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**Men's health and illness: the relationship  
between masculinities and health**

**Rosaleen O'Brien**

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requirements for the degree of Doctor of  
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## Abstract

Epidemiological data consistently reveal a distinct male disadvantage in health. One of the dominant explanations for men's poorer health is that it may result from their attempts to live up to a 'macho' image which encourages 'risky' practices; the idea that 'masculinity is dangerous to men's health'. However, few empirical studies have explored this supposition. This thesis presents men's discussions and experiences of health and illness and its relation to, and implications for, the practices of masculinity amongst a diversity of men. This work starts from the premise that men's descriptions of the practices of masculinity that they engage in and with are crucial to an understanding of men's experiences of health and illness.

Fifty five men participated in fourteen semi-structured focus group interviews. Diversity in men's experiences of health and illness and in their constructions of masculinity was sought within the sample by age (range 15-72 years), occupational status, socio-economic background and current health status. Groups of men were recruited who had had 'everyday' or unremarkable experiences of masculinity and health (largely by accessing men in a range of occupations, such as gas workers, fire-fighters, students) and groups of men with health experiences that could have prompted reflection on masculinity and health. This included groups with men who had prostate cancer, coronary heart disease, mental health problems, and Myalgic Encephalomyelitis (ME). Of the remaining groups one included men who shared experiences of recent health-related changes (principally diet and exercise), another of being full-time carers for wives with serious health problems, and another of being long-term unemployed. All of the men that participated in the study lived in central Scotland (Glasgow, Edinburgh, Dundee, Lanarkshire and Perthshire) and just one group was conducted with men of Asian origin, which reflects the limited ethnic diversity in this part of Britain.

This thesis examines three different aspects of the relationship between masculinity and health revealed in the data. The first data chapter examines participants' descriptions of their masculinity and their health-related beliefs and behaviours. The data capture both the experiences of men who felt pressured to engage in behaviours that may be harmful to their health in order to appear masculine and the accounts of those who regarded themselves as freer to embrace salutogenic health practices as they perceived there to be fewer consequences for their masculinities. The diversity of the sample also allowed exploration of how some participants re-negotiated their masculinity and health in response to critical events over the life course or in relation to their perceptions of age-appropriate behaviours.

These considerations are then followed by an examination of how participants re-negotiated male identity in the light of illness. Men's accounts of masculinity and coronary heart disease, prostate cancer, M.E and depression are examined to explore the varied challenges that different illnesses presented to participants' masculine identities. The majority of participants who had experienced major illness felt that their masculine identities had been violently disrupted by illness. However, the

losses participants experienced, and the nature of the challenge these presented to masculinity, were consequent on the illness they had suffered and, in some cases, the age at which they were when diagnosed. The data on illness emphasise the dynamic ways in which men construct and re-negotiate their health practices and identities as men. Even when illness required men to re-evaluate their health-related beliefs and behaviours and how they viewed themselves as men, a number of participants described how they were able to restore aspects of their gender identity by re-engaging in particular social practices that re-affirmed their masculinities.

The final data chapter presents participants' discussions and experiences of help seeking and its relation to the practice of masculinity. The data suggest a widespread endorsement of a 'hegemonic' view that men 'should' be reluctant to seek help, particularly amongst younger men. However, they also included instances which questioned or went against this apparent reluctance to seek help. These were themselves linked with masculinity: help seeking was more quickly embraced when it was perceived as a means to preserve or restore another, more valued, enactment of masculinity (e.g. working as a fire-fighter, or maintaining sexual performance or function). Few other studies have emphasised how men negotiate deviations from the hegemonic view of help seeking.

The main conclusion drawn from the study is that an explicit analysis of the practices of masculinity that men engage in and with in everyday social interactions is fundamental to all of the health-related beliefs and behaviours participants described. Participants did, however, describe a range of responses to the pressures they felt to align themselves with the 'hegemonic' model of masculinity. These data suggest the importance of taking more account of the diversity of men's experiences of masculinity and health and underline the need for further qualitative studies to explore the complexities in the relationship between masculinity and health.

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*In memory of my beloved parents  
Nuala Scanlon and Paddy O'Brien who  
both died during my PhD studies*

*Also dedicated with love to my sister Veronica*

*Special thanks to Praxoulla*

# Chapter 1

## Introduction

As male research subjects have long been used as the standard by which 'human' experience is measured (Harding, 1991), it may appear remiss to render women invisible once again and devote a thesis solely to examining men's experiences of health and illness. However, while women's health and its link to the social construction of gender has been a central concern for feminist medical sociologists since the 1970's and 1980's (Roberts, 1978; Clarke, 1983; Waldron, 1983; Graham, 1984; Stillion, 1985; Verbrugge, 1985), research exploring men's experiences of health and illness appears to have "lagged behind" considerably (MHF, 2004, p2), by comparison. Men are rarely consulted about their health-related beliefs and behaviours even though growing debate on the 'state of men's health' (Baker, 2001a) suggests that such an exploration is warranted.

Epidemiological data show that there is a distinct 'male disadvantage' (Watson, 2000) in health. Men in the U.K can expect to live on average five years less than women (ONS, 2004a,b) with a life expectancy at birth of 76 years (WHO, 2006). There has been debate regarding the biological (Stillion, 1995) and behavioural factors (Courtenay, 2002) that may predispose men to higher rates of morbidity and mortality. The main explanation for men's poorer health status is that men are ignorant of their bodies and are 'indifferent and resistant' (DoH, 1993) to recommended health practices. The research presented here is a response to an obvious demand for an empirical study, rooted in men's experiences, that explores the social practices that influence men's health.

Sociological theories relating to the social construction of gender (e.g. West & Zimmerman, 1991) and masculinity as social practice (Connell, 1995) have been strongly influential in the development of my thinking around the ways men's health and masculinity may be inter-related. A central tenet of work on the sociology of gender is that masculine identity emerges through social interaction through the range of gendered practices that men engage in and with, which has been described as the process of 'doing gender' (West & Zimmerman, 1991) or rather 'doing masculinity' (Morgan, 1992). One of the tasks of the thesis therefore was to facilitate men's

discussion of the ways they 'do masculinity' and to explore how these constructions of masculinity may relate to, and shape, men's health.

The central aim of this study therefore is to connect participants' accounts of their health-related beliefs and behaviours to an explicit discussion and analysis of male gender. There are a minority of writers who have consistently argued that sociological theories of masculinities might be illuminating if appropriated for the study of men's health (Sabo & Gordon, 1995; Moynihan, 1998; Connell, 1998; Watson, 2000; Courtenay, 2000a). However, empirical work that has examined the relationship between male gender and health remains scarce. The study of the social construction of masculinity was considered to be an important focus for research on men's health because one of the dominant explanations for gender inequalities in health is that men's poorer health may result from their attempts to live up to a 'macho' image which encourages 'risky' practices; the idea that 'masculinity is dangerous to men's health' (Harrison, 1978). One writer in 'men's studies' argues that "leaving men's lives unexamined leaves male privilege unexamined" (Brod, 1987a, p273) and it is my contention that leaving men's masculinities unexamined means that some of the assumptions that have been made about men's poorer health status remain unexplored.

The literature on the social construction of gender suggests that men construct their masculinities in multifarious ways according to age, socioeconomic background, ethnicity, religion, and differing experiences over the life course. As different constructions of masculinity may account for health inequalities between men (Payne, 2004) it was thought to be important to include some diversity in men's experiences of masculinity and health in this study. This was achieved partly by including a range of men by age. This provided an opportunity to consider whether men negotiated their masculinities and health in different ways depending on their life stage (Morgan, 1992). Men who did not conform to traditional notions of masculinity were also included in the sample, along with other participants who may have once conformed but who found it necessary to depart from this model at particular times in their lives (e.g. due to illness). Although it was not possible to explore all possible dimensions of diversity in this study it was considered important to examine *some* of the different ways that men 'do masculinities' and to consider what bearing these social practices

have on their health.

### **Why my interest in masculinity and men's health?**

As an undergraduate I enrolled on my final year sociology course on 'gender' knowing that I would be reading about *women's* lives and sharing lectures and seminars with an almost exclusively female audience. Much of the suggested reading for my first degree was indeed concentrated on work that focused on areas of research that examined women's experiences from feminist perspectives (for example of domestic violence, pornography, or sexual harassment in the work place). Although an analysis of male power was a central focus of this work, *men* and the analysis of male gender (i.e. discussion of men's lives, their experiences and their responses to patriarchy) were notable by their absence in both the academic courses I followed and in the work that I read. Although my postgraduate degree provided some opportunity to examine theoretical work on masculinities when considering wider developments that had been made in gender theory, there seemed to be a paucity of empirical work that critically examined the social construction of masculinity (or work that considered that men might be critical of aspects of masculinity and male power themselves). I applied for the PhD studentship<sup>1</sup> because it provided me with the opportunity to explore what I felt had been missing thus far from my gender studies. I was interested to interview men and explore how they constructed their identities as men.

Prior to the PhD I had not studied the sociology of health and illness in a formal academic setting. However, health and illness are subjects that have great personal resonance for me. I grew up in an area of South East London where there are marked social inequalities and I suppose I have always related what I saw to health because of my personal experiences. In such an environment it does not require a huge leap of imagination to consider the various ways in which people's lives might be limited by their social circumstances. However, my more immediate environment forced me to consider this in relation to my family as I watched my mother suffer with progressive multiple sclerosis for over twenty years. Living with an illness with no clear diagnosis (for a long time) and no firm aetiology makes it very difficult to come to

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<sup>1</sup> The MRC stipulate the area of interest, in this case 'masculinity and men's health', and applications are invited

terms with. On reflection, my thinking about the social factors that affect health could only have been a way of making sense of this experience. As a consequence I have always felt that I have the capacity to understand other people's experiences of health and illness. The two voluntary jobs I have done have both been health-orientated (one supporting the mental health of children whose parents abused alcohol and the other as a qualitative researcher for Greenwich Community Health Council). I was keen to develop my personal interest in health and combine it with my professional interest in research.

Although my thinking about men's health was greatly influenced by my reading of the literature, my approach to the study of masculinity and health has also undoubtedly been shaped by other personal experiences of health, illness and the kind of masculinities I have been exposed to throughout the course of my life. The majority of men in my large working-class Irish family did not live to reach retirement age; those who remain alive have suffered with chronic illnesses for most of their adult lives. Although I was aware that this is not unusual for men from this ethnic or class background, surprisingly I had not considered the issue of masculinity as a contributor to these health problems until I began working on this thesis. I became acutely aware, following conversations with family members about my research, that there were some health-related behaviours, such as heavy drinking, that were highly prized performances of Irish masculinity (at least among working-class Irish men that I know) even if the connection was made post hoc that such behaviours may have precipitated a man's early death.

It is a continual source of puzzlement to me why some men applaud the practices that can kill them or that they suspect have killed male friends and family members. This was a strong motivator for me to consider the powerful influence of hegemonic masculinity and the scenarios that encourage some men to adopt beliefs and practices that may be harmful to their health. I also consider it to be a positive step to explore the cases where men are able to reject masculine practices that may be valorised within their social group for the sake of their health.

## Summary

The thesis begins by considering the theoretical and empirical work on masculinity and men's health (Chapter 2). This chapter is then followed by a description of the methods that were used to gather data on men's experiences of masculinity, health and illness for this study (Chapter 3). Chapters 4, 5 and 6 then present research findings derived from the fifteen focus group interviews that were conducted. The three data chapters are presented to highlight the different aspects of the relationship between masculinity and health that were revealed by the study. Firstly, Chapter 4 presents men's descriptions of their masculinity and their health-related beliefs and behaviours. The next empirical chapter (Chapter 5) considers participants' accounts of a range of illnesses that required many to renegotiate aspects of their masculinities. The final data chapter (Chapter 6) explores the relationship between help seeking and men's beliefs and practices of masculinity. Finally, the main conclusions, policy implications, and reflections on the strengths and weaknesses of the study are presented in Chapter 7.

The literature review is presented in Chapter 2. This chapter begins by examining the theoretical and empirical work that has emphasised the importance of exploring men's health in relation to men's experiences *as men*. This includes a critique of the study of men's health and the omission of male gender from the majority of work in the field. The following section focuses on the sociological theories pertaining to the social construction of gender identities that have informed my thinking about, and design of, this study. I then discuss the studies that have begun to explore the relationship between masculinity and health and conclude by suggesting ways that this study might contribute to such work. It should be noted that many of the issues that have been debated extensively in the men's health literature are not rehearsed in this chapter. However, a few of the central issues that have been discussed in the literature on men's health, which were important to examine in this thesis, are discussed in dedicated literature reviews at the start of each of the data chapters. There are therefore separate literature reviews relating to masculinity and men's health-related beliefs and behaviours (Chapter 4), the challenge that illness presents to masculinities (Chapter 5) and masculinity and help seeking (Chapter 6).

Chapter 3 describes the methods used to access men's experiences of health, illness,

and accounts of their masculinities. Although qualitative methods were anticipated as having the potential to yield rich insights into men's beliefs, behaviours and experiences of masculinity and health, the literature indicated that there might be challenges both in recruiting men and in encouraging them to speak about their health and their masculinity (Morgan, 1981; McKee & O'Brien, 1983). Part of the task of the pilot work, which is described in this chapter, was to experiment with different qualitative methods and interviewing techniques to find out which are likely to produce data that are revealing of the complex relationship between masculinity and health. I then go on to discuss why focus group interviews were chosen as the primary method of data collection for the main fieldwork and details of the sample and focus group have provided. The challenging aspects of fieldwork, such as difficulty in recruiting certain groups of participants, the discomfort at times of being a woman doing research on men and having to enter 'male territory' and ask questions of men that were sometimes perceived as threatening, are also described. Chapter 3 ends with a reflexive account that considers how my gender and that of the male respondents impacted the research process and may have influenced the data that were collected.

Chapter 4 begins with a discussion of the literature on men's health practices. A reading of the literature revealed that whilst there was an abundance of descriptions of poorer health practices of all male samples, there was rarely any consideration of how men's health-related beliefs and behaviours may be influenced by men's constructions of their masculinity. The data presented in Chapter 4 explores the instances where men reject or adopt particular health-related behaviours (such as heavy drinking) in order to construct their masculinity. The empirical section of the chapter also considers the pressures some participants felt when they attempted to make recommended changes to their lifestyles when they were still immersed in peer groups who rejected such behaviours. The data also capture the experiences of men who felt freer to present themselves as concerned about their health. The diversity of the sample also allowed some exploration of how a number of participants re-negotiated their masculinity and health in response to critical life events or perceptions of age-appropriate behaviours. Participants' accounts of their health-related beliefs and practices offer insights into the perceived ideal for masculine practice, that were believed to be held both within different peer groups and more

widely in the West of Scotland.

Chapter 5 describes men's experiences of negotiating their masculinities in light of illness. A literature review is presented at the beginning of the chapter which examines theoretical and empirical work that has explored the relationship between masculinity and illness. These studies have highlighted how the loss of work identity, social roles, and bodily changes that accompany serious illness are likely to present significant challenges to masculinities. Men's accounts of masculinity and coronary heart disease, prostate cancer, M.E and depression are then presented in this chapter to explore the varied challenges that different illnesses might present to male identities. Men's accounts of their illnesses were particularly valuable in highlighting the gendered beliefs and practices that men engaged in prior to illness and those aspects of masculinity that were challenged following diagnosis.

A different aspect of the relationship between masculinity and health is examined in Chapter 6 by focusing on men's descriptions of one particular health-related behaviour; participants' experiences of help seeking. The theoretical work on men and help seeking, described in the literature review at the start of the chapter, suggests that men are reluctant to consult their doctors when they experience mental or physical health problems. This has been identified as one of the most important obstacles to improving men's health (Banks, 2001). There have been few empirical studies to date that have explicitly explored whether delays in getting timely advice may be related to the beliefs and practices of masculinity. The data that are presented in Chapter 6 therefore provide a rare opportunity to examine men's accounts of help seeking in relation to their constructions of masculinity. The aim of the chapter is to explore why some men, under some circumstances, are willing and able to seek help for some problems, while others remain reluctant to do so. The experiences of men who seek help for a range of serious illnesses are compared with those who consult with 'minor' symptoms' and others who were very reluctant to ask for any support.

This thesis presents men's discussions and experiences of health and illness and its relation to, and implications for, the practices of masculinity amongst a diversity of men in Scotland. The thesis aims to:

- Describe men's experiences of health, illness and their constructions of their masculinities by drawing on the words men used themselves.
- Provide an explicit analysis of male gender and health: a departure from the majority of existing accounts of men's health.
- Examine the cases where it appears that men's beliefs about, and practices of, masculinity may be harmful to men's health, as hypothesised by Sabo and Gordon (1995).
- Investigate the range of ways that men 'do' masculinity and consider not only the 'risky' aspects of masculinity, but to explore the complex ways in which men may conform to, depart from, or reject traditional notions of masculinity.
- Explore the circumstances that appear to enable some men to embrace recommended health practices without this presenting any challenge to their masculinity.

The approach adopted for this study suggests that gathering descriptions of the practices of masculinity is crucial to an understanding of men's experiences of health and illness.

## **Chapter 2**

### **Literature Review**

#### **2.1. Description of the literature presented in this chapter**

The importance of exploring male gender in relation to men's health has been recognised (Sabo & Gordon, 1995; Courtenay, 2000a) but has rarely been incorporated into the design, data collection and analysis of studies of men's health (Annandale & Hunt, 1990; White, 2004a, b). As this thesis aims to explore men's experiences of health and illness and its relation to, and implications for, the practices of masculinity, it was helpful to focus my reading on the largely separate bodies of work on: a) men's health and b) the social construction of gender and draw together the most useful ideas presented within these 'literatures' to inform this study. This chapter focuses predominantly on sociological theories and studies that have examined the social construction of gender identity, or more specifically, of masculinities. I will outline the reasons why I consider this work to be a useful basis for designing a study examining the relationship between male gender and men's health.

This chapter is intended to provide a general overview of work on men's health, with an emphasis in the discussion on the omission of masculinities from many studies on men's health. Many issues that have been debated in the men's health literature are not rehearsed in detail here. However, some of the central problems that have been discussed in the literature on men's health, and which were considered important to examine in order to highlight different aspects of the relationship between masculinity and health, are discussed in dedicated literature reviews at the start of each of the data chapters that are to follow. The areas of literature that will be presented later in the thesis will be described at the end of this chapter.

#### **2.2. Male gender and men's health**

Epidemiological data on men's health strongly suggest that there is a "long-established male disadvantage in health" (Watson, 2000, p22). Men in the U.K can expect to live on average almost five years less than women with a life expectancy at

birth of just less than 76 years (WHO, 2006). Large scale empirical studies and analyses of men's health across Europe (White & Cash, 2003), Australia (Van Buynder & Smith, 1995) and the United States (Verbrugge, 1985) suggest that higher mortality rates for men compared to those of women is a pattern that is common to most Western societies (see also Barford et al, 2006 and White & Holmes, 2006). Men are argued to be more "fragile" (Kraemer, 2000) or vulnerable to injury, disease and death at every stage of the lifespan from conception to old age (Stillion, 1995). Certainly, men seem particularly vulnerable to circulatory disorders (which include stroke and coronary heart disease) which are still the leading cause of death among men, closely followed by cancer (ONS, 2004c). Mortality rates for men aged 15 to 44 are highest for injury and poisoning (40 per 100,000 population for men aged 15 to 29, 43 per 100,000 population for men aged 30 to 44): these figures are largely attributable to accidents and suicides (ONS, 2003). However, in the U.K at least, the gap between men and women is smaller in terms of *health* expectancy, averaging 69 years for women compared with 67 years for men (ONS, 2004a, b).

One of the main explanations for men's poorer health is that men are ignorant of their bodies and are 'indifferent and resistant' (DoH, 1993) to recommended health practices. This merely serves to reinforce the idea that men are 'hapless and helpless' (Seymour-Smith et al, 2002) when it comes to health. The majority of work on men's health, at least in the past, has been dominated by discussion of the biological (e.g. Stillion, 1995) and behavioural aspects of men's health (e.g. Courtenay, 2002; Feigen-Fasteau, 1974; Farrell, 1975; David & Brannon, 1976; Waldron, 1976) that are believed to predispose men to illness and premature death. Men's poorer health is commonly perceived to be related to their attempts to live up to a 'macho' image and this has resulted in a particular interest in men's 'risk-taking' behaviours (Harrison, 1978; Lloyd, 1998a). However, recent work suggests that men's engagement with particular behaviours is complex. For example, one study showed that even when men presented themselves as 'risk-takers' they behaved rather differently in practice (Robertson, 2003a). Such work highlights the need to think critically about the health-related behaviours that men *appear* unwilling to engage in as well as examining those they embrace and explore how the gendered meanings men may hold about these practices may relate to these 'choices'.

There are a minority of writers who argue that the ‘male disadvantage in health’ (Watson, 2000) cannot be understood without exploring the pressures that are placed on men to engage in masculinising practices that may be harmful to their health and to reject other salutogenic health-related behaviours in order to demonstrate masculinity (Watson, 2000; Sabo & Gordon, 1995; Courtenay, 2000a&b). However, as one writer describes, this crucial issue has often been overlooked in the majority of empirical studies on men’s health:

*Few health scientists, sociologists and theorists identify masculinities – and rarely even male sex – as a risk factor; fewer still have attempted to identify what it is about men, exactly, that leads them to engage in behaviours that seriously threaten their health. Instead men’s risk taking and violence are taken for granted.*  
(Courtenay, 2000a, p1396)

The field of men’s health has appeared slow to respond to such criticisms and to consider the complex ways in which men’s health-related beliefs and behaviours may be related to the social construction of male identities (Sabo & Gordon, 1995). It is suggested that “medical and social debate around men’s health is undermined and under-informed by a failure to explore men’s perceptions of health and maleness as a personal, cultural and social phenomenon” (Watson, 2000, p2). It is clear that the relationship between male gender and health needs to be addressed and be regarded as a central area of concern for anyone with an interest in men’s health.

The discussion of men’s health and the neglect of male gender are connected to a wider debate on gender inequalities in health (Annandale & Hunt, 2000; Denton & Walters, 1999; Emslie et al, 1999; Macintyre, Hunt & Sweeting, 1996; Macintyre, 1993; Arber, 1991; Kandrack, Grant & Segall, 1991; Verbrugge, 1985; Waldron, 1988). Some, who have written about and researched men and women’s experiences of health and illness, have critiqued the omission of men’s experiences from the majority of accounts on gender and health. This oversight is largely attributable to ‘gender and health’ being viewed as synonymous with ‘women’s health’ (Annandale & Hunt, 2000). It is a concern that, although there have been developments in research on gender and health, for too long “the expectation of particular patterns of health for women and men and a focus on difference between men and women obscured contrary or contradictory results” (Hunt & Annandale, 1999, p1). Many

have recognised the need to pay particular attention to the social practices of gender when conducting research on health; making clear that 'gender' in this context means an interest in femininities *and* masculinities and how these relate to women's, *as well as*, men's experiences of health and illness (Annandale & Hunt, 2000).

The omission of men's experiences of health and illness in research on gender inequalities in health has also been much maligned by writers in the field of men's health (Haslam, 1998; Lloyd, 1998a, b; Luck et al, 2000; Meryn & Jadad, 2001; Baker, 2001a&b; Jones, 2004; White, 2004a). However, there has been a proliferation of research on men's health in recent years that has sought to address this by exploring a range of men's experiences of health and illness. Researchers have described men's experiences of male-specific illnesses such as testicular cancer (Jones & Appleyard, 1989; Ganong & Markovitz, 1987; Moore & Topping, 1999; Mason & Strauss, 2004a&b); prostate cancer (Cameron & Bernardes, 1998; Clark et al, 1997; Kiss & Meryn, 2001; Chapple & Ziebland, 2002), and illnesses that may be perceived as 'male' (Emslie et al, 2001) such as heart disease (Cowie, 1976; White & Johnson, 2000; Helgeson, 1995). There has also been some work examining some of the behavioural factors associated with men's poorer health (e.g. Courtenay, 2002), particularly in relation to smoking (Payne, 2001), drinking to excess (McCreary et al, 1999; Mullen, 1990) and a 'reluctance' to seek medical help (Tudiver & Talbot, 1999; Banks, 2001). More recent work has emphasised the importance of defining, identifying and researching a range of 'men's health issues' (Fletcher, 1997; White, 2001a; White, 2004b). Apart from a few notable exceptions (Robertson, 2006; Chapple & Ziebland, 2002; White & Johnson, 2000; Courtenay et al, 2002), masculinity has rarely been explored explicitly in the majority of discussions and studies of men's health. However, the few examples that there are of qualitative studies have provided some with the opportunity to explore aspects of male experience that had not previously been noted in the literature. One team of researchers had not anticipated exploring, or asking respondents directly about, issues relating to masculinity (Chapple & Ziebland, 2002). However, the qualitative interviews they conducted with men revealed that masculinity was integral to their experience of prostate cancer.

It is perhaps understandable, when we consider that there have been so many other

competing concerns about 'men' and men's health, that the study of masculinity has not been a focal point in the majority of empirical studies. For example, there is debate as to whether men's health (Coyle & Morgan-Sykes, 1998; Luck et al. 2000) and their 'masculinities' (Kimmel, 1987a; MacInnes, 2001) are 'in crises'. There are also reports of escalating suicide rates among young men (ONS, 2001; also see Cannetto, 1995 and Emslie et al, 2006 for discussion) and the suggestion that men may be reluctant to consult a doctor when they experience mental or physical health problems (e.g. Banks, 2001) which have intensified concerns that these and many other male vulnerabilities require urgent attention and intervention. However, work on the social construction of masculinities suggests that there are important aspects of male experience, that have been little explored, that may underpin many of the problems discussed in the men's health literature. There has been much greater progress made in endeavouring to understand how women's lives and their experiences *as women* shape their health (e.g. Graham, 1993; Doyal, 1995; Ussher, 2000; Hunt, 2002). Similar work needs to be developed to explore the relationship between male gender identity and health. The following section outlines the theoretical work on the social construction of gender, which offers some suggestions as to how masculinities might be studied empirically in relation to men's health.

#### **2.4. The social construction of gender: theoretical work**

The sociology of gender has undergone many theoretical and methodological developments over the last four decades (Charles, 2002). A major contribution of the work that emerged following the rise of second-wave feminism in the late 1960s was the critique of the notion that masculinity and femininity are 'essential' traits that are derived from biological sex (e.g. Oakley, 1972). Gender has come to be viewed as one of the most important 'organizing principles' (Connell, 1985a & 1987) of social life. Rather than conceiving of gender as being socially acquired through fixed social norms which 'prescribe and proscribe' (Thompson & Pleck, 1986) how men and women should behave, gender is more commonly viewed as a 'recurring accomplishment' (West & Zimmerman, 1991). Gender identity is understood to emerge from social interaction through the range of gendered practices that men and women engage with, which has been described as the process of 'doing gender' (West & Zimmerman, 1991). The theory of gender as social practice (Connell, 1995), which informs this study, is derived from Bourdieu's work (Bourdieu, 1990).

This theory suggests that gender identity and the gendered body are socially constructed and:

*...produced and expressed through our movements, gestures, facial expressions, manners, ways of walking, and ways of looking at the world....even basic activities such as teaching children how to move, dress, and eat are thoroughly political, in that they impose on them an unspoken understanding of legitimate ways to (re)present their body to themselves and others.*

(Moi, 1991, p1030-1031)

Many feminist writers have long maintained that a concern with gender necessarily meant incorporating an analysis of men and masculinity (e.g. Stanley & Wise, 1983; Burman, 1996). However, male gender had remained 'invisible' (Whitehead, 2001) for many years because male experience had previously been presented as *human* experience in mainstream social science (Harding, 1991). Feminist analysis of male power and social relations between men and women (e.g. see Radtke & Stam, 1994) prompted a growth of 'men's studies' (Brod, 1987b) which comprised of theoretical works on masculinity by men (e.g.: Kimmel, 1990; Hearn & Morgan, 1990; Morgan, 1981 & 1992; Mac an Ghail, 1996; MacInnes, 1998 & 2001; Connell, 1987, 1995 & 2000). Male gender began to be problematised as there was increasing recognition that: "the physical sense of maleness (was) not...a consequence of XY chromosomes, the physical sense of maleness grows through a personal history of social practice, a life history in society" (Connell, 1987, p84).

As has been the case in the field of men's health, critics of early theoretical work on masculinity argued that there was a tendency to reify a particular kind of masculinity so that the 'risk-taking', 'tough' traits associated with the 'male role' had effectively become a fixed character type (see for example David & Brannon, 1976; Oliver, 1996; Riska, 2002; Connell, 1995 for a critique of sex role theory). It was argued that masculinity should not be regarded as a characteristic that a man brings uniformly to every social encounter as it may be constructed and re-negotiated in different social contexts and at different stages in the life course (Morgan, 1981; Hepworth & Featherstone, 1998). It was suggested that theoretical work relating to male identity needed to draw on developments in the sociology of gender and begin to conceive of men as "'doing masculinities' rather than of 'being masculine'" (Morgan, 1992, p47).

Further problems were identified when it was pointed out that theoretical work on masculinity tended to generalise about masculinity from a privileged perspective (i.e. the 'masculinity' that was being described was white, middle-class, heterosexual) (Blye, 1987; Kimmel, 1990). Gay scholars (e.g. see Nardi, 2000) showed how accounts that presented a unitary view of men (and of women) were problematic as they ignored inequalities between men. There was also growing awareness that the social practice of gender must also "interact...with race and class" (Connell, 1995, p75; see also Pyke, 1996; Popay et al, 1998; Butler, 1989). Other writers revealed how masculinities may also be enacted in culturally (Cornwall & Lindisfarne, 1994; Herdt, 1981 & 1999) and historically specific ways (Ehrenreich, 1983; Kimmel, 1987; Brod, 1987; Segal, 1990). The term 'multiple masculinities' is now commonly used as acknowledgement of the diversity of ways in which men may construct and negotiate their identities as men (Buchbinder, 1994; Connell, 1995; Mac an Ghail, 1996; Beynon, 2002).

The 'male role' that was described in early work on masculinity is also now more commonly understood to refer to only one form of masculinity. 'Hegemonic masculinity' (Blye, 1987; Donaldson, 1993; Connell, 1995) is considered to be the "most honoured or desired" enactment of masculinity (Connell, 2000, p10). Hegemony has been described as "the winning and holding of power and the formation (and destruction) of social groups in that process" (Donaldson, 1993, p645). Therefore in constructing hegemonic masculinity other masculine styles (e.g. heterosexual men who are perceived to be effeminate or gay men) may be oppressed and may be viewed as "subordinate variants" (Cornwall & Lindisfarne, 1994, p3; see also Carrigan, Connell & Lee, 1987). However, it has been noted that although "the hegemonic pattern is dominant, because it is socially sustained, it can be resisted" (Blye, 1987, p165). One writer summarises the range of responses men may have to the hegemonic model of masculinity:

*Hegemonic masculinity can be...distanced from, appropriated, negated, challenged, reproduced, separated from, renounced, given up, chosen, constructed with difficulty, confirmed, imposed, departed from, and modernized. (But not, apparently, enjoyed).*  
(Donaldson, 1993, p646)

However, it has been reported that men who contest the hegemonic model of masculinity are likely to face censure for doing so (Hunter, 1993). The hegemonic model has been viewed as a form of social control (Blye, 1987) because it is thought that many men feel the need to live up to the cultural ideal of masculinity (Messner, 1992) and may feel its influence whatever position they take in response to it. There has been greater interest in doing qualitative research that exposes the "gender order" (Connell, 1995), a term that refers to the social relations and social practices that arrange different masculinities hierarchically according to power relations between men.

The idea that there is a 'plurality of masculinities' (Nixon, 1997) does suggest that there may be challenges for those wishing to design an empirical study examining masculinities. Critics have argued that to invoke the idea of endless difference, moving from the modernistic 'view from nowhere' ('human' experience) to a 'view from everywhere' (men's subjective experience of a range of masculinities) (Nicholson, 1990) is methodologically problematic (MacInnes, 1998). One writer describes the dilemma this presents for research design:

*Accentuate the 'in-group' and you are likely to run the risk of generalising from the experiences of a few, possibly highly selected individuals and hence laying oneself open to easy rejection. Accentuate the universal and you run the risk of creating false communities and constructing a generalised masculinity.*  
(Morgan, 1992, p41)

There is an interest in researching the diversity of men's responses to the hegemonic model of masculinity and the alternate ways in which men construct masculinity. However, it has been noted that it is important to consider simultaneously the beliefs and practices of masculinity that different groups of men may share (Connell, 1995; Hearn & Collinson, 1994). It has been suggested that:

*Just as members of a family may be said to resemble each other without having any single feature in common, so masculinities may form common patterns without sharing any single universal characteristic.*  
(Brod, 1987c, p276)

There is much debate as to the best ways to make the practices of masculinity explicit through the research process (Hearn, 1994; Morgan, 1981 also see Morgan, 1992

chapter entitled 'problems of studying men'; Griffin & Wetherell, 1992; Smiler, 2004). It has been suggested that the diversity of ways in which masculinities are constructed may be examined by researching the range of 'everyday' social practices that men engage in as fathers (Blain, 1993), sons, and husbands or at work or leisure (Hearn & Collinson, 1994; Hearn et al, 1998b). The following section discusses theoretical and empirical work that suggests that masculinities might also be revealed through the study of men's discussion of their beliefs about masculinity and their everyday health-related practices.

#### **2.4. The social construction of masculinity and health: theoretical and empirical studies**

Over the decade that has seen a steady increase in research on men's health, there have been writers who have consistently argued that sociological theories of masculinities could be illuminating if appropriated for the study of men's health (Sabo & Gordon, 1995; Moynihan, 1998; Connell, 1998; Watson, 2000; Courtenay, 2000a). There are a range of studies that have explored the social practices that men engage in in different cultural and social contexts (Willis, 1979; Herdt, 1981 & 1999; Tomsen, 1997; Kehily & Nayak, 1997; Messner, 1987a, b; Watson, 2000; Barrett, 2001; Frosh et al, 2002; Leyser, 2003). These accounts suggest that just as being a father (McKee & O'Brien, 1983) or a factory worker (Willis, 1979) or placing oneself in the masculine hierarchy of a school (Mac an Ghail, 1995; Connell, 1989) can be revealing of the ways in which masculinity might be constructed, men's everyday health-related practices such as going to consult a doctor or displaying a resistance to recommended health practices can also be understood as ways of 'doing masculinity' (Saltonstall, 1993; Courtenay, 2000a; Williams, 2000). However, most research exploring the relationship between male gender identity and health has not defined 'masculinity' in these terms.

It has been largely taken for granted that 'masculinity is dangerous to men's health' (Harrison, 1978; Darbyshire, 1987). The few studies of masculinity and men's health that there are have emphasised the more destructive behaviours associated with the hegemonic model of masculinity that men were assumed to engage in. Hegemonic or 'traditional' masculinity has perhaps received greater attention in research on men's health because: "health seems to be one of the most clear-cut areas in which the

damaging impacts of traditional masculinity are evident" (Sabo & Gordon, 1995, p17). Theoretical work in the field of 'men's studies' (Brod, 1987a) suggested that conformity to traditional masculinity increased men's health risks and chances of early death and restricted the open expression of emotions (Feigen-Fasteau, 1974; Farrell, 1975; Brannon, 1976; Harrison, 1978; Darbyshire, 1987). Traditional masculinity has been viewed as particularly hazardous to men's health because:

*To demonstrate physical strength and prowess, traditional masculinity encourages a man to disregard pain, act invulnerable, hypersexual, and robust....To demonstrate self-reliance, traditional masculinity requires a man to be in control and dismissive of help. To demonstrate fearlessness, traditional masculinity requires a man to be aggressive, risk-seeking, and sensation seeking. In this context of traditional masculinity, men actually express their virility when they take poor care of themselves and reject health care, thereby literally hastening their deaths in order to prove their superiority.*  
(Alt, 2001, p9)

Certainly there is empirical data that support the idea that men who strongly adhere to the hegemonic model of masculinity are likely to engage in behaviours such as heavy drinking (McCreary et al, 1999; Canaan, 1996), smoking (Payne, 2001) and poor dietary habits (Ricardelli, et al. 1998; Roos et al, 2001; Stibbe, 2004).

Whilst it has been important to explore the possibility that *some* men may indeed engage in high-risk behaviours that may be aligned with traditional constructions of masculinity, the lack of diversity in work that has explored the relationship between masculinity and health has been heavily criticised (Sabo & Gordon, 1995; Watson, 2000). One writer argues that such accounts:

*View 'men' through an external prism of risk rather than attempting the more complex task of understanding how different groups of men perceive and grapple with the world around them.*  
(Watson, 2000, p30).

The assumption that the majority of men feel compelled to align themselves with the hegemonic model of masculinity and engage in behaviours that put their health at risk may mean that the views of those who do not subscribe to the hegemonic model of masculinity may be overlooked. It has been suggested that there is a need for further research that considers a much wider range of men's experiences of masculinity.

health and illness than has been reported to date:

*Part of the mission for researchers of men's health and illness...is to describe and document substantial differences between the health options of homeless men, professional athletes, working-class men, underclass men, gay men, men with AIDS, prison inmates, men of colour, and their comparatively advantaged middle- and upper-class, white, male counterparts.*  
(Sabo & Gordon, 1995, p10)

Sociologists writing about the social construction of gender have suggested that the practices of masculinity might be revealed through scenarios in which "hegemony is constituted and contested" (Carrigan, Connell and Lee, 1987, p94). It has also been argued that masculinity is most likely to be revealed through the 'changes and challenges' (Brod, 1987c) or 'epiphanies' (Crabtree et al, 1993) that men may face throughout their lives. Data show that men's perception of their own masculinity and of their health practices are likely to vary according to their age (Emslie et al, 2004; see also Backett et al, 1995), ethnicity (Courtenay et al, 2002) and experience of illness (Moynaghan, 1998; O'Brien et al, 2005).

There are more recent examples of efforts to explore how the different practices of masculinity that men engage in may influence a wide range of health-related behaviours such as engagement with sport (Robertson, 2003b), dietary practices (Roos et al, 2001) and help seeking (Seymour-Smith et al, 2002; Moller-Leimkuhler, 2002). Some studies have documented the 'challenges' (Morgan, 1992; Hearn & Collinson, 1994) that men face when men choose (Lupton, 2000), or feel forced, to adopt less traditional masculine practices (e.g. Smith, 1998; Parker & Seymour, 1998). Health research with men has suggested that such challenges seem particularly likely to arise as a result of illness or disability (Chapple & Ziebland, 2002; Gordon, 1995; Gerschick, 1995). Some of these studies have provided insights into the way men maintain, resist and re-negotiate aspects of their male identities in light of serious illness (e.g. White & Johnson, 2000; Chapple & Ziebland, 2002). It is one of the aims of this thesis to contrast the accounts of 'healthy' men and those who have experienced illness in order to interrogate different aspects of the relationship between masculinity and health. Exploring some diversity of male experience in studies of men's health is likely to facilitate a greater understanding of why it is that

some men apparently feel freer (and others less free) to contest or reject the hegemonic model of masculinity for the sake of their health (Connell, 1995; Morgan, 1992).

### **2.5. Other areas of the literature to be examined later in the thesis**

The literature reviews that are presented at the beginning of two of the data chapters (Chapters 4 and 6) explore different health-related behaviours that have been suggested as major contributors to men's relatively poorer health status. Men's health-related beliefs and practices are often presented as partial explanation of the 'male disadvantage in health' (Watson, 2000). It has been argued that higher morbidity and mortality rates among men compared to women are strongly related to an "apparent indifference, if not resistance, to health promotion messages among men" (DoH, 1993, p105, also see Watson, 2000). The literature review presented in Chapter 4 examines the discussion and study of a range of men's health-related beliefs and behaviours (e.g. smoking, drinking, eating and physical activity) and considers whether these practices could be considered as gendered social practices. Chapter 4 goes on to examine work on masculinities which suggests that the gendered meanings men attach to particular behaviours and the social practices they feel they are expected to engage in as men may be important in understanding the health-related practices men apparently 'choose' to adopt or reject on a daily basis. Chapter 6 examines men's help seeking behaviour which is another area that has been suggested as an "obstacle to improving men's health" (Banks, 2001, p1058). The literature presented suggests that men's 'reluctance' to seek help is likely to preserve the male disadvantage in health because fewer visits to the doctor and delays in getting timely advice may decrease men's chances for prevention, treatment, and survival of disease (Mason & Strauss, 2004a & b). The literature review presented in Chapter 6 ends by examining theories relating to the social construction of masculinity and considers whether these may be helpful in exploring men's accounts of their help seeking in this study.

Another important area that has been discussed in the literature on men's health, and an aspect of the relationship between masculinity and health that I wished to highlight in this thesis, is whether and how masculinities are challenged by different illnesses. The literature review presented in Chapter 5 discusses the different aspects of

masculinity that have been revealed by studies on testicular cancer, prostate cancer and coronary heart disease. This section of the chapter goes on to consider other illnesses, such as depression and M.E. that may present challenges to male identity that may not have been documented in the literature. Chapter 3, which follows, describes the methodological literature that was helpful in designing, researching and analysing data for a study that seeks to highlight different aspects of the relationship between masculinity and health that might be revealed by interviewing a diversity of men.

## **2.6. What would be a valuable contribution to existing knowledge?**

The literature on 'masculinities' emphasise diversity in the ways that men construct and negotiate their gender identities (Connell, 1995). The different beliefs men hold about masculinity and the different practices they engage in and reject are likely to have very different outcomes for their health. It is therefore important that a range of men's experiences of masculinity are explored in order to understand what circumstances make it possible for men to show a greater regard for their health and the scenarios that pressure men into rejecting recommended health practices. This is a concerted effort to move away from the unitary view of men and the unproblematised view that has been presented of men as 'risk-takers'. It is my contention that a greater understanding of men's health may be achieved through the study of some of the 'commonalities, contradictions and conflicts' (Hearn & Collinson, 1994) in men's accounts of their masculinities and health.

The valuable contribution that 'lay knowledge' (Popay et al, 1998a) can make to a burgeoning area of research such as men's health has been discussed in detail elsewhere (Watson, 2000; Mullen, 1993). Although some researchers have already begun to examine the ways that masculinity and health might be related (Watson, 2000; Roberston, 2003a & 2006; Emslie et al. 2004; Chapple & Ziebland, 2002) there is certainly room for further qualitative studies that explore other aspects of masculinity that might not have previously been considered. It is certainly a challenge to design and conduct research that encourages men to reflect on their health in relation to their masculinities when it has been said that "the essence of masculinity can never be grasped or defined" (MacInnes, 2001, p311). This thesis will endeavour to contribute to existing knowledge on men's health by presenting an

explicit analysis of the practices of masculinity and men`s health that is firmly rooted in participants` descriptions of their masculinities, health and experiences of illness.

## **Chapter 4**

### **Methodology**

#### **4.1. Introduction**

This chapter focuses on my experiences of fieldwork spanning a twenty-month period beginning June 1999 and ending February 2001 and details the methodological decisions that were made relating to the research design and the collection and analysis of data. Firstly, I will outline the reasons why qualitative research methods were considered to be the most appropriate way of exploring some of the diversity in men's accounts of masculinity and health. The lessons learned from the pilot study, which compared the utility of individual and focus group interviews for the study, are then described in detail. All aspects relating to sample design, recruitment of participants, and focus groups design are then discussed. A description of the steps taken to analyse the data is also provided. Finally, I present a reflexive account that considers how my gender (female) and that of the male respondents impacted the research process and may have influenced the data that were collected.

When embarking on this study there were very few discussions of men's health that drew on men's own words and experiences in describing their health. An important aspect of this research was to facilitate men's detailed discussions of health in order to understand, rather than presume, what issues were of importance to men of different ages and social backgrounds. The main focus in gathering descriptions of men's health practices was in exploring those instances where men either rejected, or described a greater willingness to engage with, particular health-related behaviours. It should be acknowledged that there are already some studies that describe the health practices of all-male samples in greater detail than is presented in this thesis (e.g. Mullen, 1993). However, the primary aim of this study was to also connect participants' accounts of the health-related beliefs and behaviours they referred to, to an explicit discussion and analysis of gender. The research questioned to what extent and in what ways are men's health-related behaviours related to constructions of masculinity. The aim was to understand whether men's beliefs and practices of masculinity might facilitate or undermine men's health in different social contexts.

## **4.2. Qualitative methodology**

The project's aims were considered to be best met by qualitative methods as these had the potential to yield rich insights into men's beliefs, behaviours and experiences. It was thought that the gendered meanings that men attribute to health-related behaviours would be most likely to be revealed using a method that encouraged men to describe their beliefs and practices in their own words. Qualitative interviewing would also be of particular benefit in exploring the complex and varied ways in which different participants constructed their masculine identities. Such methods also have the advantage of allowing the researcher to tailor interviews, in this case to the gendered biographies of individuals or the ways in which a particular group of men collectively construct their masculinities. As it was difficult to predict how men would discuss their masculinities or the ways in which men would connect male identity and health, qualitative research also offered the flexibility of exploring any unanticipated topics that emerged during the interview process.

The literature on men's health highlights particular challenges in conducting qualitative interviews with men on the subject of health. One writer refers to the "inarticulacy of men on matters of health" (Mullen, 1993, p30). Others have explored the particular challenges women have faced in accessing accounts of masculinity and health from men in different interview contexts (Hearn, 1994; Green et al, 1993; McKee & O'Brien, 1983). Similarly, empirical work on masculinity has suggested that there may be difficulties in encouraging men to speak 'as men' (Morgan, 1981; McKee & O'Brien, 1983). One of the objectives of the pilot work was, therefore, to gauge how accessible men's accounts of masculinities and health were likely to be.

## **4.4. Pilot study: which method?**

Focus groups were given more careful consideration, as a possible method to combine with individual interviews, as greater thought was given to the different performances of masculinity that might be observed in different contexts. It was anticipated that men might discuss their masculinity differently when alone with a female interviewer (I assumed more freely) to how they might discuss male identity with a group of other men. On a previous project I had experience of facilitating a small number of mixed-gender groups exploring their experiences of health care and I

had observed that participants often chose to reveal 'private' experiences to me following group interviews as they did not feel able to discuss these 'publicly'. Other researchers have explored the differences in data that emerge when comparing responses in focus groups and individual interviews more formally (Merton et al. 1990; Wight, 1994 and 1996; Michell, 1999; Crabtree et al. 1993). In one Glasgow-based study on boys' talk on sex, Wight (1994) observed the powerful way in which group dynamics produced a "parody of..young men" as 'macho' sexual predators, which contrasted with earlier accounts gathered through individual interviews, revealing awareness of, and sensitivity towards, girl's views. The exploratory stage of this research was used to see whether different interview contexts yielded different insights into masculinity and men's health and was used to decide which technique, or combination of methods, would be most compatible with the aims of this study.

#### **4.4.i. Pilot Focus Groups**

Prior to any experience in the field, focus groups were considered as a useful method for piloting the issues that were likely to arise around masculinity and health. Focus group interviews were considered useful to 'test the waters' and assist in developing a detailed interview schedule, before the 'real' qualitative research, in the form of individual interviews, commenced. Much of literature on focus groups is unlikely to dissuade anyone from adopting such a view as it was suggested that focus groups are merely a 'quick and dirty' way of gauging certain issues (Bogardus, 1926; Merton, Fiske et al, 1990). Academic texts tend to promote focus groups as a valuable qualitative method possessing "a distinctive identity of their own" (Morgan 1997, p8; Barbour & Kitzinger, 1999). After conducting the pilot interviews it was obvious that focus groups could be designed and conducted to yield high quality data to the standards characteristic of individual interviews, as others have endeavoured to illustrate (Barbour & Kitzinger, 1999; Wilkinson, 1998). The first pilot interviews that were conducted were three focus groups, which were (in order): the Gay Men's Group (lasting 3 hours), the Youth Group (lasting 50 minutes) and the Unemployed and Retired Men's Group (lasting 2 hours 30 minutes). These focus groups were informal group discussions which were intended to encourage participants to speak freely and completely about their beliefs, practices and experiences of masculinity and health.

It was anticipated that a group of gay men may have had more cause to think about their masculinity and some aspects of health and were therefore thought an ideal group for an inexperienced facilitator to interview. The abundance of materials that I thought would be needed to encourage men to discuss their masculinities (e.g. headlines such as 'Male taboo puts male lives at risk', images of the male body, images used to denote different kinds of masculinity) were largely redundant (see Appendix A, page 191 for examples of some of the statements that were presented to groups on laminated cards) . The Gay Men's Group was a relaxed discussion and participants seemed able to answer questions regarding the social construction of male identity and the ways in which masculinities were negotiated. However, this interview did highlight that some revisions were necessary to the interview format to ensure that more time was devoted to exploring an explicit connection between masculinity and health in future discussions.

The second focus group, with the Youth group, proved to be the most challenging of all the groups that were eventually conducted. The young men in this group were hostile from the outset and were particularly aggressive when asked questions that they perceived as challenging to their identity as men. This was a useful experience to have early on as it made me aware of possible challenges for the remainder of the fieldwork that I had not previously considered. I had always approached interviewing with the view that the interviewer is perceived to be powerful and I was conscious of appearing non-threatening and of the need to put respondents at ease. It never occurred to me that I would conduct an interview where I would be made to feel powerless and ill at ease and be unable to control the direction of much of the discussion. I became acutely aware of the power that a group of men could have, and in this instance *did* have, if they decided to unite against me.

This they did repeatedly on subjects they had little interest in discussing or which appeared to be threatening to them as men. Cards with a factual statement about 'other men' did appear to have an important function in overcoming some of these difficulties. For example, there was a strong reaction from a number of the participants when I asked them directly about care of the male body, as is evident in the following extract:

**RO:** *...grooming products like moisturisers and stuff. do you tend to use those*

**Martin (25):** *(Shouting) Poof cream? I shave and that but I don't use poof juice (Group laugh) Moisturiser on your face? A guy?!....This isn't a bisexual club. This is a youth club....We don't use moisturisers. All these faggots (referring to pictures that were on display). You guys with them faggots.*  
**Youth Group**

However, the introduction of a card which suggested to them that use of such products might be considered by a large proportion of men seemed to work as a permissive tool so that the group could admit to something they had deemed to be 'unmanly'.

