experiences of these policies. A further policy implication of this thesis is the value which a more nuanced understanding of space and scale can add to understandings of the sculpting and performance of young people's health beliefs and behaviours, including an awareness of the interactions and intertwinings between scales and their mutlidirectionality. This thesis has argued that the hierarchical view of scale which dominates in policy settings is overly simplistic and that it is important to recognise and accommodate the multiple and intersecting scales and networks of power and influence which sculpt contemporary societies and cultures.

Finally, the discussions in this thesis offer a number of openings for further research. As was noted in Chapter 3, there is a politics associated with issues of space and scale and whilst these have not been explored in this thesis they offer opportunities for future work. Although there has been some discussion in this thesis of the ways in which individuals construct health narratives, and the sources and experiences which they draw upon, this is another area which would benefit from further research; as would the interplay between culture, issues of identity and belonging and the evolution of health beliefs and behaviours. In relation to the countryside and health, this thesis has highlighted some synergies between health geography's therapeutic landscapes and work in rural geography; but these remain under-explored. There is also considerable scope for further work exploring the ways in which the countryside and rural areas are represented and experienced by different sections of society and the wider implications for health and well-being.

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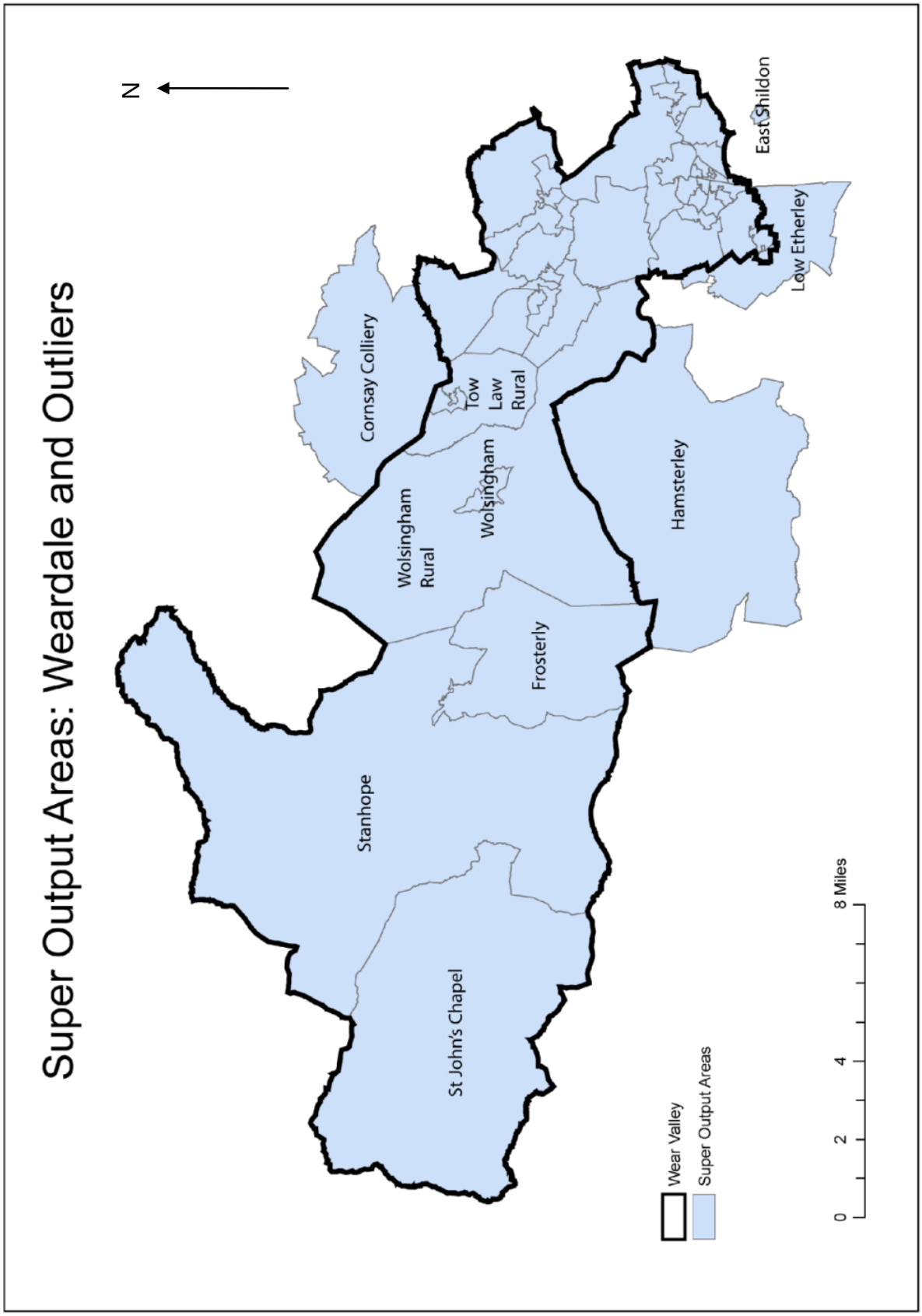
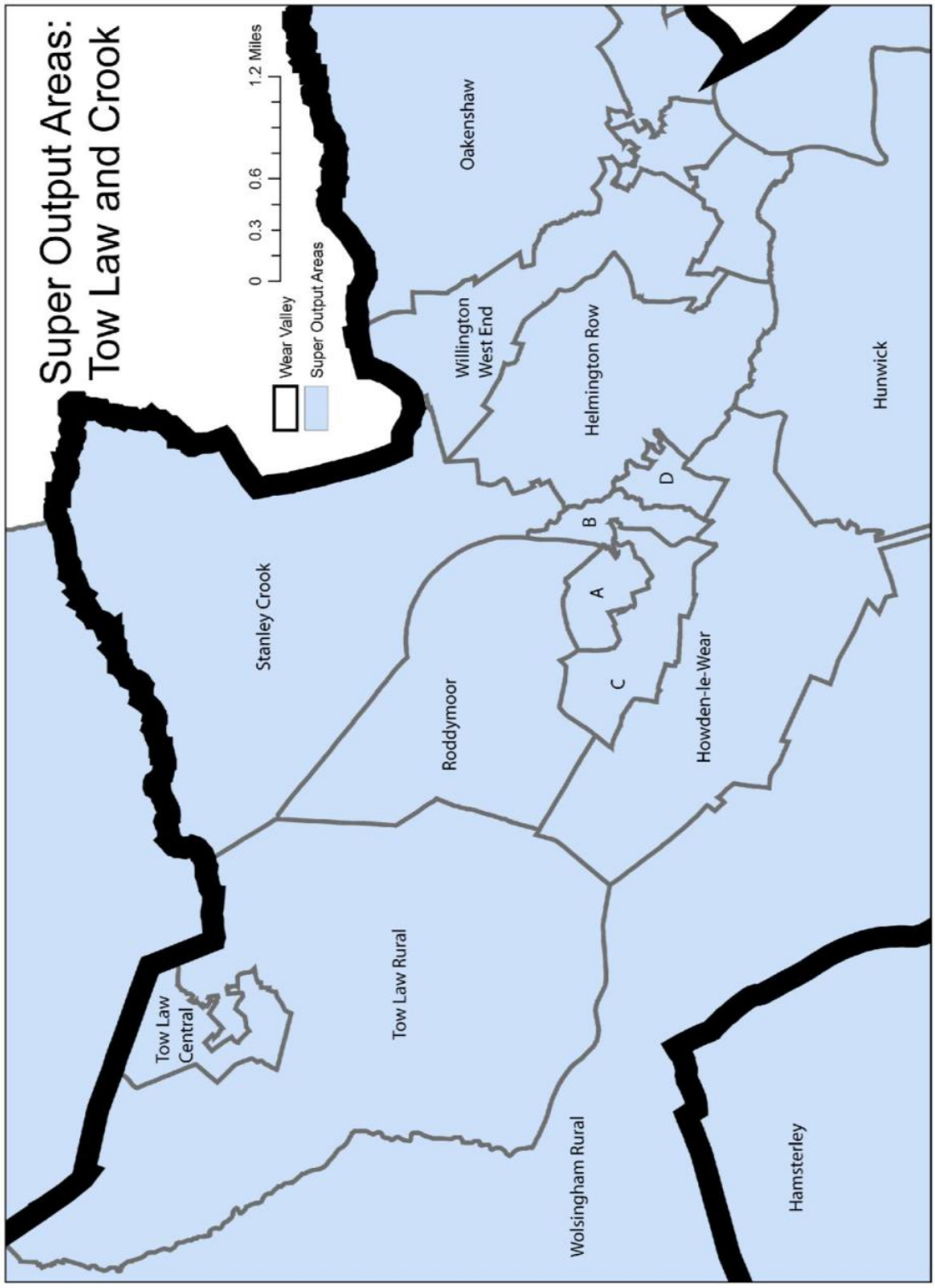
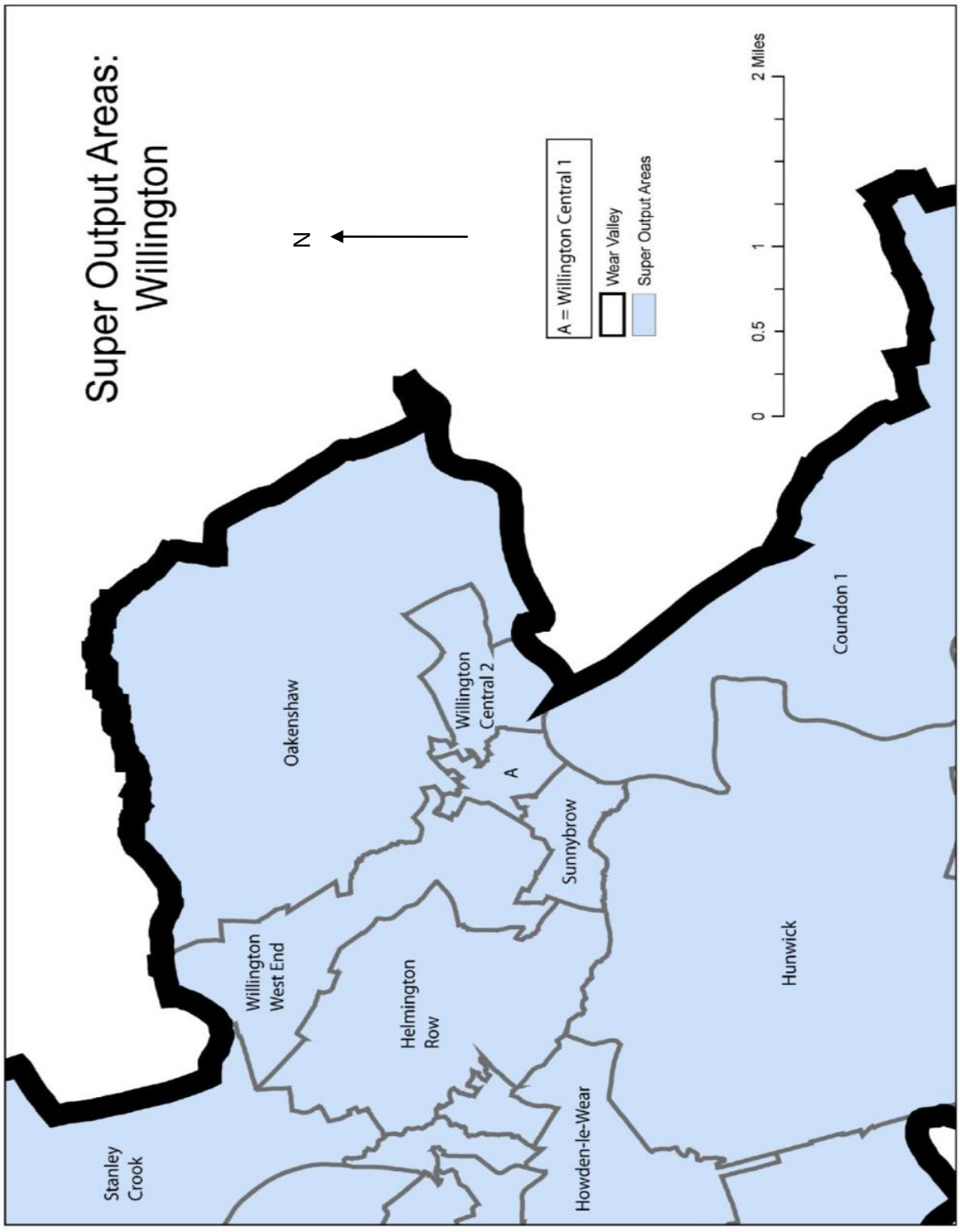
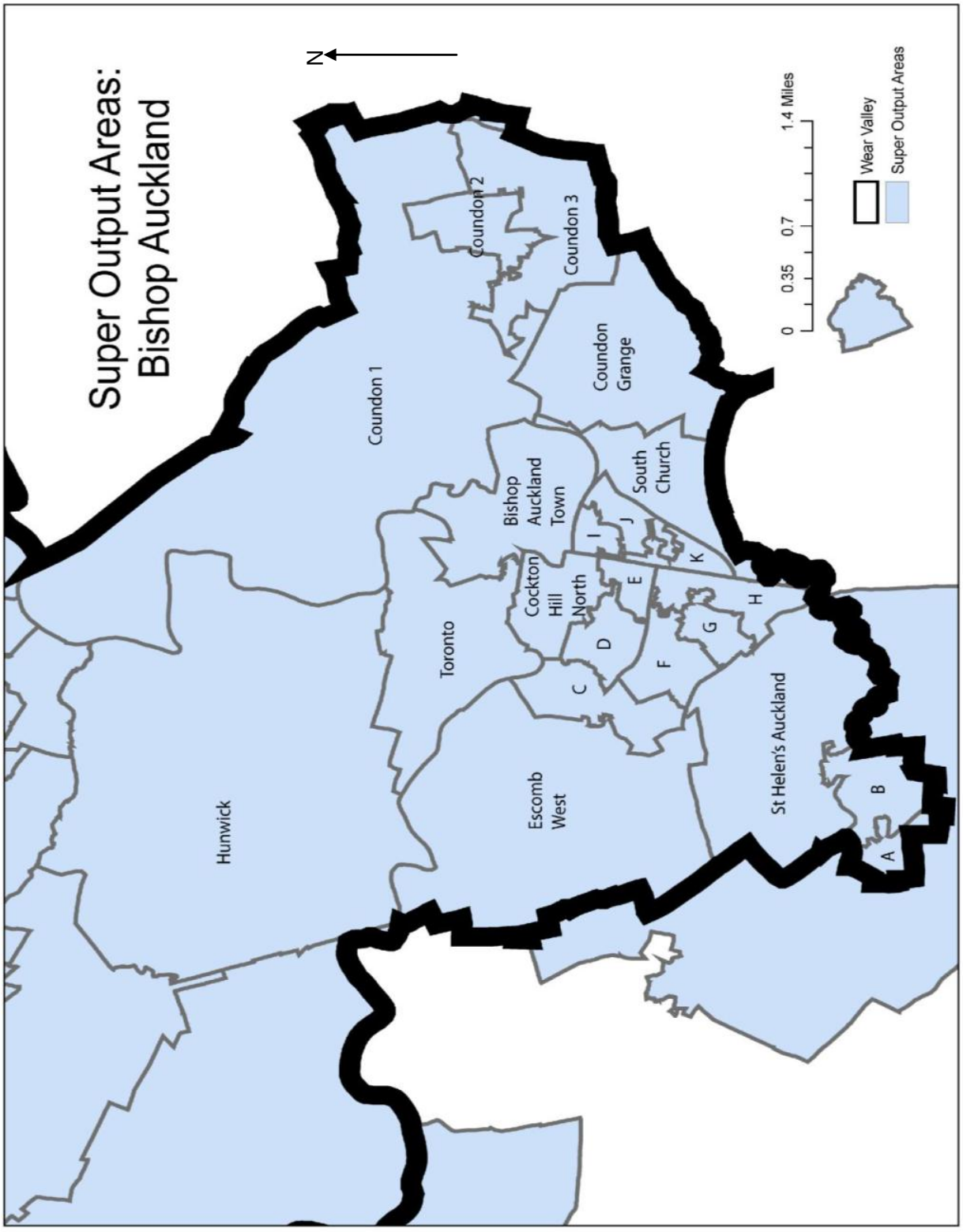
Appendix 1 Wear Valley Super Output Areas