**RO** *(Reading card) Because there's been a 25% increase in men that use these kinds of things now*

**Martin (25):** *Aye. Aye. I know I've heard that. Like the body shop stuff?....*

**Ryan (17):** *I'll tell you right, I've had cream put on. But the only time I get cream put on is if my bird's giving me a massage....*

**Martin:** *(Speaking over Ryan) See I'll put moisturiser on if I've had a shave*  
**Youth Group**

Although some inroads were made I came away from the interview feeling that I had not been successful in exploring issues relating to masculinity and men's health. However, the transcript of the interview later revealed that I had obtained a detailed record of how this group constructed, and warded off challenges to, their shared sense of masculinity. This highlighted the important contribution that the focus group interview could make in seeking to understand the processes through which masculinities are constructed.

The third interview with the Retired and Unemployed Men's Group proved to be more successful in my attempts to explore the relationship between masculinity and health. The success of the interview was attributed largely to the dynamic created by drawing together (by chance in this instance) men from different generations (men were aged 24, 43, 62 and 68). Their diverging views on how masculinity was constructed and what they considered acceptable for men with regard to health-related behaviours created a stimulating and lively discussion. This group

composition proved to be influential in considering what kinds of groups would be most useful to include in the main fieldwork. The debate between members of heterogeneous groups seemed particularly illuminating with regard to the diversity of men's experiences of masculinity and health.

#### **4.4. ii. Re-thinking the value of focus groups**

One of the most striking things to emerge from the pilot work was that accounts of masculinity and health were so readily accessible through focus group interviews. Although the majority of men stated that they were unused to discussing health because it was "not men's talk" (George, 52, Prostate Cancer Group), this was a subject that interested the majority of participants and many appeared happy to engage in detailed discussions on the topics put to them. It was common to hear participants state how much they had enjoyed being given the opportunity, or 'permission', to discuss 'taboo' subjects such as mental health, why men do not go to the doctor, and why men feel they need to be so 'macho', with other men as it was felt to be something they rarely got the chance to do in their everyday lives.

Most surprising of all was that these early discussions revealed that focus groups could produce in-depth accounts of real quality, rather than a superficial skim over key issues (I had previously assumed that individual interviewing was the method one chose to obtain data of depth). It was clear from very early on in the fieldwork that the dynamics within the focus group encouraged participants to lay bare the ways in which their masculinities were constructed. The pilot work showed that focus groups would be necessary for the main fieldwork, as they had proven, as others have suggested they would, to be a method that would be useful for generating data on subjects that are 'habit ridden' (such as health practices) or would not ordinarily be considered in such detail (masculinity) (Morgan, 1997).

#### **4.4. iii. Individual Interviews**

It was my assumption prior to entering the field that individual interviews would be the main, or only, method of data collection. Prior to this research, most of my interviewing experience had been largely limited to individual interviews with men and women on sensitive subjects and was a method that I knew could generate data of high quality. The literature on men's health and masculinities suggests that

individual interviews may be of particular help in exploring the complexities of male identity. A number of contemporary writers on masculinities have strongly endorsed the individual 'life history' interview as the primary method through which the construction of male identity can be most usefully examined (Connell, 1995; Morgan, 1981). It has been suggested that masculinities may be explored by asking the participant to describe his identity in relation to the critical points of his life (e.g. leaving school, marriage, retirement, illness, etc) (Morgan, 1981; Connell, 1995). Connell (1995) argues that the life history method can generate "rich documentation of personal experience, ideology and subjectivity" and provides evidence of masculine "practice through time" (p89). It had already been observed that the focus group facilitated the documentation of men's experiences, ideologies and subjectivities. The question following the pilot focus group interviews was whether the individual interview, modelled on the life history method, could provide a different quality of data that might not be accessible in a group context. It seemed reasonable to assume that more might be revealed about the social construction of masculinities if further data were collected that detailed participants' biographies and the key events in their life.

Men who had participated in some of the earlier focus groups were invited to attend a follow-up individual interview so that this possibility could be explored (see Table 1, p189), for details of participants in individual interviews). Men were given a form to fill in at the end of focus group discussions to provide details such as age, occupation, etc. They were also asked to state what they had thought of the group discussion and whether they would be willing to take part in another (individual) interview at a later date. The majority of men indicated that the focus group had been an enjoyable experience and few declined the invitation to be re-interviewed. Six men from three of the earlier focus groups were invited back for a second interview. Participants were selected by age in the hope that this would offer some diversity of experiences of masculinity across the life course. The oldest and youngest of each group were invited to attend (aged 24 and 62 in the Unemployed and Retired Men's Group, aged 26 and 42 in the Fire-Fighter's Group and aged 22 and 47 in the Student Group). Participants from these particular groups were selected for re-interview, rather than those who had participated in the first groups (the gay men's group and youth group) as it was only by the third focus group (with the retired and unemployed men's

group) that I was confident that I was getting the right kind of data that I was striving for. However, I needed to satisfy myself that an even greater depth of understanding of masculinity and health might be obtained by re-interviewing participants individually.

A further three individual interviews were conducted with men who had not previously participated in a group discussion (ages 17, 37, and 72). Two participants made contact after seeing leaflets about the research project in their G.P's surgery (that had been collected from a display at Men's Health Week in Glasgow). A third participant was invited to stay for an individual interview after a group discussion was terminated (a second attempt at interviewing another Youth Group that proved equally problematic). These three interviews were included to determine whether the problems encountered when re-interviewing focus group participants were related to the method or whether participants had simply exhausted their exploration of these subjects in the group interview. Nine individual interviews were conducted in total, lasting from 70 minutes to 2 hours 30 minutes (the average being 1 hour and 50 minutes).

Individual interviews were effective at building a detailed picture of participants' life histories and the key events of their lives. If this had been the sole goal of the research this would have been a highly successful outcome. The difficulty was that participants did not seem able to connect their life histories to masculinity when prompted. The most productive individual interviews at best produced only implicit accounts of the practices of masculinity, which could be inferred from their talk around particular life events. However, the same individuals had been observed deconstructing and describing masculinity with ease in the context of the group. Discussion of masculinity and health in the context of the individual interview appeared superficial compared to the quality of responses obtained in the focus groups.

With those participants who had previously participated in a focus group there was a sense they felt we had exhausted these subjects already. One participant described how apprehensive he felt when he and his colleague received a letter inviting them to a second interview: "when we found out you were coming back we looked at each

other and went (scared expression) ‘what else does she want to know?’” (Alistair, 26. Individual Interview following Fire-Fighter’s Group). In one of the lengthiest individual interviews I noted afterwards that I had:

*Found it very easy to get a general picture of his life – what he’d done career wise; achievements; phases of life (most interesting work-retirement; marriage; childhood-adulthood transitions). But much harder to delve deeply into health beliefs and particularly getting him to elaborate when he hinted at ways he demonstrates masculinity (related to physique). I know I would not have got that sense of wholeness about his life in a group, but I remember it crossing my mind while he was talking off the point, having struggled to get deeper into the areas of masculinity raised in passing, that it would have been directly addressed in a group.*

**Field notes: Individual interview with Richard, 72.  
24 April 2000**

It is possible that it might have proved easier for men to reflect on these issues had they experienced some challenge to their masculinity or had some reason to think about their health. However, none of the men interviewed individually had experienced such ‘epiphanies’ (Crabtree et al. 1993) to prompt the kind of detailed reflection required of them in this context. It is revealing that Connell (1995), one of the greatest advocates of this method, collected life histories solely from men whose masculinities were under threat or challenge (e.g. unemployment among men who had expected to be the ‘breadwinner’).

It is possible that participants who have not experienced threats to their masculinity or any challenges to their health were better able to formulate and express their opinions about male identity and health when interacting with other men who were expressing views that were similar or at odds with their own. Kitzinger (1994) observed that it is for this reason that group discussions can “facilitate the expression of ideas and experiences that might be left underdeveloped in an (individual) interview” (p116). All of the participants who had participated in a group expressed similar views to Barry who stated during his individual interview that he preferred the group interview because:

*It’s amazing how you bring things out in people starting to talk about themselves you know, their ideas (stated at the beginning of the interview)... .. You’re hearing other things other men’s opinions and sometimes it brings out things you’ve never*

*thought about or you'd forgotten about (stated at the end of the interview)*

**Barry, 62, Individual Interview, also a participant in the Unemployed and Retired Men's Group.**

Had I sampled a different group of men for the individual interviews I may have reached a different conclusion about the utility of the individual interview for this research. It would have been interesting to conduct individual interviews with some of the men that were later recruited to discuss mental health, prostate cancer, M.E and coronary heart disease to see if the individual interview might be more usefully utilised in exploring such experiences. However, the pilot work had revealed that the focus group had the potential to be adapted to the different requirements of each of the groups more creatively than the individual interview, which only appeared to be suitable for some of the participants in this research. On this basis, it was decided that the focus group interview was the most appropriate method of data collection for this study and it would not be necessary to complement it by collecting data through individual interviews.

#### **4.4. Sample for the main fieldwork**

##### **4.4. i. Sample design**

The goal in designing a qualitative sample is to ensure that a range of perspectives are included when recruiting a relatively small number of people. The use of 'maximum variety sampling', where a heterogeneous sample is deliberately selected, offered the opportunity to document commonalities and identify what was unique in participants' accounts of masculinity and health (Morse, 1994; Patton, 1990). Careful consideration was given to the kinds of male experiences that were likely to generate a broad variety of views regarding masculinity and health. The initial plan for the proposed groups was divided into three main areas of interest. The first considered groups that had the potential for exploring the identities of men whose masculinities had remained 'unchallenged'. It was anticipated that these participants would be recruited through occupations traditionally viewed as 'male' (some examples being the Scottish ship building and oil industries and the Fire Service). The second category included groups of men whose masculinities might have been challenged by illness or other experiences perceived to be threatening to male identity (e.g. testicular cancer, working as a male nurse or as a carer). The final group enabled me to explore how masculinities may change over the life course and included groups of men

recruited by age (e.g. Youth Group and Retired Men in the Retired and Unemployed Men's Group).

My experience of fieldwork revealed that the original plan, which detailed the groups that I hoped to include, had to remain flexible as it underwent continual refinement and readjustment as the study proceeded. It was not always possible to recruit the exact group that had been planned as some proved to be very difficult to access (see Appendix A, page 191 for details of the groups that were cancelled or that I had difficulties in recruiting). In such situations another group, with the potential to generate a discussion around a similar theme (e.g. how masculinity might be challenged by prostate cancer, rather than testicular cancer), was substituted. However, such revisions were most needed because the sample design had to remain responsive to the emerging themes in the data. The development of research that relies on concepts 'emerging' from and being tested in the context of the fieldwork has been described elsewhere (Hammersley & Atkinson, 1983; Strauss, 1987).

One example of this approach in this study was that the original design had considered illnesses that might be perceived as obviously 'male' or challenging to male identity, such as coronary heart disease or testicular cancer. However, in many of the focus group interviews (which had not been specially convened to discuss illness), participants referred to their belief that they had to conceal 'invisible', non-physical, illnesses and had hinted that mental illness presented particular challenges to masculinity. This led to the inclusion of groups to explore men's mental health and M.E. As Watson (2000) states this reflexive approach to sampling that is characteristic of qualitative research has the benefit of:

*Furnishing the researcher with different perspectives on the data that can widen the study beyond the 'limiting' theoretical baggage with which the researcher begins to gather data.*  
(Watson, 2000, p10)

This strategy certainly enabled me to consider men's perspectives about masculinity and health that otherwise might not have been included.

#### **4.4. ii. Description of sample**

Fifty five men participated in fifteen focus groups (conducted between June 1999 and February 2001) (see Table 2, page 190 for details of the focus groups included in the main fieldwork). Diversity was sought within the sample by age (range 15 – 72), occupational status, socio-economic background and current health status. Groups of men were recruited who were anticipated to have had ‘everyday’ or unremarkable experiences of masculinity and health (largely by accessing men in a range of occupations, such as gas workers, fire-fighters, students) and groups of men that we anticipated may have had ‘epiphanies’ (Crabtree et al, 1993) prompting reflection on masculinity and health. This included groups with men who had prostate cancer, coronary heart disease, mental health problems, and ME. Of the remaining groups one included men who shared experiences of recent health-related changes (principally diet and exercise), another of being full-time carers for wives with serious health problems, and another group with men who had been unemployed long-term. The majority of men lived in central Scotland (Glasgow, Edinburgh, Dundee, Lanarkshire and Perthshire) and just one group was conducted with men of Asian origin, which reflects the limited ethnic diversity in this part of Britain. All names used are pseudonyms.

#### **4.5. Recruitment of participants**

Constructing a sample that enabled an exploration of some of the diversity of experiences of masculinity and health posed a number of challenges with regard to recruitment. In practice this meant that I had to establish and foster contacts with a wide variety of organisations and gatekeepers, which was often a time-consuming process in order to gain access to only 4-6 men. The research was presented to gatekeepers and prospective respondents as a project on men’s health and information leaflets (see Appendix C, page 196) and invitation letters (See Appendices D and E, pages 198- 201) emphasised a general interest in men’s health, and men’s lives, but did not overtly highlight the issue of masculinity. Travel expenses (to the value of ten pounds) were reimbursed to ensure that everyone who was interested in participating would be able to attend.

The easiest path of access proved to be through community projects that specifically addressed male concerns. Around fourteen such projects in Glasgow were identified

(a list of contact names of all community projects was obtained from the Greater Glasgow Health Board before the fieldwork began). In addition there were also a number of health projects operating in Glasgow, one of which was the cardiac rehabilitation group that was recruited easily. Most of these community groups targeted low income groups and were mainly based in areas of high deprivation. Three such groups were recruited by sending letters to the group leaders of particular projects (a gay men's project, a group for unemployed and retired men in a deprived area of Glasgow, and a youth project for socially excluded young men). This was followed by a telephone call and a meeting, if this was required, to discuss the research in more detail. The leader of the Unemployed and Retired Men's Group invited me to attend one of the group's regular meetings to discuss the research with potential respondents. This gave me the opportunity to answer any queries directly, gauge interest, and arrange a time that was mutually convenient for all who volunteered. The managers of the other two projects preferred to hand out the information leaflets I supplied and ask for volunteers to participate in a group discussion to be held at their normal weekly meeting time. The names of volunteers, along with their contact details, were then passed to me and this ensured that I could make some contact with participants before the group discussion to make sure that any concerns were addressed.

A number of unsuccessful attempts were made to gain access to groups through the workplace (see Appendix B, page 195). Although the majority of focus groups were conducted in the evening, it became apparent that some occupational groups might be reluctant to participate in a group discussion if it took place outside working hours. Four groups were eventually recruited through the fire service, a worker's union, and the university. A group of students was recruited easily by putting posters and leaflets up around the campus of the University of Glasgow. Those interested sent me their contact details using a pre-paid post-card. A group of male G.P's was also recruited very quickly through an academic department offering post-graduate education for General Practitioners (my initial attempts at recruiting a group of G.P's by approaching their surgeries got a poor response).

Recruiting participants through the fire service proved to be time-consuming. The Fire master was contacted via letter initially to request permission to approach a

particular fire station for assistance with the study. Contact was then made with the Chief Station Officer to explain about the study and my requirements for the group. The Station Officer of the fire-station I eventually approached was happy to allow a group to be conducted during working hours. However this was not always the case. Managers of the participants who worked in a Gas call-centre were reluctant to allow their employees to take time off during working hours to participate in the discussion (and the participants were reluctant to attend outside of these hours). I was informed on the day of the interview that the group only went ahead because the Union shop steward, who was my contact at the company, informed his manager that he and the other members of the focus group were attending a Union meeting.

Access to another three groups was obtained by contacting a number of charities. These were the M.E. Association, Scotland, the Prostate Cancer Charity and the National Carers Association, Scotland. Contact was made initially with the Director of all of the charities via letter. A follow-up telephone call was made to ensure that the particular needs of any potential respondents were understood. The Prostate Cancer Group was arranged very easily, but it was clear that there had to be flexibility about when the interview would be conducted as this was dependent on how each of the men felt following their various treatments (e.g. radiotherapy and chemotherapy). Recruiting a group of men with M.E proved to be particularly difficult due to the disabling and often unpredictable symptoms that they experienced. Although there were a number of participants who were very keen to participate in a group discussion on M.E, on the day of the interview only two participants felt able to attend. In the case of carers, there was concern that those caring full-time would have difficulties in leaving the person they cared for to attend an interview that would last an hour and would involve further time travelling to and from the interview's location. This problem was negotiated by contacting a charity that provided weekly support meetings for carers and so the group discussion could be convened at a time when carers had all of the necessary support in place for them.

The remaining groups were recruited using a variety of approaches. Initial contact with the Asian Men's Group was provided by a colleague who had conducted many focus groups herself with men and women on the subject of ethnicity and health. The Health Change by Choice Group also resulted from a personal contact and the group

was comprised of acquaintances of mine who I knew had made changes to their diet and levels of physical activity. I thought that the participants in this group would make an interesting contrast to those who had been forced to make such changes (e.g. following a heart attack). The Men's Slimming Group was approached for similar reasons and participants were recruited through, what was publicised as, the 'only all-male slimming class in the U.K.'. The class had over fifty members and I was encouraged to attend to describe the research in person. Speaking to around fifty men as a group (some of whom were heckling!) proved to be very daunting. It was far easier to approach men informally in smaller groups once the main meeting had finished.

The final method of recruitment involved exhibiting an information stand, with leaflets about the research, at an event being held for Men's Health Week held in Glasgow City Centre September 1999 (permission was given to do this by the Health Promotion Department at Glasgow Health Board). This was held very close to the business centre of Glasgow and gave me the opportunity to discuss the project with men I might not ordinarily access easily. Although many expressed interest, this approach did not prove to be a successful method for recruiting men. It is estimated that around two-hundred leaflets were distributed at the event and only four men sent the pre-paid postcards back. However, one group was arranged as a result of my attendance at this event through contact with the co-ordinator of a mental health support group for men.

Identifying and gaining access to different groups of men proved to be a complex and time consuming task. The practicalities of arranging and conducting the focus group seemed relatively straight-forward once permission had been given to approach potential participants directly. There were of course the usual difficulties of arranging a time to suit all of the individuals participating in a group, which has been documented in the literature (e.g. Morgan, 1997; Sim, 1998; Watts & Ebbuts, 1987). However, this rarely proved to be a barrier to participation for those who had expressed interest in the project (with the exception of the male nurses) providing participants were able to choose the time and dates most convenient for them and this was carefully co-ordinated with others who wished to attend the same discussion. The lively and varied discussions that ensued more than compensated for any of the challenges that were encountered in the process of recruiting men for this study.

## **4.6. Focus group design for the main fieldwork**

### **4.6. i. Groups of strangers versus acquaintances**

There is debate in the literature on focus groups as to whether groups of strangers are preferable to ‘naturally occurring’ groups, such as friends or work colleagues (Kitzinger, 1994; Morgan, 1997; Wilkinson, 1998). Because the aim of the research was to achieve particular dimensions of diversity, the fieldwork included both pre-existing groups (n=10) and specially convened groups (n=5) (see table 2, page 190). It was necessary to draw some groups of strangers together for this study in order to connect the experiences of men who might not usually have the opportunity to meet others in similar circumstances to their own (e.g. men acting as carers, men with ME). The knowledge that participants were being invited to discuss similar experiences with a group of strangers appeared to be liberating for many and appeared to facilitate greater openness around the more sensitive issues explored (e.g. mental illness).

Morgan states that one of the “rules of thumb” in designing focus groups is that it is imperative to use homogeneous groups of strangers as participants. It is thought that participants are likely to be more comfortable talking to each other if wide gaps in social background or lifestyle are avoided (Morgan, 1997). With regard to participants’ ages, it has been suggested that “older and younger participants may have difficulty in communicating with each other either because they have different experiences with a topic or because similar experiences are filtered through different generational perspectives” (Morgan, 1997, p36). However, the use of heterogeneous groups of strangers (achieved primarily by drawing men of different ages together) was found to result in highly productive discussions. This is perhaps because masculine identities are historically and culturally located (Kimmel 1987a) and so including participants of different ages is a particularly useful way to generate lively discussions around the subject of masculinities.

An example of the benefits of using a heterogeneous group in this study was in the case of the Retired and Unemployed Men’s Group which included men of different ages. During this discussion Peter (aged 24) was encouraged to compare his experiences as a young unemployed and unskilled man with that of an older man.

Vinney (43), who had shared similar challenges to his masculinity. The inclusion of two other participants who were in their sixties and who had enjoyed far greater job security throughout the course of their careers enabled me to compare the accounts of younger men who had faced considerable challenges to their masculinities to those of older men who appeared to have retained unchallenged masculine identities. Participants in heterogeneous groups did not appear to find the expression of their differences uncomfortable, rather their differing perspectives created a dynamic that was useful, rather than detrimental, to data collection in the context of this study. It is possible that these groups were more harmonious than heterogeneous groups are often assumed to be because participants shared some common beliefs and practices of masculinity and health that united them as men.

The use of pre-existing groups has been strongly endorsed to enable the researcher to “tap into fragments of interactions which approximate to ‘naturally occurring’ data” (Kitzinger, 1994, p105). However, the focus group is of course an artificially convened discussion, requiring the majority of participants in this study to discuss subjects they did not ordinarily engage with. The knowledge that group members had of one another has been found to be useful in the context of a research interview as participants “often challenged each other on contradictions between what they were professing to believe and how they actually behaved” (Kitzinger, 1994, p105). While this dynamic was found to be largely advantageous for the purposes of this research, it also became clear that it could also present some ethical dilemmas.

There were occasions when a participant volunteered sensitive information about another group member that that individual might not have chosen to reveal. One example of this was in the Youth Group where one of the participants stated that his brother (also a participant in the discussion) had attempted suicide. Participants of pre-existing groups did at times offer me ‘inside’ knowledge of the beliefs and practices shared by their group and this was advantageous with regard to their views on masculinities and health. However, it was not always appropriate to explore some of the highly sensitive information that was volunteered about participants.

It has been noted that the dynamics that can produce insights into a group's beliefs about masculinity can, at times, inhibit group discussions. Barbour and Kitzinger (1999) have noted that:

*Pre-existing groups are likely to have established their own norms as to what can and cannot be said and hierarchies within groups and in broader society may inhibit the contributions of members in particular structural positions.*  
(Barbour & Kitzinger, 1999, p9)

This was certainly found to be the case, as the field notes that were made following an interview with a group of friends show:

*Also very interesting was Vikram's experiences of illness. He had recently discovered a lump in his spine and it was eventually found to be non-cancerous (Vikram was 21). He discussed how this had 'woken him up' to the fragility of health and he had been taking care of himself since. He hinted later when the discussion turned to masculinity that this experience had had an impact on how he saw himself. He brought up an idea of knowing that there is a 'higher masculinity' and what happens to you if you don't feel you meet that. I tried to explore this very interesting remark with him, but he made light of it. I don't think it was a comfortable situation for him to discuss that, as his friends had not had a similar experience of illness and he was clearly used to underplaying the significance of it to them.... There was lots of banter in this group and joking throughout. If that's the way your friends know you, it must be very difficult to step outside of that.*

**Field notes: Asian Men's Group, 29 January 2001**

However, participants' attempts to challenge or silence other members of their group on particular subjects were sometimes revealing of a pre-existing group's collective understanding and practices of masculinity.

#### **4.6. ii. Interview structure and facilitator's style of interviewing**

The main body of all fifteen of the discussions was facilitated by general questions (e.g. are you used to discussing health with other men? What is your experience of seeking help from your doctor?) and through discussion of topics which the participants themselves raised. The approach I adopted in facilitating the interviews was to introduce topics of interest and probe issues raised by participants and then sit back and allow the group to discuss the subject amongst themselves and observe how the group were interacting with one another. This allowed the subject of masculinity to be explored with as little input from me as facilitator as possible.

As well as considering commonalities across groups of men, each discussion had to be adapted slightly to allow for the exploration of experiences that were specific to each group (e.g. gay male identity in the Gay Men's Group, the impact of prostate cancer on masculinity in the Prostate Cancer Group). Materials (for example, presenting the statement 'masculinity is dangerous for men's health'<sup>2</sup>) were used in all groups to encourage participants to make an explicit connection between masculinity and health. Pilot work had highlighted the importance of introducing such an exercise at the end of the interview once participants had been given a chance to explore these areas themselves, using their own language (e.g. participants would describe the practices of masculinity and how these related to health but would not necessarily use the word 'masculinity' prior to the introduction of the above statement).

Different ideas as to what constituted masculinity and how 'manhood' was expressed were actively challenged by participants as well as supported, through continual comparison of opinions and experiences. Some have suggested that the mark of a good focus group is when group interaction can be used to produce data and insights that would be difficult to access by other methods (Morgan, 1997). Indeed it was my experience that questions posited by group members were "perhaps more searching than the researcher might have dared to ask" (Wilkinson, 1998, p118). Consequently, the data collected from these focus groups contain explicit accounts regarding the social construction of masculinity and 'tapped' into men's talk around masculinity and health more effectively by exploiting the "co-construction of meaning" between participants (Wilkinson, 1998) using "their language and concepts, their frameworks for understanding the world" (Kitzinger, 1994).

#### **4.6. iii. Size of Groups**

Morgan (1997) states that the crucial factor in deciding on the group size for a study is how engaged participants are likely to be with the subject of interest. It is advised to use a large group to generate a lively discussion if a topic has little personal resonance for participants (Morgan, 1997). Pilot work had revealed that the majority of participants had been easily engaged by the subjects of masculinity and health and

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<sup>2</sup> This was adapted from the title of Harrison's (1978) paper.

it was felt that a discussion could easily be sustained by a small group. In the main fieldwork it was found that even groups that were unintentionally very small (one group had to proceed with only two participants due to the illness of others and another went ahead with only three) worked really well. In the larger groups (one group was conducted with five participants, the other with six) it was observed that one or two participants dominated the discussions and it was often difficult to encourage the quieter members of the group to contribute their views in detail. A group of four participants was found to be the optimum size (nine groups of this size were conducted in total). The dynamics of a group of this size were much easier to manage and I was able to ensure that all participants contributed equally. As there was also more time for participants to explore the topics, participants' views were considered in much greater detail in a group of this size. A reduction in quality of responses was noticeable even in the two slightly larger groups, where the intimacy of the small group seemed to be lost.

#### **4.6. iv. Number of groups in the project.**

The goal of most qualitative projects is to continue recruiting individuals or groups until 'saturation' is achieved (Glaser & Strauss, 1967). This is usually indicated when the same themes begin to reoccur and it is thought that more interviews would be unlikely to generate further insights. The general questions that were addressed by all participants (e.g. do men discuss health with other men, experiences of going to the doctor) certainly did generate reoccurring themes across the fifteen groups. However, it could not be claimed, having only recruited one group from each area of interest, that this study has achieved saturation with regard to men's experiences of prostate cancer, or of being gay, or how masculinity might be related to working in particular occupational groups, etc. This focus group study was purposively designed to include a relatively large number of heterogeneous groups to explore some of the diversity in men's accounts of masculinity and health and this was achieved in the number, and nature, of the groups that were included.

#### **4.6. v. Ethical considerations**

Ethical approval for the study was granted by the University's Ethics Committee for Research on Human Subjects. Participants were informed prior to the interview that their discussion would be tape recorded. It was explained that their contribution to

the discussion would remain confidential by ensuring that any extracts from interviews were anonymised and all identifying information removed. Participants were asked to respect the privacy of others who were participating in the same discussion and to treat anything raised in the group as confidential. Participants were asked to sign a consent form (see Appendix F, page 201) indicating that the research had been explained to them, that they agreed to take part in a tape-recorded interview and that they understood how the data would be stored. Tapes and transcripts were given a new group name and pseudonyms were given to each of the participants. All transcripts, tapes and field notes were locked in a secure cabinet when not in use.

#### **4.7. Data Analysis**

Detailed field notes were written as soon as a focus group had been completed. These detailed any interactions that had taken place between me and the participants or between group members that had not been recorded formally during the interview. I also described my experience of entering different contexts, for example, what it was like for me as a woman entering 'male' domains like the fire station to meet with and interview a team of fire-fighters. I also used this writing to reflect on important issues that had been raised during the group discussion and compare these with the major themes of previous focus groups. The writing of field notes was therefore found to be an important start in the process of analysing data. Field notes were found to greatly enhance my readings of the transcripts when the fieldwork was completed and coding began.

I began transcribing all recorded speech soon after the focus group had ended to ensure that I would accurately attribute each individual's pseudonym to each of their contributions throughout the discussion. I asked all participants to name themselves on tape at the start of the interviews to use as a reference point for transcription (see Bloor et al, 2001, for further information about the particular challenges of transcribing focus group data). Prompt transcription also meant that both the discussion and participants were still vivid in my mind and I was able to recall the non-verbal communication that accompanied participants' speech and note this on the transcript. The sound quality of all of the interviews was excellent due to the use of a highly sensitive 'flat mike'. However, there were a few parts of some discussions.

usually when participants talked over one another at particularly lively parts of the conversation, which had been difficult to decipher. Transcripts were cross-checked with the tapes a second time for accuracy.

Once all the groups were completed, the transcripts were read by Kate Hunt, Graham Hart and me and the most important themes were discussed. The thesis is organised around the three broad categories that emerged from this initial reading. These areas explore the relationship between health-related behaviours and the beliefs and practices of masculinity, the relationship between masculinity and help seeking, and the impact of illness on the male identity. A detailed *horizontal analysis* or cross-group analysis was then undertaken (Miles & Huberman, 1994). This consisted of repeatedly rereading and comparing the focus group transcripts and comparing data across groups to further develop my understanding of specific themes within these broad categories. This process has been described elsewhere as 'constant comparative analysis' (Glaser & Strauss, 1967). There were a number of questions I had in mind when thinking about the data across each of the groups. These included questions such as: what were the common themes and major differences across the groups? How did responses differ when groups addressed the same questions? Were there any silences within particular groups and why? (i.e. issues that were commonly raised in other groups but were not explored in others) and how did the accounts given by men who had faced challenges to their masculinity (e.g. following a diagnosis of prostate cancer or depression) compare to men whose masculinity had remained unchallenged?

The transcripts were then re-read repeatedly in order to carry out a *vertical analysis* or within-group analysis (Miles & Huberman, 1994). My aim during this process was to understand the particular experiences of each of the groups and how these might relate to the beliefs and practices of masculinity the group had described. The group discussion often prompted participants to reflect on, and describe, their own experiences in detail. It was therefore thought to be appropriate at times to consider the voices of the individual participants and present the data accordingly. However, it was crucial to the analysis and presentation of the data to consider the distinct dynamics that were observed in each group and think about how the interaction that

resulted may have produced particular accounts of masculinity from the individuals that participated.

#### **4.8. Other considerations: reflexivity in research on masculinity and health**

There are many accounts which have explored how the gender of the researcher-researched affects the way in which interviews are conducted and the kind of data that emerge (Easterday, 1977; Oakley, 1981; Warren, 1988). Much of this work has predominantly been concerned with eradicating the imbalance of power that was observed when (usually) male researchers interviewed female respondents (Oakley, 1981). Later work has also considered women's experiences of interviewing male participants in different research contexts (Gurney, 1991; McKee and O'Brien, 1983; Green et al, 1993; Arendell, 1997; McCorkel & Myers, 2003; Gair, 2002; Letherby, 2002). There have also been a minority of reflexive accounts about the "invisible man" in the research process that have made men's roles as researchers, and their analysis of gender and fieldwork, more prominent (McKeganey & Bloor, 1991; Singh-Raud, 1999; Oliffe & Mroz, 2005). I would like to follow in this tradition by reflecting on my experiences as a woman conducting individual and focus group interviews with men about masculinity and health.

##### **4.8. i. My personal characteristics**

I am white, female and from a working-class Irish Catholic background and I was in my mid-twenties when the fieldwork was conducted. It is likely that participants viewed me as middle-class as it would be reasonable to assume that a 'researcher', as I introduced myself, would be so. This perception of me affected how two of the groups from more disadvantaged circumstances (the two Youth Groups) and a few individuals in other groups (Aidan, Student Group; Paul, Unemployed and Retired Men's Group) related to me as a facilitator. Some participants clearly felt I was being judgemental about their lives when I asked them to consider (as I had in the majority of other groups) how their individual circumstances might have affected their health. One participant stated angrily "It wasn't our upbringing or anything, we had a brilliant upbringing" (Martin, Youth Group). Aidan (Student Group), who directed his anger at me throughout much of the discussion he participated in, compared my favourable working conditions as a 'middle-class' person, "nothing much that can damage your health here (looking around the room of the MRC unit where the interview was

conducted)”, to those he had experienced as a panel beater. Most of the contributions that Aidan made throughout the remainder of the focus group discussion related to social class and health inequalities. The perception of me as a professional woman who was ‘middle-class’ was perhaps challenging for those who occupied the most unstable social positions and who may have experienced threats to their masculinity as a result. Undoubtedly this affected the kind of data that I was able to gather during these encounters.

Some of the older respondents (e.g. Prostate Cancer Group) were open in their surprise when I arrived at the location of the interview as a few stated that they had expected to discuss their experiences of prostate cancer with someone older. Other participants (Cardiac Group) enquired what the ‘student project’ was about when they saw me in person having being told previously that it was simply ‘research’ funded by the MRC. Any potential problems that might have been encountered by interviewing men who were reluctant to discuss their experiences with someone forty years their junior were perhaps avoided by exploiting the dynamics of the focus group. Men were engaged with each other during discussions rather than being obviously interviewed by me. However, I did not detect any reluctance on the part of other older participants (62 and 72) to discuss the issues put to them in the context of their individual interviews.

Many of the Scottish respondents I interviewed perceived me to be English as I have an English (London) accent. My English accent was a useful signifier to men that I might be unfamiliar with Scottish colloquialisms or not know about some aspects of Scottish culture and participants routinely paused, without being asked to, to explain certain phrases they thought would be unfamiliar to me (e.g. what a ‘ned’ was, or what deep fried mars bars were). My positioning as an ‘outsider’, partially because of my accent and at times my age, but predominantly because of my gender, was used effectively to ask sometimes ‘naïve’, at other times challenging, questions about men and the practices of masculinity.

#### **4.8. ii. The perceived role or agenda of the researcher**

Some participants appeared to expect me to challenge them or to arrive at the interview to “give us a hard time” about certain aspects of manhood because I was a

woman (Jerry, Mental Health Group). On many occasions this enabled me to ask more challenging questions than I expected to be able to ask and it is possible that my presence as a woman encouraged men to consider critiquing the practices of masculinity they spoke of. In discussions that have explored issues of reflexivity, others have highlighted how the interaction between the interviewer and participant can be affected by the professional role, or perceived position, of the researcher. Some researchers have explored how their perceived role as 'doctor', 'researcher', or 'the girl from the university', might have influenced the data they collected (Hamberg & Johansson 1999; Richards & Emslie, 2000). The most influential role that was assigned to me, more so than 'PhD student' or 'researcher', was 'feminist'. Not only was I a woman who happened to be interviewing a group of men, I was a woman doing research *about men*.

This was initially treated with suspicion by many participants as there seemed to be an assumption that I had a 'hidden agenda' and would be secretly critical of them. The perception of me as a 'feminist researcher' sometimes influenced the kind of data that was gathered, particularly the topics raised spontaneously by participants. For example, many groups discussed men and women's changing social roles at the start of their discussions and how "the pendulum had swung too far in women's favour" (Barry, Retired and Unemployed Men's Group). There were a number of angry tirades about 'men's rights' (e.g. the custody rights of fathers) (Paul, Retired and Unemployed Men's Group and Aidan, Student Group) and critical remarks made about professional women, for example, 'women get men's jobs because they have a nice smile and big breasts' (Gary, Youth Group and Aidan, Student Group stated similar). If derogatory remarks were made about women I avoided responding and I was careful not to express non-verbal surprise or annoyance so as to indicate that I was not there to censor, or be critical of, their views.

Anxieties about my 'agenda' were usually dispelled once the interview was well underway and I had had the opportunity to prove to participants that I was interested in all of the views they expressed and that I was sympathetic to, rather than critical of, the personal experiences they relayed. However, one participant approached me after a discussion had ended and commented that although he was surprised that the tone of the interview had been 'so pro-men' he fully expected me to "write up the report

with a feminist slant” (Aidan, Student Group). There are certainly many aspects of hegemonic masculinity that I am personally critical of and this could have been revealed to participants by the questions I chose to ask them during the discussions. However, I hope that I was able to make it clear to each participant that critiquing the pressures that are placed on men to behave in certain ways is not the same as being critical of men. Perhaps my questions were better received by participants who were highly critical of such pressures themselves. However, the responses of those who felt unable to question traditional practices of masculinity were very revealing of their beliefs and what they personally found threatening to their identity as men.

#### **4.8. iii. The female researcher enters ‘male territory’**

I was usually able to assess how a group would be likely to respond to me and how I would relate to them prior to the day of the actual discussion. Nine of the fifteen groups were recruited and conducted at the place men regularly gathered or worked at and this usually involved entering into a space that the group had constructed as ‘male’. It was sometimes quite daunting entering into spaces that I perceived would be very masculine (such as the Fire Station). Usually my anxieties were dispelled by the friendly reception I typically received. However, there were a few occasions when I was acutely aware of being on ‘male territory’ and the behaviour of men in such places suggested that my presence was something of an invasion. The following is an extract from field notes, which details the hostility I experienced during my first visit to the youth club for socially excluded young men from which the Youth Group were eventually recruited:

*When I came in the lads were playing pool. All of those present were men apart from Julie (group leader) and me. Julie was obviously pretty well established with the group and they seemed to treat her with respect. But I found it a very intimidating environment to enter into. It was very much like a tough men’s club and I felt inappropriately dressed (too smart), too posh, and slightly threatened by the atmosphere. I could feel myself under scrutiny as I spoke to Julie and there was a lot of macho banter between the lads and laughter (which was intimidating rather than friendly) which was assumed to be about me or due to my presence.*

**Field notes: Youth Club, 21 August 1999**

The fire-fighters, in contrast, made considerable efforts to ensure that their space was more inviting for a woman:

*I...passed a table behind an area that had been screened off where a whole series of pictures of scantily clad women were placed. It looked as if these had been hastily ripped off of the walls especially for my visit! (When asked) they claimed that they had just fallen out of some magazines. The Chief Station Officer glared at a few of the men. I obviously wasn't supposed to have seen them.*

**Field notes: Fire Fighter's Group, 18 November 1999**

The majority of groups, like the fire-fighters welcomed me into their space and it is possible that there were similar preparations made to ensure that I would feel at ease. However, I felt dependent on each group of men who, it seemed, had the power to decide whether the process of gaining access to the group was going to be a pleasant and easy experience for me or a difficult and uncomfortable one. Such difficulties can perhaps be avoided by inviting participants to attend a neutral meeting place. However, I found these visits insightful about the group's beliefs and practices of masculinity. Although the discussions that took place in the MRC Unit were perhaps less challenging for me as a woman, they did lack the 'unofficial data' I was able to collect when entering into a group's usual meeting place.

#### **4.8. iv. Personal safety in the field**

The issue of personal safety in the field was considered early on in the PhD as I had noted a number of accounts written by female researchers who relayed their experiences of sexual harassment when interviewing male respondents (Green et al, 1993; Willot, 1998). In retrospect I feel that it was perhaps a little unfair and somewhat patronising to the men who eventually participated to have assumed that they might behave in the predatory way that has been described. The majority of men took the discussions very seriously and used this forum to explore their experiences of health and illness (and therefore had very little interest in me as a woman). Interviewing men in groups perhaps offers some protection from the scenarios which may increase the likelihood of sexual harassment. To ensure the collection of quality data, I encouraged participants to put their contributions to each other rather than 'confide' in me in the way they would if I was conducting an individual interview.

It has been suggested that the intimacy of an individual interview, particularly if conducted in a participant's home, may increase the risk of sexual harassment. It is thought that there is an increased likelihood of this happening if topics that may be viewed as 'provocative', such as sexual health, are explored during the interview

(Green et al, 1993). This subject was often raised spontaneously in group discussions but this did not prove to be problematic as I was not required to interact with the group while they discussed this subject. However, in one of the individual interviews that I conducted, one of the respondents (whom I had interviewed in a group prior to this without encountering any difficulties) discussed his sexual history and his concerns about his sexual health and I became very uncomfortable when the interview appeared to become 'sexualised' (Green et al, 1993) and he asked directly about my 'sex life'.

Whilst I had found it easy to diffuse any awkward moments with humour in other interviews, I felt particularly vulnerable during this encounter because the arrangements I had made to ensure my safety had been altered by another person at the last minute. The following extract from my field notes describes the reasons for my discomfort:

*The room that he (the group leader) had booked for me was unavailable and this meant that we had to use a room in a flat located outside of the community centre....The flat (owned by the Centre) we used for the interview was round the corner from the centre in a pretty run down block of flats....Ten minutes into the individual interview, the group leader came in and stated (in front of the participant) that another group (due to use the flat also) had been cancelled and...so we would be "alone in the flat so keep your ears open in just in case as we won't be able to hear anything from the centre". This....meant I was going to be left in a flat alone with a man who knew no-one would be able to hear anything.*

**Field notes: Individual interview with Paul, 24 at his local Community Centre, 24 November 1999**

I felt much more at ease carrying out the majority of the individual interviews at the MRC unit because my personal safety could be better assured. However, the interview I did conduct with one man in his home (due to his location) did prompt me to reflect on how the practical constraints imposed on fieldwork due to issues of personal safety may have affected the data collected in some of the individual interviews. The interviews that were conducted in the MRC unit or in community centres or work-places may have been 'safe' but they lacked the intimacy of being in a person's home where we could draw on photos and other cues to prompt discussion about their lives.

#### **4.8. v. Individual interviews: considering the gender of the researcher-researched (I)**

There is much discussion in the literature regarding the discomfort men are assumed to feel when being interviewed on a one-to-one basis (McKee & O'Brien, 1983; Morgan, 1981; Oliffe & Mroz, 2005). It is often assumed that the 'problem' of the brevity of men's accounts during interviewing (McKee and O'Brien 1983) is related to men's need to remain 'strong and silent' (Oliffe, 2005). It has also been suggested that men have difficulties discussing their emotions (Courtenay, 2000). However, some argue that "such generalizations about men can be self-fulfilling prophecies that serve to inhibit or discourage the interviewer" and can also reinforce to men that they are expected to behave in particular ways (Oliffe & Mroz, 2005, p258). Admittedly, I wondered at times if this interview format may have associations with femininity for some participants (as one participant stated: "women talk about health, not men", Aidan, Student Group) and therefore might affect the kind of data I would collect. However, participants in this study were more at ease with talking about their health than is often assumed to be the case with men. It became clear that, while the majority of men did consider that it would be challenging to discuss their health with their male peers, many mentioned that they often chose a close female (mother, partner, or friend) to discuss their emotional or health problems with. My role as a female interviewer and the discussion I invited in an individual interview was perhaps not so different to the conversations participants had with the women they knew intimately.

There is little mention in the literature of the discomfort that this role can sometimes create for the interviewer. The intimacy of an individual interview, where I was required to take on the role of 'mother', 'wife', or 'friend', was sometimes an uncomfortable leap from my experience of facilitating focus groups where I was viewed by the same participants as a 'researcher'. Others have reported the difficulties they have experienced when the 'professional distance' they established in focus groups was 'brushed aside' in individual interviews (Griffin, 1991). One researcher who also interviewed men in focus groups and conducted follow-up individual interviews writes that she was surprised at "the speed with which any gloss of neutrality was brushed aside (in individual interviews)...I was not always able to adopt the detached and silent stance of kewpie doll, blending into the background

unnoticed" (Griffin, 1991, p113). I have also considered how my, perhaps obvious, discomfort at the shift in my roles across different interview contexts may have affected the dynamics of some of the individual interviews.

Another problem that emerged in the context of the individual interview was that some participants tried to dictate the entire content of the interview, or wrest control at particular times. One participant brought a written agenda and although he answered the questions I raised he was not happy for the interview to end until he had checked that all topics on his list had been covered. I did initially consider this to be an expression of male dominance which might have been constructed in relation to my role as researcher. This role could be constructed as an "acquiescent, attentive, and assenting role very close to traditional notions of femininity" (Green et al, 1993, p630). However, it should be noted that the dominance of some male respondents has affected the way both male and female researchers have collected data (McKee & O'Brien, 1983; Oliffe & Mroz, 1995).

Despite there being some awkwardness, men were able to openly discuss their lives and their experiences of health, illness and identities as men (if they had had cause to reflect on these issues) with me. As has already been noted, it did prove more difficult to explore the relationship between masculinity and health in the context of an individual interview. It is possible that some men might have felt uncomfortable discussing with me the practices they engaged in in order to construct their masculinity, particularly if they had implications for their health. This would have required them to describe these to a woman they perceived as being aligned to the 'health profession' (and therefore likely to be perceived as critical of such practices) rather than another man who was presumed to have engaged in similar behaviours at some stages of their lives. However, my experiences also suggest that the problems I encountered may be related to the diversity of men's experiences of masculinity and health and it is possible that only some men had had cause to reflect on these subjects in the detail required for an interview of this nature.

#### **4.8. vi. Focus Groups: considering the gender of researcher-researched (II)**

As I had always found interviewing an often involving, at times very intimate, method of data collection, I was surprised at how invisible and detached I often felt

when interviewing groups of men. When participants were co-operative (as they were in the main) this 'invisibility' was found to be a distinct advantage as I was able to direct the discussion by occasionally interjecting or asking participants to elaborate on certain subjects and I could then disappear into the background once again to observe how the group interacted and listen to what was being discussed. Powney has described this technique as "structured eavesdropping" (Powney, 1988). In the more difficult encounters my ability to maintain or regain power over the structure of the discussion was frequently diffused by the interaction between participants and the comments they directed towards me.

When participants in the Youth Group began to lose interest in the topic that they were 'supposed' to be discussing they manoeuvred the discussion onto the subject of whether or not I was attractive and whether they would choose to have sexual intercourse with me. To sit silently while six men discussed me in a way that obviously excluded and disempowered me can only be described as a humiliating experience. Green et al (1993) have written about similar experiences when conducting focus group interviews in which men were "displaying to other men attempts to humiliate the (female) researcher" (p631) and choosing to do so by making highly personal and suggestive remarks. The experience that I have recounted was a deliberate attempt to undermine my role as facilitator and participants were making it clear to me that I would be powerless to control the group discussion if they chose to continue to disrupt it. Barbour and Kitzinger (1999) suggest that when a woman interviews an all-male group who collectively oppose her she may be subject to some scrutiny from participants. It is perhaps inevitable that participants would at times comment on the "embodied characteristics" of my femininity considering that they felt their own masculinity was under scrutiny (Warren, 1988).

Other attempts to disempower me during the interview process appeared to be related to my status as a 'student' when interviewing men of higher status than myself. There was a very uncomfortable start to the group discussion with male GPs. The field notes detail my experience:

*They arrived and I introduced myself and asked them if Lewis had told them a bit about what I was doing just by way of getting them chatting. No one commented or*

*even nodded their head. They just looked at me like I was a babbling fool and could I not waste their time please. I felt it was a very clear message that they were in no way going to make any effort to exchange pleasantries and make it nice for everyone involved, or at least make it nice for me. Message understood I got on with the interview and was greeted with lots of monosyllabic replies. So had to do lots of firing questions until I hit on something that got them animated. There was one GP there who was approachable and considered most things put to him. Another GP was very vocal and it seemed likely he would co-operate. Another was very hard work and watched me with amused contempt throughout most of the beginning of the interview without saying anything and when he did answer it was with open derision at some of my questions.*

**Field notes: G.P's Group, 16 January 2001**

When I reflect on some of the difficulties I encountered in recruiting and interviewing some of the groups, particularly the Youth Group, I do wonder why I chose to persevere. It would seem that the kind of personal attacks I, and many others, have endured have almost been accepted as "a routine part of the data collection process" (Green et al, 1993, p628). My initial response to these difficulties was to ignore them for fear of jeopardising the remainder of the interviews. However, as others have noted, in situations where there is such poor rapport between an interviewer and respondents it is unlikely that the data collected will be of very high quality (Gurney, 1991). It would have probably been advisable, as others have suggested (McKee & O'Brien, 1993), to have made it clear that remarks that were clearly intended to intimidate and upset me would not be tolerated. However, in the case of the Youth Group I did feel so powerless and actually quite afraid of the participants so a direct challenge may not have been wise. When I was much more experienced as a facilitator I attempted to interview a second youth group and had cause to challenge them about their behaviour towards me and eventually terminate the interview. It is unlikely that the quality of the interview would have been good had I persevered in this instance. Another scenario was when one participant within a cooperative group (Aidan, Student Group) attempted to intimidate me. However, the other participants challenged him and put considerable pressure on him to modify his behaviour towards me.

Some feminist researchers view focus group research as a means of reducing the imbalance of power traditionally created by the interviewer-interviewee relationship (Montell, 1999). However, such views have typically only considered women's experiences of interviewing other women with some notable exceptions (Green et al.

1993). Accounts frequently overlook the contexts in which participants are more powerful than the researcher, as can be the case in group discussions (Wilkinson, 1998). The vulnerability of the interviewer, particularly the female interviewer moderating all male groups, often goes unreported (Lee, 1997). One writer argues that: “compared with one-to-one interviewing – the focus group obviates many ethical concerns raised by feminists about power and the imposition of meaning” (Wilkinson, 1998, p112).

#### **4.9. Conclusion**

The group interaction that was observed during the discussions appeared to make it easier for men to explore the ways in which their masculinities were constructed. My understanding of the practices of masculinity was further enhanced by the choices made with the sample (ensuring that there was some diversity with regard to men’s experiences in the groups selected) and the focus group design (by arranging groups comprising of men of different ages and backgrounds). The fieldwork raised a number of issues relating to my gender as researcher and prompted me to reflect on how this may have influenced the data I collected in different interview contexts and how this was analysed and interpreted. The research highlighted a number of issues that were of great importance to the men interviewed with regard to masculinity and health. The following chapters will examine three of these areas which include: the relationship between masculinity and men’s health-related beliefs and behaviours; the impact of illness on male identities and the relationship between masculinity and men’s help seeking behaviour.

## Chapter 4

**“The average Scottish man ...has a cigarette hanging out of his mouth...lying there with a poke of chips<sup>4</sup>”: Scottish men’s discussions of masculinity and their health-related beliefs and behaviours.**

### **4.1. Introduction and literature review on men’s health-related practices**

Men’s apparent resistance to recommended health practices and their engagement with ‘high risk’ behaviours has been well documented in the literature on men’s health (Waldron 1995; Courtenay 2003; Watson 2000). Courtenay cites over thirty behaviours that he argues men are more likely to engage in; all were associated with an increased risk of disease, injury, or death (Courtenay, 2002). Eating unhealthy foods, heavy smoking and drinking and inactivity are thought to exacerbate men’s biological propensity towards certain illnesses (Stillon, 1995; Griffiths, 1996). It is frequently assumed that poorer health behaviours are related to men’s assumed irresponsibility, ignorance or lack of regard for their own health (DoH, 1993; Banks, 2001). One influential report outlined various strategies aimed at ‘bringing home’ to men the dangers of engaging in certain health-related behaviours, which was believed to be typically shaped by the “knowledge, attitudes and beliefs of men” (DoH, 1993). However, there is very little empirical data which clearly describe the ‘attitudes and beliefs’ that men actually hold with regard to their health, with only a few notable exceptions (Mullen, 1992; Robertson, 2003a). Nonetheless, it is commonly assumed that there is an “apparent indifference, if not resistance, to health promotion messages among men” (DoH, 1993, p105, also see Watson, 2000). Consequently, the meanings that men may attribute to certain health-related behaviours have remained largely unexplored.

As has been discussed in greater detail in Chapter Two (see section entitled ‘The social construction of gender’), gender is considered to be one of the most important organising principles of social practice (Connell, 1985; Annandale & Hunt 1990:

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<sup>3</sup> This is quoted from Sam, 32. Mental Health Group. A ‘poke’ of chips is a portion.

Wetherell & Edley 1998). Health-related behaviours, along with other social practices, have been viewed as ways of 'doing gender' (West & Zimmerman, 1991; Saltonstall, 1993; Williams, 2000). Thus heavy drinking or smoking may be understood as the means through which men and women may construct their masculinity or femininity (Courtenay, 2000a, b). Researchers have explored how a variety of behaviours are used as resources in constructing masculine identities. This has included consideration of the relationship between masculinity and sports (Messner, 1987a, b); smoking (Hunt, Hannah & West, 2004); diet (Roos, Prattala & Koski, 2001; Wardle & colleagues, 2004); and alcohol (Lemle & Mishkind, 1989; McCreary, Newcomb & Sadava, 1999). One review of men's health suggested that there are, however, few detailed studies that describe how masculinity is socially constructed in relation to health:

*What has received less attention...are the negative impacts on men's health and longevity that flow from men's immersion in and pursuit of masculine identity and roles and their accompanying power and privileges.*  
(Stillion, 1995, p56).

The 'hegemonic' model of masculinity against which men are thought to traditionally negotiate their masculinities is generally perceived to be harmful to men's health (Darbyshire, 1987; Frank, 1987; Donaldson, 1993; Connell, 1995; Kupers, 2005). It has been suggested that men who adopt traditional and stereotypic beliefs about masculinity have greater health risks than their peers with less traditional beliefs (Courtenay, 2000b; Harrison, Chin & Ficarrotto, 1992). One writer has noted that:

*Many men and boys define their masculinity against positive health behaviours and beliefs....The carrying out of any one healthy behaviour can require a man to dismiss multiple constructions of masculinity.*  
(Courtenay, 2000b, p11).

However, despite a growing body of literature which explores the relationship between masculinity and health (Waldron, 1988; Helgeson, 1995; Kaplan & Marks, 1995; Sabo & Gordon, 1995; Stillion, 1995; Keeling, 1998; Courtenay, 2000a) there is little empirical data to support the supposition that men predominantly construct "toxic masculinities" (Kupers, 2005).

Theoretical work on masculinities in the last decade has emphasised the importance

of exploring the dynamic ways in which male identities are negotiated (Hearn & Morgan, 1990; Morgan, 1992; Brod & Kaufman, 1994; Connell 1995). It is important to consider a range of men's views on men's health because as Frank states: "the hegemonic pattern *is* dominant; however, because it is socially sustained, it can be resisted" (Frank, 1987). Another important consideration is that men may negotiate their masculinities in different ways at key stages of the life course (Morgan, 1992). It has certainly been shown that 'lifestyles' are adapted at different life stages (Backett & Davison, 1995). There is a clear need to illuminate the aspects of men's lives, and the practices of masculinity, that may help or hinder men in acquiring better health (Hodgetts & Chamberlain, 2002). However, it is rare to find accounts of men's health which include those who do not conform to traditional notions of masculinity or men who have conformed but have found it necessary to depart from this model of masculinity at particular times in their lives (Carrigan, Connell & Lee, 1987; Courtenay, 2000a).

The social context of this study is Scotland which is consistently ranked as having one of the worst records for malignant cancers, lung cancer and respiratory disease in Europe (Gillis, Hole et al. 1988; PHIS, 2001). The West of Scotland in particular is known for its high rates of coronary mortality and morbidity which has earned the City of Glasgow the title of the 'sick man of Europe' and the 'heart attack capital of the world' (Fracassini January 9 2005; BBC May 7 1999). Scottish men are argued to have the lowest life expectancy in the Western world (Watson, 2000). Certainly in the U.K, eight out of ten of the local authorities with the lowest male life expectancy are in Scotland. The lowest figure was for the City of Glasgow where men have a life expectancy of 69.1 years compared to 76.4 for women (ONS, 2004, data 2001-2003).

Social inequalities, which are highly correlated with poorer health, have been shown to be particularly striking in Glasgow (McCloone and Boddy 1994; Dorling 1997; Shaw, Dorling et al. 1999; Hunt, Ford et al. 2001). However, markedly higher morbidity and mortality rates among men in Scotland (WHO 1996) have been mainly attributed to an:

*...unhealthy lifestyle, one that involves little exercise, a heavy alcohol intake and a propensity to smoke. In addition, the Caledonian diet, which is often deep fried, fat soaked and lacking in fruit and vegetables, contributes to one in every five*

*Scottish men dying of heart disease before he reaches the age of 75... ..Each day (health professionals) face the results of the average Scottish men's poor health.*  
(Leishman & Dalziel 2003)

Empirical data do show that smoking and heavy drinking (i.e. exceeding recommended alcohol units) are more prevalent among men in Scotland than in England and that men in Greater Glasgow and Lanarkshire, Ayrshire and Arran are less likely than men in other regions to meet suggested daily dietary or targets for physical activity (NHS, Scotland et al. 1998). Encouraging men, “*even Scottish men*”, to care for their health is usually presented as a particular “challenge” to health professionals (Leishman & Dalziel, 2003). Although there has been increased attention in recent years to the specific health needs of Scottish men (Watson, 2000; Leishman, 2005), there are only a few detailed studies of Scottish men’s beliefs and health-related behaviours (Mullen 1992; Watson, 2000; Emslie et al, 2004; O'Brien et al, 2005).

This chapter presents participants’ perceptions of what is considered appropriate social practice for men with regard to health, along with detailed descriptions of their own health-related behaviours. The analysis of focus group discussions enabled us to compare the perspectives offered by a diverse range of men. The research questioned to what extent and in what ways health-related beliefs and behaviours were perceived to be related to the social construction of masculinity.

#### **4.2. Summary of findings**

The data that are presented here were generated using a variety of interview techniques. Participants’ perceptions of men’s health-related beliefs and behaviours and social inequalities were usually raised spontaneously by participants in the focus groups. Men in all groups were asked directly to consider how the social changes that have occurred in men’s lives might affect men’s health. It was observed that the discussion of social change would frequently encourage men to spontaneously reflect on their experiences of personal change across the life course. This was a subject that had not been considered prior to fieldwork and was a novel area to emerge from the research. Materials were used towards the end of discussions to focus participants on the area of masculinity and health and encourage them to relate their own experiences. The use of a card with the statement “Masculinity is dangerous for

men's health" was found to be particularly effective at encouraging men to explore what masculinity was and how it related to men's health. The majority of participants were prompted by the researcher and by other group members to provide examples of their own behaviours and to state how they might position themselves in relation to the masculinity described in this statement.

In the Findings section I present, first, participants' perceptions of Scottish men's health behaviours and how these were believed to be influenced by both social inequalities and the perceived ideal for masculinity in the West of Scotland. I then examine men's descriptions of wider cultural influences on masculinity and health. There was a common belief that social change had altered the ways in which men constructed their masculinity and consequently how they regarded certain health-related behaviours. Although I recognise that men's descriptions of masculinity and health may bear little relation to their actual behaviours in every day practice, these descriptions were included in detail to reveal commonly held beliefs about masculinity in our culture. Following this, I consider men's descriptions of their own masculinities and health-related beliefs and behaviours. I contrast the experiences of participants who rejected recommended health practices in order to construct their masculinities with those who described themselves as fastidious about their health. Finally, I explore how a number of participants re-negotiated their masculinity and health in response to critical life events or perceptions of age-appropriate behaviour.

#### **4.4. The perception that 'males in the West of Scotland...do particularly badly'<sup>4</sup>**

The subject of Scotland's poor record of health, viewed by many participants as "the worst...in the world" (Chris, 30, Fire Fighter's Group), was raised spontaneously in the majority of focus groups. Heart disease was highlighted by many as the "number one killer in Scotland" (Jerry, 49, Mental Health Group). Many singled out Glasgow's particularly "shocking" (Bobby, 42, Fire Fighter's Group) reputation for heart disease and it was described as the world's: "heart attack capital"<sup>5</sup> a number of times in different groups. High rates of heart disease and cancer were typically attributed to behaviours such as "heavy drinking, heavy smoking, and junk food"

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<sup>4</sup> Luke, GP's Group.

<sup>5</sup> This phrase was in use in the news around the time a number of the focus group interviews took place (BBC, 1999)

(Rajiv, 22, Asian Men's Group). Many participants spoke of these 'unhealthy' practices as if they were a part of the very fabric of Glaswegian culture and identity.

It is perhaps unsurprising, given the social context within which the interviews took place that the majority of participants' perceptions of health-related behaviours in the West of Scotland were coloured by their observation, or direct experience, of social inequalities in this part of the world. Many participants believed that men's perceived non-compliance with recommended health practices (particularly relating to diet and physical activity) was strongly related to living in areas of high deprivation in Glasgow. It was common for participants to list areas in Scotland (usually within Glasgow) that they associated with particularly poor health practices or high rates of disease and to contrast these with the health practices they believed were characteristic of men living in more affluent areas. A number of participants concurred with the view expressed by one participant that "the gap's getting bigger" (Luke, GP's Group) between Scottish men who were able to lead healthy lives and those whose practices were severely constrained by poverty.

Glasgow's notoriety for its unhealthy "junk food diet" (Sam, 21, Asian Men's Group) received a lot of attention in group discussions. One group of participants discussed the perceived contrast in the diets of men and women in 'middle-class' and 'working-class' areas of Glasgow:

**Chris (40):** *Middle class...people don't go home and put on the chip pan and fry chips the way they used to. Everybody eats better. But you go there (to areas of high deprivation) and they're still in the dark ages of... eating habits...It's still all pies and chips.*

**Denny (26):** *If you went to Clarkston (more affluent area) for instance ....and you looked at the fire station turn out that year I would guarantee you would struggle to find a chip pan fire... ..*

**Bobby (42):** *Unless there was a short circuit in the deep fat fryer!*

*Laughter*

**Fire fighter's Group**

Deep fried mars bars were probably the most frequently cited as the worst example of the Scottish diet and these were described as being more readily available in more

deprived areas.

**RO:** *Deep fried Mars bars?*

**Sam (21):** *Laughs*

**Rajiv (22):** *Have you not heard of those? Gordon Bennett! They're gross! I mean pizza if you fry a pizza I mean how much fat will that have on it? It's just unbelievable! (laughs).....*  
**Asian Men's Group**

**Andy (29) :** *Over on the Southside (area of Glasgow) there's a take away place and you can get a donor kebab pizza and see when I saw it up in the window there*

*Laughter*

**Bobby (42):** *Aye and deep fried Mars bars*

*More group laughter*

**Andy:** *Aye and everyone kind of just laughs it off but I mean that is seriously sick. All the school kids will go in...like I say (when you are) at school you don't give a monkey's*

**Bobby:** *No*  
**Fire fighter's Group**

It was more common for those who identified themselves as health conscious (Fire-fighter's Group) or highly educated about the effects of nutrition on health (Asian Men's Group who were dentists, Prostate Cancer Group who identified themselves as 'highly educated') to remark on the availability of such foods. Participants in these groups expressed a mix of horror, disgust, and amusement in their discussion of the excesses of the 'junk food diet' and other poor lifestyle 'choices' they had observed in Glasgow. By contrasting their behaviour with those who they felt did not know or care as much as them about the dangers associated with regular consumption of high-fat foods they made it clear that they were men who clearly did 'give a monkey's'.

The consumption of high-fat foods was perceived to be commonplace in the West of Scotland, a view that one participant felt was held by many people in other parts of

the U.K: “when I go down South my cousins just rip me<sup>6</sup> because Glasgow has that reputation” with regard to diet (Pritpal, 22, Asian Men’s Group). Yet, of the fifty-nine men interviewed, not *one* discussed having ever consumed foods such as those described above, or indeed actually knowing anyone who ate the high-fat, high-sugar diet they associated with the West of Scotland. Morrison and Petticrew (2004) have also noted that, although the deep-fried Mars bar continues to be cited as typifying Scotland’s diet, “we both work and live in Scotland, but (have) never seen one for sale” (p2180). Their survey of fish and chip shops in Scotland showed that Scotland’s deep-fried Mars bars were not an urban myth. However, in this study the deep-fried Mars bar did have an almost mythic status in Glasgow and the ‘folk’ who participants imagined consumed these kinds of foods (as no one would own up to doing so themselves) were clearly perceived to occupy a certain social group.

However, it was unclear if this ‘group’ could be classified purely by social class (as was suggested). The participants who were from more privileged backgrounds certainly perceived it as being strongly related to social class. In one group, heavy smoking and drinking and the consumption of high-fat, high-sugar diets was viewed as just some of the “pleasures in life for that class of person” (George, 59, Prostate Cancer Group), suggesting someone of ‘lower’ standing to his own. It was rare in this study, even among those who identified themselves as ‘working-class’, to identify with the behaviours that were generally felt to belong to a separate ‘class of people’. The majority of participants were keen to emphasise their distance from whatever social group they imagined people who engaged in such behaviours occupied. One participant voiced a sentiment frequently stated in the midst of discussions around health practices: “I don’t think it (those behaviours) really applies to us” (Murray, 70, Prostate Cancer Group). Those who had experienced epiphanies with regard to their masculinity in light of illness commonly spoke of how their behaviour had been exemplary in contrast to less educated men who they imagined engaged in riskier practices and therefore ‘deserved’ to become ill. The identification of this ‘class’ seemed to enable participants who wished to present themselves as educated, well informed and more aligned to recommended health practices to construct themselves in opposition to those who they felt showed little regard for their

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<sup>6</sup> ‘Rip me’: joke with him.

health. Hunt et al (2000) also cite some instances in their data where participants made explicit links between diet and wealth, education, and class. Some of their respondents implied that their class backgrounds carried a legacy that was to 'condition' their tastes, limiting the changes they felt they could make in later life.

A number of participants believed that the unhealthy practices and inequalities that were perceived to be inherent in Glaswegian culture were compounded for men by pressures to live up to the 'macho' image of the male Glaswegian or the 'West of Scotland man'. Participants' constructions of masculinity in the West of Scotland were class-based; their discussions predominantly presenting images and perceptions of working-class Glaswegian men (as opposed to descriptions of their own masculinity or of the masculinities of men they knew). A number of participants presented examples that exaggerated the 'legendary' toughness of Glaswegian masculinities. Some of the older participants alluded to violent masculine practices relating to male territory in Glasgow as exhibited through the "gang warfare" of the "razor years (1950's).....(where) you couldn't go out in certain streets because you....were afraid they (other men) would (attack) you" (Bill, 62, Unemployed and Retired Men's Group). Other participants connected the enactment of this kind of 'tough' masculinity to the heavily industrialised city that Glasgow once was, where "men used to do tough physical labour" (Sean, 47, Student Group). Younger participants who had grown up expecting to do these kinds of jobs (predominantly in the Youth, Student, and Gas Worker's Group) did appear to retain an idea that a particular kind of masculinity was exalted in their culture: "if...you're dead hard, you're masculine" (Colm, 32, Gas Worker's Group).

Many of the younger participants who identified themselves as 'working-class' felt that the decline in heavy industries in Glasgow presented them with fewer opportunities to engage in practices that enabled them to enact masculine toughness as perceived to be the form of masculinity considered desirable in Glasgow. Some participants suggested that by engaging in certain health-related behaviours, such as excessive drinking or being seen to flagrantly flout dietary guidelines, men could continue to construct and demonstrate masculinities that many felt were exalted in their social world. It was common for participants to discuss how 'the average Scottish man' was commonly presented:

*The average Scottish Man is overweight, he smokes, he's no' got a car. (he is citing an article that he read in a local paper in Glasgow 'The Evening Times') they had a cigarette hanging out of his mouth... ..lying there with a poke of chips.*  
**Sam, 44, Mental Health Group**

**RO:** *(Reading statement from a card) 'Masculinity is dangerous for men's health'. What would you say masculinity is?*

**Neil (54):** *Well I suppose risk taking again to be seen to be one of the boys, with risky behaviour. Go out and get drunk together or, you know, take part in dangerous sports or throw yourself into the fray... ..*

**Thomas (40):** *I think that's statement true especially if you live in the West of Scotland. Males in the West of Scotland tend to do particularly badly*  
**G.P's Group**

There was some indication, however, that there may be similar connections made between the beliefs, behaviours and practices associated with masculinity and other regions in Britain. One man interchanged his description of the 'West of Scotland male' with references to a 'Yorkshire attitude' when he discussed the relationship between cultural ideals of masculinity and its relationship to the adoption of poor health practices. He stated that:

*Trying to kid on that...they're not doing this and they're not doing that; the Yorkshire attitude.*

**Nathan, Glaswegian, 44, Slimming Group**

It is likely that the stoicism and toughness that participants often perceived to be 'Scottish' could also be interpreted as 'Irish' (see Scanlon et al, 2006), 'Welsh', 'Northern' depending on the social context of the interview. Nonetheless, participants' perceptions of Glaswegian male identity were revealing of the beliefs, behaviours, and social practices they perceived to be important in shaping men's masculinities. Many participants went on to explore the wider cultural influences that they believed informed men's beliefs about masculinity and would affect the practices they would be willing to engage with.

#### **4.4. ‘Older stereotypes of maleness (are)...a bit dated’<sup>7</sup>: the negotiation of masculinities in response to social change**

Men and masculinities were also discussed in generic terms, suggesting that participants had other reference points with which to compare their own and others’ health-related behaviours and masculinities. Some participants believed that most men, regardless of the social position they occupied or region they lived in, had a shared understanding of an ideal masculinity that they perceived to be highly valued in our culture. Many participants presented hegemonic beliefs and practices (“rules”) as recognisable to all men, such as the belief that ‘boys don’t cry’ or men should be ‘strong and silent’. It was clear that many participants believed that similar ‘rules’ governed men’s health-related behaviours. For example, some believed that health was “not men’s talk” (George, 59, Prostate Cancer Group) and that “it’s effeminate to talk about health issues and worry about your health” (Sean, 47, Student Group). There was also the belief that men were required to give the appearance of being “apathetic” about health and largely uninterested in “anything that isn’t sports (or) drinking oriented” in order to appear masculine (Carl, 19, Student Group). This initially suggested that the majority of participants felt pressured to abide by a strict ‘male code’ with regard to health-related behaviours in order to construct their masculinity. However, a number of participants suggested that social change had been instrumental in altering the ways in which men negotiate masculinities and so the ‘rules’ relating to appropriate ways of behaving ‘like a man’ (in relation to health) were likely to vary.

One participant articulated the views of many when he stated his belief that there had been more certainty for men in the past with regard to the ways in which men might construct their masculinity. He believed that it was now much more difficult for men to feel they had a shared sense of identity or reach a consensus about what would now be considered appropriate health-related behaviours for men to engage in. He stated that:

*This must be one of the hardest centuries for a guy to grow up in.....because there is really big change...I think a lot of guys (that have)...been brought up in the late sixties, the seventies there’s a lack of certainty, there’s a lack of rules.*

**Colm, 42, Gas Worker’s Group**

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<sup>7</sup> Debu, 22, Student Group

Another participant described multiple constructions of masculinity that he felt were presented to men via the media. He suggested that these may offer men alternative identities and practices that may co-exist with, or even replace, those beliefs and behaviours that might be associated with the construction of a more traditional masculinity:

*Men have become more aware and less sure about being men..... there's this whole like 'laddism' thing started in the nineties and then there's 'new men'. There's all these movements to create some kind of identity (for men). I mean, everything's changed, the way men view themselves.*

**Rob, 25, Gay Men's Group.**

The few participants who were openly critical of the hegemonic model of masculinity felt that it was no longer socially acceptable for men to be seen to continue fostering views associated with traditional masculinity:

**Andy (29):** *It's just not acceptable to be like that anymore. It did happen no doubt about it...in years gone by.....I think the whole thing's changed to be honest. I think guys have not so much have changed, I think they have changed with the times if you like.....Guys are aware now that everything's changed you know...*

**Denny (26):** *I think wives and girlfriends have changed as well so they want to see....They don't want that. They want you to be fit, they want you to be healthy.*

**Fire-fighters' s Group**

One participant who identified himself and his colleagues as 'nineties men' suggested that one of the 'newer' models of masculinity, viewed in opposition to the hegemonic model, might partially depend on his engagement with an entirely different set of health-related beliefs and behaviours. He suggested that: "as 'nineties men'...you want to eat nice things and look after yourself" (Bobby, 42, Fire fighter's Group).

Discussion of multiple constructions of masculinities indicated that hegemonic masculinity, although clearly a frame of reference for the majority of participants, was viewed as an ideal that few men could measure up to. Some participants suggested that few men would choose to cultivate this kind of masculinity given the perceived 'deadly' effects the practice of hegemonic masculinity may have for men's health. One group of participants suggested that men now feel more able to embrace

practices they would have once dismissed as they would have once been perceived to be challenging to masculinity:

**Mike (68):** *Men are losing their manlihood.....He's no longer the macho man...that did everything; run the house, pay the bills.....Now women are doing that....*

**Peter (24):** *Women are moving into things that men have traditionally (been) into, so men are saying...we can move into what they're (women) doing (referring to his perception that women are more likely to care for their health) and not feel as if we're being poofy.*

**Unemployed and Retired Men's Group**

Another participant suggested that the option for men to construct different masculinities might enable some men to feel that it is still possible to "behave kind of like a man with an interest in health" (Debu, 22, Student Group).

Others recognised that men still had the option to construct their masculinity along traditional lines but felt that they would be considered 'stupid' if they did so given the perceived consequences that the enactment of this kind of masculinity had for men's health:

*We are in a changing world...I don't think men are as masculine. They're not as stupid to be masculine now as they were twenty years ago, thirty years ago, where it would have been a death sentence.*

**Nathan, 44, Slimming Group**

Participants considered men who might continue to resist alternative ways of constructing their masculinity to be a 'dying breed'. One group of participants described such men as belonging to the "old school" of masculinity (Fire fighter's Group). One of the younger participants felt that some of the images of masculinity that men had once aspired to were now considered to be 'dated'. He describes how contemporary images of men and masculinity might encourage a 'new breed' of men who embrace a different way of enacting masculinity through their engagement with more 'positive' health-related behaviours:

*If you look at....John Wayne and his big beer gut. Yeah people like John Wayne right; big hard men. They're not exactly the most healthiest men. They weren't*

*exactly you know prime...physically fit specimens. Whereas now if you look at the kind of guys that are (role) models and stuff all of them practically have a six pack.... They're all exercising like mad! You never heard of John Wayne exercising. I think that younger people are wanting to be more like them (models) and they kind of see the older stereotypes of maleness as being...a bit dated.....So with these new role models come the way to look like that which is to go down to the gym.....*

**Debu, 22, Student Group**

There was some indication that certain health behaviours, such as smoking and drinking to excess, had been strongly associated with these 'outdated' notions of masculinity. One group of participants were particularly scornful of the idea that smoking could continue to be perceived as 'macho' because the men who had embodied this kind of masculinity were now viewed as 'extinct':

*(Following a discussion about the advertisement of smokers and how smokers are often depicted as sexually attractive)*

**Doug (47):** *Are you talking about Marlborough Man?*

**Keiron (46):** *No! That dinosaur? No thanks.....Marlborough Man has lung cancer*

**Rob (25):** *Well maybe in the past smoking (was) seen as a pretty masculine thing*

**Gay Men's Group**

Although John Wayne and Marlborough Man appeared to represent an archetypal masculinity for those who mentioned them, it was one that was associated with ill health; 'Marlborough Man has lung cancer' (Keiron, 36, Gay Men's Group). It was acknowledged that smoking and heavy drinking "still went on" and that the association between masculinity and such behaviours still lived on for some (as was believed to be particularly the case with alcohol). However, one participant believed that many men would prioritise their health over the need to appear masculine by engaging in known high risk behaviours: "I don't think you get it the same....I think more and more (men) are becoming aware that you need to look after yourself" (Denny, 26, Fire Fighter's Group).

In summary, when asked to describe their perceptions of men's health practices in relation to male identity, participants typically described the kind of masculinity that they felt emerged within a particular social context in the West of Scotland. These

accounts were also revealing of the aspects of male behaviour that many participants viewed as 'fixed' or rule-bound. However, it became clear that the majority of participants believed that social change and the impact this had had on men's lives had presented them with more than one way of 'behaving like a man'. With regard to health-related behaviours many participants felt that there was a 'dying breed' of men who they thought may persist in constructing their identities in line with hegemonic masculinity (perceived as 'bad' for men's health). Other participants (usually, but not exclusively, young men) believed that 'maleness' was now more likely to be embodied by men who were seen to take an interest in their diet and in the appearance and health of their bodies. However, men's assertions about the relative fluidity and freedom in which they felt 'men in general' were able to construct their masculinity was, at times, contradicted by their descriptions of how their own masculinity was negotiated within their peer groups.

#### **4.5. 'You don't want to feel ostracised'<sup>8</sup>: the need to engage with behaviours and practices that were considered 'acceptably' masculine within participants' social groups.**

Participants who provided descriptions of their own masculinities emphasised how important it was for them to be 'seen' to be engaged with, or indeed rejecting of, health-related behaviours depending on what was deemed to be 'acceptably' masculine within their peer groups. As one participant stated: "you don't want to feel ostracised" (Jake, 33, Slimming Group). Whilst many participants had commented that smoking was now rarely perceived to be 'macho', one participant described a scenario, based on his observations of the behaviour of his 'macho' colleagues, where this behaviour might be constructed as masculine in other contexts, such as: "walking about the office saying 'I've got my leg off, but I'm still smoking'" (Ted, 36, Gas Worker's Group). A participant from another group also discussed how particular health-related behaviours might take on different meanings for men depending on the kind of masculinity exalted within different groups.

*It becomes the thing to do for that group. As I was saying earlier on....in a certain environment it becomes the thing to do to go to a sports club, to eat the right kind of food, to take care of your health. It's acceptable for men in some*

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<sup>8</sup> Jake, 33, Slimming Group

*walks of life to be quite fastidious about what they eat and what they do. In other areas you're just sort of looked on as some kind of fruitcake for fussing about it too much*

**Liam, 44, Mental Health Group.**

The accounts that participants provided included many instances (e.g. Youth Group, Choice Group, Gas Worker's Group) where men described feeling pressured to reject recommended health practices in favour of 'riskier' behaviours that enabled them to enact a particular kind of masculinity valued by their peers. There were other examples, by way of contrast, provided by men who felt that, at least in their peer group, it was acceptable to be perceived as 'fastidious' about their health (e.g. the Fire Fighters Group). None of these participants described having to endure challenges to their masculinity as they apparently conformed to their peer group's expectations regarding masculine behaviour. However, those participants who had attempted to invoke changes to their normal health-related behaviours (e.g. with regard to diet, exercise, or reducing alcohol consumption) suggested that there may be sanctions imposed on those who tried to depart from their group's norms relating to masculinity and health-related behaviours.

#### **4.5.1. Participants whose peers rejected recommended health practices**

The accounts that drew particular concern were from those participants who presented themselves as actively engaged in potentially health-damaging behaviours, or described feeling pressured to engage in such behaviours, in order to construct the kind of masculinity that they thought was most acceptable to their peers. Participants most frequently linked masculinity and health in their descriptions of a "macho beer drinking kind of culture" (Sean, 47, Student Group). This 'culture' appeared to be recognisable to the majority of participants across groups from a wide range of ages. However, its practice appeared to be most dominant among younger participants. The drinking 'regimes' that were described appeared to be less about the consumption of alcohol per se and more about the enactment of a particular kind of masculinity.

One of the older participants described his drinking in terms of a masculine career. He described how his ability to 'handle his drink' provided him with an identity he felt was desirable and that he believed earned him a particular status amongst his peers:

*Why do I go out and drink competitively with my friends? I don't know why.... We started it at sixteen years old. Lets see who can drink the most.... That trend has carried on through all of our sort of drinking lives basically. It's like 'lets go out and we're going to drink twenty five pints each and the first person to be sick'...that's it....Everybody will have a bad time or everybody will have a bad night where they can't drink as much and they'll want to go home at ten o'clock at night in a taxi and we won't make fun of that. However, the ....other circle (of younger friends)....it's 'Colm's a drinker'...I feel as though people are watching me and I've got to do so much you know (for them to say) 'oh Colm can handle his drink'....I feel if I don't I'm letting them down (laughs)*

**Colm, 42, Gas Worker's Group**

Colm was very resistant to the idea that he could try drinking more moderately for the sake of his health; perhaps because this required him to sacrifice a practice he viewed as integral to his identity as a man. He described why he rejected advice offered by those close to him:

**Colm(42):** *Unfortunately I've got so many friends – inside and outside work – who are saying to me because of my lifestyle..that I should (do something)*

**RO:** *So when you say your lifestyle, what do you mean?*

**Colm:** *Basically very little exercise at times....Just going out Friday, all day Saturday, and possibly Sunday afternoon and just basically drinking....I've seen me going out drinking from ten o'clock in the morning and not going home until two, three in the morning....People say to me (mimics) 'that's not good for you'.*

**Gas Worker's Group**

Despite describing a history of severe mental health problems he did not appear to relate these experiences to his heavy drinking. Another group of younger participants (who elsewhere in the interview had emphasised how health conscious they were with regard to diet) described how their regular binge drinking was viewed as a 'competition' that enabled them to construct an informal hierarchy of masculinities ('pussy' versus 'the main man') for each member of their group:

**Rajiv(22):** *It's like there's a bit of competition involved there, who's going to drink the most and still stand up*

**Sam (21):** *Without puking*

**Rajiv:** *Like Vikram got a lot of abuse off folk for being feeble....After a few drinks he was away with the fairies.*

**RO:** *What would it say about you if you couldn't drink much?*

**Rajiv:** *You're weak*

**Sam:** *You're a pussy. If you're more tolerant, you're the main man.*

#### **Asian Men's Group**

It was clear that this group of participants felt that there was considerable pressure to engage in heavy drinking to avoid being exposed as 'weak' (synonymous with being 'less of a man'). However, the group did appear to be respectful towards one of its members who was Sikh who had stated that he did not "fall into that category because I don't drink and I don't smoke" (Pritpal, 22, Asian Men's Group). However, another group member, Vikram, had been subjected to censure because he had revealed himself as simply uninterested in competing in an 'appropriately' masculine way.

Other men who had attempted to extricate themselves from this kind of heavy drinking culture described the challenges they had had to endure to their masculinity in the process. Weight-loss was a common reason men provided for making changes to a long established pattern of heavy drinking. Although some seemed to find it relatively easy to replace their old routine of "ten pints (then)...Now I sit there with my diet coke" (Howie, 31, Slimming Group), this was exceptional. Many described considerable social pressure from their peers to abandon their new regime. As one participant described: "it starts off when you're young..You go to the boozers with your pals and it's a habit you get into. It's hard to get out of it" (Jake, 33, Slimming Group). A participant in another group suggested that his masculinity was repeatedly challenged when he declined invitations to participate in opportunities to drink heavily: "you can get a certain amount of stick for ....saying no to going out drinking and for turning down options, ...you get a *lot* of stick for that" (Paul, 30, Health Change Group). His solution was to give up alcohol in the short-term to enable him to achieve his weight loss goal. Once he had reached a weight he considered to be healthier, he described how he used 'healthy eating' and exercise to balance his heavy

drinking. He believed this 'balance' allowed him to continue to "drink whatever I want". He described this as the "ying and yang of fitness". This also enabled him to 'balance' his desire for a healthier body with his need to appear acceptably masculine to his peers. It seemed particularly difficult for the men whose identity rested on them being perceived as a 'drinker', and all they felt that signified about them as men, to sustain a more moderate level of drinking. Men like Paul appeared to prioritise their masculinity over their health.

The group of male carers, however, were deeply concerned about the long term effects that their 'unhealthy' behaviours had on their health. One participant expressed the particular anxieties he had about his own health: "it comes into my head, especially with the heavy smoking and the stress,...obviously thinking about (my) heart" (Phil, 41, Carer's Group). The practical and emotional demands of caring for their partners or parents full-time often meant that "you do forget about yourself" (Phil, 41, Carer's Group). It was often practically difficult for these participants to engage in a regular exercise regime as the brief periods of respite they had were used to catch up with housework or sleep. One participant stated that he was usually so "exhausted...you just sit there and watch the television" (Phil, 41, Carer's Group). These participants' accounts included descriptions of regular overeating, heavy drinking and smoking to cope with stress. Two members of the group described how they felt their circumstances affected their health-related behaviours:

**Geoff(47):** *I think it affects the way I eat, eating habits. My eating habits are just awful. .... I think it's a sort of nervous thing. I just seem to want to snack all the time. I'm not interested in eating a plate full of food um I sort of eat on the move and eat lots of trashy stuff and again my weight has gone up.*

**Phil(41):** *Yeah some days I'll just have a plate of soup and just a cigarette and I enjoy more than that sometimes (laughs) (referring to an earlier comment when he stated that he indulged in "a few large whiskies" in order to cope).*

**Carer's Group**

These behaviours were presented as a means through which participants could "switch off" emotionally from the pressures that their caring responsibilities brought (Phil, 41, Carers Group). One participant described how it was easier to rely on such

comforts when healthier kinds of support seemed difficult for them to obtain as a man:

**Phil (41):** *You can't go into a pub in Glasgow and go 'oh what a day I've had' ... You know they'd chase you (laughs). They don't want to listen to that you know.. that's the conversation that will very rarely come.*

**RO:** *How do you think men discuss health?*

**Phil:** *They don't really.*  
**Carers Group**

As their behaviours were perceived to be private indulgences they were not viewed, as many other participants saw similar practices, as ways of enacting particular kinds of masculinity. However, their need to 'switch off' did appear to be partially related to their belief that a key practice of masculinity was to cope uncomplainingly and conceal their emotional distress.

There was also a small number of participants who actively rejected the behaviours they associated with a model of masculinity they regarded as oppressive to the (usually) heterosexual men who identified with it. One participant suggested that having a gay male identity necessitated a rejection of beliefs and practices associated with hegemonic masculinity. He describes how he felt freer to engage with healthier practices as a consequence:

*Well what's positive about it (having a gay male identity) is that you don't have to conform to the perceived normal in that you've got to drink sixteen pints a day, smoke twenty cigarettes an hour...which I'm afraid in this area is the norm.....I don't think I have to conform to anything other than what I want to. I choose my lifestyle and how I live it.*

**Keiron, 46, Gay Men's Group**

However, another member of the group felt that his health-related beliefs and practices had been heavily influenced by the views of male relatives he had grown up with and he felt that it was sometimes difficult to reject ideas about appropriate practice for men even though he rejected many aspects of hegemonic masculinity. However, this group of gay men did agree that gay men may be more able to engage in healthier practices than heterosexual men because there was a greater emphasis on the need for gay men to work on their bodies and achieve an 'ideal' bodily shape.

However, there was a small number of heterosexual men who also described their rejection of hegemonic masculinity and the behaviours they associated with it.

#### **4.5.2. Participants who were open about caring for their health**

Men's discussions also included, albeit to a lesser extent, some accounts from participants who were members of peer groups that encouraged men to be more open about caring for their health with regard to diet or activity (including the Fire Fighter's Group, Asian Men's Group, Gay Men's Group, Prostate Cancer Group, and the GP's Group). The group of fire-fighters were probably the most notable for their shared interest in achieving healthy and fit bodies. Due to the nature of their work, the fire-fighters were forced to confront, almost on a daily basis, their ability to cope with the physical demands of the job. As Chris stated, "sometimes you come out (of a job) and you think to yourself, I need to start doing a bit more (training)" (Chris, 30, Fire Fighter's Group). Another participant described the responsibility he felt to his team during emergency situations: "you've got to make sure your heart will cope" (Bobby, 42, Fire Fighter's Group). One of the men felt that "it's entirely up to you..to do that...Get the finger out and make yourself feel good" (Denny, 26, Fire Fighters Group). However, the fire-fighters clearly described a culture where they were actively encouraged to "swap recipes" and compare notes about the kinds of physical activities they engaged in in order to maintain their fitness. Although there were comments that there were men in the fire service who were less interested in fitness and would "slag you for coming into the gym; 'what do you want to do that for?'" (Denny, 26, Fire Fighters Group) it was clear that their immediate team shared a common belief that care and concern about their health was integral to their identity as men and as fire-fighters.

Other participants who identified themselves as highly motivated with regard to their own health and fitness were more typically a minority within a group that did not share their zeal. One participant described how he had devised a "challenge for himself" to see if he could follow an intensive exercise program and eat a low-fat diet. He regarded it as a great achievement that he had maintained this successfully for four years. The motivation for this man, who had embarked on this plan at a normal weight for his height, was to improve his physique (he had hinted that he had a poor body image and had felt that he had been criticised by others for being "too

skinny') and to maintain his fitness long term. He summarised his aim as: "the older I get, can I keep the same way?" (Ross, 30, Health Change Group).

It became apparent that other members of the group were not comfortable with his fastidious approach to his health. One of the other group members implied that men who engaged in regular physical activity when they 'did not need to exercise or worry about their diet' (i.e. if they are of normal weight) were somehow less masculine than men who showed little regard for their bodies. Ross was put in the position of having to defend both his masculinity and his interest in his health:

**Steve (29):** *Some guys are just looking looking looking in the mirror....*

**Ross (29):** *(Interrupts) No you see I agree with you.*

**Steve:** *....all the time. It is just a total narcissism just looking at yourself like that. Most of the sports that you do....you're not automatically spending time in front of a mirror.....*

**RO:** *But why shouldn't you? I mean if you're taking care of yourself why shouldn't you?*

**Steve:** *Yeah but it's just narcissistic. You know you're looking after yourself and that's fine.*

**Ross:** *I mean I've looked in the mirror but I don't go about going (stares at pretend mirror with an admiring glance)*

#### **Health Change Group**

The majority of the participants in the Health Change Group shared a common interest in engaging in sports such as football or running. However, there was the suggestion that their engagement with such activities had less to do with the health and appearance of their bodies and more do with being seen to engage in a key practice of masculinity; competition with other men. While Ross clearly had felt able to continue with his routine regardless of how his peers viewed it, he was required to provide the group with an assurance that he was not involved in any practices that would jeopardise his own, or the group's, sense of masculine identity.

Men in other groups who had described periods when they had endeavoured to be more 'health conscious' spoke about how their enthusiasm waned in the absence of support from their peers. This was a strong feature of discussions regarding men's

attempts to establish 'healthier' eating patterns. Weight loss was commonly perceived as being a feminine preoccupation. It was considered more socially acceptable for women to "be pretty and be concerned about (their) figure" than for men (Nathan, 34, Slimming Group). One participant described how he felt he was ridiculed by other men if he expressed a concern about the shape of his body or if he was seen to be actively monitoring his diet:

*I watched what I was eating and that wasn't a problem for me. I didn't give a shit what anyone thought. They used to laugh at me eating my All Bran. I didn't care.*

**Nathan, 44, Slimming Group**

It is interesting that Nathan presents his consumption of healthy foods in the presence of other men as a knowing act of rebellion against how men are expected to relate to food.

Men appeared to face particular challenges when their attempts to change their eating habits simultaneously signified their apparent engagement with 'feminine' practices and their departure from behaviour deemed to be acceptably masculine within their peer group. One participant, who reflected on the reasons why his weight had eventually reached thirty-stone, felt that there were major barriers for men who may need support with managing their eating:

*You (can) get the message out that you need to eat properly... (but) men need to be able to get help to change their practices and for it to be acceptable for them to be open enough about their (eating) problems.*

**Jake, 44, Slimming Group**

Both Jake and Nathan eventually joined a local slimming group so that they could receive the support they lacked from their own peer groups. The acceptance they felt they received from their weekly group was considered to be crucial in the face of the opposition some participants encountered daily from other men: "if I do it myself I won't survive. I won't last the pace. I'll give up" (Nathan, 34, Slimming Group).

However, others in the Slimming Group made it clear that they only contemplated attending their slimming support group because it was 'men only' (they were attending what was reported at the time to be one of only two 'men only' slimming

groups in the UK). One participant spoke of his attempts at joining a 'woman's' slimming class, which suggests that to engage in a perceived 'feminine activity' in a 'female' space and so found 'normal' slimming groups intimidating to engage with as a man:

*Personally I was quite apprehensive about coming here...I feel more welcome coming to a guys' one. I almost went to a women's one with my Mum. I got to the door, ducked my head (and) turned and ran back out. I couldnae go in....I probably wouldn't have gone on a diet if Nathan hadn't come (to the men's class).*

**Rory, 28, Slimming Group**

It seemed important for these participants, when they had been made to feel apart from men who believed that a lack of regard for their diet was a key practice of masculinity, to see other men addressing issues similar to their own. As one participant stated: "you wouldn't think..there'd be so many guys. It's good to see so many..trying." (Nathan, 34, Slimming Group). Another participant suggested that the feeling of camaraderie among those who attended regularly was the most important thing the class offered its members:

*The patter's good. There's a couple of old guys in there. You'd just wet yourself just listening to them. Hearing the way they carry on...They've been coming since the year dot...One week gain a pound, another week lose (it).*

**Jake, 44, Slimming Group**

The membership of this group enabled participants to share a common goal with other men within an environment that had been negotiated as 'male'. This appeared to help them to deal with other social encounters in which their fastidiousness about food might be constructed as 'unmasculine' and therefore challenging to their identities as men.

Accounts from men who departed from their peer group's shared understanding of appropriate practices of masculinity provided further insights into some of the pressures men felt to engage in certain health-related behaviours. Although peer groups appeared to have a strong influence on the behaviours participants felt they could engage in, there was strong suggestion that both masculinity and participants' willingness or reluctance to engage in recommended health practices, might be re-evaluated by men at different stages of their lives.

#### 4.6. 'You grow up and you realise well that was then, this is now'<sup>9</sup>: negotiating masculinity and health across the life course

Participants of all ages spontaneously raised the issue of how both health practices and beliefs about masculinity might be re-evaluated at different stages of men's lives. Participants of all ages equated youth with 'fitness': a time when you could be 'care free' about health. Young men were commonly constructed as, and described themselves as, "indestructible" (G.P's Group; Youth Group). Participants in the Youth Group raised a number of concerns that they had about their health during their focus group discussion (including shortness of breath and experiencing pains in their chest which they related to heavy drinking and smoking). However, when they were asked whether these issues had raised concerns for them about their health, this was met with denial:

**RO:** *Is health something that worries you then?*

**Rick(19):** *I'm not bothered*

**Martin (25):** *They're young boys really. What age are you?*

**Keith(15):** *Fifteen*

**Martin (25):** *He's only fifteen do you know what I mean? He's still young and fit.*

**Youth Group**

Even though it was clear that participants cared greatly what 'smoking-related' chest pains and shortness of breath might mean for their health in the long-term, it seemed important for the group as a whole to persist in presenting themselves as 'unconcerned' and 'shouldn't be concerned (about health) at our age'. One participant who had reported having a number of health concerns (both mental and physical) stated that: "it'd (illness) bother me at the time, (but) it's not something I'm going to think about now" (Rick, 19, Youth Group). Clearly presenting anything other than an 'uncaring' attitude towards their own health would have proved challenging to the groups' idea that young men's masculinities depend upon the appearance of being 'naturally fit' and rests on the avoidance of appearing interested

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<sup>9</sup> Bobby (42) Fire Fighters Group

in engaging in practices that would betray that they took an active interest in their health.

However, the Youth Group's rejection of recommended health practices was not simply related to age. The group were fully aware of what they 'should' be doing for their health, as one participant indicated by stating: "they try and slap us with that shite about salad" (Rick, 19, Youth Group). However, they did not see the relevance of this to their lives, not only because of their age, but due to their social position. The youth group were comprised of men who were unskilled and felt that they had little prospect of gaining employment due to lack of qualifications, expulsion from school and greater problems (one of them had a prison record relating to his heroin addiction; two had spent time in youth detention centres). The lives they described seemed to lack the kind of structure and prospects that those who were employed described and this undoubtedly affected their capacity to engage in recommended health practices.

It seemed that participants who had gained employment after leaving school had more invested in taking "a long term view" of their health (Liam, 43, Mental Health Group). The fire-fighters felt that they became more aware of looking after their health when they started work because they realised that they needed to feel alert for the "next day". It appeared that the Youth Group, by way of contrast, engaged in certain health-related behaviours to provide meaning and order to their lives. One participant described how he "lived for the drink" (Rick, 19, Youth Group) as his brother Martin had once lived for heroin. Most of their life appeared to revolve around drinking in the park, which one participant described as giving them 'something to do':

*I'll spend most of the weekend in the park.....It's boredom, pure boredom. There's nothing else to do. You cannae get jobs or nothing. So what else is there to do? You sit about the park all day... You need something to keep your head.*

**Martin, 25, Youth Group**

The social environment the youth group was in clearly did nothing to motivate or encourage these men to adapt their lifestyles in accordance to recommended health

practices. On the contrary, group membership depended on their rejection of such practices.

Some of the younger participants from more privileged backgrounds also felt that health was not something they needed to be preoccupied with as young men. Many felt that while they were still resident in the family home someone else would care for their health. As Rajiv said, "I've got my Mum to take care of all that" (Rajiv, 22, Asian Men's Group). Many young men were aware of the responsibilities they should be taking for their health, but the circumstances they described did not always allow them to place this as a high priority. Although one participant was aware that he 'should' be eating a 'healthy' diet and exercising regularly, he did not feel that his lifestyle made this possible to sustain:

*If you are working sort of irregular hours and...you don't have time to go and prepare a balanced meal...you eat rubbish, you put on weight, there's no time to exercise.*

**Rob, 25, Gay Men's Group**

Similarly when the Asian men's group left home to go to University they felt that their busy working and social lives meant that their health was often neglected. One participant articulated this by saying:

*Health always seems to come last on your priority list... You tend to prioritise things. Your work, a TV programme...something like that always seems to come before your health...You've always got things to do, places to go, people to see... You don't have time to deal with the other bits, you know, like going to the gym or whatever.*

**Sam, 21, Asian Men's Group**

Young men at this stage in life were often trying to work hard to establish their careers and sustain relationships with their peers and they felt that their health was a low priority. For some, there seemed to be little incentive to learn to prioritise their health as there was an expectation that the burden of responsibility for their health in the years after leaving home would become "easier when you're married and your wife's looking after you" (Rajiv, 22, Asian Men's Group). Sam agreed that "she (wife) looks after your health" (Sam, 21, Asian Men's Group). However, this was not a view that was commonly expressed. The majority of participants expressed sentiments close to those of one participant who stated that:

*I think awareness (of needing to take care of your health) is there even from quite a young age, maybe early twenties. I think it comes down to when you..decide to do something about it.*

**Angus, 41, Gas Worker's Group**

The majority of older participants who reflected on their views on health as young men pinpointed the start of their working life as having a positive effect on their health practices. For a number of participants one of the adult responsibilities that came with working, owning their own home, and perhaps starting a family, with all of the accompanying money pressures, was also the need to 'grow out' of the health-related excesses they associated with youth.

Participants in the fire fighters group spoke about how when they were younger it was no problem "to go out drinking on a Friday, Saturday, Sunday" (Stuart, 30, Fire Fighters Group) and how "you'd get up the next day bright and breezy, big fry up for breakfast and you're out again Saturday night" (Bobby, 42, Fire Fighter's Group). Another group equated heavy drinking with the demonstration of their masculinity in their youth but they describe how they felt that it was no longer appropriate to engage in the same behaviours.