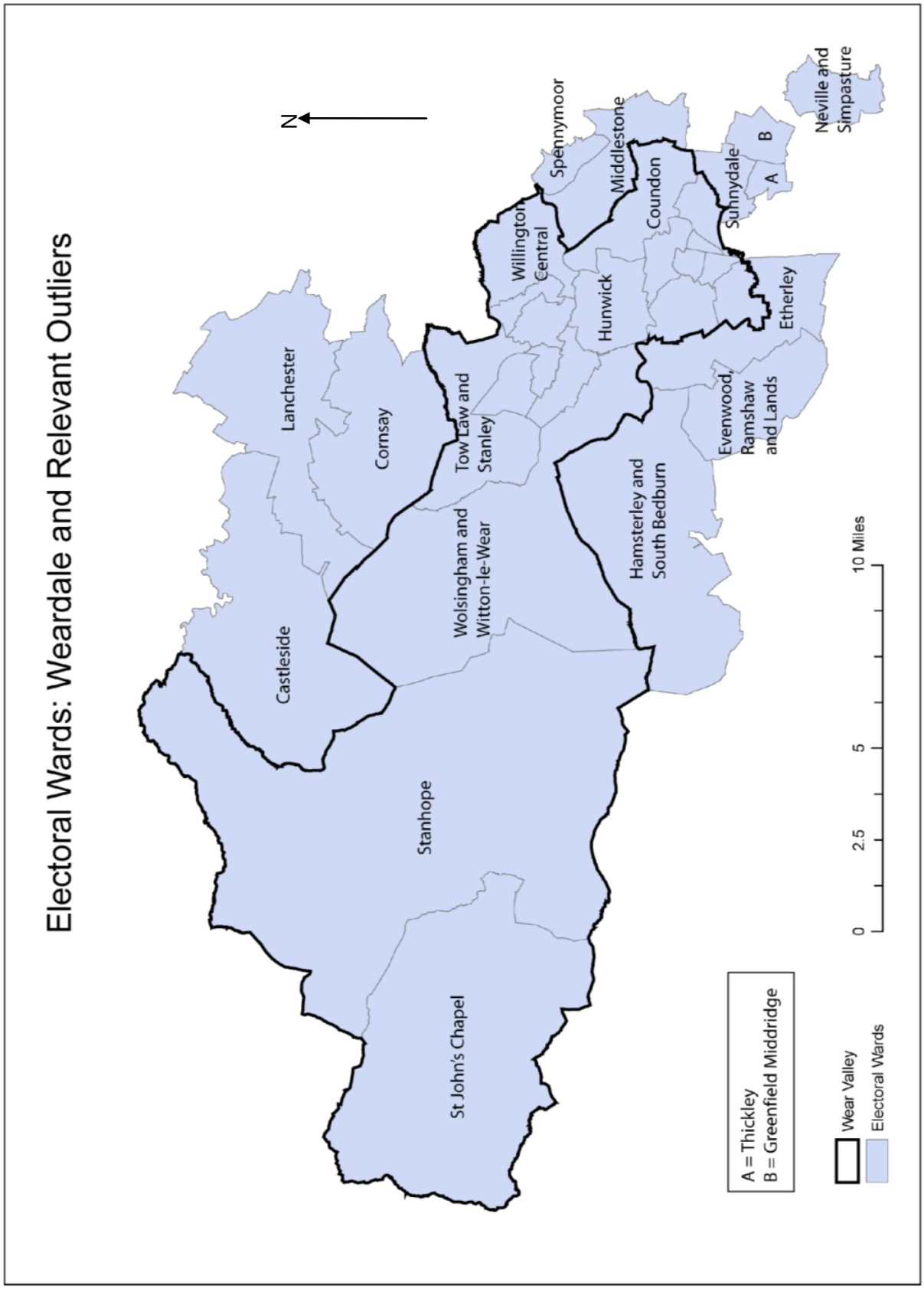

Super Output Areas:
Tow Law and Crook
0 0.3 0.6 1.2 Miles
Wear Valley
Super Output Areas
Oakenshaw
Willington
West End
Helmington Row
Hunwick
Stanley Crook
Roddymoor
Howden-le-Wear
Tow Law
Central
Tow Law Rural
Wolsingham Rural
Hamsterley
A
B
C
D
N
A = Crook South 1
B = Crook South 2
C = Crook South 3
D = Crook East

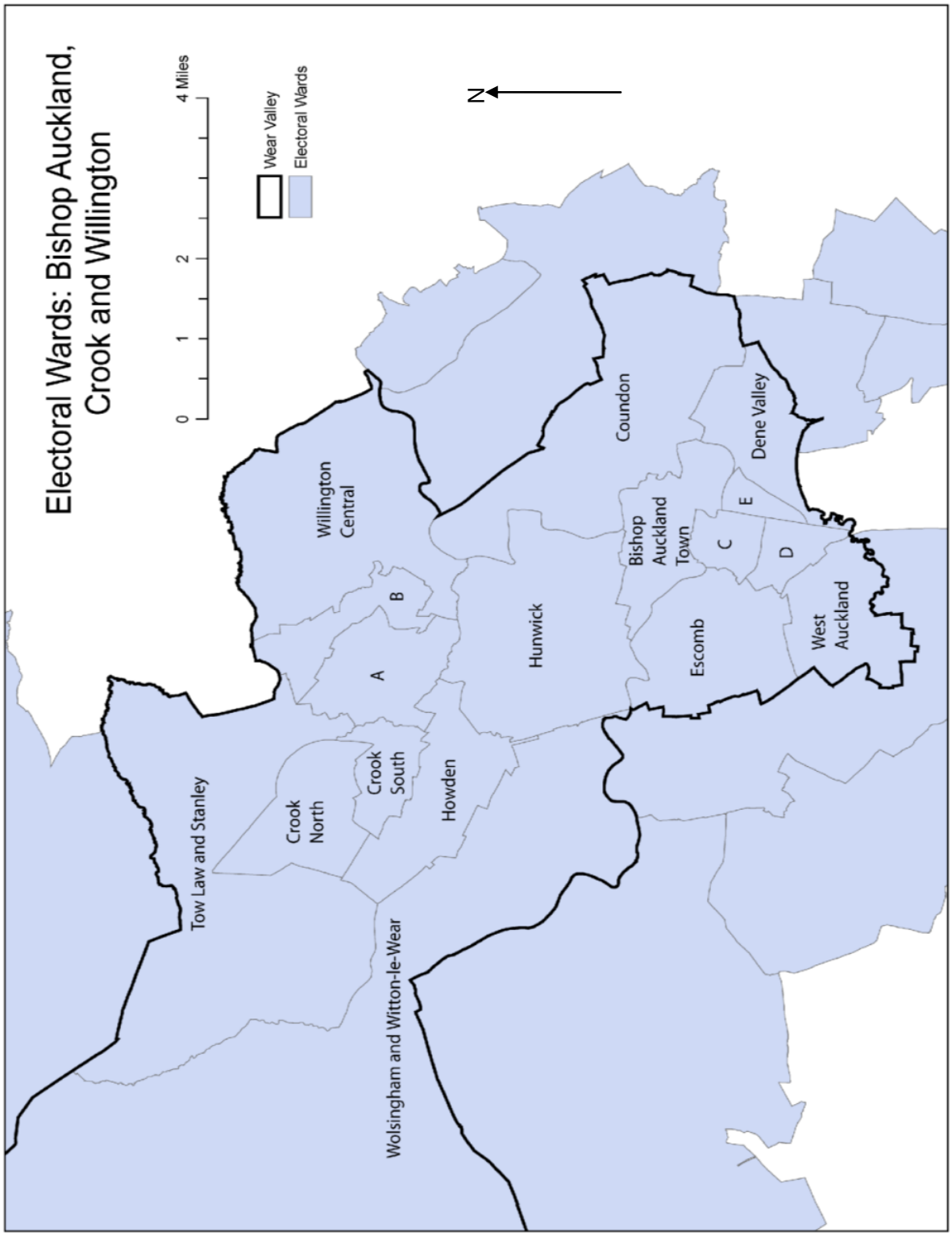

Super Output Areas:
Willington
N
A = Willington Central 1
Wear Valley
Super Output Areas
0
0.5
1
2 Miles
Stanley Crook
Howden-le-Wear
Willington West End
Helmington Row
Oakenshaw
Willington Central 2
A
Sunnybrow
Hunwick
Coundon 1



A = West Auckland West
B = West Auckland East
C = Escomb East
D = Cockton Hill West
E = Cockton Hill East
F = Woodhouse Close North
G = Woodhouse Close Central
H = Woodhouse Close South
I = Henknowle North
J = Henknowle Central
K = Henknowle South

Appendix 2 Wear Valley Electoral Wards





A = Wheatbottom and Helmington Row
B = Willington West End
C = Cockton Hill
D = Woodhouse Close
E = Henknowle

Appendix 3 Example Session Plan

Start – intro, discuss project and consent, names

Exercise 1 – participatory diagram – what is health/what does it mean – use cards if brainstorming is unsuitable/not working

Meanings of 'health'

1) What does 'health' mean to you?
2) What does it mean to be 'healthy'?
3) Do you think health is something you have, something you do are something you are? (use prompt card).
4) What factors do you think have influenced your health? (can be both positive and negative)
5) Are there particular experiences which have influenced your views about what health is/means?

Healthy/Unhealthy places

1) What factors do you think make places healthy or unhealthy? (use worksheet if discussion is not forthcoming)
2) Do you think the area where you live is healthy?
3) Why/why not?

Exercise 2 – post-its on diagram – what are the main risks or barriers to health for young people in their local area – use risk cards and matrix if post-it method doesn't suit participants

Risks/barriers to health

1) What do you think are the main barriers or risks to health for young people in this area?
2) Why do you think these are important?
3) Are there particular risks/barriers which you face?

Solutions to risks/barriers

1) Do you think you can do anything about any of the risks/barriers you have identified?
2) Which ones do you think it would be easiest to do something about?
3) What do you think you could do about it?
4) How easy do you think this would be?
5) Are the risks/barriers you think you can do something about the ones you thing are most important?
6) i) Why? Why don't you think the others are important? OR
   ii) Which ones do you think are the most important?
   Why? What do you think stops you doing something about these?

Future direction of project

1) How have you found what we've done today? Are there things which you think were particularly good or which should have been done differently?
2) Are there other things you think the project should look at?
3) What do you think could be done next? How could this be done?
4) Are there other things you would like to do as part of the project?
5) How would you feel about being involved in further sessions either as a group or for interviews?

Appendix 4 Example Interview Schedule

Hillcrest interviews - Year 9

Meanings of health
Health = state of life, mental and physical health, digestion of healthy liquids (all boys). Balanced diet and exercise (girls).

Being healthy = keeping fit/ exercise, balanced diet.

Influences on own health: Nana, Uncle.

Don't think you are healthy – can't run fast/very long (disputed by one girl). One girl didn't want to explain in group. Eat too many chips and no choice over what you eat (girl).

Risks to health: people around you (peer pressure), pressure to be thin (leading to anorexia), fatty food and sweets (more new ones keep coming out), alcohol, peer pressure and bullying (boys), depression and comfort food (boys), debate about whether bullying worse at primary or secondary school.

Other things which are important: games consoles (debate about whether these were/could be healthy), not enough PE – too many classes at once, should have double lessons of PE like in yr 8.

If you were asked the same questions as last time by some of your mates, would you have given the same replies? - Why/why not?

Is health purely a matter of individual responsibility?

Healthy/unhealthy places
Healthy and unhealthy places: smoky places unhealthy – restaurants will be healthier once ban introduced, pubs unhealthy because of smoke and alcohol.

Places where you live: most of you say they are not healthy – people smoking on street (Woodhouse), middle class areas healthier.

Lots of people in school smoke - Probe about smoking habits.

Countryside
A lot of groups have talked about living in the countryside being good for health. *Do you agree with this? Why/why not? Do you all think that you live in the countryside? What do you think are the key features of countryside?*

People who don't eat
Theme discussed in some groups. *Do you think this is important? How widespread is this? Is it just girls or is it boys as well? Do you know people who've had problems with this? What do you think caused their problems?*

Space and opportunity
Other groups have mentioned being told off by older people for playing football and changes to parks leading to a lack of opportunities to play outside. You said that playing outside was important for health. *Is this something you are able to do?*

Why/why not? Do you feel safe playing outside? Would you actually play outside if the opportunity was there? What kinds of spaces/facilities would be useful for you?

Own health

Do timeline exercise if time.

What are the main things which have influenced your own health?

How do you think you've come to hold the views you have? How/where/when have you learnt about health? Who/where/what from?

Appendix 5 Questionnaire

Durham University
Department of Geography

E·S·R·C ECONOMIC & SOCIAL RESEARCH COUNCIL

Youth Perceptions of Health
Research Project – Information about Questionnaire

I am currently conducting research into perceptions of health among young people in selected areas of County Durham as part an ESRC-funded PhD project, which will be a geographical study of youth and health. This includes a specific focus on areas which fell under the remit of the former Durham Dales Primary Care Trust.

As part of this project I am distributing anonymous confidential questionnaires to students in school years 7-10. This questionnaire will explore your beliefs and priorities with regard to health and health-related behaviours.

This questionnaire includes some personal questions, but if you feel uncomfortable answering these then please leave the questions concerned blank.