**RO:** *But what evidence is there of masculinity apart from not showing your emotions?*

**Howie (41):** *There's the going out and putting twenty pints down your neck every Friday, Saturday and Sunday night*

**Nathan (44):** *Aye. Until you mature*

**Howie:** *Aye. But some people never mature obviously you know things like that or the boy racer thing*

**Slimming Group**

There was strong suggestion that men, whose health-related beliefs and practices indicated to some that they had "never mature(d)" because they continued to "behave like an eighteen year old" regardless of family or work commitments, were frowned upon by some participants (Howie, 31, Slimming Group). One of the participants expressed anger at those men who he perceived as being able to hang on to their 'hunter gatherers attitude' (and related behaviours) unchallenged as they aged:

*When you're a daft laddy you drink all weekend and you do all the things that you're meant to do as a teenager....Then you grow up and you realise well that was then this is now. I don't want that anymore.....You might get married. Life moves on. But a lot of people see people....(have) this...hunter gatherers attitude. They get on my nerves. They get on my nerves because they're not being realistic. They're not being honest with themselves.*

**Nathan, 44, Slimming Group**

A number of other participants appeared to share the expectation that men should place less emphasis on their need to appear masculine as they aged. Another participant described how he felt there was less pressure to enact a particular kind of masculinity as an older man:

*I think it's a stage you get through in life. I mean I took my trade in the North Sea on an oil platform for five or six years and one of the guys I know he still calls me tiger, you know the North Sea Tiger that was me back in the seventies, eighties and it boosts your ego I suppose but I think it's when you're in your thirties and your twenties and thirties you want to be macho that is the way you are. Put it this way as a younger man if someone annoyed me or done something to annoy me and mine, I wouldn't think anything about hitting him. Which is not...it's masculinity it's macho isn't it? I'll take them on I didn't care if I got killed in the process, nobody does that to me and mine. But as you progress through life that feeling is still there but the number of times – you do it - could you do it?*

**Callum, 52, Prostate Cancer Group**

There was perhaps less incentive for older participants who had remained single to challenge their behaviours or beliefs about masculinity. One participant who had separated from his wife described his heavy drinking and stated that “if an eighteen year old is doing it, I can do it” (Colm, 32, Gas Worker’s Group). Another participant in the Gas Worker’s Group who had recently divorced and described how much he enjoyed being single also felt that the reason why one of his friends was “on at him” about his health practices (particularly heavy drinking) was “probably (because) he’s married and settled down” (Angus, 41, Gas Worker’s Group). Colm viewed his lifestyle, which predominantly involved heavy drinking, as an escape from the responsibilities and monotony of married life and a way of preserving his youth: he was doing what a single man ‘should’ do.

However, as the majority of the participants neared middle age, health and longevity became a much more central concern to them: “you tend to consider health issues more...as you get a bit older” (Sean, 47, Student). Many described holding similar

beliefs to those expressed by younger participants when they themselves were young. One participant in middle-age stated that “health was not a big issue” for him and his friends when they were “eighteen, nineteen, twenty” (Sean, 47, Student Group). One participant felt that as he matured he was less able to ‘get away’ with the behaviours he had engaged in when he was younger, such as heavy drinking and eating ‘junk food’, as these behaviours usually influenced how he felt during his working day (Denny, 26, Fire Fighter’s Group). This was also a time when many described becoming aware that the ‘natural’ fitness they had enjoyed as boys and younger men now required some effort to maintain (Health Change Group).

One participant was approaching an age not far off his own father’s age at death and this had caused him to reflect on the believed cause of his death (heavy drinking). He discusses how the need to alter his own drinking habits had preoccupied him as he grew older:

*When I was in my twenties I was a real headcase...Health didn't come into it. But now as I've got older I'm beginning to think about heart trouble...That's what my father got...So I'm beginning to think maybe I should cut back on the drink. But a big part of cutting back on drink is only because of the beer belly, which develops in later years...That's health for me at the moment; beer belly.*

**Aidan, 45, Student Group**

Aidan seemed to be aware that the prevention of heart trouble might require a general overhaul of his approach to health, but at the age of thirty-five the beer belly was the thing to tackle “at the moment”. Hunt et al (2001) and Emslie et al (2001) describe similar accounts from participants who were motivated to modify behavioural risk factors if they perceived themselves as being at an increased risk of heart disease because of their family history.

Signs of ageing appeared to act as a visual reminder that their bodies might require greater care as they got older. As one participant stated: “health is more immediate...There (are) more things dropping off you and things sagging” (Aidan, 35, Student Group). However, men’s responses to these cues seemed to vary. One indicated that he was conscious of the value of being a little healthier as he got older, but there was not a pressing need to make immediate changes: “mañana mañana. I’ll

do it tomorrow” (Rory, 28, Slimming Group). Others made gradual changes: one participant gave up his “part-time” social smoking and took up sports.

However, those who had experienced serious health problems found it necessary to make more drastic changes to their behaviours. For one participant, being weighed at the doctor’s had “scared the shite out of me and that was it. The diet started basically the following week” (Jake, 33, Slimming Group). As the risks of being morbidly obese had been made clear to him, he felt he had no choice but to take action:

*It’s half by choice (and) half I need to lose weight. I’ve (got) three kids. If I don’t lose weight I won’t see them going to college or whatever they decide to do with their life. It’s a simple choice - do I want to live or do I pack up – as far as I’m concerned.*

**Jake, 44, Slimming Group**

Another participant expressed similar fears having experienced chest pains at the age of thirty-one. Having resisted change for so long, the prospect that his lifestyle could kill him became a reality. He spoke about his motivation to change for the sake of his daughter:

*The thing that’s most encouraging me is (that) my daughter’s twelve years old. I want to live to see her being nineteen, twenty. I want to live to see her get married and (have) children... When I had chest pains I should have really done it then. But unfortunately ... (with) people saying ‘you’ve got to watch what you’re doing now’ and I’ve never been one to go on advice that other people give, it pushed (me) in the opposite light.*

**Colm, 42, Gas Worker’s Group**

Colm had previously described how he had been almost initiated into practising masculinity in a particular way through the ‘rites of passage’ he had shared with his cousin and he seemed reluctant to relinquish the behaviours he associated with this time. However, following his own health scare and that of his cousin, he seemed to recognise that the lifestyle he viewed as being symbolic of his status as a man may have contributed to them both becoming ill. He describes how this had made him realise that he needed to make some changes to his behaviours:

*I think one of the things that...helped me become aware...that I need to be healthier, was...I hadn’t seen my cousin for a couple of years. He (was) always the one that (has) been there for me since I was young. He’s the first person to take*

*me to a football match. He's the first person to take me to the pub...He's a diabetic now...We went out for a couple of drinks and when we got back...he basically went into a trance. I went the way that my cousin went all of his life. (He) never bothered with the health side of things. He drank, smoked, whatever. Now I've made that conscious decision that I'm not going to do that. At least I've got a chance now to do something other than go out every weekend and get absolutely bloated and have a drinking competition with my mates (to) see who can drink the most without passing out.*

**Colm, 42, Gas Workers Group**

He described how he had begun to make a concerted effort to cut down on drinking and “eat healthier” and “I’m back playing football again” (Colm, 32, Gas Worker’s Group).

Despite the urgency for change in some cases, some described the challenges of adjusting to a new lifestyle. Jake was acutely aware of the health implications of his continued “comfort eating”, but at times the compulsion to fall back into this pattern of behaviour was stronger than his real desire to change. Jake and other participants in the Slimming group discussed how personal problems and work-related stress encouraged the development of poor health practices, often described as coping mechanisms. Jake describes how he felt he only had the energy to deal with certain areas of his life when he was coping with stress. Being able to think about health was almost viewed as a luxury, to be assessed when other things in his life “settled down” (Jake, Slimming Group). When things were turbulent personally and professionally, Jake’s eating habits went awry. He provides his own explanation in the following extract:

*There was an on-going dispute at work for four years that has just..been resolved. This year I felt I've turned a page. I'm expecting to lose weight because that dispute's over. I've moved house into a better area...Everything seems to be going right this year. So all I need to do now is tackle the diet and focus on that...When you have problems and I had personal problems with my family...I felt I comfort ate to a degree...When I was talking to my Mum and Dad again I could then start the diet. Now I've fallen out with them again..the weight's coming back on. (Also) when I'm worrying about my job...I don't really care about the diet. I come along here (to Slimming Class) to stop it taking over.*

**Jake, 44, Slimming Group**

There appeared to be a combination of factors working against Jake and his attempts to change, including living in a poor area and other psychosocial stresses. Nathan and Rory empathised with Jake and also felt that work-related or personal problems

often took precedent over health issues such as modifying diet and levels of physical activity. As Nathan comments:

*We're the same (he and Rory) cos there's redundancies going around at our place...Nobody knows how many there is and who's getting made redundant..I might be redundant at Christmas. But you've got that at the back of your mind and you're like diet or redundancies – which is more important?*

**Nathan, 44, Slimming Group**

However motivated they were to change, it was clear from men's accounts that "control" and "discipline" over health practices were dependent on circumstance.

It seemed that men were most likely to consider dramatically modifying their beliefs and practices of masculinity when they experienced their own or another's illness. One of the youngest participants to suffer a health scare described how discovering a tumour (which proved to be non-cancerous) had "woken him up" and prompted him to re-evaluate his diet and levels of physical activity:

*Before Christmas I found out that I had..a tumourous growth in my back....That changed things for me and since then I've been..into healthy stuff and I'm eating fruit and all that stuff...It's just the shock. It's not life threatening, (but) it woke me up.*

**Vikram, 21, Asian Men's Group**

Participants with prostate cancer described how they had become more aware of their bodies following their diagnosis. Many members of the group described feeling out of touch with, and ignorant about, their bodies prior to their illness. It was believed that men were "less prone to checking themselves and reading (about health)" (Callum, 52, Prostate Cancer Group). The majority believed that women did not experience this disconnected feeling "because women have their period and I think since early days their mother's say this is why, do this, do that, and you get all that". However, the group described a change in awareness of their bodies and a desire to learn about its workings when they became ill. The group discussed how they built up a very detailed knowledge of literature on their disease and began to vigilantly monitor their bodies ('watchful waiting'). Men with ME described a similar level of vigilance following diagnosis with chronic illness. One man described how he began to "listen to my body, maybe being overprotective in a way" after he was diagnosed (Morris, 52, ME Group).

#### **4.7. Discussion and conclusion**

The data presented here support findings reported elsewhere that suggest that the adoption of particular health-related behaviours may be understood as a way of 'doing gender' (Saltonstall, 1993; Williams, 2000). The majority of participants' accounts included descriptions from men who felt that sanctions might be imposed on their own or others' masculinities if they were seen to 'eat the right kind of food' and be actively 'taking care of their health'. The diversity of participants' experiences illustrate that although the hegemonic model was clearly dominant it was, in some instances, rejected by those who prioritised their health over their masculinity. Consequently, a much more varied picture of men's health emerges than was initially presented of the "average Scottish man" (Leishman & Dalziel, 2003, p90, also a phrase used by a participant, see title on p1), characterised in this study as having 'a fag hanging out of his mouth, lying there with a poke of chips'.

Many participants suggested that the symbolic value of the 'fag hanging out of the mouth', and what it once represented for men, was now defunct. Participants appeared sensitive to changes in the way in which gendered images of smoking have been presented (Elliot, 2001). Although smoking was described as having been an important means of expressing a particular kind of masculinity in the past, many men expressed strong views regarding the 'death' of the image of the macho smoker. Other researchers have highlighted how the "morass of complex gendered imagery surrounding smoking" has become increasingly feminised (Hunt et al, 2004, p247). Some of the men in this study certainly reject the idea of smoking as a masculine practice forcefully. However, there were many others, such as the Youth Group, in which smoking from a young age (in this case from the age of nine or ten) was a sign of masculine toughness and presented as a badge of honour to others in their group.

It became apparent that some participants engaged with other behaviours such as 'heavy' drinking because this enabled them to construct their identities in line with the "hegemonic model" of masculinity (Carrigan et al, 1987; Donaldson, 1993). This supports other findings which have shown that there are higher levels of alcohol consumption among those (usually men, but also women) who score highly on measures relating to traditional masculinity (Tomsen, 1997; McCreary et al, 1999)

However, further research would need to clarify what different men mean by 'heavy drinking' and how much they would be required to consume in order to appear masculine. One study suggested that masculine identities might be challenged in cases of extreme alcohol abuse (Mullen, 1990).

It was also clear that sports were viewed as another means through which some participants felt that they could negotiate their masculinity. However, health was rarely mentioned as being the motivation for engaging in such activities (with the exception of a few individuals and the fire-fighters). Other writers have shown that key practices of masculinity may be revealed through men's participation in sports (Messner, 1987a). The data presented here largely support findings reported elsewhere that have suggested that men's engagement in sports enables them to construct their identities around traditional notions of competition and 'success' and 'failure' as men (Messner, 1987a). However, in the majority of groups it did not appear to be viewed as 'masculine' for it to be known that men might be engaging in such activities out of concern for their health. One exception, Ross (Health Change Group), had clearly been motivated to engage in physical activity to work on his body so that it might more closely resemble the 'cultural ideal' of the male physique (Wienke, 1998). Yet his peers felt that this 'narcissistic' pursuit was 'unmasculine'. Other writers have commented that the muscular body can simultaneously be viewed positively as a symbol of masculine attainment and as a source of suspicion as "anything less than functional physicality (is) suspect" (Klein, 1995, p116). However, in different social contexts such pursuits may be viewed positively, as was the case with the gay men's group (Fawkner & McMurray, 2002). In the Fire-Fighter's Group work on the body was related to notions of masculine responsibility that echoed the way some participants had referred to their masculine responsibilities as 'breadwinner'. Mishkind and colleagues have suggested that:

*Men arrange themselves along a continuum, from unconcerned with body at one end to extremely concerned at the other. This conceptualization may help predict the type and degree of behaviour in which individuals engage to change their physical appearance and come closer to the masculine ideal.*  
(Mishkind et al, 1987, p38)

However, it is clear from this study that the 'masculine ideal' may be understood by men to be related to appearance or to ideals about appropriate social practice for men

depending on what is considered most important in their social group.

Some participants described instances where they had rebelled against what they felt was expected social practice for men. Men have been reported elsewhere to be less likely than women to follow healthy eating recommendations (Wardle et al, 2004). Many participants in this study believed an interest in diet and nutrition was a feminine preoccupation. Some of the men who described themselves as concerned about the kinds of foods they ate appeared to be defiant about flouting conventional practices of masculinity. These accounts had interesting parallels to Orbach's discussion of women who eat compulsively; a behaviour that is described as an "attempt to articulate a different femininity" (Orbach, 1993, p44). Orbach suggests that women's compulsive eating is a "rebellion against an imprisoning social role" and against the position that women are supposed to care about the quantity and quality of foods that they eat (Orbach, 1993, p44). It was clear that some men felt that they were enacting a different kind of masculinity by following a more restrictive diet and visibly displaying to others, through the quality of their food choices, their concern about their health. Other research has also highlighted the importance of masculinity in men making specific diet-related choices (Roos et al, 2001)

The research also considered the experiences of men whose sense of masculinity and membership of their peer group *depended* on them demonstrating their concern about their health by engaging in 'healthy' practices. It appeared that the groups of men who were united in either conforming to (e.g. the Youth Group) or rejecting traditional 'masculine' behaviours (e.g. the Fire-Fighter's Group) had much in common. All were motivated to align themselves to the kind of masculinity that was valorised by their peers in order to avoid feeling 'ostracised'. Those who had felt ostracised by their peers (e.g. the Slimming Group) described seeking out other social groups where their behaviour was viewed positively and could be re-negotiated as 'male'. Similar findings that relate to the influence of peer group social norms in shaping individual behaviour have been discussed elsewhere (Berkowitz, 2003; Courtenay, 2004). However, these accounts rarely consider the positive influence that social norms may have on men's health-related behaviours.

A novel area to emerge from data was that masculinity and health-related beliefs and behaviours were adapted to what was considered appropriate for participants' life stage. This supports other findings which have examined how health beliefs and practices change across the life course (Backett & Davison, 1995). Many of the younger participants made it clear that it was sometimes more important for them to be seen to have engaged in health-related behaviours and practices considered appropriate for their stage in life rather than concern themselves with recommended health practices. The oldest participants were more likely to question why they had engaged with particular behaviours in their past, including those perceived to have had potentially detrimental effects on their health (e.g. drinking excessively). The majority of middle-aged and older participants felt that the perceived 'health damaging' past behaviours they had engaged in were strongly related to the beliefs they had held regarding the appropriate practice of masculinity for them at particular points in their lives. It was clear that for many of the older participants, but by no means all, a concern for health began to eclipse the need to appear 'as masculine' as they grew older. Participants seemed most likely to re-evaluate their health practices and beliefs about masculinity at strategic points during the life course, for example when: establishing a career; getting married; after the birth of their children; experiencing bereavement or illness; and generally adapting to their ageing bodies and being perceived, and perceiving themselves, as 'older' men.

The experiences of the majority of participants revealed that men's views on their health and their masculinities were felt to have been re-evaluated at different points in their lives. A number of participants described 'growing out' of the excesses of masculinity that they associated with their youth and appeared critical of those who had not followed suit. This supported findings reported elsewhere that have shown that there are widely held lay beliefs about the kind of behaviours considered appropriate at different stages of the life course (Backett et al, 1994; Backett & Davison, 1995). Levinson described the process of change that some men experience over the life course as "detrribalization" which is when a man:

*becomes more critical of the tribe – the particular groups, institutions, and traditions which have the greatest significance for him....He is less dependent upon tribal rewards, more questioning of tribal values.*  
(Levinson, 1978, p242)

However, in this study, rather than this being a 'natural' part of the ageing process, men appeared more likely to question their group's masculine values in response to critical life events such as marriage, starting work, or the experience of their own or others' illness. Some men who had presented themselves as reluctant to engage in recommended health practices had described how fatherhood had been the only event in their lives that had encouraged them to make changes to their lifestyle. This corresponds with other data that has shown that fatherhood might be beneficial to men's health (Bartlett, 2004). The obligations of a father-child relationship and a committed partnership have been viewed as "replacing the more 'chaotic' character of singledom, particularly for men" (Backett & Davison 1995, p634). A well established finding in social epidemiology is that married men are healthier and survive longer than single men (Litwak & Messeri, 1989; Umberson, 1992). However, recent data show that men are now more likely than women to be single (never married) (ONS, 2004) which suggests that there may be health implications associated with this trend. The findings presented here raise questions about how men of different ages, life stages and differing experiences construct their masculinity in relation to their health. This is an area that would clearly benefit from further research.

There was also suggestion that social change had been influential in the ways in which men viewed their own masculinity and health-related behaviour. Those writers who have referred to the 'crisis of masculinity' have examined the critical events that they believe have led to the emergence of new masculinities (Kimmel, 1987a; MacInnes, 2001; Beynon, 2002). However, few have explored how these perceived changes to men's lives, or the 'new' ways of articulating masculinity that may have emerged, have impacted on men's health. Some writers have expressed their hope that social change might create a climate where "men will begin to see...that following good health habits can be manly as well as lifesaving" (Courtenay, 2004, p276). In this study, 'healthy' behaviours (e.g. healthy diet and regular physical activity) were constructed as both manly and lifesaving within particular contexts where this was permissible (e.g. the Fire-Fighters Group). However, the majority of participants in this study described their belief that such changes were taking place "in a slow fashion" (Debu, Student Group). Many who showed awareness of changes that had taken place at a cultural level described the practical constraints they felt

were still placed on them in everyday life to continue to behave in ways that were regarded as traditionally masculine. Further research might provide a more detailed examination of the social circumstances and characteristics of those men who appear able to embrace the idea that a concern with men's health is 'manly'.

## Chapter 5

### **“Standing out from the herd”: men negotiating masculinity in the light of illness<sup>10</sup>**

#### **5.1. Introduction and literature on masculinity and illness**

Chronic illness is one of the major catalysts for ‘biographical disruption’ (Bury, 1982). The loss of work identity, social roles, and sense of isolation that can accompany serious illness can present significant challenges to individuals, resulting in a ‘loss of self’ (Charmaz, 1983). There has been a more recent emphasis on how such experiences impact on masculinities and femininities (e.g. Sabo & Gordon, 1995; Kiss & Meryn, 2001). Chronic illness has been characterised in men as a period of “intensity, severity, and uncertainty” and can pose fundamental challenges to or ‘dilemmas’ for masculinity (Charmaz, 1994). As Giddens (1979) (who discussed the disruption of identity following ‘critical incidents’) has noted, “we can learn a good deal about day-to-day situations in routine settings from analysing circumstances in which those settings are radically disturbed” (Giddens, 1979, p123). It is thought that when masculine identities are ‘radically disturbed’ by illness, it causes men to reflect on taken-for-granted gendered beliefs and practices of masculinity engaged in prior to illness, as well as prompting them to examine aspects of masculinity challenged since. Research to date has focused on testicular and prostate cancer and coronary heart disease and has suggested that the losses men refer to (with regard to masculinity) are consequent on the illnesses they have suffered.

##### **5.1.1. Testicular Cancer**

Although not explored in this research, the study of men’s experiences of testicular cancer provided valuable insights when considering the range of ways in which masculinities may be challenged by illnesses that threaten fertility and sexual functioning. Men with testicular cancer are not only faced with the physical effects of their illness but also have to come to terms with the cultural implications that a loss of a testicle has for a (usually young) man (Gordon, 1995). Even though we might

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<sup>10</sup> The majority of this chapter is to be published (see copy of paper currently In Press in Appendix F, p198)

reasonably expect that men experience great challenges to masculinity in light of such illness, studies have shown the reality men present to be quite different. Accounts from men who were “unanimous in their denial” suggest that masculinity might not be radically challenged by illness with an “excellent prognosis” (Moynihan et al. 1998). Men may be able to disregard the initial challenge testicular cancer poses to their identity once they are able to resume social practices that reaffirm their identities as men (such as work and sexual activity) (Gordon, 1995; Moynihan et al, 1998). However, in one study men did report that they felt less masculine immediately after surgery (Gordon, 1995). This suggests that there may be a process whereby men with testicular cancer experience loss, followed by recovery, of masculinity. Whilst it proved difficult in this study to recruit a group of men with, or who had had, testicular cancer, the literature on testicular cancer suggests a need to think about similar experiences of illness that men may have had that prompt them to reflect on their experiences of loss of what is otherwise taken for granted and also causes men to consider the practices of masculinity they engage with during the recovery of both their health and masculinity (when recovery is possible).

### **5.1.2. Coronary Heart Disease**

The loss and recovery of masculinity has also been explored through qualitative research that has explored men’s accounts of sudden onset of illness, such as that experienced with chest pain or heart attack (Cowie, 1976; White, 1999; White & Johnson, 2000; Clark, 2001). The symptoms of coronary heart disease (CHD) that first bring men to hospital (or may result in death) are commonly perceived as being abrupt, dramatic and somewhat shocking (Emslie et al, 2001a). The permanent adjustments to health practices and an end to working life, which are usually necessary during rehabilitation, can also mean that men experience CHD as a ‘critical incident’ for male identity (Cowie, 1976). An important aspect of research in this area has been in documenting the precise nature of the challenge to identity that men experience when admitted to hospital (which may be shocking but short-lived) as well as considering the further challenges to masculinity that men experience when they are forced to make permanent changes to their health practices during convalescence. Recent research has explored male patients’ efforts to recover or reconstruct aspects of male identity that had been lost through CHD (White, 1999; White & Johnson, 2000). Patients’ emphasis on recovery appears to be strongly

related to the belief that the 'mechanical heart' can be 'repaired or replaced' (Emslie, et al, 2001b, p212) and that aspects of masculinity that were lost through illness might be recovered once the body has been 'fixed'. Men's experiences of the loss and recovery of masculinity are explored in this chapter through men's accounts of coronary heart disease.

#### **5.1.4. Prostate cancer**

The literature detailing men's experiences of other illness suggested that it may be important to include groups in this research that permit a contrast between men's experiences of an illness where recovery may be possible to one where the chances of this is more remote or where the challenge to masculinity might be endured for longer. Sufferers of prostate cancer, in contrast to descriptions of men with testicular cancer, sometimes have to cope with permanent side effects of surgical or radiotherapy treatments, which (dependent on the treatment given) can include incontinence, impotence, loss of libido, breast growth and hot flushes, which can present persistent challenges to male identity (Clark et al, 1997; Chapple & Ziebland, 2002). Researchers have noted the challenge men face in adjusting to such changes to their bodies and being forced to renegotiate aspects of masculinity, such as sexual performance and loss of physical strength (Chapple & Ziebland, 2002; Gray et al, 2002). In addition to the physical and emotional impact, other side effects of treatment (exhaustion and loss of physical strength) may mean that men of working age have to face a permanent loss of work identity (Chapple & Ziebland, 2002). One team of researchers have emphasised that the changes prostate cancer imposes on men may have different meanings for their masculinity depending on the age of the onset of illness (Chapple & Ziebland, 2002). Older men may accept the loss of aspects of masculinity (such as sexual functioning and termination of employment) more readily as such losses can be attributed to the ageing process (Cameron & Bernardes, 1998; Gray & colleagues, 2002). There is a clear need for further research on masculinity and illness that considers the diversity of men's experiences of particular illnesses and how the challenges to masculinity may vary according to the illness, life stage at which they are diagnosed, and the impact this may have on different men's lives.

#### **5.1.4. Myalgic Encephalomyelitis (ME)**

I also examined some of the work on M.E when considering other ways in which illness may present challenges to male identities. Most research on the impact on masculinity has typically considered illnesses that are sex-specific such as testicular and prostate cancer, or those that have been viewed as 'male diseases' such as coronary heart disease and lung cancer (Emslie et al, 2001b; Payne 2001). There is less research that explores men's experiences of illnesses perceived as 'female'. However, some researchers have explored the rarer occurrences of illness that present obvious challenges to male identity (for example the study of the emasculating effects of breast cancer in men (Bunkley et al, 2000). Bunkley and colleagues (2000) argue that the misconception that breast cancer is "a woman's disease" has the effect of "feminizing" men who are diagnosed (p94). However, there may well be a number of other illnesses that might have a similar 'feminising' effect on men (Seymour-Smith et al, 2002).

The majority of commentaries on the subject of ME (also referred to as Chronic Fatigue Syndrome, CFS), describe a "largely female CFS patient population" (Richman & Jason, 2001, p15). One study noted that patients who presented with symptoms they believed were indicative of ME were often characterised as "bored housewives" by their General Practitioners, suggesting another illness that may be commonly perceived as 'female' (Cooper, 1997, p190). Researchers have reported that sufferers of ME often have a collection of disabling symptoms, which can either be persistent or relapsing, which can include: exhaustion, severe muscle fatigue and muscle and/ or joint pain and can also include depression, severe headaches, weakness, dizziness, concentration difficulties and short-term memory loss (Cooper, 1997; Richman & Jason, 2001). Particular symptoms may present different challenges to the gender identities of men and women. Muscle weakness may have particular cultural connotations for men where hegemonic masculinity demands strength in men (Connell, 1995; Gerschick & Miller, 1995). ME may have similar effects on men's feelings of masculinity and stigmatisation as expressed by other men whose disabilities "serve as a continual reminder that they are at odds with the expectations of the dominant culture" (Gerschick & Miller, 1995, p183). ME is also an illness with an uncertain aetiology and few consistent symptoms and its status as 'organic disease' (rather than psychosomatic) has been formally contested to date

(Cooper 1997). This view of ME as a “non-disease” must present considerable challenges to the identities of sufferers of ME (regardless of gender) when they become unable to work or ‘prove’ that they have an authentic illness (Cooper, 1997, p187). In the absence of men’s accounts of ME in the literature on masculinity and illness, I was interested in including some men’s experiences of an ‘invisible’ yet nonetheless incapacitating illness and exploring how this might challenge their masculinity.

### **5.1.5. Depression**

It follows that the invisibility of mental illness may also present significant challenges to male identities. Whilst medical sociologists have shown interest in exploring women’s traditional and changing roles and their apparently greater risk for depression (Weissman & Klerman, 1977; Lennon & Rosenfield, 1992), there has been little exploration of men’s experiences of depression or on impact of inequalities on men’s mental health (Miller & Bell, 1996). The incidence and prevalence of anxiety and depression (and GP consultation) is notably higher for women than men (ISD 2000; ISD 2003a, b, c & d). Yet suicides by men outnumber those by women by a ratio of more than 2:1 (DoH, 2003). Recent campaigns concerning men’s experience of depression would suggest that there is a greater awareness of male sufferers (RCP, 1998). However, there is a concern that a ‘masculine form’ of depression (Kilmartin, 2005) often goes undetected because men feel obliged to be “controlled and silent about their emotional life” (Moynihan & colleagues, 1998; see also Brownhill et al, 2002 & 2005). Yet, recent data suggest that there may be some who are willing and able to discuss their experiences of depression much more openly than is usually reported (Emslie et al, 2006).

The association between femininity and the expression of emotion is thought to contribute to the hidden nature of depression among men (Elgie, 2002). One writer has commented that “the linkage between depression and femininity may provide men with the strongest motivation to hide their depression from others” (Warren, 1983, p15, cited in Courtenay, 2000a). Although men’s mental health is beginning to receive greater attention in recent years (Robbins, 2004; Elgie, 2002; Kilmartin, 2005; Brownhill et al, 2002) little is known about the particular challenges that the experience of depressive illness may present to male identity. However, there are

some empirical data that indicate that help seeking with depressive symptoms may present particular difficulties for men because of the challenge this presents to masculinity (Moller-Leimkuhler, 2002; Heifner, 1997).

## **5.2. Summary of findings**

In this study we actively sought to conduct some of our focus groups with men who had a range of major health problems. The data presented here therefore focus, firstly on the experiences of men with physical illnesses that have been stereotyped as masculine to explore the relationship between masculinity and illness. One group of participants with a range of heart conditions was included (two had suffered heart attacks, one had had bypass surgery, the other a replacement valve) and explored whether participants felt their masculinity was challenged by their heart condition and examined the ways in which masculinity had to be negotiated as they adjusted to a new lifestyle following diagnosis. The second group explored the experiences of men with prostate cancer and explored whether the varied and persistent challenges to masculinity resulting from their illness posed different dilemmas for men of different ages. Groups with men suffering from ME and depression were also included to explore their experiences of illness and to consider whether illnesses that have been highly feminised present different challenges to masculinity to those usually documented. It was primarily these four groups that reflected on the ways in which illness had threatened their identities. However, the experiences of individuals in other groups, who did sometimes raise issues relating to identity and their experience of illness, are included where relevant.

## **5.4. A “blow” to masculinity: Coronary Heart Disease**

The force of the impact on male identity resulting from a heart attack or having to undergo heart surgery was evident in the language participants used to describe their experience of illness (“It really hits you” (Alf), it was a “blow”, Danny, 71, Cardiac Group). It was clear from the start of the focus group that work was of central importance to participants’ identities as men. The biggest ‘blow’, or challenge to masculinity, for these men appeared to be that illness meant ‘the end of working life’ (Jack, 64, Cardiac Group). Some were keen to emphasise that they had never had to endure such challenges to their masculinity prior to experiencing heart problems: “I’ve always enjoyed good health right up until the time this happened” (Alf, 72,

Cardiac Group). However, it was clear from similar presentations of their health as ‘good until that point’ that this conflicted with the history of ill health divulged throughout the focus group. For example Danny revealed that in addition to his stomach ulcer and early ‘warning’ of the heart problem which he had experienced, he was diagnosed with type II diabetes when he was sixty-six. Where his heart attack differed (in presenting a challenge to masculinity) was the extent to which it interfered with his working life, which ‘up until that point’ had defined him as a man.

While the majority mourned the loss of aspects of masculinity that they felt were derived from work, participants’ experiences of loss caused them to reflect on how practices of masculinity may have been significant in developing heart and other health problems. When the focus group commenced, Danny stated his belief that stress was an unavoidable bi-product of being the breadwinner (my first question to the group had asked about their awareness of health prior to their cardiac problems). Over the course of the focus group, it became apparent that Danny had had several serious health problems over the years which he considered to have been “warnings” that he had been working too hard. His earliest warning was when he was hospitalised at twenty-six with a perforated stomach ulcer. He described his work pattern prior to becoming ill:

*I was working night and day, forgetting meals and things like ...I came back to the house (after work) and...passed out. Blood here, blood there.*

**Danny, 71, Cardiac Group**

Although he described how “it frightened the life out of” him, he did not change the gruelling work schedule he believed contributed to his health problems. When I asked him whether he was aware of how stressed he was, his response suggested that he had felt compelled to endure virtually any ailment in order to fulfil his duty as a man:

*I was aware of it but what could I do? I had a family I had to bring up and I had the rest of the men depending on their wages from us...I used to work from eight in the morning until nine o'clock at night...and that wasn't just for a week or two, that went on for months and that's when I got this... But I had to do it.*

**Danny, 71, Cardiac Group**

He repeats his belief that he felt he “had to” endure such pressures when discussing

another occasion that may have been an early indication of the heart problems to come. He described how he ignored this and continued working “as hard as ever”: “I had a warning there, but that was in 1975. I don’t think people appreciate the stress...It’s murder. (But) you have to take it” (Danny, 71, Cardiac Group). This idea that men ‘had to’ take such pressures, regardless of signs that it was having deleterious consequences for their health, was something participants remembered being told they would have to endure. Some recalled that there were frequent reminders as young men that masculinity was strongly connected to a man’s financial responsibility for the family. As Jack stated, “your father’s last bit of advice to you when you got married was ‘now you’ve got a wife and that’s your first responsibility’” (Jack, 64, Cardiac Group). It was apparent that Danny’s account of how he continued to ‘take’ stress regardless of how ill he became were strongly related to his beliefs about what men ‘have to’ do in order to be considered masculine.

Once diagnosed, participants were not able to overcome the effects of their heart conditions by the ‘masculine’ way in which they had tackled other episodes of illness (by ignoring symptoms and continuing to engage in practices such as work that affirmed their sense of themselves as men). The changes that were forced on participants as a result of CHD were devastating. Danny, who ran his own business and had not envisaged retiring “ever”, felt that everything had been taken away from him as a result of his illness. He stated that: “you just feel then that’s you finished, you just think well that’s it then” (Danny, 71, Cardiac Group). Others who were nearer the statutory retirement age, and had anticipated having to give up work anyway, felt more fortunate. Bernard stated that he felt he was “lucky mine happened when I was near retirement age as that was the end of working” (Bernard, 67, Cardiac Group). It may be that Bernard felt ‘lucky’ as he did not feel unusual or apart from other men of his age in having to give up work at this time; it was what his peers did or expected to do when they reached that age whether they were healthy or ill. However, Alf, who was slightly younger, felt cheated out of the final year he had to go before he retired. He felt “you’re just snapped off just like that....you’ve bounced, you feel you’re out of the running”.

The further loss of physical strength also challenged the view participants had of

themselves as men: “your attitudes change when you’re physically changing” (Jack, 64, Cardiac Group). One participant suggested that illness had caused him to reflect on practices of masculinity that he engaged in without question prior to diagnosis (such as demonstrating physical strength by engaging in demanding physical tasks). Jack considers how prior to developing CHD he “would never give it (physically demanding tasks) a thought...(and after diagnosis) You’ll stop and you’ll say to yourself ‘is this just a bit too much? Should I be doing this?’” (Jack, 64, Cardiac Group). Jack had begun questioning himself in a way he had never had to do prior to illness; was he still masculine enough to engage in activities that were physically challenging? Participants described the loss of physical strength as another “blow” to their masculinity and the loss of their former physical capabilities left some with the feeling that “it was the end of the world” (Danny, 71, Cardiac Group).

Following this low-point, Danny and others who relayed similar feelings were keen to present a period of transition in which they focused on physical recovery. Participants affirmed the idea for each other that their hearts would recover:

**Jack (64):** *(the doctor) says ‘there’s no such thing as..a slight heart attack or a massive heart attack. It’s a heart attack and the muscle’s been infected. That’s it*

**Danny (71):** *But it can recover you see. The heart muscle can recover.*

**Jack (64):** *Oh aye. So there’s no doom and gloom*

**Danny (71):** *But it seems to be when it happens.*

#### **Cardiac Group**

The group were keen to share some of the methods by which physical recovery could be best achieved. Participants seemed particularly keen to be seen to embrace the recommended levels of physical activity that they felt heightened their chance of physical recovery: “for two months (after hospitalisation) I think I walked all over (chuckles) (Danny, 71, Cardiac Group). The group collectively recognised that “a change to your way of life” (Jack, 64, Cardiac Group) in the form of exercise was one way they could be proactive in preventing further problems from developing. As some of the group stated:

**Jack (64):** *I think I just came to the stage where I thought 'I'm not going to sit on my backside and wait for something else to happen'.*

**Bernard (67):** *Keep going, aye. Put some effort in, you feel the benefit....as long as you're active, it's good, but the minute you're static*

**Alf (72):** *That's when it hits*  
**Cardiac Group**

Participants believed that exercise was a way of aiding recovery in the short-term, but importantly also was perceived to be useful armoury for warding off further blows (or 'hits') to their masculinity in the long-term. Exercise was a new practice that had the added incentive of "getting back" an important aspect of their masculinity (their physical strength).

In describing their physical recovery from CHD participants placed heavy emphasis on the recovery of lost aspects of masculinity. It was observed (as in the following extracts) that when some participants reflected on the losses they had experienced Danny would offer assurances that these aspects of masculinity could be recovered:

**Extract 1/**

**Alf (72):** *It took my confidence away for a while*

**Danny (71):** *But as I say I got it all back again*

**Extract 2/**

**Bernard (67):** *All of a sudden you're sitting in the passenger seat*

**Danny (71):** *But you do recover from it*  
**Cardiac Group**

It was my impression that this was sometimes employed as a strategy by Danny to avoid detailed reflection of his and others' feelings of loss. However, it also seemed vital that Danny avoid further challenges to his masculinity, particularly as the masculine identity he had successfully re-negotiated was heavily dependent on him being seen as 'recovered'. He described how he gradually drifted back "into the office (to) do single projects" and was soon "back working as hard as ever" despite his doctor stating: 'I think you've had enough don't you? Stop!'. But listening to this

advice would have jeopardised his newly recovered masculinity and perception of himself as 'recovered' ("I'm alright now. I've got over it", Danny, 71, Cardiac Group).

Jack also felt that once he had begun to recover physically he could resume certain practices of masculinity that would enable him to recover lost aspects of his masculinity. He knew he was supposed to avoid strenuous activity, yet he described engaging in heavy physical work as a challenge for himself or as a way of 'testing' his progress (such as lifting heavy boxes or heavy digging in the garden). He stated that the only thing that would challenge his idea that he had recovered fully was "if there was a symptom that suggested to me, like if I started to sweat..then I'd stop it (the activity)". Jack was also keen to avoid any suggestion that he was not 'back to normal'. The paradox is that Danny and Jack were risking further challenges to their masculinity (or death) by engaging in such practices. However, their willingness to engage in risky practices reveals how important it was to their identity as men to present themselves as 'recovered'.

However, those around them (family, friends, and neighbours) repeatedly questioned the idea that they had fully recovered, presenting a continuous challenge to the identities they had re-negotiated. Bernard described how others would continually question his physical capabilities, which did not fit with his perception of himself prior to illness: "all of a sudden you've folks saying to you 'watch what you're doing. I'll come up and cut the grass Dad'" (Bernard, 67, Cardiac Group). Bernard added that he felt it was virtually impossible to recover in other people's eyes: "Just the fact that once your family emphasise the fact that you've had a heart attack then that's it" (Bernard, 67, Cardiac Group). The discrepancy between how participants wished to view themselves (as 'recovered') and how others saw them is illustrated in the following extract:

**Jack(64):** *The worst thing I get is when somebody comes up to me saying 'by God you're looking well considering what you've come through' and I say to myself 'what the heck have I come through?'*

**Danny (71):** *laughs*

**Jack (64):** *That sometimes brings things home to you*

**Bernard (67):** *...Neighbours will shout across to you 'should you be doing that?' ....the lass across the road from me, she's up in the accident and emergency unit...she's constantly yelling at me for doing this (and that).*

#### **Cardiac Group**

Comments from neighbours, friends, and family presented continual challenges to identity and undermined participants' attempts to present their masculinity as having been 'recovered'.

In summary, men with CHD were forced to make immediate changes to their lifestyle, the most challenging of which in terms of masculinity was having to give up the 'breadwinner' role. However, the loss of physical strength was also discussed as presenting a significant challenge to participants' identities as men. It was difficult for participants to accept that the loss of masculinity that they had experienced might be permanent and they set about working towards the recovery of both their health and their masculinity. Some participants would take on new practices of masculinity that replaced others they had lost (for example by accepting they had to give up work, but continuing to engage in heavy activities), in order to affirm their masculinity. Others would resume old practices (for example working against their doctor's advice) to the same end. However, these repaired identities appeared to be fragile and were subject to repeated challenges from those in their family and wider social network who did not share their view that they were entirely recovered.

#### **5.4. Masculinity guillotined: the impact of Prostate Cancer**

Participants suffering from prostate cancer also used violent and sudden imagery to describe the impact illness had had on them: "(I) never had any major complaints and then bang it just hits you" (George, 59, Prostate Cancer Group); "I got hit with this" (Callum, 52, Prostate Cancer Group); "Guillotine" (Murray, 70, Prostate Cancer Group). The group discussed many areas of masculinity they felt had been forcefully challenged by their illness (e.g. sexual performance and physical strength). However, loss of work identity (even for Callum, 52, who had been forced to retire in his late forties) did not appear to be as big an issue for the Prostate Cancer group as it was for other groups (Cardiac Group, M.E Group) who described their experience of illness.

The feeling that prostate cancer had taken something ‘inherently male’ away from them seemed to eclipse the impact that other challenges may have presented to their masculinities. The experiences of participants with prostate cancer differed to those described by men with CHD, ME, and depression in that they were reflecting on parts of their masculine selves they felt had gone forever and that could never be recovered (“It’s gone”, “it’s been taken away from you”. Ben, 60, Prostate Cancer Group).

The side-effects of the different treatments for prostate cancer (participants spoke about radical surgery, hormone therapy, chemotherapy and radiotherapy) presented the most dramatic and varied challenges to masculinity. One participant felt that radical surgery, or “castration” as he referred to it, was seen as “the only way to cut it (cancer) off totally” (Murray, 70, Prostate Cancer Group). However, three of the participants suffered from impotence as a result of their surgery and this had had a dramatic effect on how they felt as men. Ben voiced the concerns that many in the group had said they had when he spoke of how he mourned the loss of his libido and ability to perform sexually:

*If you think maybe in your forties how your sex drive was an important part of your life...and you think in your fifties and sixties it might still have had an important part of your life.*

**Ben, 60, Prostate Cancer group**

Ben was particularly concerned about the impact his impotence would have on his relationship with his partner, or rather how it might change how she viewed him. He told the group a story about a man he knew whose wife had left him the day after she learned that he had been diagnosed with prostate cancer. This was presented as a reminder to the other men in the group that losing aspects of masculinity, such as libido, could make you appear to be ‘less of a man’ in other people’s eyes.

One of the greatest challenges was for those who experienced the loss of ‘natural’ aspects of masculinity following their surgery and who felt that their masculinity had been severed “before it’s time” (Murray, 70, Prostate Cancer Group). It was clear that participants felt that most of the men their age would expect to retain their sex drive and their ability to perform sexually well into old age (which this group perceived as being around late seventies or early eighties). Ben, who was sixty, described how

such a loss at a relatively young age had made him feel apart from others his age who, in his opinion, could have been expected to enjoy active sex lives for “maybe ten, twelve or however many years” beyond the point his was “taken away”. He added that:

**Ben (60):** *The difficulty perhaps in the sexual front is you realise when you get to a certain age, and it varies with individuals, that you are going to lose your sex drive. The hard bit I think is having it taken away from you... You have to get it clear in your mind and accept that...*

**George (59):** *I think that's very well put...that's (it) exactly*

**Ben:** *To...think that...maybe ten twelve or however many years ahead...then it would just occur naturally. But the fact that we've had it physically taken away early I think is the hard bit*  
**Prostate Cancer Group**

Ben also felt distressed about the premature loss of other aspects of masculinity he regarded as ‘natural’. He felt that illness had robbed him of the physical power he had once enjoyed that had enabled him to “run marathons and do all sorts of things” in his thirties. He acknowledged that now:

**Ben (60):** *It's gone (referring to his ‘natural’ masculinity)...I used to run around Balloch Park six times, the Barras two and a half miles...I can hardly walk around it now*

**George (59):** *No, but you try don't you?*

**Ben:** *I cannae try*

**George:** *Oh, you don't even try it. See I find...I can't do what I used to do ten years ago...but I don't think it's anything to do with the prostate cancer*  
**Prostate Cancer Group**

George felt that the loss of physical strength was easier to come to terms with as he had anticipated that he ‘would not be able to do what (he) used to do ten years ago’ as he aged. Murray expressed similar views:

*If you reflect or think about it. By the time you were seventy or eighty...you'll probably be in that situation that you're in now...you just can not...go on for ever doing things that you used to do.*  
**Murray, 70, Prostate Cancer Group**

The difference was, of course, that Murray *was* in his seventies and so perhaps found it less difficult to “reconcile the..problem” (Murray, 70, Prostate Cancer Group). Ben, however, felt that there was nothing ‘natural’ about the kind of fatigue and weakness he experienced. He had the most advanced cancer of the four (he had found out that the cancer had spread to his bones prior to the focus group, whereas other group members had said that treatment had finished and their cancer was being monitored by biannual PSA testing or ‘watchful waiting’ as it is sometimes referred to). Ben’s increasing physical deterioration meant that the likelihood that he might never reach his ‘seventies or eighties’ may well have been dawning. It is understandable therefore that he found it harder to reconcile than other men in the group. In his own words, he said he “feel(s) deprived” because “it’s now rather than ten, twenty years time” (Ben, 60, Prostate Cancer Group).

The two participants who had received hormone therapy (George and Callum, Callum later went on to have radical surgery when this proved ineffective) also spoke about the distress they felt about the changes in the bodies they once regarded as ‘masculine’. George felt that his body had become increasingly feminine as his hormone treatment progressed (“men grow breasts and develop hips”). Callum reported similar changes along with a loss of libido and impotence, stating that the combined impact of these changes was that “it lowers your macho-ness without a doubt” (Callum, 52, Prostate Cancer Group). George appeared willing to accept the challenge to masculinity of “basically being turned into a woman” if it meant that “the hormone treatment stops the flow of testosterone and hence prevents the cancer from growing” (George, 59, Prostate Cancer Group). Despite a similar acknowledgement that the treatment was likely to halt the progression of disease or even save his life, Callum seemed more resistant to the idea that his ‘macho-ness’ had been entirely removed by hormone therapy, believing it to have been merely “lowered”. He added: “I still feel like a man, although I’ve the same problem as my friend here (loss of libido and impotence)” (Callum, 52, Prostate Cancer Group).

Towards the end of the discussion all participants arrived at the conclusion that it was fruitless for them to dwell on aspects of masculinity that they felt had been lost forever, as the treatment that had prompted these side-effects had also kept them alive. Murray (70) stated that when he was first diagnosed he had to “weigh up” the

losses he was potentially going to be faced with “the fact that you’re going to live longer”. Ben felt that he had had a choice to refuse treatment if he had felt retaining an unchallenged masculine identity was more important than his life. Ben and George explain the dilemma that the treatment for prostate cancer presented them with:

**Ben (60):** *You’ve got to adjust to it (loss of libido, physical strength)...because the alternative is you’re probably going to be dead. Well you would be dead. I’ve been on treatment for about five years probably. I wouldn’t be here today if I had made a conscious decision to say ‘I’m not going to take treatment. I’m just going to live a full life’...So it’s...one of those decisions you’re faced with. You cannae evade it..you cannae put it aside. You’ve got to make a conscious decision and say ‘well, OK’....It can still....emotionally still be a slight problem I think.*

**George (59):** *It’s not good (laughs). It’s not good, but you put up with it because you’re alive.*

#### **Prostate Cancer Group**

Faced with few alternatives, they appeared to have reached the conclusion that there was little point in hanging on to aspects of masculinity they once valued (“what is it? A cheap thrill every now and again?”; George, 59, on the subject of sexual performance) if they were likely to precipitate an earlier death.

Callum seemed to accept that illness had robbed him of the aspects of masculinity that made him feel ‘male’ and he could see little point in engaging in practices that affirmed his masculinity. He felt this would not enable him to recover this ‘essential’ part of himself. He contented himself with his belief that he had proven his masculinity at a stage in life when he felt it had mattered more to appear ‘macho’. As he described:

*I think it’s a stage you get through in life. I mean I took my trade in the North Sea on an oil platform for five or six years and one of the guys I know he still calls me tiger, you know the North Sea Tiger that was me back in the seventies, eighties and it boosts your ego I suppose but I think it’s when you’re in your thirties and your twenties and thirties you want to be macho. That is the way you are. Put it this way; (as) a younger man if someone annoyed me or done something to annoy me and mine I wouldn’t think anything about hitting him. Which is... masculinity. It’s macho isn’t it? I’ll take them on I didn’t care if I got killed in the process, nobody does that to me and mine. But as you progress through life that feeling is still there*

*but....could you do it? I mean it's....if you're young enough and fit enough to do it*  
**Callum, 52, Prostate Cancer Group<sup>11</sup>**

Callum felt that illness meant that he was no longer young enough or fit enough to enact or affirm his masculinity in this way any longer. It seemed that, even as a relatively young man, he had been forced to accept the loss of masculinity (he seems to be reflecting on a chapter of his life that has been closed) and embrace his new 'stage..in life'.

However, George was keen to emphasise that while he had suffered many losses and challenges to his masculinity, he still felt that there were many ways in which he could re-affirm his masculinity through social practice. George may have lost his libido but he felt he could still 'act' like a man if the situation called for it: "I wouldn't say it still affects my maleness. If somebody did me wrong I would still go for them (physically attack them) but I wouldn't call on my wife to go and fight my battles you know but um, no I don't think it's changed anything else it's only the sexual side of things for me". So George still 'felt' male even if he could not perform in one area.

However, Ben, Callum and Murray felt that it was hard to retain the idea that their 'maleness' remained unchanged as they believed other men viewed them differently because of their illness. All participants thought that other (healthy) men talked about them when they became ill and this talk singled them out as abnormal or apart from the rest of their peer group: "oh did you hear about Ben. Jesus, he's got prostate cancer" (Ben, 60, Prostate Cancer Group). One participant indicated that this kind of talk served to exclude those that were spoken about: "they'd be saying 'Ben's got prostate cancer', but Ben wouldn't be sitting there" George, 59, Prostate Cancer Group). The feelings of exclusion from their peers described by participants of the prostate cancer group were reminiscent of the concerns raised by Barry in an individual interview. Barry had imagined that one of the biggest challenges that

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<sup>11</sup> This quote also appeared on p91 to illustrate the point that performances of masculinity may change over the life course. However, the same quote is also Callum's reflections on the aspects of male identity he felt has been challenged or lost through his illness and his description of himself as the 'North Sea Tiger' provides him with some assurance that he had once engaged in masculine practices that he considered appropriate and were approved of by other men, even if he was now prevented from doing so.

illness presented to masculinity (he was referring to an illness he considered threatening to male identity; testicular cancer) was being made to feel apart from other men, that he 'was no longer part of the group'. His biggest fear (even though he had never experienced this kind of illness and was only speaking in hypothetical terms) was that:

*Other people (found) out about it (illness). Other men. You're standing out from the herd...When you're a male you hear about 'oh so and so has lost his testicles' or something like that. You know 'ha ha ha'...and face to face they'd be saying 'oh it's terrible, it's a shame' and that....You've got this fear of being ridiculed or just standing out from the crowd. You're not just part of the group. You're no longer part of the group.*

**Barry, 62, Individual Interview, formerly from the Unemployed and Retired Men's Group**

Participants with prostate cancer recalled a number of incidents where they were made to feel apart from their peer group following diagnosis. Callum described how he was treated at a social club he had attended for many years when a male friend 'told everyone in the club':

**Callum (52):** *When I came out I was like a leper...Cos its amazing the amount of people that didn't want to know you...It took me weeks and weeks for me to come back in, they didn't want to know me...they're embarrassed...*

**Murray (70):** *I don't think at the end of the day when you reflect back and say they didn't want to know you.....they found it awkward to speak to you about it....*

**RO:** *Other men is this?*

**George (59):** *Men yes*

**Callum:** *more so other men aye*  
**Prostate Cancer Group**

Participants seemed to want to break the silence they anticipated they would be met with: "you had this choice. You either keep quiet or you tell everyone about it" (Ben,

60, Prostate Cancer Group). However, participants had to look for other means of getting social support from other men when faced with peers who 'found it awkward to speak' to them about prostate cancer. There was some indication that some had coped alone after diagnosis and it was not until they were hospitalised and came into contact with other men with prostate cancer for the first time that they were able to share experiences. As Murray described:

*I think it started in the hospital...(there were) two or three in the one ward of prostate patients, so you begin to exchange views...I think the more you talk about it, and again, it's a personal view, I think the easier it is to live with it. You've got to cope with it.*

**Murray, 70, Prostate Cancer Group**

Although Ben said that he had been unused to talking freely about his emotions prior to the onset of illness ("at the start you're a wee bit...(reluctant)" he did not find his need to do this as threatening to his identity as other challenges he had had to endure following diagnosis. As Ben stated:

*You go through degrading things (as part of treatment)...when you've went through that sort of thing there's very little left..that you're not prepared to talk about.*

**Ben, 60, Prostate Cancer Group**

Murray eventually went on to set up a support group for other men with prostate cancer (that George, Ben, and Callum attended). Participants said the social support they received had been crucial in helping them to come to terms with the emotional impact their illness had had on them. The men were also able to share the losses they had experienced and the challenges they believed they would face (real or imagined) from other men, thus making these experiences they had in common with other men like them rather than feeling these continued to make them 'stand out from the herd'.

### **5.5. "It's a strength thing...a male should be masculine": ME**

One of the two participants who suffered from ME also regained the sense of community that he felt he had lost through illness by attending a support group (Morris, 52, ME Group). Donald (69) felt that the group he attended was orientated towards younger men and women ("there wasn't really one person (in) my age group") who had faced considerable challenges to their identity through illness. He

felt that ME meant “catastrophe” for men who were considerably younger than him (like Morris) who were in his opinion beginning to “achieve and were having to pack it in (work) and didn’t know what was going to happen” (Donald, 69, ME Group). Donald’s concerns (and reason for joining the group originally) were of a more practical nature. He had hoped that when he joined his local ME group he would get advice and support to enable he and his wife (Donald’s wife became ill with ME at the same time as him) to continue engaging in everyday activities (such as shopping or assisted holidays) as they faced progressive physical incapacity through illness and old age. However, as regards the fundamental challenge to his masculinity, he felt that “in a sense I was lucky (as) I didn’t have their problems” (Donald, 69, ME Group). Donald and Morris’s conflicting accounts indicated that some men felt that they ‘stood out from the herd’ more than others, even if they shared similar experiences of illness.

Morris had been a young man (early forties) when ME began to impinge on his life. Physical incapacity had presented great challenges to his masculinity, forcing him to give up work (he described feeling guilty because he was “no longer the provider”), along with his sporting commitments, and also put an end to ‘whatever socialising I did..so I basically became isolated’ (Morris, 52, ME Group). As Morris described, illness “takes away a lot of things; self esteem (and) self worth. Confidence. It takes away all of those things” (Morris, 52, ME Group). He felt that his illness made it impossible for him to continue to engage in ‘normal’ masculine practices and that this made him stand out when he compared himself to other men he had known (he refers to his father and men of his father’s generation) who “always struggled on” with illness and “always say ‘I’m fine’” and “soldier on”. Morris felt that this idea was reinforced by family and friends who “couldn’t understand..why I couldn’t get out and about and do things that other people did which caused a lot of problems at home” (Morris, 52, ME Group, referring to his wife). He described how he “proceeded to go downhill a bit depression wise...I had a lot of time on my hands to basically do nothing and I suffered from depression....I ended up in (hospital) for seven weeks” (Morris, 52, ME Group). The emotional support he received from others with ME who had faced similar losses was therefore vital to Morris.

Donald (69) had also been forced to retire early and he and his wife had become

increasingly socially isolated the more physically incapacitated they became. However, this did not appear to present the same challenges to Donald's masculinity as it did for Morris (who likened his experience of the loss of working and social life to a "bereavement"). There are two possible explanations why this might be so. Firstly, Donald had been much older than Morris when he first became ill and although he initially did "resent it because I felt that in a way you were losing a bit of life" (by having to retire earlier than he would have liked) when he compared his experiences to those of Morris, he felt that he was fortunate that most of his working life had been undisrupted: "I was lucky in that when it hit me I was...just in the middle of negotiating early retirement, so I was pensioned off. All I had to worry about was myself and my future" (Donald, 69, ME Group). In contrast, Morris' working life had been disrupted at a stage in life where he could have reasonably expected to work for another twenty years and so he faced a great deal of uncertainty about his future: "the shock hit me: I no longer have a job after twenty-three years. I started (to ask)... 'where am I going to be?', 'how am I ever going to get a job again?'" (Morris, 52, ME Group). Donald's retirement at an age he and others regarded as appropriate for his life stage did not cause as great a disruption to his working life or indeed his identity as a man. On the contrary: "we (he and his wife who also retired) were quite glad at that time to say of their careers 'well, we've been there, we can let it go'" (Donald, 69, ME Group). Donald also accepted (with regard to masculinity) that at his age "now you're seventy it's (masculinity) naturally going to go (laughs) more and more" (Donald, 69, ME Group).

Donald also had the second advantage of having the understanding of his wife (who also suffered from ME) and he described how they were able to "support each other" through their shared experience of illness. It is possible (although Donald did not mention this) that ME could have been perceived to have been less of an emasculating process if he observed the same symptoms and level of disability in his wife. As well as providing emotional support, Donald's wife was able to continually verify that his experience of illness was legitimate in the face of criticism from his many "doubters". Donald describes how he remained 'unchallenged' by those who questioned the authenticity of his illness: "I just...felt...well I just accepted that they didn't understand. I was so poorly that I wasn't really caring very much either way" (Donald, 69, ME Group). Morris, with far less social support than Donald, was more

affected by the criticism he encountered. When Morris experienced brief periods of remission his wife would ask ‘are you...alright now?’ Like you know ‘have you really got this?’”. Morris interpreted this as meaning: “men should be able to cope no matter what’s going on....Men should be there when x happens in the house, whatever it be. You’re there you should be able to deal with that. You’re the man of the house sort of thing” (Morris, 52, ME Group). As Morris was unable to provide conclusive proof that he was not a “charlatan” (with regards to the authenticity of his illness) he was also unable to ward off associated challenges to his masculinity.

Morris felt particularly vulnerable to challenges to his masculinity in situations that required him to explain his loss of physical strength to others. He believed that there was an expectation that men should be strong and be able to engage in physically demanding tasks when required. He felt that ME, a less tangible illness than others he could think of (“if I’d said ‘I’ve got a bad back’...then maybe you’d understand”), would not be perceived by others as a legitimate ‘excuse’ to exempt him from pressures he thought all men felt to engage in practices that demonstrate masculine strength. Morris described a situation where such expectations had been made apparent to him and how emasculated he had felt by his inability to perform physical tasks as required:

*You have to say to people ‘sorry, I cannae really do that because...I’ve got this problem’... and it’s ‘wait a minute, you’re a man you should be able to. Why can’t you give me a hand with this?’ Um like pushing a car. It’s happened to me several times.....They look at you as if ‘what do you mean?’ ....I think it’s a strength thing...a male should be masculine.*

**Morris, 52, ME Group**

Morris felt that persistent challenges like this had had an enormous impact on the way he felt about himself as a man. He commented that “when you don’t have the physical strength...it starts to affect you mentally” (Morris, 52, ME Group).

Donald was also “much more conscious of a loss of ability to do things”. Donald did at times “measure myself against my previous self” to assess the impact his ME (and angina) had had on his identity. Donald found the loss of “natural” aspects of masculinity, which he felt had been “cut off” prematurely, particularly challenging to his masculinity. He described how he was continually reminded of what he had lost:

*...You would see youngsters with their bikes and hiking gear or you're watching television then you see stretches of countryside and people climbing across it and I think 'well this is gone forever'. Well now you're seventy it's naturally going to go (laughs) more and more. But at the beginning, ten years ago, that was the kind of thing that upset me that you were cut off from that in a way.*

**Donald, 69, ME Group**

Donald's comments echo those of participants in the Prostate Cancer Group who also mourned the loss of 'natural' aspects of masculinity that they felt were taken from them before it was time. Donald suggests that his feelings of loss were easier to accept as he neared the age of seventy (the age he believed physical strength would 'naturally' decline) but indicates that this had been challenging to his identity as a man of sixty (when he first became ill). Despite finding the change to his physical capabilities to be initially 'shattering' he seemed able to reconcile the limits his illness imposed on him more readily (when he compared his experience to Morris) with the fact that he had experienced this kind of loss at an older age. Morris who, as a much younger man had not anticipated that he would lose the 'natural' aspects of masculinity and found it more difficult to accept that this aspect of masculinity had gone forever, occasionally felt compelled to "push yourself a wee bit and see how far you can go" (Morris, 52, ME Group). Whereas Donald stated that: "I know the limits I can operate in".

There were points in the interview where Morris revealed that there was a tension between trying to accommodate new physical limitations and emotional needs on some occasions and fighting them on others. Morris discussed how "when I took this (ME)..I tended to try and listen to my body...maybe being overprotective in a way" (Morris, 52, ME Group). Early on in the interview, Morris described how he would have to continually monitor how he felt and respond immediately to fatigue to prevent a full relapse. For example, engaging in relaxation exercises or "five minutes in the car can be enough to revive me". Similarly Donald spoke about how important it was to be able to judge when to keep going and when his body required immediate rest. As he stated:

*It's not enough to rest, you've got to relax. I do relaxation exercise...If you have a bad relapse you can be two or three days....(but) there comes a point where you do*

*have to just get going and if you do get going you seem to be able to keep going and things pick up a bit. It's very difficult to judge...which is which.*

**Donald, 69, ME Group**

However, there were parts of the discussion that conflicted with Morris' account of 'listening to his body'. He mentions the attempts he made to resume his old activities. Before he became ill he was a member of a running club and used to do marathons and after being diagnosed with ME he "tried ten minute runs..but I've just ended up sore for hours". Morris described his efforts to re-engage with sports in combative language as a way to "fight my way out of this (illness) then I'd just collapse again".

It seemed that as a much younger man than Donald, and with less social support, Morris still felt enormous pressure to engage in certain practices of masculinity and this fuelled the tension between what his new limits were and what he felt was expected of him as a man. Such attempts to engage in practices of masculinity enabled Morris to present the idea that he was able (or at the very least trying) to recover lost aspects of masculinity (as was observed with men with CHD). However, in Morris' case these attempts simply proved too challenging to engage in regularly as his repeated failures to perform as he had prior to illness reminded him of what he had lost rather than giving him hope that masculinity might be recovered.

### **5.6. "You just don't talk to other guys about it": depression**

The subject of depression arose frequently in focus groups with 'healthy' participants. There were suggestions from healthy men that being strong and silent and concealing mental health problems (for example, "we don't call it depression we just call it stress", Phil, 41, Carers Group) were practices men felt they had to engage in to ensure that their masculinities remained unchallenged by depressive illness. We wondered how men who did define themselves as mentally ill felt their illness affected their masculinity or if they too felt they had to engage in masculine practices in order to conceal their distress. This prompted us to convene a focus group devoted to men's experiences of depression (participants were recruited through a mental health charity in Scotland). This section therefore draws on examples from several different groups, only one of which included participants who explicitly defined themselves as sufferers of a depressive illness (Mental Health Group).

Contrary to what we had anticipated, and had observed in the other groups in which participants related their different experiences of illness and subsequent challenges to masculinity, participants in the mental health focus group rarely reflected on the personal challenges depressive illness presented to their identities as men. Instead participants spoke about men in generic terms, stating that men would view “anything...to do with mental health..... as having a stigma attached to it” and would find it challenging to masculinity (Liam, 43, Mental Health Group). Participants in other groups made it clear that being seen to succumb to mental illness would present a great challenge to masculinity because there was an expectation that “a real man puts up with pain and doesn’t complain...As a man (suffering from depression) you just pull your socks up” (Aidan, 35, Student Group). Many participants shared similar views to Jake, who stated that when ‘a man’ suffers from depression they would know that they were expected to conceal their distress because “Men..don’t show emotions...we bottle things up...(it’s) male bullshit” (Jake, 33, Slimming Group). The majority of participants, whether they defined themselves as ‘healthy’ or ‘ill’ preferred to reflect on how cultural constructions of masculinity (rather than their own masculine identities) might be challenged by depressive illness.

It was thought that the challenges depressive illness presented to masculinity were easier to avoid and the concealment of emotional distress easier (“if they don’t see it (mental illness)”) than acknowledging their distress (Jerry, 49, Mental Health Group). Physical illness or injury was perceived as being more immediately visible to others (“if you’re walking about with a (plaster) on your leg, people will turn around and say ‘well, what happened?’”, Jerry, 49, Mental Health Group). As “mental health can’t be seen” (Jerry, 49, Mental Health Group) the only way participants felt that a man could make depression ‘visible’ to others was by talking about the problem and admitting their feelings. Whilst there were some kinds of pain that participants felt would be acceptable for men to discuss with other men (“if you’re talking about football injuries...people talk about those kind of things all the time”, Liam, 43, Mental Health Group), they felt that men would need to be a “bit more guarded about who they would talk to” about “emotional pain” (Liam, 43, Mental Health Group). Appearing unemotional and remaining ‘strong and silent’ were therefore key to avoiding potential challenges to masculinity. One participant stated that he

instinctively knew that “you just don’t talk to other guys about it” (Ross, 29, Choice Group). In such a climate it is little surprise that Jerry stated “you tend not to talk too much about it..I didn’t want to admit it (his own mental health problems)” (Jerry, 49, Mental Health Group). As Debu added it was for this reason that “for a lot of men....certain events in life are just bottled away” (Debu, 22, Student Group).

Liam believed that if a man articulated the precise nature of his suffering (i.e. making it ‘visible’) it would meet with censure from other men. He describes what he thought was a commonly held belief among men, that men should be uncomplaining about symptoms of mental illness and ‘put up with’ emotional distress without support:

*It’s probably difficult for a lot of men to talk about it (mental health problems). I would suspect that even if somebody with the problem finds that they can talk about it, other people might not be terribly willing to listen...I suspect that there’s still an element that you’re expected to put up with it and not complain or at least I think a lot of men feel that they’re expected to put up with it and not complain...It possibly comes to the same thing in the end.*

**Liam, 44, Mental health Group**

It was observed that the majority of participants who, like Liam, had implied that they had suffered from depression at some point in their lives, were engaged with this practice of concealment as they described it. It was clear that many participants could not bring themselves to name the illness they were referring to (e.g. as shown above: you tend not to talk about ‘it’, I didn’t want to admit ‘it’, somebody with ‘the problem’ etc.). Participants also distanced themselves from the hypothetical cases they describe, discussing the experience they imagined other men might have rather than articulating how they themselves had felt.

Colm (32) and Ted (36) were the only participants who described their own experiences of depressive illness (Gas Workers Group). Colm (32) described how he would unplug his telephone, and avoid contact with friends and family so as not to reveal anything of what he was feeling. There was the suggestion that he tried to keep his problems hidden ‘behind closed doors’: “the door’s shut behind me...I didn’t want to be seen by any of my friends. I felt isolated”. Ted (36, Gas Workers Group) also felt that he had to remain silent about his depression and describes how “I wouldn’t talk to my wife. I wouldn’t talk to my friends about it, wouldn’t talk to my

mum". However, Ted felt able to seek counselling and he felt this was important in decreasing his feeling of isolation and coming to terms with the problems that triggered his depression. Colm also eventually sought medical help and was given antidepressants. However, Colm was concerned that "once you've admitted to a weakness then you're thinking that people are going to be looking at you laughing".

Both Colm and Ted felt that the challenge of being perceived as mentally 'weak' was harder to overcome than the threat other illnesses posed to masculinity. In the following extract they describe their belief that another kind of illness, by contrast to mental illness, might offer more opportunities for them to redeem themselves in the eyes of other men if they resumed their engagement in masculine practices:

**Ted (46):** *A broken leg or sort of....cancer is MANLY (says in a 'manly' voice) or anything*

**Colm (42):** *Smoking is*

**Ted:** *Walking about the office saying 'I've got my leg off but I'm still smoking'.*

#### **Gas Workers Group**

It was my impression that Colm and Ted believed that the damage wrought by suffering from an illness perceived as 'unmanly' would be irreversible. Colm eventually decided to stop taking his medication and sought no further help even though he continued to experience emotional distress ('Oh bugger it. I'll just put up with the stress'). Colm's attempts to make his illness more visible to others proved challenging to his masculinity and he reverted to the practice of concealment in order to maintain an 'unchallenged' identity. As he stated: "you can't cope. You're not going to admit it to a bunch of strangers" (Colm, 32, Gas Workers Group). However, he had been willing to reveal the challenges he had experienced to a friend he knew had suffered in a similar way (the Gas Workers Group were both friends and work colleagues). However, it was important for Colm to present the masculine way in which he countered that challenge, by reverting to concealment, rejecting help, and 'fighting': "it takes more courage to fight through it, fight through the problem" alone (Colm, 32, Gas Workers Group).

However, not all participants who were interviewed with their peers were permitted to discuss their experience of depression as openly. One of the participants of another naturally occurring group admitted that there had been a time when he “should have talked to someone...(but) You’ve just sort of worked your way through it”. (Ross, aged 29, Choice Group). Ross then tries to get his group of friends to explore the possibility that certain practices of masculinity could be harmful to men if it meant men denied each other emotional support. His comments were met with the following response:

**Ross (29):** *There’s just something in our make-up that you just don’t talk to other guys about it*

**Tony (29):** *Aye well if it’s total lads they’re going to rip the pish out of you for it anyway*

**Paul (40):** *Don’t you forget it (mock threatening tone)*

(Group laughter)

**Health Change Group**

Although this can be viewed as simply a humorous exchange between friends, there is also a reminder that Paul is a ‘total lad’ and that he is willing to ‘rip the pish’ out of other group members who question conventional practices of masculinity. Paul effectively curtails the discussion of depression, moving the topic away from personal experiences of depression (which both Paul and Ross had hinted had been a personal difficulty) and any critique of the practices of masculinity that Ross may have been trying to instigate. His ‘reminder’ also prevents anyone else in the group reinforcing Ross’ view without jeopardising their own masculinity.

Discussions relating to depressive illness were found to differ greatly to the accounts of men suffering from other illnesses. As has already been noted, the experience of CHD, prostate cancer and ME caused the majority of participants to reflect on their experience of illness and the challenge this had presented to their masculinity. However, the majority of participants who raised the subject of depression focused their discussion around ‘other’ men and reflected on the ways in which men might engage in practices of masculinity that effectively conceal mental illness. The majority of participants were reluctant to present themselves as ill, or to describe

challenges to their own masculinity resulting from depression, when their accounts were presented for the consumption of other 'healthy' and 'unchallenged' men. However, this also seemed to be the case for men interviewed with groups of friends or in a specially convened group where all members were known to have suffered from depression. Participants' attempts to conceal their own experiences of depression, in a discussion that predominantly focused on why men "just don't talk to other guys about it", were in themselves indicative of the practices of masculinity they sought to describe.

### **5.7. Discussion and Conclusion**

The majority of participants who had experienced major illness felt that their masculine identities had been violently ('guillotined', 'cut', 'blow') disrupted by illness (Bury, 1982). Participants who suffered from four very different illnesses faced many common challenges to their masculinity resulting from the loss of working, sporting, and social lives, as well as from changes to the appearance of their bodies and their general physical capacity. This supports other research that suggests that masculine identities are constructed through embodied experience and engagement in social practices (Messner, 1992; Morgan, 1992; Connell, 1995; Watson, 2000). By contrasting the experiences of men with CHD, Prostate Cancer, ME, and Depression, we can see that the losses participants experienced, and the nature of the challenge this presented to masculinity, were consequent on the illness they had suffered. Our findings are in line with other research that shows that the losses men experience through illness can expose the practices of masculinity that men engaged in prior to illness (Chapple & Ziebland, 2002).

Participants with CHD described feeling an enormous sense of loss of masculinity when they were forced to give up work following the development of their heart problems. Their accounts revealed that they believed that work and their identity as the breadwinner of their family were crucial to their masculine identities. These findings are similar to those reported elsewhere that have highlighted the importance of work identity for masculinity and the impact the loss of employment has on male identity (Eales, 1989; Morgan, 1992; Collinson & Hearn, 1996a). Participants felt that they had acquired their heart problems by engaging in masculine practices (by 'taking' or enduring the pressures of the breadwinner role). It was a paradox that the

very practices that had once affirmed their sense of masculinity had resulted in an illness that challenged their identity as men. This supports research that suggests that certain practices of masculinity may be perceived as detrimental to men's health (Harrison, 1978; Darbyshire, 1987; Sabo & Gordon, 1995).

Men with CHD presented themselves as compliant with the majority of the new health practices that had been recommended by medical staff for rehabilitation (i.e. changes to diet and levels of physical activity). Other researchers have highlighted that the dynamics of any changes associated with 'doing something' to aid recovery or promote health (or indeed recover feelings of masculinity) might be quite different from those associated with losing aspects of identity (MacLean & Lo, 1998; Koch, Kralik & Taylore, 2000). Charmaz (1994) suggests that physical activity in particular may help to restore masculinity and would be preferable to the 'forced passivity' accompanying illness that she argues presents a persistent threat to masculinity. Participants in this study were advocates of health practices that aided physical recovery as it allowed them to engage in old social practices, such as returning to work, or indeed take up new ones (for example Bernard's description of doing heavy digging in the garden as a means of measuring his increasing physical strength). Re-engagement in such practices enabled participants to construct a "restored self", or rather a restored masculine identity (Charmaz, 1987; White, 1999).

Participants with CHD made attempts to "bracket" their experience of illness away from their masculine identities ("I think of it as a twenty minute situation". Alf, 72, Cardiac Group) once they perceived themselves as 'recovered' (Charmaz, 1994). Moynihan and colleagues (1998) found that the initial challenge illness presented to her participants' masculinities was overcome, and threats to masculinity denied, once they were able to re-engage in social practices that restored their feelings of masculinity (e.g. work and sexual performance). However, we found that the re-negotiated identities described here were fragile and the view that masculinity had been restored was subject to repeated challenges by friends and family ("should you be doing that?") who regarded them as having been permanently altered by their illness.

Men suffering from prostate cancer found it much more challenging to try and

recapture the aspects of masculinity they felt had been lost through illness. Participants with prostate cancer had experienced multiple challenges to their masculinity, including the loss of work, social life, and ability to perform sexually (as one participant said “there’s very little left”). The loss of libido, physical strength and the feeling that something inherently masculine had been “taken away” from them, most affected their feelings of masculinity (see Chapple & Ziebland, 2002). for similar findings). The very fact of their illness evidenced some absence or lack of masculinity which they felt could never be recovered by social practice. Other researchers have suggested that the symbolic effects of castration on a man and the meaning this has in our culture may present particular challenges for men with prostate cancer (Clark et al, 1997). The enduring side effects of treatment (which included impotence and loss of libido) presented men with persistent challenges to their masculinity compared to men with CHD who ‘bracketed’ their experience of illness. Charmaz (1983) has stated that the experience of unrelenting debilitating illness is tantamount to an assault upon the self. Certainly the language participants in this study used (“taken away from me”; “cut off”; “guillotined”) suggest that they felt their masculinity had been mutilated and severed permanently by prostate cancer and its treatment. It was these aspects of masculinity that had been so greatly challenged by serious illness that had made them feel they ‘stood out from the herd’.

Participants suffering from ME mourned the loss of physical strength and felt that their ‘weakened’ bodies presented the greatest challenge to their masculinity. Charmaz (1994) has noted that this kind of physical incapacity can affect a man’s feelings of masculinity because it: “challenges men’s assumptions about male mastery and competence” (p273). Other researchers have noted that: “men’s bodies allow them to demonstrate the socially valuable characteristics of toughness, competitiveness and ability” (Gerschick & Miller, 1995, p183; also see Messner, 1987a). Participants had to reconcile their loss of masculinity with the knowledge that men who are able to demonstrate physical strength are socially valued in our culture (Saltonstall, 1993; Gerschick & Miller, 1995). Participants with prostate cancer and CHD did not express the same doubts as to the legitimacy, or perceived femininity, of their illness as men with ME (and depression) did. Men who are prevented from engaging in social practices that affirm identity due to “body failure” may receive more sympathy than those whose masculinity is perceived to have failed

(Corbin & Strauss, 1987). Participants with ME had to live with highly visible (“obvious signs”) of illness and disability that undermined cultural notions about men’s bodies, physical strength, and masculinity, without having a medical diagnosis that legitimised this loss of masculinity (Bury, 1982, p172; also see Blaxter, 1976; Gerschick & Miller, 1995).

The accounts given by participants with CHD, ME and prostate cancer would suggest that masculinities are most challenged by illness that are (or have been) visible to others. Studies have shown that men can recover their masculine identities following illness (Gordon, 1995; Moynihan et al, 1998; White & Johnson, 2000; White, 1999). However, it seems crucial that illness leaves no visible traces if a man’s restored identity is to remain unchallenged. The symptoms of CHD can completely vanish without a trace after a few hours (White & Johnson, 2000). White (1999) observed that men with chest pain found it harder to continue to interpret their masculinities as being challenged beyond the crisis period when they were hospitalised because “it is not visible, then you’re fine” (p70). Gordon (1995) has also noted the importance of concealing signs of illness to facilitate the restoration of masculinity: “the physical traces of treatment, such as the loss of a testicle and surgical scars, are not visible when the men are dressed” (p252). However, for participants with ME and prostate cancer, it was more difficult to restore their masculine selves when they (and others) had “concrete daily reminders of their restrictions” (Charmaz, 1983, p181).

Men with prostate cancer can suffer from highly visible symptoms that present particular challenges to their masculinity due to their associations with femininity. As Chapple and Ziebland note: “the effects of treatment for prostate cancer were often visible because men taking hormonal treatments such as Zoladex experienced hot flushes, increased body weight and some developed breasts” (Chapple & Ziebland, 2002a, p837). This may be one of the reasons why men in this study could not conceive of their masculinity ever being restored. As already noted, the physical incapacity that can accompany ME can also prove greatly challenging to masculinity because of the meaning that obvious physical disability has for men in our culture. As Charmaz states:

*Visible disability typically becomes a master status and a master identity. It is a*

*master status because this position overrides and subsumes others; it is a master identity because it defines every other identity.*  
(Charmaz, 1994, p277)

This may mean that men who are 'seen' to be ill cannot enact masculinity or restore their identity as easily as men who are able to conceal their history of illness. This difficulty is evident in the CHD group's descriptions of the challenges they faced when they attempted to restore their masculine identities because their status as 'coronary candidates' (Emslie et al, 2001a) became their master identity.

The key way for participants to make their illness visible (particularly with illnesses that are not easily seen such as ME and depression) was to talk to others about their experiences. There were varying degrees to which it was possible for participants to face up to the social consequences of illness, in terms of disclosing or making visible their experience to others. It has been reported that men who undergo surgical or chemical castration feel stigmatised and believe their masculinity has been compromised by their treatment (Clark et al, 1997). Gray and colleagues also describe how men with prostate cancer avoid disclosure about their illness to evade possible stigmatisation, which can result in feelings of isolation (Gray et al, 2002). However, in this study we found that men with prostate cancer had faced up to this possibility, and although they acknowledged the existence of both felt and enacted stigma they sought proactively to make the illness more visible to others. Whilst this is much more likely in a group of men who actively come together in order to gain support from each other, it does contrast quite markedly with men in the mental health group, and others who reported experiences of depression. They were much more secretive, positively eschewing disclosure to others. The cardiac group sought support from each other (particularly in the area of the social limits imposed by others) but would speak about the issue to others when approached. However, they were not proselytisers, like the prostate cancer group, and did not experience the stigma expected by the ME and mental health groups.

The accounts of men with, or who talked about, depressive illness suggest that some illnesses are denied and concealed to enable men to continue to present unchallenged masculine identities. The need to avoid challenges to masculinity appeared to be so

great for the majority of participants with depression that they remained silent about their experiences even when they knew they were being interviewed with men who had experienced similar difficulties. For the participants in this study the very discussion of emotional distress (particularly with other men) seemed to flout conventional practices of masculinity (see also Brownhill et al. 2002 for similar findings). Participants in this study who suffered from depression believed that if their experience of mental illness was made visible to others it would distinguish them from other men with less 'feminised' (Elgie, 2002) illnesses or injuries as well as making them stand apart from other healthy men who had unchallenged masculinities.

Miller and Bell (1996) have suggested that the masculine practices of concealment of and silence about emotional problems could serve an important function in that "male inarticulateness (about depression) sustains the myth of masculinity" (Miller & Bell, 1996, p319). Bendelow (1993) suggests that such beliefs and practices are deeply rooted in boyhood socialisation when emotional expression is "actively discouraged....and adult males (feel) an obligation to display stoicism" (Bendelow, 1993, p281). One study found that men from a range of age groups felt that they had been socialised to believe that 'boys don't cry' (a phrase that was used repeatedly by participants in this study) and thus avoided expressing their physical and emotional pain and suffering for fear of being ostracised by other men (Brownhill et al, 2002). The findings presented here echo those of others who have described the "sense of isolation, inadequacy and uselessness felt by a man with depression" (Elgie, 2002, p77). The data also underline the importance of understanding the cultural beliefs and practices that men draw on to negotiate their gender identities and how this process is likely to affect discussion of, access to, and diagnosis and treatment of men who may be suffering from depression (Kilmartin, 2005).

A separate issue that many participants touched on (and one that has been considered by other researchers) is that older men may view illness as a 'natural' part of the ageing process and therefore accept the loss of masculinity more readily than younger men (Gray et al, 2002; Cameron & Bernardes, 1998). Charmaz (2000) suggests that conceptualising illness as 'just ageing' is a way of maintaining continuity and coherence of self and enables a man to think of his masculinity as unchallenged (see

also White & Johnson, 2000). It was not clear whether mental illness proved particularly challenging to participants' masculinities (although our findings suggest this was so) as it was predominantly young men who discussed depression and any illness may have made them feel marginalised. We found that some of the older men in this study did feel that they stood out from their peers less because they felt that the loss of certain aspects of masculinity, such as libido and loss of physical strength, were perceived to be a 'natural' part of the ageing process (e.g. Murray, 70, Prostate Cancer Group). The majority of older participants also said that they felt 'lucky' that illness had occurred so close to retirement age, as other men close to their age would soon be prevented from engaging in social practices as they were. Younger men with prostate cancer seemed to reconcile their loss by viewing it as having entered another 'stage in life' where the enactment of masculinity was not as important as it had been when they were much younger (Callum, 52, Prostate Cancer Group). However, it was also Callum, the youngest of the participants in the prostate cancer group, who provided many examples of how he felt ostracised by other men when his illness became public knowledge.

There were other participants who did not conceive of their loss of masculinity as 'natural' and felt 'robbed' of aspects of their masculine selves 'before it's time'. Some men did not accept that they should ever have to relinquish practices (such as work) that affirmed their masculinity just because they were getting older. Indeed there were many examples of men in their late sixties who were keen to reinvent themselves and recover lost aspects of masculinity through social practice, supporting other findings that challenge the assumption that old age is a time of decay and 'natural' decline (Van Dongen, 2001). Our findings would suggest that chronological age was not as important as the life stage participants expected to be at and the degree their particular illness was perceived to disrupt that anticipated trajectory. Two men suffering from the same illness at the same age can clearly perceive the challenge to masculinity differently (e.g. George, 59, and Ben, 60, Prostate Cancer Group). This issue would benefit from further research that explores the contrasting challenges illness presents to men's experience of early, middle, and late age masculinity in greater depth.

Further research might also clarify other issues that this study has raised. It would be

useful to find out whether there might be a distinction between the public persona that men present for the consumption of other men and their private feelings about how illness has affected their masculinity (Charmaz, 1994). Our findings suggest that the two are not mutually exclusive. Participants' feelings of masculinity were clearly affected by their perceptions of how other men viewed them in the light of illness. I question whether it is common for men (healthy or ill) to view their masculinities and masculine behaviours as they imagine others will see them. Foucault's (1995) concept of surveillance might prove helpful in exploring this in future work. However, it was noted that some participants were able to retain at least some aspects of masculinity in the face of considerable challenges to their gender identity. One participant in the prostate cancer group said that he "still (felt) like a man" despite all of the challenges to his masculinity that he had recounted (George, 59, Prostate Cancer Group). It would also be useful to explore some of the ways in which men might be able to restore or preserve masculine identities following illness, despite intense personal, social, and cultural pressures related to societal expectations about masculinity.

## Chapter 6

### **‘It’s caveman stuff, but that is to a certain extent how guys still operate’: men’s accounts of masculinity and help seeking<sup>12</sup>**

#### **6.1. Introduction and literature on masculinity and help seeking**

Over the last decade men’s health has consistently been constructed as being ‘in crisis’ (Coyle & Morgan-Skyes, 1998). One of the main concerns has been whether and why men are reluctant to confront health issues proactively and seek medical help. Elevated suicide rates, particularly among young men, have been connected to men’s ‘unwillingness’ to discuss their emotional distress with peers, relatives, or health professionals, leading some working in the area of suicide prevention to conclude that “women seek help – men die” (Angst & Ernst, 1990, see also Russell et al, 2004). One recent review of men’s help seeking, for both physical and mental health problems, suggests that: “Men are often characterized as unwilling to ask for help when they experience problems in living. Popular stereotypes portray men...avoiding seeking needed help from professionals. A large body of empirical research supports the popular belief that men are reluctant to seek help from health professionals” (Addis & Mahalik, 2003, p5). Such beliefs have come to prevail over other popular constructions of men relating to their help seeking, such as that of the “whingeing male” which portrays men as seeking informal help from female relatives and friends and exaggerating their experience of minor illness (Macintyre, 1993). Men’s “apparent reluctance to consult a doctor” has been identified as “an important obstacle to improving men’s health” (Banks, 2001, p1058). There is concern that fewer visits to the doctor and delays in getting timely advice may decrease men’s chances for prevention, treatment, and survival of disease (Mason & Strauss, 2004a & b).

Empirical data do show that men consult their general practitioners (GPs) less often than women, and gender differences in GP consultation rates are particularly marked in the reproductive years (women in the 15-24 and 25-44 age groups are twice as

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<sup>12</sup> The majority of this chapter has been published (see Appendix G, page 225)

likely to visit a GP compared to men (ISD, 2000)). At least part of this excess is accounted for by consultations for contraception and pregnancy. Beyond this it is often assumed that women have higher rates of morbidity and a greater propensity or willingness to consult than men (especially for 'minor' symptoms) although there is little empirical evidence to support this hypothesis (Macintyre et al, 1996; Wyke, Hunt & Ford, 1998; Hunt et al, 1999; Adamson et al, 2003). Courtenay (2000a) has noted that "the interpretation that men really are ill and they are simply denying it is rarely proposed" (p1395).

Men are often portrayed as being "hapless and helpless" on matters relating to health prevention (Seymour-Smith et al, 2002, p265). Some recent discussions have attributed men's "reluctance" to seek help with certain physical, emotional, and sexual health problems (McKee, 1998, p601) to a 'poorer awareness of health' (Banks, 2001) or an unwillingness to take responsibility for their health (DoH, 1993). Emphasis has also been placed on the "perceived or real barriers that prevent men from accessing the health care system" (Tudiver & Talbot, 1999, p47). Some have explored the 'constricting role expectations' or the 'psychological difficulties' men are thought to bring to the consulting room (Maharaj, 2000, p1005; see also Good & Dell, 1989). It has been suggested that men may be put off by "male unfriendly" general practice surgeries and the "testosterone driven consultation" (Banks, 2001, p1061; Tudiver & Talbot, 1999) and that gender has a strong influence on communication between doctor and patient (Kiss, 2004). Furthermore, men are often portrayed as being reliant on female partners (or other female relatives) in health matters and women are said to encourage awareness of health issues, to assist men in interpreting symptoms, and to play a key role in persuading men to seek help (Umberson, 1992; Norcross et al, 1996; Tudiver & Talbot, 1999; White & Johnson, 2000; Banks, 2001; Seymour-Smith et al, 2002). However, some of this research (e.g. Seymour-Smith et al, 2002; Tudiver & Talbot, 1999; Banks, 2001) is based on doctor's perceptions of male patients and constructions of masculinity as opposed to men's actual experience.

Whilst the presentation of sex-disaggregated data (and explanations for apparent behavioural differences) is an important starting point for research on gender and help seeking, it has the inherent danger of reifying differences between men and women.

It gives the impression that there are “qualities, or indeed deficiencies, intrinsic to maleness or gender role somehow inherent in men” (Mason & Strauss 2004b, p95). Developments in gender theory have highlighted the importance of exploring men’s *masculinities* so as to emphasise that men are not a homogeneous group and that their experiences are likely to differ according to the social position they occupy (see, for example, Kimmel, 1987b; Hearn & Morgan, 1990; Brod & Kaufman, 1994; Connell, 1995; Mac an Ghail, 1995). Men’s views on help seeking and how these relate to men’s beliefs about masculinity are, therefore, unlikely to be uniform. Perhaps the question should not be ‘why are men reluctant to seek help?’, rather, as Addis and Mahalik (2003) phrase it: “why are some men, under some circumstances, able and willing to seek help for some problems but not...others?” (p7). This raises questions about how men of different ages, life stages and social backgrounds (who may differ in their beliefs regarding masculine practices) consider consulting for symptoms of ill-health in relation to masculinity.

Those studies of help seeking behaviours which have been published have tended to concentrate on particular groups of men, predominantly with diseases affecting male organs (testicular or prostate cancer) and coronary heart disease (CHD) which continues to be stereotyped as a ‘male’ disease (Emslie et al, 2001a). It has been suggested that delays in getting timely advice for testicular cancer may be related to men’s beliefs about masculinity (Ganong & Markovitz, 1987; Moynihan et al, 1998; Moore & Topping, 1999) and fears about appearing weak or lacking in masculinity (Chapple et al, 2004a). This reluctance to consult doctors has also been noted in the accounts of men with prostate cancer (Chapple & Ziebland, 2002; George & Fleming, 2004), impotence (Ansong et al, 1998) and severe chest pain (White, 1999; White & Johnson, 2000). Others have proposed that particular practices of masculinity (e.g. the concealment of emotion) make it particularly challenging for men who suffer with mental illness to seek appropriate support (Oliver, et al, 2005; Kilmartin, 2005; Robbins, 2004; Elgie, 2002; Moller-Leimkuhler, 2002; Williams, 2000; Cape & McCulloch, 1999; Heifner, 1997; Miller & Bell, 1996) and difficult for health providers to recognise and treat depression in men (Brownhill et al, 2002). There has also been some interest in exploring the perceived barriers to help seeking among younger men (Davies et al, 2000). Accounts of help-seeking from wider groups of men and how this relates to their sense of masculinity are limited, with a few notable

exceptions (White, 1999; Robertson, 2003a & 2006).

Research by Connell (1995) (also see Carrigan, Connell & Lee, 1987; Connell, 1987; Mac an Ghaill, 1995) has revealed that masculinities may be subject to repeated challenges. There may be a need for men to prove 'what kind of a man' he is through his interactions with peers (Kimmel, 1994). One study, which focused on the ways in which young men's masculinities are policed by their peers, found that the rejection of certain behaviours because they signified that a man was 'soft', 'sissy', or 'effeminate', was a kind of performance or 'display of opposition' through which masculinity was constructed (Nayak & Kehily, 1996; Kehily & Nayak, 1997). It is possible that there are similar displays of opposition (or indeed actual opposition) towards help seeking because of the meaning it holds for men and their masculinities. Although there has been little research conducted which has explored the meanings men attach to help seeking, one recent study suggests that:

*The masculine stereotype does not allow help-seeking even if help is needed and could be available. Already perceiving a need for help would offend traditional role expectations and admitting this need would be a double offence...help seeking implies loss of status, loss of control and autonomy, incompetence, dependence, and damage of identity.*

(Moller-Leimkuhler, 2002, p6).

Courtenay has drawn a direct link between the denial of weakness and rejecting help as key practices through which masculinity is constructed. He argues that:

*The most powerful men among men are those for whom health and safety are irrelevant....By dismissing their health care needs, men are constructing gender. When a man brags, 'I haven't been to a doctor in years', he is simultaneously describing a health practice and situating himself in a masculine arena.*

(Courtenay, 2000a, p1389)

However, it is arguable that only a man who had remained relatively healthy all of his life would be able to construct his help seeking and masculinity in this way. This raises further questions about how men with everyday or unremarkable experiences of masculinity and health might view help seeking and how these compare with men who may have experienced challenges to their health. Connell (1995) contrasted accounts from men whose "masculinity was under pressure" with men who occupied

a more privileged social position (p90). He argues that this comparative approach can yield many insights into the practices of masculinity.

This chapter presents discussions and experiences of help seeking and explores the links participants made with such behaviours to the 'practices' of masculinity. Through analysis of focus group discussions we can compare the perspectives offered by a diverse range of men. The research questions to what extent and in what ways help seeking behaviours are related to constructions of masculinity.

## **6.2. Summary of findings**

Twenty-six of the fifty-five participants discussed having had one or more serious health concerns at some stage in their lives; most groups included at least one such man. Unsurprisingly past experience of ill-health was less common in groups comprising mainly younger men and those who were currently employed, and their descriptions of help seeking were mainly confined to discussion of consulting with 'minor' symptoms. As four groups (M.E, Prostate Cancer, Mental Health, and Cardiac Rehabilitation) had been recruited to focus specifically on the experience of illness and its relationship with masculinity, it is perhaps no surprise that the recognition of symptoms and participants' experiences of help seeking featured so strongly in their discussions. However, it was clear that these issues were also of concern to the majority of participants in other groups even when their identities had remained unchallenged by illness. The majority of participants were able to reflect on their own approach to help seeking in response to questions or others' contributions, whether they described non-attendance, occasionally presenting with 'trivial' complaints, or frequent visits to their doctor for regular treatment.

The findings section of this chapter will focus, first, on the meanings men gave to help seeking and why consulting was commonly perceived as challenging to masculinity. I then explore men's unwillingness to consult their GP's with complaints perceived to be 'minor', as expressed largely by younger men with no major health problems. To follow this, I look at how men who have experienced major heart problems and mental health problems discuss help seeking. I then document a greater willingness to consult in particular groups of men (those with prostate cancer and ME, and men working as fire fighters), or different kinds of

putative health problems (those affecting sexual performance). Lastly, I examine men's willingness to engage in preventative health practices, in which participants described how they might monitor their bodies with a view to detecting problems early and seeking timely advice

#### **6.4. Learning the meaning that help seeking has for men**

All participants believed that help seeking presented great challenges to masculinity. A few were able to reflect on the meaning help seeking had for them and why it is commonly perceived to be a problematic issue for men. These data revealed how cultural resources that were available to men in boyhood and adulthood were highly influential, along with interactions within family and peer groups and educational and work environments, in constructing their ideals regarding 'appropriate' masculine behaviour in relation to help seeking.

A few of the participants described how they had learnt from an early age that there were certain standards of masculinity that they felt they would be expected to adhere to. Help seeking, viewed as synonymous with complaining or crying, was seen as a departure from conventional masculine practices. Liam described the many media through which this ideal had been communicated to him as a boy and a man:

*(By the) peer group, from family...You read stories as a child where boys are supposed to...The guy had a broken leg or something and the idea was that he was a good boy because he didn't cry while his broken leg was being set. ...That kind of story (is) presented to male children. I think (that) carries on into later life.*

**Liam, 44, Mental Health Group.**

Earlier in the interview, Liam described how, as a man, his interactions with peers, work colleagues, and medical staff had reinforced this idea that 'inappropriate' behaviours such as help seeking could challenge masculinity.

*I suspect that there's still an element that you're expected to put up with things and not complain...or at least I think a lot of men feel that they're expected to (do that)... From early on... there's an idea that you shouldn't complain or show that you're unwell or injured or upset...I think that's reinforced as you get older.*

**Liam, 44, Mental Health Group.**

The "stories" that Liam described had left him with the belief that he needed to conceal distress about injury or illness (rather than expose it by asking for help) in

order to appear masculine. Liam was critical of the effect such stories had on men (and in doing so positioned himself away from the ideal masculinity he referred to) as he felt they acted as a strong deterrent to seeking help during times when he had been in urgent need. However, despite his apparent distance from the ideal, Liam still clearly felt pressured by its existence in his social world. He described how he felt compelled to avoid help seeking to avoid challenges to his own masculinity, even though he could see that ‘putting up with things’ in order to appear masculine might jeopardise his own health.

Other participants focused on how family life had played a large part in reinforcing the idea that men should resist help in order to preserve their masculinity. Nathan believed that his father’s reluctance to seek help when ill had shaped his view of how he should behave when he was ill. Nathan concluded that, “he (father)...doesn’t do that, (so) men don’t do that kind of thing” (Nathan, 34, Slimming Group). Both Jerry and Morris had similar experiences to Nathan:

*As a child...I can’t remember my father ever going to the doctor. Your father’s probably your first role figure that you have and you see him persevere so you do the same and that carries on until later life.*

**Jerry, 49, Mental Health Group**

*I think in the past...thinking about my Dad or my Uncle...men always struggled on. They wouldn’t go to the doctor with anything. They’d always say ‘I’m fine’ and go out to work, whereas women tend to say well I’d better say what was wrong with me....Men tend to say no I’ll be fine and soldier on and maybe don’t share with each other in situations. I think it’s a macho thing that.... ‘I’m OK, I don’t have to tell you’.*

**Morris, 52, M.E Group**

As a result of their social experiences these participants believed that men were expected to take the view that help seeking behaviour was only to be contemplated following a period of endurance or ‘struggle’, non-disclosure of true feelings, and display of stoicism in the face of visible injury or effects of illness. With this ideal in mind, it is little wonder that there was a “feeling that you’re letting yourself down if you share (that)..you’re unwell” (Morris, 52, M.E Group).

Participants of all ages reported feeling significant pressures from their peers to be seen to engage in practices of masculinity that their group deemed to be acceptable.

Many expressed a common fear, similar to Liam's, that other men "would feel free very often to make fun of a man who's complained because he's not doing well or because he's injured....or because he's upset about something" (Liam, 43 Mental Health Group). Jerry described his fears that if he was seen to be seeking help for something others in his peer group might consider trivial it would affect his social standing:

*In some situations a man may want to go and see a doctor, he may want to seek help. But your standing within the group could be affected... 'What do you mean you're going to see the doctor about that?'..So he won't do it even though consciously they know that they should go and see someone about it.*

**Jerry, 49, Mental Health Group**

Some participants believed that if they engaged in certain behaviours that were considered to be undesirable for other members of their peer group (such as openly showing distress in front of other men, or admitting the need for help) they would be subjected to a form of humour known colloquially in Glasgow as "slagging".