The project has received university ethics and risk assessment clearance, and the storage and use of data will be in line with university data protection procedures. The school will receive some feedback from the questionnaire but this will not allow individual students to be identified. No-one in the school will read the answers you write.

Question 11 asks about where you live. The information you give here will be used by the researcher to identify what area you live in and compare her data to existing information about that area such as the Census and Index of Multiple Deprivation. Where there are very few young people in a given area this information will be combined with that for a neighbouring area so that you cannot be identified. Detailed information about different areas and neighbourhoods will not be given to the school.

Durham University
Department of Geography

E·S·R·C ECONOMIC & SOCIAL RESEARCH COUNCIL

Youth Perceptions of Health
Research Project - Questionnaire

Are you? *(please tick the appropriate year group and gender)*

☐ Year 7 ☐ Year 8 ☐ Year 9 ☐ Year 10 ☐ Female ☐ Male

1) What is health? *(tick all that apply)*

☐ Being able to cope with day to day life
☐ Eating the right food
☐ Feeling good
☐ Happiness
☐ Looking good
☐ Not being ill
☐ Physical fitness
☐ Strength and/or stamina
☐ Other *(please specify)* _____

2) What does it mean to be healthy? *(tick all that apply)*

☐ Being active or taking regular exercise
☐ Being fit or able to resist illness
☐ Being happy about yourself
☐ Feeling strong
☐ Having a good diet
☐ Having an ability to keep going
☐ Having willpower, self-discipline or self-control
☐ Other *(please specify)* _____

3) How important do you think health is? *(Please circle the appropriate number on the scale below)*

Not at all important	Not particularly important	Neither important nor unimportant	Of some importance	Very important
1	2	3	4	5

4) What are the main things which affect health for young people in this area? *(tick all that apply)*

☐ Alcohol
☐ Drugs
☐ Gangs
☐ Lack of money
☐ Lack of outdoor space
☐ Lack of sports facilities
☐ Peer Pressure
☐ Poor diet
☐ Sexual health issues
☐ Smoking
☐ Stress
☐ Other *(please specify)* _____
☐ None of these

5) How healthy do you think you are? *(Please circle the appropriate number on the scale below)*

Very unhealthy	Unhealthy	Average	Relatively healthy	Very healthy
1	2	3	4	5

6) What are the main things which have influenced your own health? *(tick all that apply)*

☐ Alcohol/drugs/smoking
☐ Childhood illnesses
☐ Family/parents
☐ Friends
☐ Hobbies/Sport
☐ Ill-health/disability
☐ Faith/religious beliefs
☐ School
☐ Other *(please specify)* _____

7) How happy would you generally say you are? *(Please circle the appropriate number on the scale below)*

Very unhappy	Unhappy	Neither happy nor unhappy	Happy	Very happy
1	2	3	4	5

8) Do you smoke? *(tick ONE box)*

☐ No ☐ Tried and didn't like ☐ Yes - Occasionally *(e.g. a couple of times a month)* ☐ Yes - regularly

9) How much alcohol do you drink in an average week? *(tick ONE box)*

☐ None ☐ 1-2 glasses or small bottles ☐ 3-5 glasses/small bottles or 1 large bottle ☐ More than 5 glasses/small bottles or more than 1 large bottle

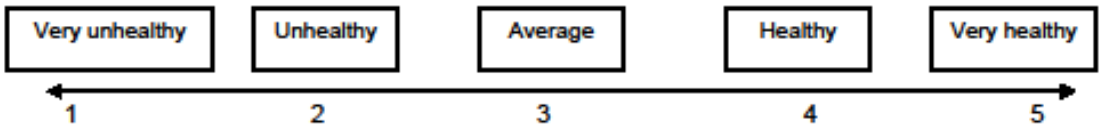
10) Have you ever taken unprescribed/illegal drugs? *(tick ONE box)*

☐ No ☐ Tried and didn't like ☐ Use occasionally *(e.g. a few times a year)* ☐ Use regularly

11) Where do you live?

Postcode_____ OR Street name and area_____
(e.g. DL14 6JT) *(e.g. Woodhouse Lane, Bishop Auckland; High Street, Willington)*

12) Is the area where you live healthy? *(Please circle the appropriate number on the scale below)*



Why?_____

_____

_____

_____

13) What kinds of places do you think are healthy? *(tick all that apply)*

☐ Cities ☐ Parks ☐ Rich areas _____
☐ Countryside ☐ Poorer areas ☐ Other *(please specify)* _____
☐ Fast food outlets ☐ Restaurants

Why?_____

_____

_____

14) What kinds of places do you think are unhealthy? *(tick all that apply)*

☐ Cities ☐ Industrial areas ☐ Restaurants _____
☐ Countryside ☐ Parks ☐ Rich areas _____
☐ Fast food outlets ☐ Poorer areas ☐ Other *(please specify)* _____

Why?_____

_____

_____

15) What jobs do your parent(s)/guardian(s) do? *(e.g. unemployed, teacher, manager, housewife)*

_____

16) What do you hope to do when you leave school?

☐ Get a job ☐ Training scheme or apprentice ☐ A-levels/GNVQ ☐ University ☐ Nothing

Appendix 6 Information and Consent Forms for Group Sessions and Interviews

Department of Geography

Youth Perceptions of Health Research Project

Information Sheet

Background

This research is being undertaken as part of an ESRC-funded PhD course at Durham University. The research will explore young people's perceptions of health using a variety of approaches, and will focus on selected areas of County Durham. The research is intended to be an unfolding, 'participatory' project in which the young people and organisations involved will be able to contribute to the planning, design and direction of the research if they want to. As such, the exact nature of the activities undertaken as part of this project will vary between different groups and organisations in order to better reflect the interests and priorities of those involved.

Methods

The project will initially involve young people in group discussions which will usually comprise of between 4-8 young people. Some exercises ('participatory diagramming' techniques) will be included to help with the brainstorming and synthesis of ideas. These exercises will generally involve a small amount of writing, but this can be adapted to suit the strengths of different participants and will not be a test of their literacy. The discussions and related activities will have an informal tone and aim simply to discover which issues participants think are important for their age group – the aim is not to educate or inform. Following preliminary analysis of discussion group data, some participants may be invited to an informal interview with either the researcher and/or a peer-researcher.