The function of slagging, as the Fire Fighters describe in the following extract, was to spotlight inappropriate masculine behaviours and invite others in the group to ridicule and sanction the individual being 'slagged':

**Bobby (42):** *It's all about trying to be funny and*

**Stuart (40):** *and nobody makes you a target!....*

**Bobby:** *The male mentality is if you're doing the slagging then you're not being slagged*

**Fire Fighters Group**

Slagging would include terms of abuse such as 'wimp', 'faggot, or 'girl'. Use of such terms served to emphasise that a particular behaviour had resulted in a loss of, or presented a considerable challenge to, the masculinity of the person being 'slagged'. Many participants were understandably keen to avoid behaviours that might subject them to this kind of scrutiny. Colm felt that his behaviour was continually measured against the standard set by others in his social group and if he was seen to 'slip' it would affect his social standing. He stated that: "I feel as though people are watching

me and I've got to do so much you know.....but I feel if I don't I'm letting them down" (Colm, 32, Gas Workers Group). Colm's belief that he had to do 'so much' before he could seek help with his emotional problems, otherwise his peers would view him as a lesser "weaker" man, meant that he delayed getting support and treatment for depression. The power that slagging had in policing men's behaviour was clear from Colm's comments: "once you've admitted to a weakness then you're thinking that people are going to be looking at you laughing. I certainly feel that" (Colm, 32, Gas Worker's Group). This is reminiscent of Nayak and Kehily's (1996) findings, which showed how boys policed the behaviours of other boys through a performance of opposition to 'inappropriate' masculine practices. It is arguable that slagging was used to the same effect. Those doing the slagging could simultaneously display their opposition to inappropriate behaviours believed to challenge masculinity (such as help seeking) and in so doing, construct their own behaviour as aligned with conventional practices. This also had the benefits of allowing them to avoid scrutiny themselves (as "if you're doing the slagging then you're not being slagged").

Participants' accounts revealed that their beliefs about masculinities and the meanings they attributed to help seeking were constructed through social interactions and through the use of cultural resources that were available to them as boys and men. Their accounts are revealing of the ideologies of masculinity that were exalted in their peer groups, families, educational and work environments. It was remarkable, given the diversity of the sample, how similar participants' views were as to what constituted appropriate masculine practice in relation to help seeking. Some of the ways in which masculine practices (in relation to help seeking) were constructed includes: not crying or being seen to complain; to conceal illness, injury or upset; avoiding disclosure; to 'persevere and 'soldier on'; 'real men' ignore their health care needs in order to fulfil masculine duties (e.g. by avoiding taking time off work to go and see the doctor). The data support the notion that an ideal or 'hegemonic' masculinity had a powerful influence on participants' views (and possibly their approach) to help seeking. Participants who demonstrated a greater willingness to consult, or who were critical of the constraints they felt were placed on male behaviour, only did so with reference to their departure from their understanding of a dominant masculinity. Those who presented themselves as unwilling to consult their GPs with 'minor' complaints sought to align themselves more closely to the

masculinity exalted in the social world they occupied.

#### **6.4. Men's unwillingness to consult their GPs with 'minor' complaints**

It was common for participants to state that they would avoid seeking help and tolerate symptoms of illness if they considered them to be 'minor'. Common reasons for this were feeling "daft..wasting the doctor's time with some triviality" and the wish to avoid "making a fuss about nothing" (Liam, 43, Mental Health Group) and preferring to "wait and see if it goes away" (Nathan, 34, Slimming Group). It was clear that many, like Steve, felt the need to trivialise and appear to diminish their experience of painful injury or symptoms of illness that caused distress, because: "(it's) a weakness to say 'oh I've got a wee niggle...it's only a small wee thing'" (Steve, 29, Health Change Group). Many participants felt that appearing to be 'strong and silent' about 'trivial' symptoms was a key practice of masculinity because it reinforced cultural ideals of masculine strength and endurance (Steve, 29, Health Change Group).

This masculine ideal was exalted by younger participants in particular. Younger men emphasised how closely their own behaviour resembled conventional practices of masculinity by stressing the rarity of their visits to their doctor. The few examples of help seeking that are provided by younger participants stress that their symptoms were derived from acceptably masculine pursuits. As one participant said:

*The only time I have (gone) to hospital or seen a doctor..was when I had been punched in the face (and)..I needed stitches...or a relative tells you that you've got to go...even then I've been reluctant to go, it's other people...tells you 'you've got to go and get that seen to''*

**Aidan, 45, Student Group**

Aidan related this to: "the whole idea about what constitutes a man. A real man puts up with pain and doesn't complain" (Aidan, Student Group). He, like others, reinforced his reluctance to consult and (unwillingness to flout the conventional practices of masculinity) by emphasising how he would have to be 'nagged' or told 'you've got to get that seen to' and by stating: "I'm not even registered" (with a GP practice).

Participants in the Health Change Group shared similar beliefs and explained in more detail why they considered the ability to endure pain or illness to be a key practice of masculinity, one that would be seriously undermined by help seeking before it reached a more acceptable 'serious' stage.

**Steve (29):** *You don't like to make a fuss because it's a macho thing just to say you're being the strong silent type... You'll endure it, you can take it. So if there is something wrong you won't talk to anyone about it. You have to be bed-ridden or half dead before you'll go (to the doctor's).*

**Interviewer:** *Why would you leave it until that stage?*

**Steve:** *That's what being a man is*

**Ross (29):** *Aye. You can't really describe it. But most guys are like that.*  
**Health Change Group**

Similarly, a discussion in the Slimming Group revealed similar beliefs that men should appear unwilling to go to the doctor's with a minor injury and endure illness as a mark of masculinity.

**Rory (28):** *I broke my thumb and it took me two days before I went to see a doctor..It was going sceptic, going green and purple and black and I was like I'm not going to bother them.*

**Jake (44):** *I think that's just a male trait*

**Nathan (44):** *Aye it's (puts on very deep voice) 'I am man the hunter'. I think it's that*

**Rory:** *I don't even think it's that...It's just I couldnae go to the doctor's with that*

**Nathan:** *If a woman cut themselves they'd be away to the doctor. A guy'd be like I'll just go and get myself a bit of Sellotape and wrap it up*

**Rory:** *Aye. I put a bit of a tape on it and carried on*

**Nathan:** *That's just a man thing though isn't it*

**Rory:** *Aye that's just a man thing. I'm hard, I'm daft, I'll cut my arm off and just grow another one back.*  
**Slimming Group**

It was important for Rory to emphasise that he constructed his masculinity in opposition to femininity. It was vital that he was seen to minimise his distress about a highly visible injury (it was “green and purple and black”), and endure it without assistance, in order to affirm his masculinity and avoid behaving ‘as a woman would’ and go to the doctor.

Many participants who had not experienced serious illness described how they would be willing to visit their doctor “if it’s something really wrong...like if I had a pain that indicated ‘right, this isnae normal’” (Nathan, 34, Slimming Group). However, there was uncertainty regarding what was considered ‘normal’ and considerable elasticity in what symptoms men understood as being ‘trivial’ and how much ‘should’ be tolerated before seeking help. While some like George were simply describing “normal aches and pains, a sore throat” when they spoke about ‘trivial’ complaints (George, 59, Prostate Cancer Group), there were others who spoke about most things being trivial “unless you’re dying” (Jake, 33, Slimming Group). When another participant was asked “how do you decide what is or is not trivial?” (Ros) the response was “you wait ‘til you take a heart attack” (Nathan, 34, Slimming Group). This suggested that participants might delay or avoid treatment for symptoms they perceived to be minor and that serious symptoms might be trivialised or overlooked. This was also evident in the discussion of the two men in the ME group who spoke about their need to sometimes test the limits of their debilitating illness. Both experienced symptoms that most men might identify as ‘trivial’, with little or no physical signs of pain. One man described how he would “try to push yourself to see how far you can go” (Morris, 52, M.E Group). This suggests that even chronically ill men were not immune from the pressures to test the limits of their masculinity.

Some participants described how they would test the limits of their masculinity by demonstrating their ability to withstand severe symptoms that others would recognise as needing urgent attention. The presence or absence of pain was used initially to indicate that there may be a problem: “you’re always defining what ill health is by being in physical pain” (Steve, 29, Health Change Group). Some believed that it was ‘manly’ to tolerate a high degree of pain and distinguished between “wee twinges” that would not need treatment and ‘real pain’. Ross describes ‘real pain’ as:

*Basically something that will stop you doing something. It's not the case of 'oh, I've got a wee sort of twinge'. You probably won't see a doctor if you've got a wee twinge. It probably won't stop you doing things so you tend not to mention it.*

**Ross, aged 29, Health Change Group**

Paul described how he delayed getting help until his pain was unbearable and could be observed by onlookers.

*I'd basically pulled a muscle in my groin and he (doctor) said just rest it...I waited four days and I called him back and I was in absolute agony. He (said) 'why didn't you say anything?' and I was like..... 'You told me to rest it'. The ambulance had to come..and I had to get lifted down the stairs and taken in...I was in absolute agony...almost in tears before I called him again.*

**Paul, 40, Health Change Group**

In emphasising his ability to tolerate pain that caused observable distress, Paul presents himself as compliant to the groups' shared understanding of how far a man 'should' go before it can be deemed acceptable to ask for help. It seemed that when it came to minor symptoms the majority of participants believed they "should be able to push things further and say 'no, I'm hardly ever ill'" (Ross, 29, Health Change Group) before seeking help. However, this proved to be a burden for those participants who felt pressured to trivialise symptoms of illness and avoid seeking help when they had serious concerns about what their symptoms might indicate.

Some of the older participants had no choice but to think critically about the pressures they felt to adhere to conventional practices of masculinity. Liam said that he would have liked to feel able to consult the doctor as concerns arose. However he described feeling pressured to consult the doctor with something "concrete", with ailments that are "easy to see and to point to" for fear of being seen as a "time waster" (Liam, 43, Mental Health Group). He describes his difficulties with seeking help with 'minor' or *hidden* symptoms and his concern about how this might appear to others if the seriousness of his condition was not visible.

*Like a swollen knee (because) I can say there's something wrong here, because I can see it and so can you. Whereas if you go along because you've got a...pain in your..head or you've got a cough or something it's..a little bit less concrete, a little bit less easy to see and to point to and identify (unfinished)....I think you'd be reluctant to go unless you've got something to point at that says this is something*

*that is definitely wrong. You can touch it, it's there..as plain as the nose on your face. Whereas, if you're going with something that's internal... (unfinished)*

**Liam, 44, Mental Health Group**

He suggests that his wife's input, and her affirmation of the visibility of his problem, was crucial in ensuring that he eventually sought help with a long-standing problem (he would not specify what this was but it eventually led to emergency hospital treatment).

*I think it's interesting that somebody was saying earlier (about) getting your wife to suggest that you go to the doctor...I've heard that before from other men. That they let somebody else take the initiative for them to go..They almost have to get somebody else to confirm that there is something wrong and that it's worth their while to go to the doctor. It's the right thing to do. It's not a time wasting thing to do. It's like somebody else saying 'there, you've got to that point, now you can go to the doctor'..If it's suggested to you that you shouldn't be making an issue of your health, then you almost need somebody else to say to you 'right, you need to make sure of this. There is something wrong. It's a reasonable thing to do to come and have it checked out'.*

**Liam, 44, Mental Health Group**

This suggests that, even among men who appeared to be critical of masculinity, the need to "push it further" remained. However, some participants, like Liam, seemed to be uncertain about how far they had to go before their symptoms would no longer be considered as 'trivial' to the observer and would instead be viewed as 'serious'.

Many men had learnt to reject behaviours that seemed to encourage "too much" concern about their body (viewed by some as synonymous with an interest in other masculine bodies) or focused on the 'unnecessary' monitoring of healthy bodies (Youth Group and Health Change Group). One of the older participants believed that 'too much' awareness of one's body (for men) was threatening to masculinity. As Mike stated, "in our day you were a big sissy (if you were concerned about your body)...men are beginning to get more...like females than males" (Mike, aged 68, Unemployed and Retired Men's Group). Therefore knowledge about, and vigilance of, the body was viewed by some as key practices of *femininity*, behaviours many men felt they were required to distance themselves from in order to construct oppositional masculine identities.

### **6.5. The shift from minimising 'in extremis' to a more immediate response: emergency treatment for heart problems.**

Nine participants had required emergency treatment with chest pain, heart attacks, angina, or had needed bypass surgery. All of these participants described having had very little contact with their doctor prior to the emergence of a heart problem, because of their unwillingness to seek help with 'minor' problems and the belief that "it'll go away tomorrow" (Bernard, 67, Cardiac Group). One participant described the difficulty he had believing that his symptoms, which he perceived to be 'mild', could have proved to be fatal if left untreated.

*There were people there getting urgent attention and they had revival kits and everything and I was thinking 'what the hell am I doing here?'*

**Alf, 72, Cardiac Group**

He described the perception he had of his symptoms prior to diagnosis:

*I broke out in a sweat and my cure for anything like that is go to your bed. Then I found I was up through the night drinking milk..I thought it was indigestion..So my wife was up and down Friday night so she says 'you've got to go to the doctor'. So I was hoping that I'd go in on the Saturday morning and...he's say 'aye, everything's alright'...The next thing I was whipped up the (hospital) and they reckon there'd been a heart condition. I spent four days there. I never had any of the symptoms that you hear people normally associating with heart attacks, no strange pains. So I found the biggest problem was accepting the fact that I had a heart attack to be quite honest...the symptoms I had I thought I had terrific flu.*

**Alf, 72, Cardiac Group**

There were other participants, like Alf, who found it hard to accept that their symptoms were dramatic enough to warrant medical attention. Some participants talked of the role their wife played in encouraging them to seek help with such symptoms that they would have otherwise have dismissed as 'minor'. Danny described how he had decided to leave the hospital because the pain he had experienced, prior to the arrival of the ambulance, had stopped:

*I couldn't believe it was a heart attack...They sent an ambulance and they gave me oxygen. By the time I got to the infirmary I had no pain, so I just jumped off the trolley and said 'sorry it must be muscular tension' and made my way to the door....(A) doctor said 'Mr A get in that bed!'*

**Danny, 71, Cardiac Group**

Another participant recalled having concerns about wasting his doctor's time with 'trivial' symptoms (chest pain) which he imagined would turn out to "be nothing but I'll go (to the doctor's) anyhow". He described his shock at the discovery that he was in need of a quadruple bypass because "up until that time I felt that I was wasting their time" (Barry, 62, Individual interview following Unemployed and Retired Men's Group). It seemed that even when men had a clear medical emergency there was still a tendency for men to view their symptoms as trivial and feel that they were making a fuss over nothing or being 'daft'.

Some found it impossible to shake off strong feelings that their masculinity would be challenged if they were to show that they had been bothered by 'a bit of pain' (and to seek help was perceived to 'show' that you had been bothered). Mike believed that his ability to tolerate pain without immediately seeking help was a mark of his masculinity. Following his heart attack, he no longer felt he could resist seeking help when he experienced chest pain because he knew it was likely to be serious and could not be dismissed as 'trivial'. However, this need bothered him.

*A man is not likely to go to the doctor as readily as a woman is. You might get a pain and say well I'll not bother going to a doctor. That's what a man is more inclined to do. He'll not say until it's really bad 'look, I've got a pain. There's something wrong here'. ....Now if we feel a bit of pain there we'll go and see a doctor but before...we just accepted the thing.*

**Mike, 68, Unemployed and Retired Men's Group**

Some participants described how they felt 'watched' by others following the diagnosis of their heart problem. The youngest participant who had experienced heart problems found this particularly challenging to his masculinity. He described how he 'rebelled' against the advice he was given following his admission to hospital with chest pain.

*When I had the chest pains I should have really done it then. ...The more people...spoke to me about it the more I basically didn't want to do anything....people said well you've got to watch what you're doing now and I've never been one to go on advice that other people give me.*

**Colm, aged 42, Gas Workers Group**

Similarly, the Cardiac Group described how help from well intentioned relatives and

neighbours was regarded as challenging to their masculinities:

**Bernard:** *All of a sudden you've got folks saying to you 'watch what you're doing'*

**Jack:** *I think men are kind of macho, they don't like to be helped. It took my confidence away.....*

**Bernard:** *The lass across the road from me she's up in accident and emergency, she's a nurse, and she's constantly yelling at me for doing this and that you know.*

**Cardiac Group: Bernard, aged 67, and Jack aged 64**

However, the majority acknowledged that their health crisis was a sign that certain practices of masculinity might have to be adapted to prevent the recurrence of life-threatening symptoms. They seemed more willing to accept that seeking help at the first sign of a problem, a practice they previously would have rejected, was now crucial following their 'scare'.

**Jack :** *I don't hesitate to go*

**Bernard:** *If you're unwell go to your GP straight away*

**Jack:** *After I took the heart attack I would agree with that. Prior to that I would have said I'll work it off*

**Ros:** *What do you mean by 'work it off'?*

**Jack:** *Well...like I said when I was taking aspirin I knew there was something brewing in my tummy. Normally I would have just said 'ah, I'll let it go', but I was along there like a flash. Normally when I went to the doctors he'd say 'you should have been here a fortnight ago'.....That's the macho male coming out. You can take it.*

**Jack, aged 64; Bernard, aged 67, Cardiac Group**

One participant described how he became very conscientious about safeguarding his health following his diagnosis: "I go and see a doctor, a consultant every three months. I have to pay for that, but it sets my mind at ease....he gives me a check-up right through" (Danny, aged 71, Cardiac Group). Similarly, another reflected on his views on help seeking prior to his heart attack and contrasted that with the approach he said he would take in future:

*Before I'd say alright I'll just go on and not see anyone. As a matter of fact the*

*doctor I had when I went to see him I wasn't on his books.... You didn't tend to go to the doctors you know, well I didn't... It was only when I got the pains in my heart that made me go to the doctor.. I wouldn't hesitate now if I had to go to the doctor's if I felt anything was wrong*

**Barry, aged 62, Individual Interview**

Barry described how he “never felt ill enough” to seek help prior to his diagnosis with angina and his subsequent bypass operation. As he said “the only times I went to the doctor I used to be kind of apologetic. ‘I hate to be using up your time doctor’ (laughs). That would be for small things” (Barry, aged 62, Govan Men’s Group).

Thus, most men who had survived some form of heart disease changed their perspective on consulting to some degree and were apparently prepared to consult more readily. However, it may be that their earlier response to symptoms may derive at least in part from their belief that in order to be masculine men ‘should’ tolerate ‘a bit of pain’ without medical intervention. This may be in part related to participants’ perceptions that the symptoms of heart disease (predominantly pain) were ‘macho’. This raises questions about how experience of less ‘macho’ illnesses, such as depression, may affect views on consulting.

#### **6.6. Consulting the GP with Depression**

The subject of help seeking for depression was raised frequently, and often spontaneously, by participants and seemed to be an area that presented men with considerable challenges to their masculinity. This subject was discussed more freely in the Gas Workers Group and the Mental Health Group where the majority of participants shared common experiences. However, it was often very difficult to penetrate the machismo that this subject precipitated in other groups, where maybe only one participant had experienced such problems, and explore how men might go about getting help if they experienced depression. The main problem was in establishing who had suffered from depression, as men would merely suggest that they might have experienced emotional difficulties or “stress” in the past, but were unwilling to elaborate, or to define their problem as ‘depression’ (at least in the context of the focus group).

Some of the interactions within the younger peer groups around this subject were

particularly illuminating with regard to particular challenges participants might have with help seeking for depression. The Youth, Health Change and Asian Men's Groups all seemed to share especially rigid views regarding how men are expected to behave when experiencing emotional problems. One participant described how he and others in his peer group believed that non-disclosure of emotions and self-sufficiency were key practices of masculinity:

*The more masculine man is defined by a man who doesn't share stuff with other people. He can sort it out himself. He's totally in control. He doesn't need anyone else.*

**Rajiv, aged 21, Asian Men's Group**

Another participant felt that this was the reason "males don't tend to talk about what's bothering them or why they're depressed because they're all man-like (smirking, others in the group laugh). It's true though, they tend to keep quiet about it" (Sam, aged 21, Asian Men's Group). There was some recognition, indicated by the laughter about the generalised descriptions of how 'males', rather than how they behaved, that they were presenting a stereotypical idea of the way in which masculinity and help seeking might be related. However, despite the laughter, the group agreed that there was some 'truth' in the version the group presented. Indeed a participant in another group spoke of his experience of depression and explained why he felt that seeking help was not an acceptable practice for men:

*The very idea of going to the doctor if I feel, you know from personal experience, if I feel in any way down or in a depressed mood...If I was a woman I'd probably go to the doctor and get some...anti-depressants....But as a man you just pull your socks up.*

**Aidan, aged 45, Student Group**

However, references to personal experiences of depression were rare regardless of whether the group was specially convened (comprising of strangers) or included naturally occurring groups (of friends or work colleagues). In many of the groups where depression was raised for discussion, there was a strong resistance to exploring issues relating to depression on a personal level, even when there was suggestion that one or more members of the group (who knew of each other's histories) had experienced this problem. This is evident from the hostility shown in the Youth Group when Martin revealed his brother (Rick, also a participant) had attempted

suicide:

**Martin:** *Tell her about the powder (he was referring to an overdose of kettermine)*

**Rick:** *Am I fuck! (Shouting very loudly and getting up threatening to leave)*  
**Youth Group: Martin, aged 25; Rick, aged 19**

There were four other participants present who were part of Rick's peer group and it may be that he felt his masculinity would be scrutinised if he was 'made' to admit his emotional distress and need for emergency treatment in this setting. This kind of resistance was also evident from the interaction between the participants of another group. One participant began this discussion by admitting that there had been times he had experienced emotional distress and states that: "I should have talked to someone...(but) You've just sort of worked your way through it". (Ross, aged 29, Choice Group). However, others in his group (who were also his peer group) remind him that there are certain constraints on masculine behaviour:

**Ross:** *There's just something in our make-up that you just don't talk to other guys about it*

**Tony:** *Aye well if it's total lads they're going to rip the pish out of you for it anyway*

**Paul:** *Don't you forget it (mock threatening tone)*

*Group laughter*

**Choice Group: Ross, and Tony, aged 29; Paul, aged 40**

Although this can be viewed as simply a humorous exchange between friends, there is also a reminder that Paul is a 'total lad' and that he is willing to 'rip the pish'<sup>13</sup> out of other group members who depart from his model of masculinity. His 'reminder' prevents anyone else in the group reinforcing Ross' view without jeopardising their masculinity. Paul effectively curtails the discussion of the reasons why men do not seek help for depression, moving the topic away from personal experiences of depression (which Paul hinted had been a personal difficulty) and any critique of the practices of masculinity that Ross may have been trying to instigate.

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<sup>13</sup> Laugh at: make fun of

Those who did feel able to discuss their problems in greater detail often couched their experience in more acceptably masculine terms. Some preferred to refer to their depression as 'stress'. Phil said that he felt more comfortable describing it in this way "we don't call it depression we just call it stress" (Phil, aged 41, Carer's Group). It seemed that for some, "stress is seen as a mental thing", although a man's 'inability' to cope alone with 'stress' was perceived to be a weakness (and therefore a direct challenge to masculinity) by some.

This is exemplified by Colm who described the symptoms of severe depression (which he interpreted as work-related 'stress') and referred to a past suicide attempt. In the following extract he describes his depression and how he feels that as a man he should be able to cope better with 'stress':

**Colm:** *It's absolutely terrible. I mean I go in and the door's shut behind me and I just felt that I never wanted to do anything. I didn't want to see any of my friends. I felt isolated from my friends as well as my family.*

**Ros:** *That's how you feel at the moment?*

**Colm:** *Ongoing for about eighteen months. It's just the whole stress environment...I think some men see it as a weakness and some of us, well, I certainly don't want to be seen to have any weaknesses. Not to myself and not to anyone else. I think that's the perception..... 'What's he going to the doctor's about and complaining about a minor thing' and stress is just a weakness*

**Colm, 42, Gas Workers Group**

When he did eventually seek help and was given antidepressants he stopped taking them after a short period because he felt that as a man he should be able to 'put up with the stress':

*She (doctor) gave me tablets and they didn't really work...I said oh bugger it I'll just put up with the stress...I thought I'd just wait a month or two months more or less until I'm back to normal.....*

**Colm, 42, Gas Workers Group**

Colm seemed to be particularly concerned about other men's talk about his problem. He believed that other men had the power to define and police his masculinity and feared being exposed as 'weak'. As the discussion continued he seemed to acknowledge that he had experienced genuine distress and no longer refers to seeing

himself as unable to cope with 'stress' or as 'weak'. However, the perception of how 'stress' was viewed by other men remained the dominant concern.

**Ros:** *So would what you describe as a minor thing?*

**Colm:** *Well I've never sought any help for anything I went through in the last eighteen months. Although I've been told that I should have and that I should have gone and spoken to somebody and spoken to them to get it all out and I never have....I tend to...speak to my Mum...I tend to do that when I'm out drinking at two o'clock in the morning and my Mum's in bed..and I'm on the mobile phone crying as I'm walking along the road because it gets too much for me....I think it's because stress is seen as a mental thing...It's a real macho thing, they (men) will not admit to it....It's not always easy. It's not always easy.*

**Gas Workers Group**

It would seem that there is not only the need for men to test the limits of their masculinity by enduring physical pain (as was observed earlier) but some men felt similar pressures to practice masculinity through demonstrating their ability to cope uncomplainingly, that is to say in a 'macho' way, with emotional difficulties.

However, a minority described seeking help with depression in spite of the perceived consequences for their masculinity. Ted sought help following bereavement and described himself as "proactive" about his depression and seemed very positive about his experience of receiving help.

*I went last year to the doctor actually. It got so bad I actually asked for help, for tablets. Had a long conversation ten, fifteen minutes talking it through and I found that very useful. I met with a counsellor weekly for oh it must have been four or five months...I don't think I would have got through it without it...So I am very proactive if I've got something wrong with me. ...It worked for me and I think it's important but other people are different.*

**Ted, aged 46, Gas Workers Group**

However, there was some suggestion that he had suffered for an acceptably long period before seeking help (which has parallels earlier discussions of tolerating physical pain and "pushing things further" before seeking help). It could be that coming to terms with a death has little to do with measuring masculinity or the associated ability to withstand stress, or that bereavement is accepted as a more 'legitimate' reason for experiencing depression. Another participant sought help for

depression which he felt was related to the burden of caring for his chronically ill wife. He explains that concerns about his masculinity played some part in delaying getting help immediately (he suffered for a number of years before seeing his doctor).

As he said,

*It takes you a long time to understand, just to think about your emotions....Maybe it's because we bottle it up. We don't frequent the doctors when we do feel unwell..It's sort of the macho thing isn't it?..I suppose you find it difficult asking for help really"*

**Phil, aged 41, Carers Group.**

Another participant gave similar reasons for his reluctance to seek help:

*I was involved in talking and lecturing on mental health for twenty years but when the ball was on the other foot and I started to go down the sort of mental health area I didn't want to (pause). I knew it as there, but I didn't want to accept it. I didn't want to admit it....It would take my wife to turn around and say 'Jerry, GO, and see a doctor'.*

**Jerry, aged 49, Mental Health Group**

Both Phil and Jerry felt they had a responsibility to their wives (particularly Phil as his wife's carer) to seek appropriate help and this was a strong motivation to put aside what seeking help might mean for their masculinity. However, the crucial thing in understanding why all three men (Ted, Phil and Jerry) did not appear to find help seeking as challenging to their identity as other participants, is how their long standing depressive illness made them feel as men. In all cases they described feelings of isolation and 'otherness'; a feeling of being apart both from other men and from the man they used to be. It may be that their experience of illness meant that they no longer felt part of the masculine culture where they felt they had to measure their behaviour against masculine ideals.

It seemed that, with regard to the discussion of depression at least, the focus group situation largely encouraged a rehearsal of conventional practices of masculinity, which interfered with the opportunity men had to share their personal experiences of depressive illness with one another. However, the interactions this encouraged proved to be illuminating in relation to men's attitudes to masculinity and its relationship to help seeking.

### **6.7. Exceptions to the norm: accounts of greater willingness to consult**

Not all participants reported a reluctance to consult or felt able to engage in conventional practices of masculinity uncritically. Participants with prostate cancer showed a much greater willingness to seek help than the majority of men discussed thus far. These men were very proactive in seeking help when they felt something was wrong and in getting appropriate support and treatment once diagnosed. Most of those participants had experienced a less dramatic onset of symptoms than those reported by the Cardiac Group. One of the participants sought help when he noticed a drop in urine pressure. Another man described how his diagnosis emerged as a result of an initial consultation for flu. Ben described how he had made frequent visits to the doctor over a two year period with “back pain and all sorts of things” but it was only when he stopped urinating that the problem was detected and he was told “you’ve got advanced cancer” (Ben, 60, Prostate Cancer Group). Callum described how he consulted his GP after he experienced severe pain in his groin (“lying on the floor stuff”). Although he was unsure about how to interpret his symptoms and was unaware of the symptoms of prostate cancer, he said it did occur to him that he might have something like testicular cancer, which he says “was in the back of my head what was wrong with me” (Callum, 52, Prostate Cancer Group). He partly blamed his slowness to seek help on his own lack of knowledge, as a man, about the workings of his body. Others in the group agreed about their previous lack of knowledge about their bodies.

**Callum (52):** *I didn't know the prostate existed until the doctor said*

**George (59):** *I knew roughly it was down there..but I couldn't have drawn you a diagram*

**Callum** *I didn't even know its function*

**Murray (70):** *Exactly*

**Ben (60):** *I didn't know it would apply to me*

**Callum:** *Because it didn't apply to me*  
**Prostate Cancer Group**

They discussed how a ‘feminine’ culture encouraged men to scrutinise their own and

other female bodies and felt that women were more adept at recognising subtle signs of change in their bodies as a consequence:

*Women have their period and I think since early days their mothers say 'this is why (you) do this'...men don't have monthly cycles so you don't get cramps or flushes that women experience throughout their life and that is why they're more prone to checking themselves and reading more about it"*

**Callum, 52, Prostate Cancer Group**

Callum believed that men were actively dissuaded from taking too much of an interest in their bodies for fear of appearing feminine to their peers and that his socialisation into manhood did not require the same kind of vigilance about his body. However, the recommended practice of 'watchful waiting' for prostate cancer (which means that the cancer is not treated aggressively and is just simply monitored by PSA testing and self-monitoring to detect any worsening of symptoms), encouraged participants to monitor changes in their body more closely.

The prostate cancer group had experienced so many challenges to their masculinity over (in some cases) years of illness. Participants gave the impression that they had become used to medical intervention and no longer considered it to be the challenge they had regarded it to be prior to the onset of illness, although they were keen to stress that they had never shown interest in their bodies or in seeking help, in line with the masculine ideal, until they were forced to. One participant spoke of how he had become so used to invasive medical procedures that he no longer perceived help seeking threatening: "they've stuck tubes up your penis, hands up your backside. In many ways you go through degrading things. You've just got to do it" (Ben, aged 60, Prostate Cancer Group). One participant spoke of his dominant concern which presided over any fears he may have had about the loss of masculinity: "I just wanted to know if I was going to live" (Murray, aged 70, Prostate Cancer). There was awareness, however, that many men who did not have a 'life or death' dilemma might avoid seeking help if they felt they would be subject to such invasive examinations because of the threat this posed to their masculinity:

*If they feel that they're too macho they will not come forward...or will not admit that they think they have prostate cancer – something which would affect their sex life. I think there's a danger in that. It's maybe inhibiting some men from coming*

*forward. Men who think they've got it but they're not going to do anything about it.*  
**Murray, aged 70, Prostate Cancer Group.**

As the experience of prostate cancer had presented many challenges to participants' identities as men, they seemed particularly well placed to critically examine the pressures and constraints of masculinity.

The threat of testicular cancer also had resonance with many participants concerned about potential challenges to their masculinity, although only one participant, Angus, had actually discovered a lump in his testicle. He described how in other circumstances he would not ordinarily go to the doctor's: "I only went the last time to basically register at my new doctor's...If I felt ill and everything I just don't bother really". However, when he observed changes in the size of one of his testicles it prompted immediate action:

*I found a lump in my nether regions... Obviously it didn't develop overnight because there was such a big lump.....I went and I made an appointment that day ...The next night I ended up in the (name of hospital) having an operation...*

**Angus, 41, Gas Worker's Group**

Angus did not seem to dwell on the challenge, if any, which help seeking on this occasion, might have created for him. Rather, he described how concerned he was about his health and how important it was for him to seek advice with the view to getting the problem treated immediately. This motivated him in persisting in visiting his doctor a number of times over a period of days until he was offered an emergency referral, instead of having to "wait seven weeks" with a suspicious lump in his testicles.

Participants in other groups also seemed less reluctant to consult when they experienced symptoms that they thought might hinder their sexual performance. As Steve said "if you have a problem that gets in the way of sex. You get it sorted pretty quick" (Steve, 29, Health Change Group). Similar views were expressed in the Youth Group by participants who were otherwise hostile to the idea of getting help with physical and emotional problems. Although a few in the Health Change Group admitted "it might be embarrassing" (Paul, 29, Choice Group), they were agreed with Tony that it would be "the first thing a guy would go for, probably top of the list"

(Tony, 29, Choice Group). Ross added: “Aye. You don’t wait. It’s not a case of no, no, I feel OK. It’s like I can’t have sex! Neeeeeeow!” (sound to indicate that he would speed to the doctor) [Ross, 30, Choice Group]

A further scenario, in which men apparently were able to make exceptions to the rule and discard their deep-rooted reluctance to seek help, was provided by the two men with ME. It seemed that both participants had a lot invested in seeking help to enable them to obtain medical confirmation that their ‘invisible’ symptoms were genuine and that they had legitimate grounds for rejecting conventional practices of masculinity. Both experienced their illness as challenging to their masculine identities. Donald felt that the reason it took so long to get to the root of his problem was that, “the series of GPs I’ve had have never been very interested in the feelings side of things...You had to have something *wrong*” (his verbal emphasis). Morris found it particularly difficult to cope with the idea that others would doubt that he had genuine reasons to ‘shirk’ his masculine responsibilities as breadwinner. As he explained:

*I thought I really must be mentally ill, (that) I really can't have all these symptoms and I can't feel this way...You start doubting...even my own feelings, how I felt. 'Maybe I am a charlatan. Maybe I should have done this. Maybe I should be able to work'....If someone does believe that you have it, then it...makes a difference.*

**Morris, aged 52, M.E Group**

Even though Morris describes times when he had delayed seeking help and went against advice to ‘push it further’ in line with conventional practices of masculinity, help seeking was crucial to affirm he had a legitimate illness and reasons to relinquish certain practices of masculinity.

Perhaps the most strikingly different view (and one that was not connected with significant prior health problems) was articulated by men in the fire-fighters group. The fire fighters recognised men’s reluctance to seek help as relating a kind of masculinity they described as the “old school mentality”: “the old school (being) – a man’s man.... ‘I’ve a wee pain in my heart today but I’ll be alright, nae bother” (Stuart, aged 30, Fire fighters). One participant viewed men who trivialised symptoms and diminished their need for help as “naïve. I wouldn’t say that’s masculine” (Stuart, aged 30, Fire Fighters Group). Another man stated that: “men are

getting more aware of their health with the media....if we feel a little bit of pain we'll go and see a doctor....but before....we just accepted it...you'd hope these things go away" (Bobby, aged 42, Fire fighters Group). However, the group acknowledged that there were men who would still be reluctant to seek help even though they as a group regarded such resistance as a "joke": "it still happens unfortunately...I know it's completely moronic, I mean, it's caveman stuff, but that is to a certain extent how guys still operate" (Denny, aged 26, Fire fighters). The "old school mentality" did not fit with the group's view of masculinity, as their gender identity rested on having a fit masculine body to enable them to perform effectively at work. All members of the group believed that seeking help immediately at the first sign of symptoms and even asking for preventative health checks were key to ensuring that their ability to work effectively was not jeopardised. As Bobby stated "if I thought anything was wrong with me, say if I got ill next week, I'm straight down the doctor...I've got no problem" (Bobby, aged 41, Fire fighters group). Thus, contrary to the challenge that help seeking presented to other men, consulting was a way for the fire-fighters to preserve, not threaten, their masculinity. The fire fighters were unique in having a supportive peer group who shared an interest in health matters and were similarly motivated to preserve their work identity. As Andy describes: "if you're in a watch, a station, my philosophy is if there is something wrong you'd tell the men" (Andy, aged 29, Fire fighters Group). This was in stark contrast to the majority of groups who believed the subject of health and illness was "not men's talk" (George, aged 59, Prostate Cancer). This supportive climate was an environment in which the fire-fighters felt safe to critique the constraints of the "old school mentality", even laugh it, as they appeared able to reject it without consequence for their masculinity.

#### **6.8. Willingness to engage in preventative health practices: monitoring the body with a view to detecting problems early and seeking timely advice**

There were incidences when men who had never experienced health problems (and had described being otherwise reluctant to seek help) described engaging in, or exhibited a willingness to engage in, preventative health practices (such as self-examination or health checks) with a view to 'catch it early' and seek timely advice. Testicular cancer was raised as a particular concern by many participants of all ages and there were references to public health campaigns which had left many with the feeling that this was an area of their health which they as men 'should' be concerned

about. Many worried that they lacked basic knowledge e.g. about the ‘warning signs’ and how to perform a self-examination (leaflets on self-examination were offered to at the end of the discussion if such concerns had been expressed during the focus group and the vast majority of participants accepted them). One participant, who was highly motivated in seeking help with any health problems, expressed his concerns about the lack of support he felt was available to even the most proactive men:

*I still don't think it's put about well, how to check yourself...I've honestly never seen anything ever on how to check yourself. Whereas I think with females, maybe I'm wrong, but I think females go to the doctor for a check up or whatever and does the doctor not say 'well we've got to check for that'. I don't go to the doctor very often, but I broke my finger a couple of years ago and I was attending quite a lot...and they never said 'by the way' once. 'Do you know how to do this, do you know how to check?' ...I'm quite ignorant about it to be honest – what's the correct method and what I should be doing.*

**Stuart, aged 40, Fire fighters group**

Another man expressed his dissatisfaction regarding the differences he perceived in information and support provided to men and women about risks of gender-specific cancers:

*I don't think there's a large recognition of men's health in the same sense as for women's...I know more about what women have to do as regards to say cervical smear tests, what they have to do to get one, how often it's got to be and what is entailed. If I needed, well I don't know (laughs). What do you do? What? Downstairs, you know...What's prostate cancer? I haven't got a clue.*

**Aidan, aged 45, Student Group**

Some stated that they already engaged in a regular routine of testicular examination (e.g. Callum, 52, Prostate Cancer Group; several members of the Fire-fighters Group and Unemployed and Retired Men's Group). Those who had already faced challenges to their gender identity through illness were perhaps more inclined to examine themselves routinely (or at least more inclined to discuss this practice in the context of the group interview), even if they were not in a particularly high risk category. One participant, who had previously suffered a heart attack, discussed how a campaign he had seen about testicular cancer, advising men to check themselves in the shower, had encouraged him to do something he would have rejected prior to his illness:

*I was thinking...about the campaign they had about the testicular cancer – to feel your testicles when you're in the shower and that, to feel any lumps. I would have never have done that, but I do now...I think see 'I'd better have a wee feel down here and see if everything's OK'.*

**Barry, 62, Unemployed and Retired Men's Group**

Another participant described his vigilance for signs of further illness following his experience of angina and prostate cancer: "I saw a programme on television about (testicular) cancer...so for a while every time I came out of the shower I would sit and look in the mirror" (Callum, 52, Prostate Cancer Group). Other men indicated that it was important to them to engage in such practices in private, even if publicly they felt that this would be perceived as challenging to masculinity. As one man stated:

*You wouldn't talk about it to a fellow work mate in the toilet but you know, I check. Yes, I check. .... You're stupid if you don't.... It's like women checking themselves for lumps you know. You just have to do it.*

**Ted, 46, Gas Worker's Group**

Even though the fire-fighters group worked in a supportive environment in terms of enabling them to discuss health practices openly, one participant felt that the discussion of testicular cancer was perceived to be "still quite taboo.....you will get guys that will never talk about this, it's as simple as that" (Stuart, 30, Fire Fighters). However, this did not deter him from engaging in practices he felt were important to safeguard his health. Although, some felt that it would "start to become a subject that people talk about" if more was done to convey that it was 'acceptable' for men to care about their health (Ben, 60, Prostate Cancer Group), there was still obvious discomfort for some who touched on the subject:

*Note: Group are shown card with the statement 'Health taboo puts male lives at risk'*

**Vikram (21):** *Well, being in the medical kind of profession (dentists) I don't really think that affects us. But generally I suppose (pause). But amongst us, not really. We can pretty much talk about anything. Nothing really would be embarrassing (long pause). Obviously some things (laughs) are going to be embarrassing (laughs) I guess like fertility problems.*

**Ros:** *Yes I was wondering about that*

*(Note: Long silence followed by nervous laughter. Clear from body)*

*language they are not willing to pursue the subject, they appeared uncomfortable)*

### **Asian Men's Group**

However, the fact that many were engaging in health prevention practices that they recognised would be difficult for many men to talk about, does raise questions about what men are willing to admit to doing for their health and what they may do in private. There were a number of participants, whether they had experienced illness or not, who clearly cared greatly about their health and were highly motivated to engage in preventative practices to safeguard their health and ward off potentially emasculating illnesses. However, these accounts suggest that participants believed that masculine culture still had to change before the majority of them would feel comfortable discussing openly how they care for and examine their bodies.

### **6.9. Discussion and conclusion**

The literature on masculinity generally finds that there is a dominant form of masculinity, or “hegemonic masculinity” as Connell (1995) refers to it, that influences men’s understandings of what practices of masculinity men need to engage in order to be perceived as ‘acceptably’ masculine. This masculine ideal is associated with “heterosexuality, toughness, power and authority, competitiveness and the subordination of gay men” (Frosh et al, 2002, p76). The meanings participants in this study attached to help seeking echo findings reported elsewhere that suggests that men associate help seeking with: a loss of masculine status; loss of control and autonomy; incompetence or the appearance of being unable to cope; and ultimately, damage to masculine identity (Moller-Leimkuhler, 2002). Participants’ accounts showed remarkable similarities in their descriptions of ‘what men should be like’ with regard to help seeking, which included the following ‘rules’: a man should not cry or complain; he puts up with things, “struggles on”, “perseveres”; he conceals illness, injury and upset; he does not share feelings; in resisting the need for help he shows strength (asking for help reveals “weakness”). In their discussions men emphasised the importance of: stoicism; having endured symptoms to some acceptable threshold; having physical and visible symptoms; and the influence of others (particularly spouses) in their decisions about help seeking. Many participants were eager to embrace a dominant culture of men’s slowness and reluctance to consult (like the ‘reluctant patient’ described by Goode et al. 2004) and to emphasise

their lack of health service use, and were conscious that help seeking for minor symptoms might put their masculinity up for scrutiny. This mirrors findings from other research, both in men with particular health problems (e.g. Chapple & Ziebland, 2002; Moller-Leimkuhler, 2002; White, 1999; White & Johnson, 2000) and those without (Davies et al, 2000; Richardson & Rabiee, 2001; Robertson, 2003a). The data presented here is testimony to the existence of hegemonic masculinity and its power to influence men's views on help seeking.

This influence was particularly evident amongst the younger participants who presented their behaviour as being aligned to an ideal model of masculinity, which appeared to be constructed in opposition to 'what women would do' and in relation to 'subordinate' masculinities ('what lesser men than themselves would do') (Connell, 1995). These participants were particularly keen to support the idea that men needed to be seen to endure pain and to be "strong and silent" about 'trivial' symptoms, especially about mental health or emotional problems. They appeared to have a lot invested in concurring with their peers' views about what it was to be a man and it was rare, in the context of an all-male group discussion at least, for these men to critically examine these views and reflect on how they interfered with help seeking, unless this met with their group's collective representation of masculine identity. Indeed there was strong suggestion that any departure from conventional practices of masculinity might be penalised by others in their peer group through 'slagging'.

Participants' descriptions of 'slagging' are similar to men's accounts reported elsewhere that have shown how young men's masculinities are policed through humour of this kind (Nayak & Kehily, 1997). This also supports others who have suggested how conformity to a group norm can affect men's help seeking behaviour and how men might be dissuaded from seeking help if they believe they will be stigmatised for doing so (Addis & Mahalik, 2003; Mansfield et al, 2003). Given that much of the "rich vocabulary of abuse (such as) wimp....turkey, sissy (and) lily liver..." that is used to mark out 'subordinated' masculinities (Connell, 1995, p79) can be closely and directly applied to men's inability to tolerate, withstand or overcome physical pain, discomfort or disability, it perhaps no surprise that it was so important to participants to be seen to be rejecting too ready a recourse to medical help or advice. Other researchers have suggested that the transition from adolescence

(when boys may be encouraged to have more frequent visits to their doctor through school or by their parents) to young adulthood may be crucial in deciding the kind of contact men will have with health services in later life (Marcell et al, 2001). This research suggests that the kind of masculinity valorised by young men's peers is highly influential in deciding whether they opt to distance themselves from available help or embrace it when they are in need.

By contrast, men who had experienced serious illness had been forced to question the constraints of conventional practices of masculinity. In the majority of cases, the desire to stay alive took precedence over the need to be seen to be engaged with 'acceptably' masculine practices. Other participants, although recognising the dominant or hegemonic script for the practice and performance of masculinity, had chosen to reject it in their own experience (e.g. fire-fighters). The majority of these men only made these departures from the ideal, whether this was by choice or by force, with reference to the conventional practices of masculinity they had erred from. The fire-fighters, who appeared to be unusually open in their willingness both to consult and critique traditional practices associated with masculinity, were only able to present themselves as 'new men', with an apparently 'modern' approach to help seeking, with reference to the 'old school mentality' they discredited. This supports Connell's (1995) finding that this ideal, or "hegemonic masculinity" is rarely attainable or may not be embraced by some, but men do position themselves in relation to it, even if it is to critique or subvert it.

It is rare to find research that has considered the ways in which men may depart, in their views and behaviour, from conventional practices of masculinity. However, Robertson (2003a) has highlighted that how men actually behave in daily life may differ from how they feel they are expected to behave as men. His study revealed the distinction his participants made between 'don't care' and 'should care' with regard to their health. Many of the participants he interviewed distanced themselves from the 'macho' ideal (i.e. being strong and stoical when in need of help: 'don't care') when asked about their own behaviour in daily life. The exceptions in our own data are interesting because they reinforce the interrelationship between help seeking and masculinity. The fire-fighters, whose occupational role gave them access to a strong masculine identity, emphasised that consulting even for trivial problems was

important in enabling them to *preserve* both their health and masculinity. This supports other research findings that has suggested that men employed in traditional male-orientated work environments (such as the army or police force) may enjoy a more secure position as men compared to men in other occupations (Mason & Strauss, 2004a). Mason and Strauss emphasise that men's perceptions of the challenges that help seeking may present to masculinity may be affected by the social position men occupy and the environments in which their identity is negotiated. Our own data suggest that the fire-fighters may well have felt *more* vulnerable to challenges to their masculinity had they not adopted the attitude and approach they did. In presenting a greater willingness to consult the fire-fighters were actually conforming to the values of their very close-knit team and to their group's ideas of what constituted appropriate practice for men in their social world.

Another example of how some men might be motivated to seek help in order to preserve important aspects of their masculinity came from some of the younger participants' discussion of sexual health problems. The inability to perform sexually was the only scenario considered 'serious' enough to 'risk' their masculine status by consulting, as it appeared to put their identities in greater jeopardy by not being able to have sex. The data therefore support the work of other researchers who have observed how men, who are otherwise reluctant to go to the doctor, may alter their view of consulting in certain scenarios if they feel they have got 'permission' to engage in such behaviour from their peer group (Aouin et al, 2002) particularly, it would seem, if it allows them to continue to engage in masculine practices that are held in high esteem by others. The instances where normally reluctant men sought help were crucial as these were rare opportunities for health providers to 'normalize' their help seeking behaviour and encourage this to become a practice they would repeat (Goode et al, 2004). It was interesting, by way of contrast, that the two men in the ME group were motivated to seek help in the hope that a diagnosis would legitimise their *inability* to continue to engage in conventional practices of masculinity (e.g. working, 'providing' for the family, being able to exhibit 'masculine' physical strength). It could be argued that consultation presented the prospect of *restoring* a masculine identity that had been undermined by the nature of the symptoms of their illness and exempted them from the need to engage in traditional masculine practices.

The participants who were perhaps the most vulnerable were those with emotional or mental health problems, which they often construed as 'stress' rather than admit to the 'unmanly' diagnosis of depression. These men appeared very conscious of the unwelcome scrutiny of their male identities that they felt would result from admitting to and consulting for depression. They had sometimes experienced serious, long-term problems with their mental health which they strove to conceal from family, friends and work colleagues, as well as avoiding seeking medical help. This corresponds with the findings of others who have reported that men are socially conditioned to suppress emotional distress and avoid asking for help (Brownhill et al, 2002). This is troubling, as participants in this study who had been reluctant to consult with 'minor' physical health problems had at least appeared willing to seek informal advice from female relatives or partners. Corney (1990) reports similar findings, describing how the presence of physical symptoms appeared to make help seeking more acceptable for both men and women. However, in her study men were least likely to consult with psychosocial problems or distress and had less confidants than women (Corney, 1990). Seymour-Smith and colleagues have highlighted how:

*Hegemonic masculinity is both critiqued for its detrimental consequences for health and paradoxically also indulged and protected (by health care professionals)...Men who step outside 'typical' gender constructions tended to be marked as deviant or rendered invisible as a consequence.*  
(Seymour-Smith et al, 2002, p253).

Furthermore, they suggest that "what health care professionals might see as most problematic for male patients is not 'behaving like a typical man' (i.e. constructing themselves as reluctant to consult) but behaving 'like a woman'" (Seymour-Smith et al, 2002, p264). There is clearly a need to develop a greater understanding of the meaning particular illnesses hold for men with regard to their masculinities and to consider the ways in which the view that men are 'behaving like a women' (as expressed in health care and every day contexts) affects men's capacity to seek timely (or any) advice for mental health problems.

It is possible, given that these accounts of help seeking were all provided within exclusively male groups (with the exception of the facilitator), that the focus group

discussions were merely an opportunity for men to present stereotypical notions about masculine behaviour for the consumption of other men. I have considered the possibility that their descriptions of their help seeking behaviour may not reflect men's actual past actions or intentions (or lack of) to seek help in the future. Even if this were true, the data presented in this thesis support the view that:

*Stereotypes or dominant discourse are powerful because they set the horizon for what can be articulated or thought in any relevant context. Interviews are an opportunity to rehearse the taken for granted....these dominant discourses must be relevant to understandings of what is possible and what various potential performances of masculinity might mean and how they might be interpreted.*  
(Seymour-Smith et al, 2002, p265).