After the initial discussion groups the direction of the research will be determined by the interests and preferences of the young people and organisations involved (in some instances there may be no further involvement with the project). Activities may, for example, include:

- Diary work
- Self-directed photography (auto-photography)
- Video work
- Website design
- Poster production
- Other methods chosen by the young people (with the agreement of the host organisation).

In some organisations this work will involve the use of peer-researchers who may or may not have been involved in the initial discussion groups. Preliminary findings from the discussions groups may be shared with peer-researchers, but they will not have access to the raw data and will not be told who has provided specific pieces of information.

Follow-up Work

Information gathered from the work outlined above will be used as a basis for the design of a questionnaire which will be used for a second phase of this PhD project. This will be distributed more widely to young people in the study areas. There may be an opportunity for a small number of young people to be directly involved in the design of this questionnaire.

Further Information

The researcher has obtained enhanced-level clearance from the Criminal Records Bureau (a 'police check'). The project has received University ethical and risk assessment clearance.

If you have any questions about this project please contact:

Miss Natalie Beale, Research Postgraduate, Department of Geography, University of Durham, Science Laboratories, South Road, Durham. DH1 3LE
Telephone: 0191 334 1853
Email: n.h.beale@durham.ac.uk

Session Code:

Department of Geography

Youth Perceptions of Health
Research Project

Parent/Guardian Consent Form

This research will explore young people's perceptions of health and risks to health. It is part of a geographic study of youth and health which is being undertaken for a PhD course at Durham University.

In order for your son/daughter/ward to participate in this project you are being asked to sign a consent form. By signing this form you will confirm that you are happy for your son/daughter/ward to participate in the research session and agree to the points below:

1. His/Her contribution to this research will involve participation in some discussion groups that will also include some brainstorming and problem-solving activities. These discussions will be recorded, stored digitally on a password-protected computer drive and transcribed (typed up). The recorder can be stopped at any point if he/she wants to say something which they don't want to have recorded. In order to protect his/her privacy, his/her name and that the school/youth organisation will not be used when the recording is transcribed. Other people will not be able to access the recordings.
2. He/She may be invited to be involved in an informal interview with either the researcher and/or a peer-researcher and one or two other group members. This would be recorded and transcribed as in point 1, above. If he/she does not want to be involved in this then he/she will not be interviewed.
3. He/She may be invited to be involved with other activities such as diary work, self-directed photography, group-directed video work or other group-defined projects which may be undertaken outside of school/youth organisation meeting hours either with or without the researcher present. These may involve one or more peer-researchers. However, he/she will be able to opt out of these if he/she wishes. Safety advice will be given to your son/daughter/ward where appropriate if he/she is involved in self-directed photography work or other activities where the researcher is not present.
4. Material from the session will be used in a report which will be written about the research project. This report will be written by the researcher for Durham University, but there is a possibility that work may be published at a later date. Your son/daughter/ward's name and that of his/her organisation will not be used in any of this work.
5. The copyright in your son/daughter/ward's contribution will be assigned to the researcher. This means that things he/she has said or done during the research (e.g. comments and diagrams) can be reproduced by the researcher and can therefore be included in the researcher's work, unless he/she tells the researcher he/she would like something to remain private.
6. A short summary of findings for all the sessions carried out within your son/daughter/ward's school/youth organisation will be provided for the school/youth organisation and he/she will be able to see a copy of this. His/Her name will not be used in this.
7. Your son/daughter/ward will be asked to sign a consent form before the session commences. If he/she were to refuse consent for any aspect this would take precedent over your consent. For example, if your son/daughter/ward did not consent to tape recording then the session would not be recorded even if you have given consent to permit this.

Confirmation and consent

I confirm that I understand the points above and agree that _____ may participate in this research project.

Parent/Guardian's name: _____Signature: _____Date: _____

Any queries about this form or the project should be directed to **Miss Natalie Beale**, Department of Geography, University of Durham, Science Laboratories, South Road, Durham. DH1 3LE
Telephone 0191 334 1853

Session Code:

Department of Geography

Youth Perceptions of Health Research Project

Participant Consent Form

This research will explore young people's perceptions of health and risks to health. It is part of a geographic study of youth and health which is being undertaken for a PhD course at Durham University.

In order to ensure the research is carried out properly you are being asked to sign a consent form. Please read the following points and check that you understand and agree with them. Please ask if there is anything you are unsure about. By signing this form you will confirm that you are happy to participate in this research and agree to the points below:

1. Your contribution to this research will involve participation in some discussion groups that will also include some brainstorming and problem-solving activities. These discussions will be recorded, stored digitally on a password-protected computer drive and transcribed (typed up). The recorder can be stopped at any point if you want to say something that you don't want to have recorded. In order to protect your privacy, your name and that of your school/youth organisation will not be used when the recording is transcribed. Other people will not be able to access the recordings.
2. You may be invited to be involved in an informal interview with either the researcher and/or a peer-researcher and one or two other group members. This would be recorded and transcribed as in point 1, above. If you do not want to be involved in this then you can say so.
3. You may be invited to be involved with other activities such as diary work, self-directed photography, group-directed video work or other group-defined projects which may be undertaken outside of school/youth organisation meeting hours either with or without the researcher present. This may involve one or more peer-researchers. However, you will be able to opt out of these if you wish. You will be expected to follow any safety advice given by the researcher.
4. Material (quotations and diagrams) from the research will be used in a report which will be written about the research project. This report will be written by the researcher for Durham University, but there is a possibility that work may be published at a later date. Your name and that of your organisation will not be used in any of this work.
5. The copyright in your contribution will be assigned to the researcher. This means that things you have said or done during the research (e.g. comments and diagrams) can be reproduced by the researcher and can therefore be included in her work, unless you tell the researcher you would like something to remain private.
6. A short summary of findings for all the sessions carried out within your school/youth organisation will be provided for your school/youth organisation and you will be able to see a copy of this. Your name will not be used in this.