The data show a diversity of views expressed by men with regard to what was 'taken for granted' in their particular group in relation to help-seeking. Although all acknowledged the 'hegemonic' view that men 'should' be reluctant to seek help, some quite clearly departed from this model and felt they were expected to justify their rejection of what was considered conventional practice. This suggests that future research needs to move away from the idea that men are 'hapless and helpless' and pay more attention to the meanings men attach to help seeking with particular illnesses and explore how men's beliefs about masculinity may, in specific contexts, encourage or inhibit their willingness to consult.

## **Chapter 7**

### **Discussion**

This discussion chapter begins by considering the main conclusions that can be drawn from the research. It then considers the policy implications of the findings. Next the strength and weaknesses of the study are outlined. Finally the chapter closes with a review of the study's aims followed by a discussion of potential areas for future research that this study raises.

#### **7.1. Summary of findings**

The findings support the premise that the practices of masculinity that men engage with are integral to, and have major implications for, men's health (Sabo & Gordon, 1995). There have been other reports of associations between the hegemonic model of masculinity and particular behaviours such as heavy drinking (McCreary et al, 1999; Canaan, 1996), smoking (Payne, 2001) and poor dietary habits (Ricardelli, et al, 1998; Roos et al, 2001; Stibbe, 2004). However, this study is rare in showing how a wide range of health-related beliefs and behaviours are strongly related to men's constructions and practices of masculinity. The findings presented in this thesis show that participants' beliefs about, and constructions of, masculinity affected: their capacity to embrace, or reject, recommended health practices; their decisions regarding help seeking; and their perception of themselves as men following a diagnosis of a serious illness. However, the data suggest that there may be many other health-related experiences and behaviours that are related to men's beliefs about, and practices of, masculinity that also warrant similar attention.

The data do overwhelmingly indicate that the majority of 'unhealthy' behaviours such as heavy drinking or showing a disregard for the nutritional value of food are still socially rewarding behaviours for many men in terms of their masculinities. Men's accounts of help seeking also reveal that there seems to be prestige attached to being seen to endorse the 'hegemonic' view that men 'should' be reluctant to seek help and that men should tolerate pain until an 'acceptable' level of suffering has been reached. Little is known of the circumstances that might encourage such men to re-think the performances of masculinity that have potentially detrimental effects for their health.

However, ageing, illness, and fatherhood were suggested as some of the experiences that may prompt men who may have previously prioritised their masculinity to re-evaluate their health practices.

The data do suggest that younger men may find it particularly perilous to be seen to engage in health-related behaviours that are perceived as challenging to their masculinity. Older participants appeared more able to question the behaviours they had engaged in as younger men (that usually involved them avoiding challenges to their masculinities) and consider why they had engaged in potentially health-changing behaviours as they aged without apparently fearing consequences to their masculinity. By contrast, it was rare, in the context of an all-male group discussion at least, for younger men to critically examine their views on hegemonic masculinity and reflect on how these may have interfered with engaging in recommended health practices unless this met with their group's collective representation of masculine identity. Some of the data presented in this thesis certainly suggest, in line with other findings, that for young men "male peer group networks are one of the most oppressive arenas for the production and regulation of masculinities" (Haywood & Mac an Ghail, 1996, p54). However, it may be a little simplistic to connect the performance of hegemonic masculinity only with young men. There were a number of examples of middle-aged men, whose descriptions of their beliefs and practices echoed many of their younger counterparts.

The data relating to participants' experiences of illness suggest that visible signs of illness were also greatly challenging to male identity, and men described the need to deny and conceal injury or illness to enable them to continue to present unchallenged masculine identities. Participants who were perhaps the most vulnerable were those with emotional or mental health problems. Men described how they would strive to minimise the visibility of their depression but the illness would still present challenges to their identity as men when the effects of their mental health problems could no longer be hidden. Many participants who raised the subject of depression spontaneously had experienced serious, long-term problems with their mental health as a result of this masculine practice of striving to conceal their suffering from family, friends and work colleagues, as well as avoiding asking for help. Men with prostate cancer also found the visible signs that their body was becoming increasingly

'feminised' by their illness or treatment to be greatly challenging to their masculinity. The visibly weakened bodies of those men who had experienced coronary heart disease and ME also greatly affected how they felt as men. Many of these participants were keen to be seen to be engaging with practices (e.g. heavy digging in the garden) that reinforce to themselves and others that their masculinity had been restored. These findings are consistent with other studies who have described how men re-engage with particular practices of masculinity in order to restore their former masculine selves (Gordon, 1995; Moynihan et al, 1998; White & Johnson, 2000).

It can be concluded that for the majority of participants, the need to appear 'acceptably' masculine normally took greater precedence over a concern for their health. Taken at face value this would seem to lend weight to arguments that men sometimes display an 'uncaring' and 'irresponsible' (DoH, 1993) approach with regard to their health. However, Robertson (2003a) has highlighted that how men actually behave in daily life may differ from how they say they behave. The data presented here suggest that there is a need to be critical when reporting men's 'poor' health practices and question whether the *appearance* of being 'indifferent and resistant' (DoH, 1993) is the same as *being* indifferent and resistant. The *appearance* of masculinity, *as conveyed through the meanings of the social practices that men choose to reject or engage in and with*, clearly need to be a central focus to work that considers a range of men's experiences of health and illness.

## **7.2. Policy implications**

The men who, for complex reasons, persisted in endorsing the hegemonic model of masculinity clearly present the greatest challenge for health providers and those working in the area of health promotion who may wish to persuade men to engage with recommended health practices. Some writers have suggested that the long term effective response to the 'crisis' in men's health requires nothing less than the redefinition of masculinity (Alt, 2001; Stillion, 1995). It is hoped that social change might create a climate where "men will begin to see...that following good health habits can be manly as well as lifesaving" (Courtenay, 2004, p276). In this study 'healthy' behaviours (e.g. healthy diet and regular physical activity) were constructed as both manly and lifesaving within particular contexts where this was perceived to be permissible (e.g. the Fire-Fighter's Group). The perceived pressure to engage in

certain practices that may be 'damaging' to men's health depended on the kind of masculinity that was valorised within a particular group. The fire-fighters viewed the hegemonic model of masculinity as a gross caricature of manhood rather than as an ideal to aspire to and were able to reject it, even laugh at it, without facing any challenge to their identity as men in this context at least.

The majority of participants in this study described their belief that changes in what is considered ideal masculine practice for men were taking place "in a slow fashion" (Debu, Student Group). The data suggest that whilst it is important to continue to encourage and support men in making the recommended changes for the sake of their health, there is a need to incorporate into this work an awareness of the practical constraints that men feel are placed on them in their everyday interactions. Participants in this study who wanted to make changes to their lifestyle provided some explanations as to why some men may continue to behave in ways that may mean they continue to be perceived as 'indifferent or resistant' to their health, when they are anything but. Some participants in this study believed that changes were taking place at a cultural level, which made a concern about health issues more acceptable for some men. However, it seems that for the majority of men an obvious display of concern about their health was still considered 'unmanly' (Courtenay, 2004).

The call to change masculinities at a cultural level seems a rather ambitious project and it is perhaps more realistic to focus on ways to encourage men to change their view of certain health-related behaviours as performances of, or challenges to, masculinity. The data on smoking and masculinity indicate that some men can and do change the associations they make between particular health-related behaviours and masculinity. Participants appeared sensitive to changes in the way in which gendered images of smoking have been presented as other researchers have found (Elliot, 2001; Hunt et al, 2004). Although smoking was described as having been an important means of expressing a particular kind of masculinity in the past, many men expressed strong views regarding the 'death' of the macho smoker. This was predominantly because smoking was associated not only with a 'dying' masculinity that was no longer relevant to contemporary masculine ideals but the behaviour was strongly connected with death and disease: as one participant stated 'Marlborough

man has lung cancer' (Keiron, 36, Gay Men's Group). This does suggest that it may be possible to alter the way that some men perceive behaviours that are currently viewed as acceptable ways of 'doing masculinity' and persuade men to reassess those behaviours they may regard as challenging to male identity. However, the data from the Youth Group indicate that smoking may still be an integral part of some men's gender identities; for this group smoking from a young age (some of the participants in this group began at the age of nine) appeared to be an important way of gaining acceptance from their peers and of ensuring continued membership of their group. It may be that only some men can be reached and persuaded to think differently about their associations between smoking or other health-related behaviours and their masculinities.

Some of the data suggest that there may be potential for some men to make positive changes to their lifestyle, even when they face pressures to reject recommended practices, providing the right kind of support is in place. Men who had attempted to make changes to their lifestyle for health reasons were interesting as their accounts emphasized the real and perceived pressures that may be placed on men when their interest in following recommended health practices is made visible to others. Men described how they often felt pressure to display a flagrant disregard for their bodies and their health through their food choices. As many participants ate publicly at work, socially, as well as in the home, eating 'healthy' food was perhaps one of the most conspicuous ways of signifying an 'unmanly' interest in health. Many men felt there was continual pressure to present themselves as 'uncaring' about their health in conversation with other men but there was evidence that those who were highly motivated to make changes to their health were willing and mostly able to withstand the challenges to their identity that a visible interest in their health attracted. The experiences of the men in the slimming group suggests that it may be important for men to see other men making similar lifestyle changes and to have the opportunity to collectively re-negotiate recommended health practices and construct them as 'masculine'. The data therefore highlight some of the ways that health care providers and health promotion specialists might work positively with men to assist them in overcoming some of the practical constraints certain masculinities impose on their health-related practices.

A major concern about some of participants' accounts of help seeking was that the need to avoid challenges to masculinity was so entrenched for some participants that they remained resistant to help even when they had been told they were experiencing a heart attack. This corresponds with data reported elsewhere which also describe how men sometimes have difficulty accepting both a diagnosis of coronary heart disease and the help that may be offered to them following a period of serious illness (White & Johnson, 2000). These findings underline the importance of considering how the practices of masculinity can interfere with men's capacity to ask for adequate help and support or in their attempts to change their health practices for the better (Watson, 2000). The real and perceived pressures that participants in this study experienced, to avoid seeking help in order to appear masculine, suggest that men have particular needs, experiences and concerns around help seeking that need to be accommodated by health promotion campaigns and health services targeting men (Baker, 2001b). Some of the data do indicate that some men show a greater willingness to seek help if it was perceived as a means to preserve or restore another, more valued, enactment of masculinity (e.g. maintaining sexual performance or function or physical capacity for work). This knowledge could help to reinforce the idea to men that, rather than being an emasculating experience, a visit to the doctor can enable them to avoid the potentially serious challenges that serious illness may present to their masculinities.

#### **7.4. Strengths of the study**

Qualitative studies have a particular contribution to make to the study of men's health as they can further our understanding of the complex ways in which men construct their identities as men and may offer some suggestions as to how the practices of masculinity affect men's health. Quantitative studies (e.g. White & Cash, 2004; Emslie et al, 1999; Arber, 1991) and Official Statistics (ONS, 2001; ONS, 2004d) relating to gender inequalities and men's health raise many important questions regarding the health-related practices that men engage in. However, these studies are not able to capture and describe the gendered meanings men attribute to health-related behaviours or explain why some men reject, and others embrace, recommended health practices. There has been some qualitative work that has described the health practices of all-male samples (Mullen, 1993; Saltonstall, 1993). However, there is a clear need for studies to make male gender explicit in research (Hunt & Annandale,

1999), rather than merely including an all-male sample. Watson (2000) argues that the absence of an analysis of gender and the wider social factors that affect men's lives continues to undermine work on men's health. One of the strengths of this study is that it has been successful in making gender explicit in men's accounts of health. This was achieved by asking participants to discuss their masculinities in detail during focus groups and by reflecting, when analysing and writing about the data that were gathered, on the many different ways that men's health and masculinity were related.

Another key strength of the study was in its effectiveness at highlighting different ways in which masculinity and health may be inter-related. The inclusion of men who had experienced 'epiphanies' with regard to their health or masculinity was particularly useful at exploring the diversity in men's accounts. Firstly, men's discussions of their health-related beliefs and practices, as well as the data on help seeking, supported the findings of other researchers in showing that health-related behaviours are gendered social practices that men engage with, or reject, in order to 'do masculinity' (Saltonstall, 1993; Courtenay, 2000; Watson, 2000; Williams, 2000; with reference to West & Zimmerman's, 1991, 'doing gender'). The data on illness, in line with other research (e.g. Chapple and Ziebland, 2002; White, 1999), showed that the losses men experience through disease were revealing of what men thought masculinity was and exposed the practices of masculinity that participants engaged in prior to illness. These accounts of illness also highlighted the practices of masculinity that men felt they needed to continue to engage with in order to 'recover' both their masculinity and their physical capacity following an episode of serious ill health. Finally, the range of views gathered from men of different ages also suggested that participants' masculine identities and their health-related beliefs and behaviours were unlikely to remain static over the life course. Many participants described how their view of themselves as men and how they regarded their health changed in response to different life experiences (e.g. bereavement or illness) and around key stages of their lives (e.g. getting married, becoming a father). Few other studies have presented the multiplicity of views that were expressed by the men in this study in relation to a range of experiences of health, illness and masculinity or have examined cases that are counter to expectations of masculine practices.

#### **7.4. Weaknesses of the study**

The main weakness of the study was that the main fieldwork was dependent on a self-selected sample which consisted of men who became part of the study because they volunteered when asked to by gatekeepers or their employers. Some participants expressed an interest in participating themselves when they had seen posters or leaflets about the study. It is therefore likely that many of the men who volunteered may have had a particular interest in discussing men's health (issues relating to masculinity were not explicitly described in any of the information materials) and may have held and expressed stronger opinions on the subject than other men who may have had less invested in discussing the subject. The prostate cancer and M.E groups for example were recruited through the support group network which is likely to draw men who are willing and able to discuss their experiences openly and may not be representative of men who struggle to articulate their distress about their illness and the challenges to masculinity (that may be different to those discussed here) that they may have faced. A major disadvantage of a self-selected sample is that it can mean that the researcher has very little control over who participates; a problem when one is trying to design a study that purposively includes participants with a range of experiences of masculinity and health. However, it seems that directly targeting a wide range of community groups, voluntary organisations, work places and public places such as gyms, and GP surgeries where men were likely to be, ensured that the desired range of participants did volunteer themselves.

On reflection, if I was going to design the study from scratch I would like to have found a more reliable way of purposively sampling respondents with a range of experiences of health and masculinity. My assumptions about the kind of groups of men to approach, for example, who may be aligned with traditional masculine practices, were not always correct. For example, it was assumed that because of their chosen careers, the fire fighters might align themselves with more traditional practices of masculinity. However, this clearly did not prove to be the case. Perhaps a better way to recruit men in future is to design a survey (that for may help identify men who strongly identify with hegemonic masculinity for example) or a screening instrument that will assess their views and experiences of masculinity and health. This could be used prior to interviewing and could be used as the basis for purposive sampling to ensure a range of men are included.

Designing a study that includes a broad range of views on men's health and masculinities was found to be somewhat frustrating, however, as drawing on the experiences of relatively few participants for each of the different groups means that it could be argued that the focus group discussions merely skimmed the surface of the deep and complex issues that were to emerge. There can be no claim that this thesis provides an exhaustive analysis of men's experiences of, for example, depression, M.E or how masculinity and health changes over the life course. However, this study has been effective in its aim of highlighting some of the different ways that masculinity and health are inter-related and raises a number of important issues about men's health-related experiences that have the potential to be explored further in research that can focus in more detail on some of the more pressing issues that were raised (e.g. masculinity and men's experiences of depression, particularly around the area of help seeking).

Given that one of the aims was for diversity in men's experiences of health, masculinity and illness, the limited range of men from different ethnic groups could mean that some arenas that produce and regulate hegemonic masculinity may have been left unexplored. The inclusion of just one group of Asian men in this study does, however, reflect the limited ethnic diversity in this part of Britain rather than being a deliberate omission. However, even if it had been possible to recruit more groups of men based on their ethnicity, it is unlikely for it to have been possible for these issues to be explored fully in relation to men's experiences of masculinity, health and illness. A range of men from different class backgrounds were represented in the study but the already lengthy focus group format (each interview lasted on average two hours) could not be extended further to explore the relationship between class, masculinities and health. However, there was suggestion that this was an important area that warrants some attention. Although it was beyond the scope of this study to explore issues of class or ethnicity in relation to masculinity in detail, I was aware throughout the research process that there must be different ideals of masculinity according to men's social background.

An exploration of women's experiences of health and illness in relation to their femininities was also beyond the scope of this study, but would have been a welcome

comparison to men's accounts. A common criticism of this study when presenting at conferences and in less formal settings has been that much of the data that is presented in this thesis may also be true of women and that the thesis can not, therefore, purport to describe a uniquely 'male experience' of health. As a woman conducting research on men's health and male identity and writing about these issues I have constantly compared my own experiences or those of other women I know, to the experiences men describe of help seeking, health-related beliefs and behaviours and their relationship to gender identity. The behaviours and experiences that are described in this study are not unique to men and I am sure many women would identify with many of the experiences that men relayed that are presented in this thesis. However, this study does explore how these behaviours and experiences of health and illness relate to their identities as men and I believe that such a focus is justified because men's experiences of health and illness in relation to their identities as men have been so neglected. It would of course be valuable to explore how women might relate similar behaviours and experiences (e.g. the challenge of particular illnesses) to their constructions of femininity.

#### **7.5. Possibilities for further research**

The data underline how important it is in the study of men's health to endeavour to understand the ways in which masculinities are produced, policed and negotiated by men in different groups. Inevitably, the study was only able to explore some aspects of the highly complex processes that men engage in in order to construct and negotiate their masculinities. One area to emerge in many of the discussions was how some men's health-related behaviours were regulated by a form of humour, described as 'slagging'. Participants who discussed their everyday interactions with their peers described how they felt that this kind of humour could leave them exposed and ridiculed for not conforming to an ideal of masculinity that was held by their peers, and they often sought to avoid certain health-related behaviours, such as overt concern for their health or their bodies or being seen to ask for help, to avoid such censure. There was suggestion, which was reminiscent of Foucault's model of the panopticon (Foucault, 1995), that some men monitored and corrected their behaviours without active social pressure because they had learnt to view their masculinity and masculinising practices through the eyes of other men. As these and possibly other processes could clearly affect men's willingness to engage in particular health-related

practices it seems particularly urgent to gain further insights into how men's masculinities are policed and negotiated through their everyday interactions.

It would also perhaps be useful to further explore the kind of life experiences, which may be related to aging or particular life experiences such as fatherhood, retirement, experience of particular illnesses or bereavement, that make it more likely for men to re-evaluate their health practices and beliefs about masculinity. The findings presented here certainly support the idea that it is "quite conceivable that a certain hegemony could be constructed for masculinities that are less toxic" (Connell, quoted in Yancey Martin, 1998, p476). However, there is a need to explore the inequalities between men that currently mean that only *some* are free to embrace 'new' ways of articulating their masculinity which bring health benefits whilst others feel pressured to continue engaging in practices of masculinity that may be harmful to their health. Examining the kind of exceptions to what is commonly assumed to be true of men with regard to their health (i.e. that men's health practices are uniformly poor) may create further opportunities to explore the circumstances that enable some men to embrace recommended health practices without impunity and work toward encouraging those who find this challenging to their identities as men to do the same.

It is a query whether the data relating to men's constructions of masculinities merely reflect cultural ideals held by men in Glasgow and the West of Scotland or if the practices men describe are representative of ideals of masculinity in other regions in Britain. A regional comparison, if limiting research to the U.K., might be useful in exploring the commonalities and any differences in men's constructions of masculinities and health. However, a wider analysis of masculinities cross-culturally may be more revealing of how cultural ideals of masculinity are enacted by men to the benefit or detriment to their health.

There is a clear need for further qualitative studies that focus in detail on men's experiences of health and illness as they relate to masculinity. This is important to emphasise as the majority of writing over the last decade which seeks to address the invisibility of men from health studies by cataloguing a wide range of 'men's health issues' is reminiscent of the feminist response to mainstream or 'malestream' social science's omission of women's experiences from the majority of social science

research (Harding, 1991). Although this recognition meant that a large amount of research ‘on women’ was generated (i.e. research that was based on all-female samples) a criticism of this work was that it said very little of women’s lives or of their experiences *as women* and how this affected their health; “adding women and stirring was no longer enough” (Rose, 1994, p.x). The task for researchers who study on men’s health is to avoid the temptation of merely ‘adding men and stirring’ to a field that has omitted men’s accounts of health and illness and move beyond descriptions of the health practices of all-male samples and make male gender explicit in research.

## **7.6. Review of the aims of the study**

In summary, the primary objectives of this thesis were to present men’s discussions and experiences of health and illness and consider their relation to, and implications for, the practices of masculinity amongst a diversity of men in Scotland. The main aims of the study were to:

- Describe men’s experiences of health, illness and their constructions of their masculinities by drawing on the words men used themselves and in doing so provide an explicit analysis of male gender and health.
- Explore some of the diversity in men’s accounts of masculinity, health and illness

The basic premise of this research was that an analysis of the practices of masculinity has to be the focus of an empirical study that seeks to understand men’s experiences of health and illness.

## **7.7. How the research met these aims**

### **7.7.1. The aim to gather men’s descriptions of their masculinity and health**

The valuable contribution that ‘lay knowledge’ (Popay et al, 1998) can make to a burgeoning area of research such as men’s health has been considered in detail elsewhere (Watson, 2000; Mullen, 1993). This thesis presents a discussion of men’s health that is firmly rooted in participants’ descriptions of their masculinities, health and experiences of illness. Although the relationship between masculinity and health usually receives some passing reference in writing on men’s health (e.g. Banks, 2001:

Lloyd, 1998) and has been explored more extensively in theoretical work (e.g. Sabo & Gordon, 1995; Courtenay, 2000a), empirical data, and particularly qualitative data, are rarely presented in the majority of discussions of this subject. As very few qualitative studies to date have explicitly connected men's health-related beliefs and behaviours to their masculinities (Watson, 2000; Roberston, 2003a & 2006; Emslie et al, 2004 & 2006; Chapple & Ziebland, 2002; White, 1999 being the exceptions), the inclusion of men's detailed descriptions of both their masculinity and health in this study is an important contribution to the existing knowledge on men's health.

This research provided a good opportunity to explore some of the methods that might be useful in facilitating a better understanding of the complex relationship between masculinity and health. In this study, the practices of masculinity were found to be more easily interrogated and made transparent through focus group discussions rather than individual interviews. Many of issues that were raised in focus groups such as discussion of health-related behaviours, views on help seeking and the challenges that illness presented to identity are not behaviours or experiences that are unique to men. In this study of masculinity and health the behaviours than men described were, to some extent arbitrary. Men's descriptions of behaviours (e.g. heavy drinking) or an aspect of men's health-related experiences (e.g. reluctance to consult a G.P with a health problem) was found to be a useful inroad into exploring the beliefs and practices of masculinity that men associated with them. The focus group method was particularly useful for the purposes of this study at generating data on subjects that were 'habit ridden' (such as health practices) or would not have ordinarily been considered in detail by men (masculinity) (Morgan, 1997).

Hearn has suggested that women researching masculinity should do so covertly as "overt taping by women....breaks the 'men-onlyness' of the situation, and to an extent the observable and the audible are clues to the full meaning of the situation" (Hearn, 1994). In this study there was clearly value in disrupting the social norms of all-male groups through my presence as a female facilitator as it encouraged a critical analysis of the relationship between masculinities and health. This is not to suggest that masculinities can only be made explicit by the use of focus group discussions or by a female facilitator. Such 'disruption' might be achieved by a male facilitator whose presence challenges a group's ideals of masculinity (for example see Wight,

1994). On reflecting on the utility of methods that have been used to explore male identity in research, other researchers have also found that individual interviews with men conducted by men (Connell; 1995; Morgan, 1981; Watson, 2000; Robertson, 2003a) and women (Emslie et al, 2004 & 2006; Moynihan et al. 1998; Chapple & Ziebland, 2002) yield deep insights into masculinities and male identity and health. In the current study individual interviews did seem to prove problematic when exploring the experiences of 'healthy' men or those whose masculinities have remained 'unchallenged' (Morgan, 1997) and who have therefore never had reason to reflect on issues relating to their health or masculinity. This thesis can not purport to present an exhaustive analysis of the contribution that different qualitative methods make to the understanding masculinity and health. However, the data that are presented do suggest that our understandings of masculinity and health are shaped by the methods of data collection and gendered dynamics between the researcher and the researched.

It is clear from the data that the relationship between male identity and health is multifaceted and at times this proved difficult to capture, analyse and describe. Participants in this study were clearly not 'uncaring' and 'irresponsible' when it came to their health. However, many provided complex and varied explanations as to why they may appear as such. Care is obviously needed in future research to avoid producing data and discussion on men's health that caricatures men's health-related practices and reifies hegemonic masculinity. Qualitative studies that are rooted in men's experiences of health and descriptions of their masculinities may be helpful in achieving this.

#### **7.7.2. The aim for diversity in men's accounts of masculinity, health and illness**

The literature on 'masculinities' emphasises diversity in the ways that men construct and negotiate their gender identities (Connell, 1995). Yet, the diversity of men's experiences of health in relation to masculinity has been little studied, as some writers have endeavoured to highlight (Sabo & Gordon, 1995; Courtenay, 2000; Watson, 2000). To address this omission, a range of men's experiences of masculinity and health was explored in this study by recruiting participants by age, social background and men who had 'everyday' or unremarkable experiences of masculinity and health and comparing them with other groups of men that were anticipated to have

experienced 'epiphanies' (Crabtree et al, 1993) or 'changes and challenges' (Morgan, 1997) to their masculinities.

The data clearly show that although there were commonalities across different groups of men with regard to their descriptions of masculinity, there was great diversity in the way men negotiated their identities and health in relation to the masculine ideals they described. The data show that men predominantly adhered to the hegemonic model of masculinity. However, there were scenarios that were described that suggest that hegemony may be embraced, rejected, or contested depending on the experiences or the circumstances men find themselves in. Those who were ill often had little choice but to adopt practices they would have found challenging to their masculinities prior to diagnosis. Similarly men who usually avoided seeking help to avoid challenges to their masculinity were willing to ask for support if it was perceived as a means of preserving a valued aspect of their identity as men. The contradictions that are generated by a study that draws on a diverse sample of men appears to have troubled other writers who have found a cohesive analysis of 'masculinity' elusive. Hearn and Collinson write that:

*Masculinities....are characterised by contradictory tensions. On the one hand, men often seem to collaborate, cooperate and identify with one another in ways that reinforce a shared unity between them; but on the other hand, these same masculinities can also be characterised by conflict, competition and self-differentiation in ways that highlight and intensify the ambiguities and contradictions"*

(Hearn and Collinson , 1994, p72).

However, one of the main conclusions that can be drawn from this study is that it is the commonalities, contradictions and conflicts revealed through a range of men's experiences of masculinity and health that are crucial in highlighting many aspects of men's health that have not previously been raised in the literature.

**Table 1: Individual Interviews\***

<b>Pseudonym (age) and occupation of participant</b>	<b>Prior Interview? **</b>	<b>Location of the interview</b>
<b>Barry (62)</b> , Retired engineer (car industry)	FG (Unemployed/ Retired)	Private room in Community Centre
<b>Peter (24)</b> , Unemployed, formerly a gardener	FG (Unemployed/ Retired)	Private room in Community Centre
<b>Bobby (42)</b> , Fire Fighter	FG (Fire fighter's Group)	Fire Station
<b>Andy (29)</b> , Fire Fighter	FG (Fire fighter's Group)	Fire Station
<b>Sean (47)</b> , Politics student, previously ran own business	FG (Student Group)	MRC Unit
<b>Debu (22)</b> , Medical student	FG (Student Group)	MRC Unit
<b>Matt (46)</b> , Mature student (anatomy) and PT Property Consultant	1 <sup>st</sup>	MRC Unit
<b>Colin (17)</b> , Following New Deal Course	1 <sup>st</sup>	MRC Unit
<b>Richard (72)</b> , Retired policeman and former Naval Officer (also participated in at least 3 marathons (worldwide) a year and wanted to swim the Channel!)	1 <sup>st</sup>	Respondent's home

\* In order by which they were conducted

\*\*FG (Previously participated in a focus group); 1<sup>st</sup> (First contact with respondent)

**Table 2. Focus group participants**

<b>Group (n participants)*</b>	<b>Pseudonym (age) and occupation of Participants</b>	<b>Pre-Existing?***</b>	<b>Summary of health problems discussed in relation to consultation patterns</b>
<b>Gay Men (4)</b>	Doug (47), FT carer to parents Billy (45), Unemployed Keiron (36) Shop Assistant Rob (25) Gay men's health worker	P	1 (Keiron) had attempted suicide when younger. 1 (Doug) described himself as anorexic during his teens and twenties.
<b>Youth Group (6)</b>	Gary (25); Rick (19); Max (18); Harry (17); Keith (16); Toby (15) All attending project for young unskilled men. Few or no qualifications (the majority had been excluded from school and had been in young offender's Unit, or in Gary's case, Prison.	P	1 (Gary) was an ex-heroin addict and was recovering from a stroke
<b>Unemployed/Retired (4)</b>	Mike (68) Retired engineer (car industry) Barry (62) Retired engineer (car industry) Vinney (43) Unemployed, unskilled labour in the past Peter (24) Unemployed, formerly a gardener	P	2 (Mike and Barry) had heart problems.
<b>Fire fighters (4)</b>	Bobby (42); Stuart (30); Andy (29); Denny (26) All worked for the fire service	P	4 in regular contact with their GP to have health checks for their job.
<b>Students (5)</b>	Sean (47), Politics student, previously ran own business Aidan (35) Previously an apprentice turner Debu (22) Medical student Carl (19) Science student Owen (19) Politics student	C	1 (Aidan) hinted that he had been depressed and had been reluctant to seek help.
<b>Health change (4)</b>	Paul (29), Advertising sales Tony (29), Unemployed Ross (29), Insurance sales Steve (29), Insurance sales	P	1 (Paul) hinted that he had depression. Minor sports injuries.
<b>Slimming (4)</b>	Nathan (34), Warehouseman Jake (33), Inspector/ Depot Clerk Howie (31), Computer analyst/ programmer Rory (28), Forklift truck driver	P/C***	1 (Jake) described a serious episode of depression and sought help from his GP but described it as 'stress'.
<b>Prostate Cancer (4)</b>	Murray (70), Retired Local Government education advisor Ben (60), Consultant engineer George (59), Customer Services Manager Callum (52), Retired (due to ill-health) panel beater	P	1 (Callum) also had angina
<b>Cardiac (4)</b>	Alf (72), Regional transport manager Danny (71), Retired electrical contractor Bernard (67), Retired (due to heart problems) HGV driver Jack (64), Retired railway signalman	P	All had sought emergency treatment for heart problems
<b>G.P's (4)</b>	Neil (54); Luke (52); Arthur (46); Thomas (30)	P	
<b>Gas workers (4)</b>	Angus (41), Customer Service Advisor Colm (32), Customer Service Advisor and Union Shop Steward Ted (36), Administrator	P	1 (Angus) had had a testicular lump 2 (Colm & Ted) had suffered severe depression 1 (Colm) had heart problems and had past suicide attempt.
<b>Asian (4)</b>	Sam, Vikram, Rajiv, Pritpal, all aged 21-22 and were dental students	P	1 (Vikram) had investigations for lump which proved to be benign.
<b>Mental (4)</b>	Jerry (49), long-term sick, previously a psychiatric nurse Liam (43) Local Government officer Sam (34) long-term sick, formerly a security guard	C	2 (Jerry & Sam) described having nervous breakdowns.
<b>M.E (2)</b>	Donald (69), Retired psychology lecturer Morris (52), Long-term sick, formerly an engineer	C	1 (Donald) also had angina 1 (Morris) had been hospitalized with major depression.
<b>Carers (4)</b>	Frank (43), Former builder, caring for wife FT Pat (59), works PT with Blood Transfusion Unit, cares for wife PT Phil (41), Former chef, cares for wife FT Geoff (37), Formerly a computer programmer, caring for parents FT.	C	2 (Phil and Geoff) reported major depression.

\*By order in which groups were conducted

\*\*P (Pre-existing group); C (Group of strangers specially convened for the study)

\*\*\*The slimming group was comprised of two friends who had joined the group that evening and were joined by two long-standing members of the group who attended infrequently and so did not know one another

Masculinity is  
dangerous to  
men's health

Death rates in all age groups are higher for males than females.

[ONS]

**Suicides in men  
aged 15-24 rose by  
80% between 1982  
and 1996 (ONS)**

Health taboo  
'puts male  
lives at risk'.  
**[Daily Telegraph]**

**Appendix B: Cancelled/ difficult to recruit focus groups**

<b>Group targeted</b>	<b>Contacts</b>	<b>Problems encountered</b>	<b>Cancelled?*</b>
Shipyards workers	Wrote to and spoke to Director of shipyard	Wanted to assist, but the shipyard was facing an uncertain future (which was why I thought it would be a good group to recruit) so declined.	R
Men with testicular cancer	Clinical Nurse Specialist, Oncology Centre	4 months in total trying to recruit as letter was passed to various people. Head of Oncology was not interested in assisting when the query eventually reached him.	R
Afro-Caribbean Men	Afro-Caribbean Advice Service in Glasgow	I did not spend too long trying to pursue this group as the advice service appeared to be winding-down when I first made contact and there was little interest in assisting.	R
Male nurses	Senior Research Nurse at local hospital  also  Unison (who provided further contacts at a hospital)	Spent almost a year trying to recruit this group and was almost successful. There was a long period when my query was passed from person to person. I eventually was passed the names of four potential participants and it proved very difficult to juggle different shifts/ other commitments so that all could attend the discussion. The interview date was arranged twice and on both occasions only one participant attended.	C
Men's sexual health	Consultant, Department of Genitourinary Medicine and Sexual Health	Met with consultant who was very keen to assist and who agreed to pass information leaflets on to clients of his clinic. Rather than difficulty with recruitment, this group did not go ahead as the momentum and contact needed to set up a group was lost when I had to take several months off work.	-
Youth Group (New Deal)	New Deal Co-ordinator	Lots of help in setting up a group from the co-ordinator. However, the boys who attended behaved in a threatening and unco-operative manner and I terminated the interview (one participant was interviewed individually).	C

\* C (Group eventually arranged but cancelled); R (Proved too difficult to recruit or would have been too time-consuming to pursue).

## Appendix C: Information leaflet

### ABOUT THE RESEARCH

Discussions with groups of men from Glasgow are being used to understand the factors that may influence men's health. **We need men of different ages and backgrounds to give us their views.**

Men's health has received little research attention. It is therefore important that you consider volunteering. We can use what you tell us to build a picture of the key events in men's lives and explore how these relate to health.

Those working on the project are not medics. We are concerned with understanding men's beliefs about health and what influences and motivates their approach, rather than being concerned with the lifestyles people feel they 'should' be leading.

### WE WANT TO HEAR FROM YOU

Health may not be a subject you are used to discussing, and you might be put off from volunteering in the belief that will not have anything interesting to say, or everyone else taking part will know more than you. We are not interested in hearing the most unusual or exceptional cases. It is important we find out about health in relation to your experiences.

### WHAT WE ARE ASKING OF YOU

If you agree to take part, you will be asked to join a group discussion with three other men who will be from similar backgrounds to you. This will last for about an hour and a half. Discussions are very informal, often lively, focusing on what matters most to men and their health. We will only pursue subjects you feel comfortable speaking about. All information you provide is anonymised and will remain completely confidential. Discussions will be held either at the research unit or another location convenient for participants. Each man will get £10 to cover travel expenses.

**Detach and return this slip.**  
POSTAGE IS FREE.

Best days/times for interview:

\_\_\_\_\_

Name: \_\_\_\_\_

Telephone no:

Daytime: \_\_\_\_\_

Evening: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Postcode \_\_\_\_\_

Age \_\_\_\_\_

Current/Last Job \_\_\_\_\_

### CIRCLE:

Single/ Married/ Divorced/Widow

Number of Children: \_\_\_\_\_

Where you picked up leaflet

\_\_\_\_\_

BUSINESS REPLY SERVICE  
Licence No. GW522

2

R. O'Brien  
MRC Social and Public Health Sciences Unit  
4 Lilybank Gardens  
Glasgow  
G12 8RZ

#### WHO WILL BE DOING THE RESEARCH?

This research is being carried out at the MRC's Social and Public Health Sciences Unit, based on the campus of the University of Glasgow. Rosaleen O'Brien will interview you. Rosaleen will be happy to chat to anyone who has any questions about taking part.

Rosaleen can be contacted at:

MRC Social and Public Health  
Sciences Unit  
4 Lilybank Gardens  
Glasgow  
G12 8RZ  
Telephone: 0141 357 3949

IF YOU DECIDE YOU WOULD LIKE TO TAKE PART  
COMPLETE THE ATTACHED FORM AND RETURN  
TO THE MRC

**MRC**  
Medical Research Council

**MEN'S HEALTH  
PROJECT**

## Appendix D: Example of recruitment letter sent to participants



**Social and Public Health Sciences Unit  
University of Glasgow  
4 Lilybank Gardens  
Glasgow  
G22 8RZ**

Telephone +44 (0) 141-357 3949  
Fax +44 (0) 141-337 2389  
Web [www.msoc-mrc.gla.ac.uk](http://www.msoc-mrc.gla.ac.uk)

Dear M.E Association Member,

I recently contacted the M.E. Association Scotland to ask for help locating men who have M.E. I was given permission to contact a few members of the Association directly and you were selected randomly from the list of members in Scotland. I am writing in the hope that you will consider taking part in a one-off interview on the subject of men's health.

We have considered a wide range of men's views on health and experiences of illness to date. It is important that we also include men's experiences of chronic illness. If you were willing to talk about your experience of M.E as well as putting forward your thoughts as to what you feel influences men's health in general, you would be invited to attend a group discussion along with three other men who also have M.E.

The interview would take place at a time and place considered convenient to yourself and others who agree to participate. If you are happy to travel, there are rooms at the MRC unit that we can use for the discussion. Ten pounds will be given to all men that participate to cover expenses incurred (wherever the interview is held).

The group discussion would last for a maximum of two hours and would cover mostly general subjects about what men tend to do for their health, how they think about health, talk about health, etc. It is understood that your experiences of M.E. are deeply personal and it is entirely your decision how much or how little you divulge on this matter. It is hoped that inviting those who have had similar experiences to talk together will make it a comfortable setting should you wish to discuss issues surrounding M.E. fully.

With your permission the interview will be tape recorded to ensure that we can quote verbatim. It should be emphasised that all identifying information divulged during the discussion will be anonymised. Tapes and transcripts are locked away and only my two supervisors and myself have access to these to ensure confidentiality. I have enclosed a leaflet about the study for further information.

Should you wish to discuss any aspect of the interview please do not hesitate to get in touch. I hope that you will consider taking part in what I am sure will be an interesting discussion on men's health. I hope to hear from you with your thoughts on participating. I will assume you would prefer not to participate in the project if I do not hear from you in the next ten days.

Yours sincerely,

Rosaleen O'Brien

Enc: Project Information Leaflet

**Appendix E: Example of recruitment letter sent to organisations/ gate keepers**



**Social and Public Health Sciences Unit  
University of Glasgow  
4 Lilybank Gardens  
Glasgow  
G22 8RZ**

Telephone +44 (0) 141-357 3949  
Fax +44 (0) 141-337 2389  
Web [www.msoc-mrc.gla.ac.uk](http://www.msoc-mrc.gla.ac.uk)

Dear Sir or Madam,

I am writing in the hope that you will be able to assist me with my research. Discussions with groups of men from Glasgow are being used to understand the factors that influence men's health. We have considered a wide range of men's experiences to date and would like to include a group of men who have M.E.

The majority of men I have interviewed who have not experienced chronic illness have discussed the problems they have recognising signs of ill health and in deciding what would be regarded as 'serious' and what would be seen as 'trivial'. It stuck me that many of the symptoms men have difficulty accepting as serious could be associated with M.E. It would be most interesting to find out how men discuss their health in light of a diagnosis of M.E.

If you are willing assist, we can discuss the most appropriate way of recruiting four people to take part in a group interview. The discussion would last for approximately two hours. It would take place at a time considered convenient for participants and will usually be held at the MRC research unit. However if this location is not convenient for participants alternative arrangements can be made. It is intended that the discussion will be relaxed for all involved and it should be emphasised that all identifying information divulged during the discussion would remain completely confidential. Each man will be paid £10 to cover expenses. Please find enclosed the information leaflet for yourself and anyone interested in taking part.

The project is being carried out by Rosaleen O'Brien, a PhD student funded by the Medical Research Council (supervised by Professor Graham Hart and Kate Hunt) and is based at the MRC's Social and Public Health Sciences Unit at the University of Glasgow.

We could discuss the project and possibilities for recruitment of a group this week, once you have had a chance to consider the information enclosed.

Yours faithfully,

Rosaleen O'Brien

Enc: Project Information Leaflet

Appendix F: Consent form

# MRC

Medical Research Council

Social and Public Health Sciences Unit

**WE NEED YOUR CONSENT TO PROCEED**

**PLEASE SIGN THIS FORM TO INDICATE YOU AGREE WITH THIS STATEMENT:**

The purpose of the study on men’s health has been explained to me and I agree to take part in an interview. I have given my permission for the interview to be tape-recorded. It has been explained that any identifying information in interviews will be anonymized and remain confidential. I understand that tapes will be locked away securely and only the researcher will have access to them and these tapes will be destroyed when the project has been written up.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Appendix G**

*‘Standing out from the herd’:*

*Renegotiating masculinity*

*in relation to men’s experience of illness*

**R O’Brien**

**G J Hart**

**K Hunt**

MRC Social & Public Health Sciences Unit  
University of Glasgow

Paper accepted (June 2006) for publication in a forthcoming issue of the  
International Journal of Men’s Health

*Abstract*

In this paper we investigate whether a mental illness (depression) presents different challenges to masculinity than those experienced in relation to a stereotypically male disease (coronary heart disease, CHD) and a gender-specific disease (prostate cancer). Fifty nine men from central Scotland participated in 15 focus groups, and 9 took part in individual interviews between June 1999 and February 2001. We found that masculinity is negotiated and re-negotiated by men in the light of the limitations placed on them by their own and others' understandings of the social and personal consequences of these diseases. Participants with depression in this study believed that if their mental illness was made visible to others it would distinguish them from other men with less 'feminised' illnesses or injury. There remains a taboo for men – reflected in the absence of discussion of this issue between them – in disclosing and help-seeking with regard to depressive illness.

## Introduction

The importance of exploring male gender in relation to men's health has been recognised (Sabo & Gordon, 1995; Courtenay, 2000) but has rarely been incorporated into the design, data collection and analysis of studies of men's experiences of health and illness (Annandale & Hunt, 1990; White, 2004). Male gender identity is understood to emerge from social interaction through the range of gendered practices that men engage with, which has been described as the process of 'doing gender' (West & Zimmerman, 1991), or 'doing masculinities' (Morgan, 1992). There are a range of studies that have explored the social practices that men undertake in order to construct and negotiate their identities as men, which may vary depending on the cultural and social context (Willis, 1979; Herdt, 1981 & 1999; Tomsen, 1997; Kehily & Nayak, 1997; Messner, 1987; Watson, 2000; Barrett, 2001; Frosh et al, 2002; Leyser, 2003). These accounts suggest that just as being a father (McKee & O'Brien, 1983) or a factory worker (Willis, 1979) or placing oneself in the masculine hierarchy of a school (Mac an Ghail, 1995; Connell, 1989) can be revealing of the ways masculinities are constructed through social practice, the study of men's everyday health-related practices such as going to consult a doctor or displaying a resistance to recommended health practices may also offer insights into the ways men 'do masculinity' (Saltonstall, 1993; Courtenay, 2000b; Williams, 2000). There has been some discussion as to how different aspects of the relationship between masculinity and health might be explored through empirical research (Sabo & Gordon, 1995; Watson, 2000; Courtenay, 2000).

Some studies of men's experiences of a range of illnesses have been important in highlighting some of the ways in which male identity and health are inter-related (e.g. Mason & Strauss, 2004; Kilmartin, 2005; Chapple & Ziebland, 2002; Elgie, 2002; White, 2001; Gijsbers Van Wijk et al, 1999). Chronic illness is a major catalyst for 'biographical disruption' (Bury, 1982). Men's chronic illness has been characterised as a period of "intensity, severity, and uncertainty" that can pose fundamental challenges or 'dilemmas' for masculinity (Charmaz, 1994). The loss of work identity, social roles, and sense of isolation that can accompany the physical and mental effects of serious illness can present significant challenges to individuals, resulting in a 'loss of self' (Charmaz, 1983). Giddens, who has discussed the disruption of identity following 'critical incidents' has noted, "we can learn a good deal about day-to-day situations in routine settings from analysing circumstances in which those settings are

radically disturbed” (Giddens, 1979, p123, cited by Bury, 1982). It is thought that when ‘masculinities’ (Connell, 1995) are ‘radically disturbed’ by illness, it prompts men to reflect on taken-for-granted gendered beliefs and the practices of masculinity they engaged in prior to illness, as well as those affected subsequently. Research to date has endeavoured to highlight different aspects of the relationship between masculinity and health by focusing on the particular challenges that specific illnesses (coronary heart disease; testicular and prostate cancers; depression) present to male identities.

### *Coronary heart disease*

Qualitative research on men’s experiences of coronary heart disease has highlighted the nature of the challenge to identity that men experience when admitted to hospital (which may be shocking but short-lived) as well as considering the further challenges to masculinity that men experience when they are forced to make permanent changes to their health practices during convalescence (Cowie, 1976; White, 1999; White and Johnson, 2000; Clark, 2001). The symptoms and sequelae of coronary heart disease (CHD) are commonly perceived as being abrupt and life-threatening for men (Emslie, Hunt and Watt, 2001); this suggests that the losses men experience with regard to masculinity may be equally dramatic. Research has described men’s efforts to retrieve or reconstruct aspects of masculine identity following a diagnosis of a heart problem (White, 1999; White and Johnson, 2000). This is related to a highly mechanistic construction of the body in which the heart can be “repaired or replaced” (Emslie, Hunt and Watt, 2001: 212) allowing aspects of masculinity that were lost through illness to return once the body has been ‘fixed’. By studying men’s experiences of coronary heart disease we can explore the aspects of male identity that are immediately challenged by sudden life-threatening illness and examine the social practices that men engage in in order to reconstruct their identities as men.

### *Prostate Cancer*

The adage that men are more likely to ‘die with prostate cancer than of it’ means that the chance of full recovery, and the hope that their bodies might be ‘fixed’, can feel more remote for men with this disease, even if they have a good prognosis. Men with metastatic prostate cancer have to cope with the permanent side effects of surgery, radiotherapy or hormonal treatments, which can include incontinence, impotence, loss of libido, breast growth and hot

flushes (Chapple and Ziebland, 2002; Clark et al, 1997). This presents challenges to them in adjusting to these changes to their bodies and being forced to renegotiate “performances” of masculinity, such as sexual activity (Gray et al, 2002; Chapple and Ziebland, 2002). In addition to the physical and emotional impacts, the loss of physical strength (that may be a symptom of progressive disease or a side effect of treatment), can mean that men of working age have to face a permanent loss of work identity (Chapple and Ziebland, 2002). It has been suggested that older men accept the loss of aspects of masculinity (such as sexual functioning and termination of employment) more readily as such losses can be attributed to the ageing process (Gray et al. 2002; Cameron and Bernardes 1998). The nature of the challenges that men face to identity when diagnosed with prostate cancer are therefore likely to be dependent on age, treatment, and extent to which their illness interferes with their engagement in their usual social practices.

### *Depression*

Whilst medical sociologists have shown interest in exploring women’s traditional and changing roles and their apparently greater risk for depression (Weissman & Klerman, 1977; Lennon & Rosenfield, 1992), there has been little exploration of men’s experiences of depression (Emslie et al 2006) or on the impact of inequalities on men’s mental health (Miller & Bell, 1996). The incidence and prevalence of anxiety and depression (and GP consultation) is higher for women than men (ISD 2000; ISD 2003; ISD 2003; ISD 2003; ISD 2003). Yet suicides by men outnumber those by women in the U.K by a ratio of more than 2:1 (DoH, 2003). Recent campaigns concerning men’s experience of depression would suggest that there is a greater awareness of male sufferers (RCP, 1998). However, there is a concern that a ‘masculine form’ of depression (Kilmartin, 2005) often goes undetected because men feel obliged to be “controlled and silent about their emotional life” (Moynihan & colleagues, 1998; see also Brownhill et al, 2002).

The association between femininity and the expression of emotion is thought to contribute to the hidden nature of depression among men (Elgie, 2002). Warren has commented that “the linkage between depression and femininity may provide men with the strongest motivation to hide their depression from others” (Warren, 1983, p15, cited in Courtenay, 2000a). One study suggests that depression in men may go undetected as expression of emotional distress can be

constrained by traditional notions of masculinity (Brownhill et al. 2005). Although men's mental health has begun to receive greater attention in recent years (Robbins, 2004; Elgie, 2002; Kilmartin, 2005; Brownhill et al, 2002; Emslie et al, 2006) little is known about the particular challenges that the experience of depressive illness may present to male identity. However, there is some empirical data that indicate that help seeking with depressive symptoms may present particular difficulties for men because of the challenge this presents to masculinity (Moller-Leimkuhler, 2002; Heifner, 1997).