Confirmation and consent

I confirm that I understand the points above and agree to participate in this research project. I have been given the opportunity to ask questions about this project and my involvement in it.

Participant's name: _____ Signature: _____
Date: _____

I confirm that I have explained the points above to the participant and given him/her the opportunity to ask questions. I have not forced him/her to be involved in this research.

Researcher's name _____ Signature: _____
Date: _____
Department of Geography, University of Durham, Science Laboratories, South Road, Durham. DH1 3LE

Appendix 7 Questionnaire Letters

Shaped by the past, creating the future

Department of Geography

Youth Perceptions of Health
Research Project - Questionnaire

Information Sheet for Parents/Guardians

28th June 2007

Dear Parent/Guardian,

I am currently conducting research into perceptions of health among young people in selected areas of County Durham as part an ESRC-funded PhD project, which will be a geographical study of youth and health. This includes a specific focus on areas which fell under the remit of the former Durham Dales Primary Care Trust.

As part of this project I will be distributing anonymous confidential questionnaires to students in school years 7-10 at [*name of school*]. The questionnaire will explore young people's beliefs and priorities with regard to health and health-related behaviours. This will include some personal questions which students will not be obliged to answer if they are not comfortable doing so.

The project has received university ethics and risk assessment clearance, and the storage and use of data will be in line with university data protection procedures. The school will receive some feedback from the questionnaire but this will not allow individual students to be identified.

Your child will automatically be included in this project unless you are unwilling for him/her to be involved. If you would like to withdraw your child from this work then please complete the slip below and return it to their learning manager before Friday 6th July.

If you have any questions about this project please feel free to contact me.

Yours faithfully

Miss Natalie Beale,
(Research Postgraduate)

I would like to withdraw _____ from the Youth Perceptions of Health Research Project.

Signature

Date

Science Laboratories South Road Durham DH1 3LE

Enquiries +44 (0)191 334 1800 Fax +44 (0)191 334 1801
www.durham.ac.uk/geography

Appendix 8 National Statistics Socio-economic Classification (NS-SEC)

This thesis has used the Eight-class version of the NS-SEC, Which includes the following categories:

1 Higher managerial and professional occupations
  1.1 Large employers and higher managerial occupations
  1.2 Higher professional occupations
2 Lower managerial and professional occupations
3 Intermediate occupations
4 Small employers and own account workers
5 Lower supervisory and technical occupations
6 Semi-routine occupations
7 Routine occupations
8 Never worked and long-term unemployed

Appendix 9 Electoral Wards, Super Output Areas and School Attended

School attended by Electoral Ward, based on questionnaire responses.

	School Attended		
Ward Name	Hillcrest	Meadowcroft	Riverview
Bishop Auckland Town	10	7	#
Castleside	0	0	#
Cockton Hill	39	#	#
Cornsay	0	0	5
Coundon	#	#	0
Crook North	0	17	8
Crook South	0	58	17
Dene Valley	36	0	#
Escomb	53	0	#
Etherley	6	0	0
Evenwood, Ramshaw and Lands	0	0	#
Greenfield Middridge	#	0	0
Hamsterley and South Bedburn	#	0	10
Henknowle	41	0	0
Howden	0	#	20
Hunwick	0	20	20
Lanchester	#	0	#
Middlestone	#	0	0
Neville and Simpasture	#	0	0
Norton South (located in Stockton-on-Tees, Teesside)	0	0	#
Spennymoor	#	0	0
St John's Chapel	0	0	20
Stanhope	0	0	69
Sunnydale	5	0	0
Thickley	6	0	0
Tow Law and Stanley	0	11	72
West Auckland	23	0	0
Wheatbottom and Helmington Row	0	34	7
Willington Central	0	72	#
Willington West End	0	22	#
Wolsingham and Witton-le-Wear	0	0	71
Woodhouse Close	90	0	0

= number removed as greater than 0 but less than 5

School attended by Super Output Area, based on questionnaire responses.

	School Attended		
Super Output Area Name	Hillcrest	Meadowcroft	Riverview
Bishop Auckland Town	#	#	#
Byers Green	#	0	0
Castleside	0	0	#
Cockton Hill East	18	0	0
Cockton Hill North	13	0	#
Cockton Hill West	9	#	0
Cornsay Colliery	0	0	5
Coundon 1	0	#	0
Coundon Grange	15	0	#
Crook East	0	23	6
Crook South 1	0	32	9
Crook South 2	0	12	#
Crook South 3	0	14	#
Eldon	#	0	0
Escomb East	26	0	#
Escomb West	26	0	0
Frosterley	0	0	36
Hamsterley	#	0	10
Helmington Row	0	11	#
Henknowle Central	8	0	0
Henknowle North	17	0	0
Henknowle South	14	0	0
High Etherley	#	0	0
Howden-le-Wear	0	#	20
Hunwick	0	20	20
Lanchester Central East	#	0	0
Lanchester Rural	0	0	#
Low Etherley	5	0	0
Middridge 2	#	0	0
Neville and Simpasture East	#	0	0
Oakenshaw	0	10	0
Roddymoor	0	17	8
Shildon East	5	0	0
South Church	20	0	0
Spennymoor Central	#	0	0
St Helen's Auckland	12	0	0
St John's Chapel	0	0	20
Stanhope	0	0	34
Stanley Crook	0	11	25
Sunnybrow	0	23	#
Sunnydale	#	0	0
Thickley	#	0	0
Toronto	6	6	#
Tow Law Central	0	0	20
Tow Law Rural	0	0	18
Tudhoe Grange West	#	0	0
West Auckland East	7	0	0
West Auckland West	#	0	0
Willington Central 1	0	21	#

Willington Central 2	0	18	0
Willington West End	0	22	#
Wolsingham	0	0	27
Wolsingham Rural	0	0	26
Woodhouse Close Central	32	0	0
Woodhouse Close North	24	0	0
Woodhouse Close South	27	0	0

= number removed as greater than 0 but less than 5