In this paper we investigate whether mental illness presents different challenges to masculinity than those experienced in relation to a gender-specific disease (prostate cancer) and a disease primarily (if erroneously) associated with men (CHD) (Emslie et al, 2001; Sharp, 1994). We begin with men who have had CHD, to explore how their masculinity is challenged by their heart condition. We then explore the experiences of men with prostate cancer and the particular problems of emasculation confronting them. Finally we turn to men with depression and the impact that this has on both their practices of masculinity and the perceptions of others. In choosing two physical diseases and a mental health problem we also seek to interrogate the notion that men make distinctions between mental and physical illness, and that this impacts on the psychosocial experience of these illnesses. We also anticipate that each might compromise masculinity in different ways.

### **Methods and Analysis**

Fifty nine men participated in fifteen focus groups, and a further nine men took part in individual interviews (conducted by RO between June 1999 and February 2001 in central Scotland). We sought diversity within the sample by age (range 15 to 72 years), occupational status, socio-economic background and current health status. Rather than recruiting men to specifically explore 'Scottish masculinity', we recruited groups of men whom we anticipated would have had a range of masculinities<sup>14</sup>. Men who anticipated would have had 'everyday' or unremarkable experiences of masculinity and health were interviewed (largely by accessing men in a range of occupations, such as gas workers, fire-fighters, students) in addition to groups of men that we anticipated may have had 'epiphanies' (Crabtree et al., 1993)

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<sup>14</sup> However, this study does raise questions as to whether the masculinity men described in this study is culturally specific. This issue will be explored more extensively in a forthcoming paper on men's health-related practices.

prompting reflection on masculinity and health. These included a Prostate Cancer Group, a Cardiac (CHD) Group, Mental Health Group, and Myalgic Encephalopathy (ME) Group. It should be noted that, although only one group of men with mental health problems was recruited, the subject of depression or emotional problems arose spontaneously in several other groups. Indeed over half the participants in the sample spoke about mental health problems. Therefore the data that are presented here on prostate cancer and CHD are drawn from each of the group discussions on these subjects, whereas the data on depression are drawn from a number of different focus group discussions. The remaining groups include men who were: committed to diet and exercise changes (Slimming Group: Health Changes Group); full-time carers for wives with serious health problems (Carers Group); and long-term unemployed. Although we recognise that men are likely to construct their masculinity in different ways according to ethnicity, we were only able to conduct one group with men of Asian origin. This reflects the relatively limited ethnic diversity in this part of Britain. The majority of the men lived in central Scotland (Glasgow, Edinburgh, Dundee, Lanarkshire and Perthshire). All names used are pseudonyms; further details of the sample can be found elsewhere (O'Brien et al, 2005).

There is debate in the literature on focus groups as to whether groups of strangers are preferable to 'naturally occurring' groups, such as friends or work colleagues (Kitzinger, 1994; Morgan, 1997; Wilkinson, 1998). Because of our aim to achieve particular dimensions of diversity, our fieldwork included both pre-existing groups (n=10) and specially convened groups (n=5). Drawing a group of strangers together was in some cases the only way to access people with certain experiences (e.g. men acting as carers; men with ME). Discussions with pre-existing groups were held in their usual meeting place. The research was presented to gatekeepers and prospective respondents as a project on men's health, and information leaflets and invitation letters emphasised a general interest in men's health and men's lives. Ethical approval for the study was granted by Glasgow University's Ethics Committee for Research on Human Subjects.

Discussion was facilitated using general questions (e.g. Are you used to discussing health with other men? What is your experience of seeking help from your doctor?) and, in the latter stages of each group, some statements about men's health were presented to the group.

However the main body of the discussion was facilitated by general questions and through discussion of topics which the participants themselves raised. This allowed the subject of masculinity to be explored with as little input from the facilitator as possible. In the focus groups the men engaged in prolonged discussion of masculinity. Different ideas as to what constituted masculinity and how 'manhood' was expressed were actively supported and challenged by members of the group, through continual comparison of opinions and experiences. Consequently, the data contain explicit accounts regarding the social construction of masculinity and 'tapped' into men's talk more effectively by exploiting the "co-construction of meaning" between participants. We believe, as Morgan (1997) suggests, that this method was useful for generating data on subjects that are 'habit ridden' (such as health practices) or would not ordinarily be considered in such detail (masculinity).

All the focus groups were fully transcribed, then cross-checked with the tapes for accuracy by RO. In the early stages of analysis all authors participated in ongoing discussions about emerging issues and any difficulties or problems encountered in the course of fieldwork as the interviews progressed. Once all the groups were completed, all authors reread the transcripts and discussed and identified the most important themes. Thereafter more detailed analysis was undertaken by RO who repeatedly reread and compared the interviews to further develop the understanding of specific themes. This paper explores just one of these major themes. Another theme, men's help seeking behaviour, is explored elsewhere (O'Brien, Hunt and Hart, 2005).

## Results

### 'Should you be doing that?' CHD and limits to masculinity

It was clear from the start of the discussion that work was of central importance to all participants in the Cardiac Group and was an integral part of their identity as men. Whilst much of the discussion around work was devoted to examining participants' feelings of loss when they were forced to give up employment following diagnosis of a heart condition, a prior issue related to masculinity, work and illness emerged.

While the majority mourned the loss of their working life, many believed that work-related stress had been a significant factor in developing heart and other health problems. However, some participants had been reluctant to acknowledge the seriousness of earlier episodes of illness that had not required such a dramatic change in life style as their cardiac conditions (i.e. they could continue working despite being ill). Their accounts reveal how strong their need to continue engaging in masculine practices (such as continuing work) was despite awareness that it was making them ill.

When the interview commenced, Danny stated his belief that stress was an unavoidable by-product of being the 'breadwinner'. Although he described how his earliest 'warning' (a burst stomach ulcer when he was twenty-six) "frightened the life out of" him and he had "no hesitation to go to the doctors" with similar symptoms following this incident, he had no desire to change the gruelling work schedule he believed contributed to his health problems. When asked whether he was aware of how stressed he had been and what effects it might have, his response suggested that he felt compelled to endure virtually any ailment in order to fulfil his duty as a man:

*I was aware of it but what could I do? I had a family I had to bring up and I had the rest of the men depending on their wages from us...I used to work from eight in the morning until nine o'clock at night...and that wasn't just for a week or two, that went on for months and that's when I got this...But I had to do it. (Danny, 71, Cardiac Group)*

It was apparent from this and other extracts that Danny's views on 'taking' stress regardless of how ill he became were strongly related to his beliefs about what men 'have to' do in order to

practice masculinity.

The pressure for men to engage in such practices is perhaps a consequence of growing up in a climate where there were frequent reminders that their family's welfare was a man's sole responsibility. As one respondent stated, "your father's last bit of advice to you was 'now you've got a wife and that's your first responsibility'" (Jack, 64, Cardiac Group). It is unsurprising therefore that participants described ignoring signs of serious illness in order to continue a practice they saw as central to their masculinity. However, once diagnosed with a heart condition they were forced to make changes to their working life.

When asked what illness meant to men with coronary heart disease, Jack replied "the end of your working life" (Jack, 64, Cardiac Group). All participants in the Cardiac Group had been advised to stop work following their diagnosis to aid a full recovery. The abrupt termination of their working life was clearly perceived to be the biggest challenge to their masculinity as a result of illness. Some seemed keen to emphasise that they had never succumbed to illness prior to their heart attack and had had an undisrupted working life: "I've always enjoyed good health right up until the time this happened" (Alf, 72, Cardiac Group). However, Danny's presentation of his health as 'good until that point' conflicts with the long history of ill health he divulged throughout the interview. Where his heart attack differed, it seemed, was the extent to which it interfered with his working life which, until that point, had defined him as a man.

Those nearer retirement age found it easier to bear the end of working life than others. For example, Bernard stated that he was "lucky" that his heart attack happened near retirement age "as that was the end of working" (Bernard, 67, Cardiac Group), whereas Alf, who had been younger at the time of the attack, felt cheated out of the final year he had to go before he retired. He described feeling "snapped off just like that....you've bounced, you feel you're out of the running".

While participants described an initial "blow" to their masculinity, and a feeling that "it was the end of the world" (Danny), there was a period of transition. They reported that they went on to test the limits that had been imposed on them as part of their rehabilitation programme.

and began to engage in practices that re-affirmed their masculinity. If they could no longer work, they would challenge themselves with heavy physical tasks. Participants were particularly keen to embrace new health practices that enhanced their chance of recovery. They were, for example, great advocates for the benefits of exercise. The group collectively recognised that “a change to your way of life” (Jack, Cardiac Group) in the form of exercise was one way they could be proactive in preventing further problems:

Jack: *I think I just came to the stage where I thought ‘I’m not going to sit on my backside and wait for something else to happen’.*

Bernard: *Keep going, aye. Put some effort in, you feel the benefit....as long as you’re active, it’s good, but the minute you’re static*

Alf: *That’s when it hits (Cardiac Group)*

The group chose to believe that exercise was a way of aiding recovery in the short-term but also, and importantly, it served to ward off further blows to their masculinity in the long-term. However, participants had more difficulty in accommodating change in other areas of their lives once they felt they had fully recovered. Exercise was a new practice that had the incentive of “getting back” an important aspect of their masculinity (their physical strength), but external reminders of the permanent changes they would have to make to their life following illness were much harder to refute. Although participants wanted to believe they had recovered fully and could resume normal physical activity, those around them repeatedly questioned this, and this presented a continuous threat to their ‘restored’ identity. As Bernard stated: “Once your family [start to] emphasise the fact that you’ve had a heart attack then that’s it”. He described how others would question whether he was physically capable, which he found difficult to deal with having never faced this particular challenge to his masculinity previously:

*...Neighbours will shout across to you ‘should you be doing that?’ ....the lass across the road from me, she’s up in the accident and emergency unit...she’s constantly yelling at me for doing this... (Bernard, 67, Cardiac Group)*

He described how he previously had taken his physical strength for granted and how he had always considered himself to be:

...very very fortunate in having a good health span...I had my golf. I had my walking. I went swimming...I mean there was nothing really and all of a sudden you've folks saying to you 'Watch what you're doing. I'll come up and cut the grass, Dad'.

It was clear that the experience of illness had left him feeling redundant in some ways and that that he no longer felt he occupied a pivotal role in family life.

In summary, after the recognition of their heart problem, men were faced with the need to make immediate changes to their lifestyle, the most challenging of which were giving up physical tasks and work. It was however difficult to accept a prolonged challenge to their masculinity and participants set about working towards the recovery of their masculinity as much as they worked towards the recovery of their health. Some participants would take on new practices of masculinity that replaced others they had lost (for example by accepting they had to give up work, but continuing to engage in heavy activities), in order to affirm their masculinity. Others would begin to engage in old practices (for example work against doctor's advice) to the same end. However, these repaired identities appeared to be fragile and were subject to repeated challenges from those in their family and wider social network who did not share their view that they were entirely recovered.

#### *'Standing out from the herd': Prostate Cancer*

Loss of work identity was not as big an issue for the Prostate Cancer Group as for the Cardiac Group, mainly because the majority of participants had enjoyed an undisrupted working life and had already retired when diagnosed with cancer. Nevertheless, the treatment that participants underwent for prostate cancer had forced all participants to "weigh up" their feelings about the losses they had experienced with regard to masculinity against "the fact that you're going to live longer" (Murray, 70, Prostate Cancer Group).

Three of the participants had suffered impotence, and another the loss of libido, as a result of surgery or drug treatment and this had had a dramatic impact on how they saw themselves as men, as Callum hinted at (and then tried to conceal). "it lowers your macho(ness) without a

doubt. You don't feel as (pauses). Well I don't know. I still feel like a man, although I've the same problem as my friend here (impotence)" (Callum, 52). Another side effect of some hormone therapies was a series of changes in physique, which could be experienced as emasculating ("men grow breasts and develop hips"). George perceived this to be yet another "blow" to manhood:

*Well I'm probably not (impotent), well I say probably because I've lost all of the libido and everything because of it.....the hormone treatment stops the flow of testosterone and hence prevents the cancer from growing - that's the treatment. And the side effect of that is that your body loses testosterone and you're basically being turned into a woman (George, 59, Prostate Cancer Group)*

These physiological modifications to maleness constitute an extreme challenge to masculinity, gynaecomastia in particular representing a significant threat to male identity (Monaghan, 2001). Others described how they had felt robbed of natural aspects of masculinity 'before its time' and admitted that this had devastated them, as the following extract illustrates:

*I think it's...the difficulty perhaps in the sexual front is you realise when you get to a certain age, and it varies with individuals, that you are going to lose your sex drive. The hard bit I think is having it taken away from you.....maybe ten, twelve or however many years ahead and then it would just occur naturally you know, but the fact that we've had it physically taken away early I think is the hard bit (Ben, 60, Prostate Cancer Group)*

When the majority in the group tried to point out the positive side of this (e.g. "we wouldn't be alive" without treatment (George, 59)) it did not seem to appease Ben. He still mourned the loss of the 'natural' aspects of masculinity he felt healthy men could expect to last into old age. One of his concerns was loss of the ability to engage in the kind of physical activity he had been involved in as a younger man. As he described: "in my late thirties I used to run marathons and do all sorts of things" (Ben, 60, Prostate Cancer Group). He returns to this topic much later in the interview, emphasising his sense of loss:

Ben: *It's gone. It's like I used to run around Balloch Park six times, the Barras two and a half miles...I can hardly walk around it now*

**George:**                   **No, but you try don't you?**

**Ben:**                       *I cannae try*

**George:**                   *Oh, you don't even try it. See I find obviously I can't do what I used to do ten years ago...but I don't think it's anything to do with the prostate cancer (Prostate Cancer Group)*

It is clear that George and Ben did not perceive the same challenges to masculinity when they experienced similar side effects. George seemed to accept that his physical abilities would decline around the age he was and so seemed more content when he experienced fatigue as a side effect of treatment.

Ben was particularly concerned about the impact his impotence would have on his relationship with his partner. He told the group a story about a man he knew whose wife had left him when she heard he had been diagnosed with prostate cancer. This seemed to be presented as a reminder that losing aspects of masculinity, such as libido, could make you 'less of a man' in other people's eyes. The majority of participants in the Group felt it was fruitless to dwell on aspects of masculinity that they felt had been lost forever when the treatment that prompted these side effects had been entirely necessary to keep them alive. Later in the interview there was more serious consideration of this point:

*You feel deprived (but) you know you've got to adjust to it...because the alternative is you're probably going to be dead. Well you would be dead. I've been on treatment for about five years probably. I wouldn't be here today if I had made a conscious decision to say 'I'm not going to take treatment. I'm just going to live a full life' ...So it's...one of those decisions you're faced with..... (Ben, 60, Prostate Cancer Group)*

Nevertheless, there was an acceptance (in a way the Cardiac Group did not demonstrate) that certain aspects of their masculinity were gone for good. These men appeared to have reached the conclusion that there was little point in hanging on to aspects of masculinity they once

valued if there was a possibility they would increase the risk of mortality (for example, George said on the subject of sexual performance: “What is it? A cheap thrill every now and again?”).

However, some were keen to emphasise that while they had suffered many challenges to ‘natural’ masculinity, they still felt that there were ways of affirming their masculinity through social practice. George, for example, had lost his libido but felt he could still ‘act’ like a man if the situation called for it: “I wouldn’t say it still affects my maleness. If somebody did me wrong I would still go for them.....I wouldn’t call on my wife to go and fight my battles”.

Several of the group participants talked about their experience of being the subject of other men’s conversation: “ ‘Oh, did you hear about Ben: Jesus, he’s got prostate cancer”. Whilst Ben seemed to appreciate that this might be an expression of concern, he clearly felt excluded by what was said about him. As George said, “they’d be saying ‘Ben’s got prostate cancer’, but Ben wouldn’t be sitting there”. Fears that they might be ostracised by other men due to illness are reminiscent of the concerns raised by Barry in an individual interview. He stated that should he become ill with a condition directly challenging to his masculinity (the example he gives is testicular cancer) his biggest fear would be:

Other people finding out about it (illness), other men. You’re standing out from the herd....When you’re a male you hear about ‘oh so and so has lost his testicles’ or something like that. You know ‘ha ha ha’...and face to face they’d be saying ‘oh it’s terrible, it’s a shame’ and that....You’ve got this fear of being ridiculed or just standing out from the crowd. You’re not just part of the group. You’re no longer part of the group.

*(Barry, 62, Individual Interview, Long-term Unemployed Group)*

Callum’s experiences suggest that this perception of how other men may react was grounded in reality. He provided an example of how he was excluded by other men when his illness became public knowledge. He described how he was treated at a social club he had attended for many years:

*Callum (52):* I had a so called friend that was up visiting me all the time in the hospital.....and he told everyone in the club!.....When I came out I was like a leper.....[It was] amazing the amount of people that

didn't want to know you.....It took me weeks and weeks for me to come back in, they didn't want to know me

RO: *Why's that?*

George: They're embarrassed they don't know how to.....

Callum: They didn't know what to say to you

RO: *Other men is this?*

Callum: More so other men aye (*Prostate Cancer Group*)

Upon diagnosis participants seemed to want to break the silence they anticipated they would be met with: "You had this choice. You either keep quiet or you tell everyone about it" (Ben, 60).

It was unclear at what stage men began to talk freely about their illness. As Ben suggested he felt freer to discuss things as the disease progressed but acknowledged that "at the start you're a wee bit (reluctant)". There was some indication that some had coped alone after diagnosis and it was not until they were hospitalised and came into contact with other men with prostate cancer for the first time that they began to share experiences:

*I think it started in the hospital cos..two or three in the one ward of prostate patients, so you begin to exchange views...I think the more you talk about it, and again, it's a personal view, I think the easier it is to live with it. You've got to cope with it. (Murray, 70, Prostate Cancer Group)*

The fact that they were discussing their feelings and experiences freely with other men did not seem to pose as great a threat to their identity compared to the challenges they met as their illness progressed. As Ben stated:

*You go through degrading things (as part of treatment)....when you've went through that sort of thing there's very little left...that you're not prepared to talk about. (Ben, 60, Prostate Cancer Group)*

Inevitably, a diagnosis of prostate cancer raised many questions for participants. It appeared that their first instinct was to alleviate some anxieties by gathering information about the disease, its treatment, and probable prognosis. Arguably, their quest for knowledge was a key strategy in seeking to claw back some of the power they had lost because of their illness. It was clear that their diagnosis created great uncertainties and had made their once unchallenged orderly lives chaotic. Their “education in prostate cancer” (George, 59) was one means of making sense of the losses they had had to endure.

Men suffering from prostate cancer found it much more challenging to try and recapture the aspects of masculinity they felt had been lost through illness. They had experienced multiple challenges to their masculinity, including the loss of work, social life, and ability to perform sexually (as one participant said “there’s very little left”). The loss of libido, physical strength and the feeling that something inherently masculine had been “taken away” from them, most affected their feelings of masculinity. The very fact of their illness evidenced some absence of lack of masculinity which they felt could never be recovered by social practice. The enduring side effects of treatment (which included impotence and loss of libido) presented men with persistent challenges to their masculinity compared to men with CHD who ‘bracketed’ their experience of illness. Certainly the language participants in this study used (“taken away from me”; “cut off”; “guillotined”) suggest that they felt their masculinity had been mutilated and curtailed permanently by prostate cancer and its treatment. Despite the obvious effects this had on their identities as men, participants seemed to conclude that a potentially terminal illness made them feel that they ‘stood out from the herd’ more than the feelings of loss of masculinity that they reported.

#### *‘You just don’t talk to other guys about it’: Depression*

The subject of depression arose more frequently in groups than any other illness. It seemed that all participants suffering from depression had experienced a major life change or crisis that had triggered their illness. Despite its significance, there was a notable absence of any description of such events, and participants did not provide details of their experience of depressive episodes. This contrasts greatly to discussion of other illnesses (e.g. of cardiac and prostate cancer) where men appeared freer to discuss what had triggered their illness, and to

detail general experiences of their respective illnesses. Participants who had been depressed seemed very reluctant to define themselves as ill or, if they did, to give their illness such a taboo name. Many expressed similar sentiments to Phil who said: “we don’t call it depression - we just call it stress” (Phil, 41, Carers Group)

These silences are better understood when one considers what men were able to articulate about the practices of masculinity. Many described how exhibiting visible signs of emotional distress or articulating how they felt flouted the conventional practice of masculinity. The following extract illustrates why this might be so:

Jake (33): *Men...don't show emotions the same way as women. Women, you look at them the wrong way and it's blubbing. They're more open and they talk, whereas we bottle things up*

Nathan (34): *Aye, I would say that's true*

Ros: *Why do you think that is then?*

Jake: *Male bullshit...I'm ready to take the load off other people's problems but I just won't share mine with anybody*

Nathan: *Aye, that's a very male trait. (Slimming Group)*

The majority believed that it was appropriate to remain silent and conceal their experience of mental illness in line with what they felt was expected of them as men.

Some indicated that there might be powerful ‘rules’ that dictated what would be considered appropriate and inappropriate subjects for men to discuss. Certain illnesses or injuries were not considered to be as challenging to masculinity as the symptoms of depression:

Ted (36): *A broken leg or sort of....cancer is MANLY (says in a 'manly' voice) or anything*

Colm (32): *Smoking is .....*

Ted: *Walking about the office saying 'I've got my leg off but I'm still smoking'. (Gas Workers Group)*

Similarly, one respondent considered other symptoms or experiences that would not be thought of as challenging to masculinity, such as “if you’re talking about football injuries or things like that, people talk about those kind of things all the time” (Liam, 43, Mental Health Group). However, when it came to emotional ‘pain’ Aidan (and many others) made it clear that “a real man puts up with pain and doesn’t complain....as a man (suffering from depression) you just pull your socks up” (Aidan, 35, Student Group). Debu added “for a lot of men....certain events in life are just bottled away” (Debu, 22, Student Group). As a consequence, participants seemed to be “a bit more guarded” about who they would talk to about depression or “anything that is generally regarded as having a stigma attached to it....if it’s got something to do with mental health” (Liam, 43, Mental Health Group). In such a climate it is little surprise that Jerry stated “you tend not to talk too much about it....I didn’t want to admit it” (Jerry, 49, Mental Health Group).

Of those participants who admitted to having had a mental health problem, there was a clear view that that even if they were to articulate their experience of depressive illness they would get little understanding from others (particularly other men). The mental health group found it difficult to conceive of a time when they might be able to openly discuss an ‘invisible’ illness (and one that men in particular were expected to keep hidden):

*Mental health can't be seen...I mean if you're walking about with a (plaster) on your leg, people will turn around and say 'well what happened?'. They have a certain amount of sympathy for you. But if they don't see it...The person with the mental health problem might be in mental and physical agony. (Jerry, 49, Mental Health Group)*

The group pointed out that this “stigma” was not necessarily specific to men. As Liam stated: “I wouldn’t be sure if that just applies to men. I think there’s still a general stigma attached to mental health whether it’s men or women”. Although there have been campaigns to try to counter the stigma of depression among men (see for example the Royal College of Psychiatrists, 1998; National Institute of Mental Health, 2006), the majority of men in this

study who spoke about depression felt that there were particular pressures to engage in practices of masculinity that heightened their sense of isolation and encouraged them to “hold things back a wee bit” (Jerry, 49, Mental Health Group).

Liam feared that exhibiting signs of mental illness and discussing his experience with friends might threaten the social network he had managed to maintain. It was his perception that the majority of men he knew believed that men should keep their emotional problems to themselves, and he believed that many men would be unsympathetic if he approached them to discuss his problems. He reflects on this in more detail in the following extract:

*It's probably difficult for a lot of men to talk about it. I would suspect that even if somebody with the problem finds that they can talk about it other people might not be terribly willing to listen...I suspect that there's still an element that you're expected to put up with it and not complain... ..* (Liam, 43, Mental health Group)

This was clearly evident in the humour used by some members of the Health Change Group when discussing the issue of depression. When one of the group members admitted that there had been a time when he “should have talked to someone...(but he) just sort of worked (his) way through it” (Ross 29, Health Change Group), he tries to get the group to explore the possibility that there are disadvantages to being masculine if it means being denied support. This comment was met with the following response:

Ross (29): *There's just something in our make-up that you just don't talk to other guys about it*

Tony (29): *Aye well if it's total lads they're going to rip the pish out of you for it anyway*

Paul (30): *Don't you forget it (mock threatening tone) (Group laughter) (Health Changes Group)*

Although this can be viewed as simply a humorous exchange between friends, there is also a reminder that Paul is playing the role of a ‘total lad’ and that he is willing to mock (‘rip the pish out of’) other group members who depart from a shared model of masculinity. Paul effectively curtails the discussion of mental health, moving the topic away from personal

experiences of depression (which he hinted had been a personal difficulty) and any critique of the practices of masculinity that Ross may have been trying to instigate. His 'reminder' also prevents anyone else in the group reinforcing Ross' view without jeopardising their own masculinity.

Colm (32, Gas Workers Group) was certainly constrained by the fear that "once you've admitted to a weakness then you're thinking that people are going to be looking at you laughing". He described how he would unplug his telephone, and avoid contact with others so as not to reveal anything of what he was feeling. There was the suggestion that he tried to keep his problems 'behind closed doors': "the door's shut behind me...I didn't want to see any of my friends. I felt isolated". Ted (36, Gas Workers Group) also felt that he had remained silent about his depression and describes how "I wouldn't talk to my wife. I wouldn't talk to my friends about it, wouldn't talk to my mum". However, Ted had been able to seek counselling and he felt this was important in decreasing his feeling of isolation and coming to terms with the problems that triggered his depression. Colm, on the other hand, felt that it would be challenging to his masculinity to reveal that "you can't cope. You're not going to admit it to a bunch of strangers" (Colm, 32, Gas Workers Group).

There was a suggestion from one participant that remaining silent and rejecting potential sources of help in the midst of deep depression was viewed by some to be the ultimate demonstration of masculinity. There was an awareness that many would find it difficult to cope under such circumstances and an acknowledgement that they might be at risk of suicide. However, suicide was associated with bravery and being 'hard', symbolising the end point of a period of masculine endurance, silence, and strength:

*People say that these people (who commit suicide) are shirking their responsibility, (that) they're weak people...I find people who actually commit suicide are a lot braver, a lot harder than they're given credit for...I know for one thing when I was in the pits of depression a few years back the one question doctors will ask you (was) 'Have you ever had thoughts of self-harm?' and I said 'Of course. We all do'. 'Have you ever thought of suicide?'. 'Aye, of course'. 'Have you ever acted it out?'. 'You must be joking. I'd be too frightened'. I wasnae brave enough to carry that out. (Jerry, 49, Mental Health Group)*

In such a context, the idea that it is 'braver' to conceal problems and 'take them to the grave' rather than challenge one's masculinity by revealing emotion is a troubling one. It is particularly disturbing as such notions are frequently echoed in the responses of other participants who spoke of how they "struggle(d) on" (Phil, 41, Carers Group), "soldier(ed) on" (Morris, 52, ME Group) or tried to "fight" their illness alone (Colm, 32, Gas Workers Group).

Although the subject of depression arose more frequently across groups than any other illness, the majority of participants who had suggested they had suffered depression seemed reluctant to reflect on how their experience had affected their identities as men. Men perceived that there was a stigma attached to depression (for women as well as men) and this may have influenced their unwillingness to discuss the subject freely. There were also suggestions that men suffering from depression had to cope with a culture of silence and pressures to conceal their emotional distress in order to appear masculine. With this in mind, it is perhaps unsurprising that when the subject of depression was raised in pre-existing groups where other participants had not admitted such problems (as was the case in the Slimming, Health Change and Student groups) the group did not reflect on the subject in detail. It is reasonable to assume that participants might well have been constrained in a group composed in such a way. However, this kind of constraint was also evident in two specially convened groups where men with common experiences were brought together and there was an expectation that depression might be an area explored (Mental Health Group and Carers Group). It seems that the silence surrounding the issue of masculinity and depression may be particularly difficult to penetrate.

## Conclusion

We have explored how three very different illnesses affect men's understandings of masculinity and, in some cases, their attempts to regain control over masculine roles after diagnosis and treatment. Coronary heart disease, prostate cancer and depression all constitute contrasting challenges for middle and late age masculinity. Our findings, in line with other research, show that the losses men experience through illness can reveal what men think masculinity is and expose the practices of masculinity that participants engaged in prior to illness (Chapple and Ziebland, 2002a).

These data support other research that has shown how illness can disrupt identities (Bury, 1982; Charmaz, 1983). The violence with which illness ‘hits’ and the force of opposition to the challenges this presents to male identity in particular are clear from the accounts presented here (see also Charmaz, 1994, for the ‘dilemmas’ illness can present to male identity). The changes imposed on the lives of men in the cardiac group following diagnosis of their heart condition had initially dealt a shocking “blow” to their identities as men. Their accounts revealed that they believed that work and their role as the ‘breadwinner’ were crucial to their masculine identities. These findings mirror those reported elsewhere that have highlighted the importance of work identity for masculinity and the impact of loss of employment on male identity (Morgan, 1992; Collinson and Hearn, 1996a; Eales, 1989). However, participants in this study ultimately felt they had been able to overcome, at least in part, the challenges CHD presented subsequently.

The Cardiac Group spoke of the socially derived aspects of their male identity that had been lost, although there was a sense that these could be replaced by other social practices once they had recovered physically. Some participants spoke of gradually going back to old activities that had always affirmed their sense of masculinity (e.g. returning to work, doing physically demanding tasks, taking exercise). If the possibility of taking up old activities had been ruled out they would find new ways of affirming their masculine identities. This has parallels to other research that has shown that men may be able to ‘restore’ their masculine selves once they are able to engage in old or new practices that affirm their masculinity (Charmaz 1987; White, 1999; Moynihan, 1998). However, we found that the re-negotiated identities described here were fragile and the view that masculinity had been restored was subject to repeated challenges by friends and family (“should you be doing that?”) who regarded participants as having been permanently changed by their illness.

Other researchers have suggested that older men may view illness as a ‘natural’ part of the ageing process and therefore accept the loss of masculinity more readily than younger men (Gray et al, 2002; Cameron and Bernardes, 1998). Charmaz (2000) has stated that conceptualising illness as ‘just ageing’ is a way of maintaining continuity and coherence of self and enables a man to think of his masculinity as unchallenged (see also White and

Johnson, 2000). We found that some of the older men in this study did feel that they 'stood out from the herd' less because they felt that the loss of aspects of masculinity, such as libido and loss of physical strength, would be perceived to be a 'natural' part of the ageing process. The majority of older participants said that they felt 'lucky' that illness had occurred so close to retirement age, as other men of their age would face similar challenges to their masculinity.

The extent of the challenge a particular illness presented to masculinity depended on the nature of the loss men experienced. In contrast to the Cardiac Group, those who had experienced prostate cancer felt they had changed as men because 'essential' aspects of male identity (e.g. libido, sexual performance) had been 'guillotined' as opposed to aspects of gender identity that they felt were socially derived (e.g. through work). As others have found, men with prostate cancer who were of working age accepted the loss of masculinity more readily than participants in other groups, as they had more immediate concerns about their survival (Chapple and Ziebland, 2002). Nonetheless, the feeling that their masculinities had been permanently altered by their illness remained and participants' descriptions of their experiences highlight the embodied aspects of identity and describe the major challenges these men faced when their bodies no longer resembled those of other men, or were incapable of performing as 'masculine' bodies should (Watson, 2000; Chapple and Ziebland, 2002). For participants with prostate cancer, it was much more challenging to seek that essential inner masculine self as the physical manifestations of their illness evidenced some absence or lack which it was not possible to recapture through social practice. Although there were some assertions that they would still be willing to engage in practices to affirm their masculinity, it seemed that the majority accepted that there were parts of masculine identity lost forever.

There were varying degrees in the extent to which it was possible for participants with prostate cancer to face up to the social consequences of illness, in terms of articulating or disclosing the experience to others. It has been reported that men who undergo surgical or chemical castration feel stigmatised and believe their masculinity has been compromised by their treatment (Clark et al. 1997). Gray and colleagues (2000) also describe how men with prostate cancer avoid disclosure about their illness to evade possible stigmatisation, and feelings of isolation. Participants in this study faced up to this possibility and sought proactively to educate others and to demystify the subject. Whilst this is much more likely in

a group of men who actively come together in order to gain support from each other and information about the disease, it does contrast quite markedly with the men who reported experience of depression. They were much more secretive, eschewing disclosure to others, in the main because of the very negative consequences they expected to follow from informing friends, family and, in particular, other men of their problems.

The accounts of men with, or who talked about, depressive illness suggest that some illnesses are denied and concealed to enable men to continue to present unchallenged masculine identities. Although Gordon (1995) reported that men with testicular cancer were able to restore their masculine identities once they recovered from their illness, he observed that the restoration of their identities may have depended on their ability to hide the emotional distress they continued to feel. It has been noted that the "denial of depression is one of the means used to demonstrate masculinities and to avoid assignment of a lower-status position relative to women and other men" (Courtenay, 2000: 1397). One study suggests that it is these very practices of traditional masculinity (such as staying 'strong and silent') that contribute to or exacerbate men's depression and often means that men's emotional distress remains undetected (Good & Wood, 1995). Certainly, participants in this study believed that if their mental illness was made visible to others it would distinguish them from other men with less 'feminised' illnesses or injury as well as making them stand apart from healthy men.

The very discussion of emotional distress (particularly with other men) was felt to flout conventional practices of masculinity. It has been noted how

*Childhood socialisation actively discouraged emotional expression in boys and adult males felt an obligation to display stoicism. Several male respondents felt that expressing pain (including emotional pain) would brand them as 'sissy' or effeminate, and would imply that they were homosexual*  
(Bendelow, 1993: 281).

Participants in this study believed that men were expected to remain silent and uncomplaining about their emotional problems. These findings correspond with those reported elsewhere that indicate that men adopt a "strong, silent approach" and must be "controlled and silent" about anxiety and depression (Moynihan, 1998: 1076). Men in this study enacted masculine control

over their emotions by remaining silent about their own experiences of depression during focus group discussions and by referring to the problems of ‘other’ men. Recent research on men who had, in the main, recovered from serious depression demonstrated the importance to them of reconstructing “a valued sense of themselves and their own masculinity” (Emslie et al. 2006, p2246). Significantly, Emslie et al concluded from their research that “it *is* possible to locate men who can, and will, talk about depression and their feelings” and that “generalisations about depressed men *always* being silent are misleading (p2245, emphases added).

In this paper we have compared and contrasted men’s experiences of three quite different illnesses in order to interrogate the implications of specific health problems for gendered constructions of identity. Masculinity is negotiated and re-negotiated by men in the light of the limitations placed on them by their own and others’ understandings of the social and personal consequences of these diseases. In some circumstances this means submitting to physiological imperatives (e.g. loss of libido), and in others of resisting unwanted attempts at limiting acceptable activity. That some of the men feel that they have to join with other men to achieve this, and in other cases believe that they must inevitably be entirely alone in their efforts, is a further variation in masculine response to illness. Finally, there remains a widespread taboo – reflected in the absence of discussion of this issue between men – in disclosing and help-seeking with regard to depressive illness, which may in part explain the male excess, and recent increases, in suicide and suicidal ideation. The distinctive situation of men with mental health problems certainly warrants further detailed attention.

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Correspondence to:

Kate Hunt (email: [kate@msoc.mrc.gla.ac.uk](mailto:kate@msoc.mrc.gla.ac.uk))



# ‘It’s caveman stuff, but that is to a certain extent how guys still operate’: men’s accounts of masculinity and help seeking

Rosaleen O’Brien, Kate Hunt\*, Graham Hart

*MRC Social and Public Health Sciences Unit, 4 Lilybank Gardens, Glasgow G12 8RZ, UK*

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## Abstract

It is often assumed that men are reluctant to seek medical care. However, despite growing interest in masculinity and men’s health, few studies have focussed on men’s experiences of consultation in relation to their constructions of masculinity. Those that have are largely based on men with diseases of the male body (testicular and prostate cancer) or those which have been stereotyped as male (coronary heart disease). This paper presents discussions and experiences of help seeking and its relation to, and implications for, the practice of masculinity amongst a diversity of men in Scotland, as articulated in focus group discussions. The discussions did indeed suggest a widespread endorsement of a ‘hegemonic’ view that men ‘should’ be reluctant to seek help, particularly amongst younger men. However, they also included instances which questioned or went against this apparent reluctance to seek help. These were themselves linked with masculinity: help seeking was more quickly embraced when it was perceived as a means to *preserve* or *restore* another, more valued, enactment of masculinity (e.g. working as a fire-fighter, or maintaining sexual performance or function). Few other studies have emphasised how men negotiate deviations from the hegemonic view of help-seeking. © 2005 Elsevier Ltd. All rights reserved.

*Keywords:* Men’s health; Masculinity; Help-seeking; Scotland

## Introduction

As developments in sociological theories of gender, and masculinities in particular, have focussed more attention on men’s health over the last decade there is increasing interest in whether and why men are unwilling to seek medical help. One recent review of men’s help-seeking suggests that: “Men are often characterized as unwilling to ask for help when they experience problems in living. Popular stereotypes portray men ... avoiding seeking needed help from professionals. A large body of empirical research supports the popular belief that men

are reluctant to seek help from health professionals” (Addis & Mahalik, 2003, p. 5). Men’s “apparent reluctance to consult a doctor” has been identified as “an important obstacle to improving men’s health” (Banks, 2001, p. 1058). Underlying this is a concern that fewer visits to the doctor and delays in getting timely advice may decrease men’s chances for early detection, treatment, and prevention of disease. Thus, men’s ‘underusage’ of the health care system has been clearly constructed as a social problem.

Empirical data do show that men consult their general practitioners (GPs) less often than women, and gender differences in GP consultation rates are particularly marked in the reproductive years (women in the 15–24 and 25–44 age groups are twice as likely to visit a GP compared to men (ISD, 2000). The higher number of

\*Corresponding author. Tel.: +44 141 357 3949;

fax: +44 141 337 2389.

E-mail address: kate@msoc.mrc.gla.ac.uk (K. Hunt).

consultations amongst women has attracted various explanations. At least part of the excess is accounted for by consultations for contraception and pregnancy, consequent on the medicalisation of reproduction. Beyond this it is often assumed that women have a greater propensity or willingness to consult than men (especially for 'minor' symptoms), although there is little empirical evidence to support this supposition (Adamson, Ben-Shlomo, Chaturvedi, Donovan, 2003; Hunt, Ford, Harkins, & Wyke, 1999; Wyke, Hunt, & Ford, 1998). Courtenay maintains that "the interpretation that men really are ill and they are simply denying it is rarely proposed" (Courtenay & Keeling, 2000). Some have attributed men's "reluctance" to seek help with certain physical, emotional, and sexual health problems (McKee, 1998, p. 601) to a 'poorer awareness of health' (Banks, 2001), or an unwillingness to take responsibility for health (e.g. Calman, 1993). Emphasis has also been placed on the "perceived or real barriers that prevent men from accessing the health care system" (Tudiver & Talbot, 1999, p. 47), and the 'constricting role expectations' or 'psychological difficulties' men are thought to bring to the consulting room (Maharaj, 2000; Good & Dell, 1989). It has been suggested that men may be put off by "male unfriendly" surgeries with few male receptionists and practice nurses and a preponderance of material on child and women's health in waiting rooms (Banks, 2001).<sup>1</sup> Furthermore, men are often portrayed as reliant on female partners (or other female relatives) in health matters, and women are said to encourage awareness of health issues, to assist men in interpreting symptoms, and to play a key role in persuading men to seek help (Norcross, Ramirez, & Palinkas, 1996; Seymour-Smith, Wetherall, & Phoenix, 2002; Tudiver & Talbot, 1999; Umberson, 1992; White & Johnson, 2000). However, some of this research (e.g. Seymour-Smith et al., 2002; Tudiver & Talbot, 1999) is based on doctors' perceptions of male patients as opposed to men's own reports of their experiences.

Whilst the presentation of sex-disaggregated data (and explanations for apparent differences) is an important starting point for research on gender and health, it has the inherent danger of reifying differences between men and women, and homogeneity within gender classes. This is particularly the case where the "commonsense knowledge [is that] men and women act differently" (Connell, 1995, p. 4). The statistics showing that men (as a group) consult less frequently than

women, and the infrequently challenged 'commonsense knowledge' that they consult less 'readily' than women, raises questions about what help-seeking means for men and how it is placed in relation to constructions of masculinity. Connell has argued that:

Rather than attempting to define masculinity as an object (a natural character type, a behavioural average, a norm), we need to focus on the processes and relationships through which men and women conduct gendered lives. 'Masculinity', to the extent to which the term can be defined at all, is simultaneously a place in gender relations, the practices through which men and women engage that place in gender, and the effects of these practices in bodily experience, personality and culture (Connell, 1995, p. 71).

Such arguments have been influential in the increasing recognition of the complexities of masculinity (see, for example, Brod & Kaufman, 1994; Hearn & Morgan, 1990; Mac an Ghail, 1996; Whitehead & Barrett, 2001). It is now commonplace to view masculinities as multiple, contested, dynamic and socially located in both time and place. As Kimmel has remarked, "masculinity must be proved, and no sooner proved that it is again questioned and must be proved again" (Kimmel, 1994, p. 122). He describes masculinity as

... a constantly changing collection of meanings that we construct through our relationships with ourselves, with each other and with our world. Manhood is neither static nor timeless; it is historical. Manhood is not the manifestation of an inner essence; it is socially constructed. Manhood does not bubble up to consciousness from our biological makeup; it is created in culture. Manhood means different things at different times to different people. We come to know what it means to be a man in our culture by setting our definitions in opposition to a set of 'others'—racial minorities, sexual minorities, and above all, women (p. 120).

Hearn and Morgan have suggested that "many of the central concerns of men and masculinities are directly to do with bodies" and that we need to "elaborate theoretical links between constructions of the body and bodily processes in society ... and constructions of gender and gender identities" (Hearn & Morgan, 1990, p. 10). Although health has emerged as a focus of interest in masculinities research (see, for example, Watson, 2000), less empirical research has been done on masculinity and help seeking. This is surprising given the emphasis in social theory on 'what bodies do' (Connell, 1995, p. 71) as the perception of symptoms and signs of illness suggests disruption to normal 'bodily processes'. Those studies of help-seeking behaviours

<sup>1</sup>This assumption that men will prefer to consult male doctors has not been widely researched. One small study of health and help-seeking amongst young men (Richardson & Rabiee, 2001) showed that they had a marked preference to seek help from female doctors. In this study two of the three groups of men interviewed made homophobic comments about male doctors as 'justifications' for not being able to 'trust' them.

which have been published have tended to concentrate on particular groups of men, predominantly men with diseases affecting male organs (testicular or prostate cancer) and coronary heart disease (CHD) which continues to be stereotyped as a 'male' disease (Emslie, Hunt, & Watt, 2001). It has been suggested that delays in getting timely advice may be related to men's beliefs about masculinity (Davies et al., 2000; Ganong & Markovitz, 1987; Moore & Topping, 1999; Moynihan, 1998; White, 1999; White & Johnson, 2000). This reluctance to consult doctors has been noted in the accounts of men with prostate cancer (Chapple & Ziebland, 2002), and severe chest pain (White, 1999; White & Johnson, 2000). Accounts of help-seeking from wider groups of men and how this relates to their sense of masculinity are limited, with a few notable exceptions (Robertson, 2003).

Courtenay has drawn a direct link between denial of weakness and rejecting help as key practices of masculinity and help seeking behaviour. He argues that:

The most powerful men among men are those for whom health and safety are irrelevant... By dismissing their health care needs, men are constructing gender. When a man brags, 'I haven't been to a doctor in years', he is simultaneously describing a health practice and situating himself in a masculine arena (Courtenay, 2000, p. 1389).

This raises questions about how men of different ages, life stages and social backgrounds, and those who have not experienced major health crises or who have conditions which are more commonly constructed as being 'feminine' (e.g. anxiety and depression), consider consulting for symptoms of ill-health in relation to masculinity.

This paper presents discussions and experiences of help seeking and the links made with 'practices' of masculinity. Through analysis of focus group discussions we compare the perspectives offered by a diverse range of men. We question to what extent and in what ways help-seeking behaviours are related to constructions of masculinity.

## Method

Fifty five men participated in 14 focus groups (conducted by RO between June 1999 and February 2001) (see Table 1). We sought diversity within the sample by age (range 15–72 years), occupational status, socio-economic background and current health status. We recruited groups of men whom we anticipated would have had 'everyday' or unremarkable experiences of masculinity and health (largely by accessing men in a range of occupations, such as gas workers, fire-fighters,

students) and groups of men that we anticipated may have had 'epiphanies' (Crabtree, Yanoshik, Miller, & O'Connor, 1993) prompting reflection on masculinity and health. This included groups with men who had prostate cancer, coronary heart disease, mental health problems, and ME. Of the remaining groups one included men who shared experiences of recent health-related changes (principally diet and exercise), another of being full-time carers for wives with serious health problems, and another of being long-term unemployed. The majority of the men lived in central Scotland (Glasgow, Edinburgh, Dundee, Lanarkshire and Perthshire), and just one group was conducted with men of Asian origin, which reflects the limited ethnic diversity in this part of Britain. All names used are pseudonyms.

There is debate in the literature on focus groups as to whether groups of strangers are preferable to 'naturally occurring' groups, such as friends or work colleagues (Kitzinger, 1994; Morgan, 1997; Wilkinson, 1998). Because of our aim to achieve particular dimensions of diversity, our fieldwork included both pre-existing groups ( $n = 9$ ) and specially convened groups ( $n = 5$ , Table 1). Drawing a group of strangers together was in some cases the only way to access people with certain experiences (e.g. men acting as carers, men with ME). Discussions with pre-existing groups were held in their usual meeting place. The research was presented to gatekeepers and prospective respondents as a project on men's health, and information leaflets and invitation letters emphasised a general interest in men's health, and men's lives, but did not overtly highlight the issue of masculinity. Ethical approval for the study was granted by the University's Ethics Committee for Research on Human Subjects.

Discussion was facilitated using general questions (e.g. Are you used to discussing health with other men? What is your experience of seeking help from your doctor?) and, in the latter stages of each group, some statements about men's health were presented to the group. However the main body of the discussion was facilitated by general questions and through discussion of topics which the participants themselves raised. This allowed the subject of masculinity to be explored with as little input from the facilitator as possible. In the focus groups the men engaged in prolonged discussion of both help seeking and masculinity. Different ideas as to what constituted masculinity and how 'manhood' was expressed were actively challenged by members of the group as well as supported, through continual comparison of opinions and experiences. Indeed questions posed by group members were "perhaps more searching than the researcher might have dared to ask" (Wilkinson, 1998, p. 118). Consequently, the data collected from these focus groups contain explicit accounts regarding the social construction of masculinity (in contrast to accounts generated in different

**Table 1**  
Participants in the focus groups

Group ( <i>n</i> )	Age and occupations	Summary of health problems discussed in relation to their own consultation patterns	Pre-existing?*
Cardiac ( <i>n</i> = 4)	Age range 64–72 Transport manager, electrical contractor, HGV driver, signalman (3 now retired)	All had emergency treatment for heart problems	P
Mental health ( <i>n</i> = 3)	Age range 34–49 Psychiatric nurse, local government officer, security guard	2 had had nervous breakdowns	C
M.E. ( <i>n</i> = 2)	Age range 52–69 Retired psychology lecturer, classroom assistant	1 also had angina	C
Prostate cancer ( <i>n</i> = 4)	Age range 52–70 Local government education advisor, Consultant engineer, customer liaison, Panel beater	1 also had angina	P
Health change ( <i>n</i> = 4)	Age range 29 Advertising sales, unemployed, Insurance, Sales	Minor sports injuries	P
Slimming ( <i>n</i> = 4)	Age range 28–34 Warehouseman, depot clerk, Programmer, forklift driver	1 hinted that he had depression	C
Firefighters ( <i>n</i> = 4)	Age range 26–42	All in regular contact with GP and had regular health checks because of their job	P
Gas workers ( <i>n</i> = 3)	Age range 32–41 Employed with same gas company	1 had had testicular lump, 1 had severe depression, 1 prior heart problems and past suicide attempt	P
Unemployed ( <i>n</i> = 4)	Age range 24–68	2 had heart problems	P
Young unskilled ( <i>n</i> = 6)	Age range 15–25 All attending project for young unskilled men	1 ex-heroin addict was recovering from a stroke	P
Student ( <i>n</i> = 5)	Age range 19–47	1 hinted that he was depressed	C
Gay ( <i>n</i> = 4)	Age range 25–47	1 attempted suicide when younger	P
Asian ( <i>n</i> = 4)	Age range 21–22 All students	One had investigations for lump which proved to be benign	P
Carers ( <i>n</i> = 4)	Age range 37–59	Two reported serious depression	C

\*P—pre-existing group; C—group specially convened for the study.

contexts, e.g. through individual interviews) and 'tapped' into men's talk around help-seeking more effectively by exploiting the "co-construction of meaning" between participants (Wilkinson, 1998), using "their language and concepts, their frameworks for understanding the world" (Kitzinger, 1994, author's emphasis). We believe, as Morgan (1997) suggests, that this method was useful for generating data on subjects that are 'habit ridden' (such as health practices) or would not ordinarily be considered in such detail (masculinity).

All the focus groups were fully transcribed, then cross-checked with the tapes for accuracy by RO. In the early stages of analysis all authors participated in ongoing discussions about emerging issues and any difficulties or problems encountered in the course of fieldwork as the interviews progressed. Once all the groups were completed, all authors reread the transcripts and discussed and identified the most important themes. Thereafter more detailed analysis was undertaken by RO who repeatedly reread and compared the interviews to further develop the understanding of specific themes. In focussing on help-seeking for health problems, this paper explores one of these major themes: others (e.g. the impact of ill health on men's identities, and the links between masculinity and health-related behaviours such as drinking) will be explored elsewhere.

As the accounts we draw on were all provided within exclusively male groups (with the exception of the female facilitator),<sup>2</sup> the men's descriptions in the groups are perhaps best viewed as being themselves a presentation of masculinity, for the consumption of other men, and may not necessarily reflect their 'actual' practice. Rather, these accounts are likely to be renditions of men's expectations and experiences of acceptable masculine practice.

## Findings

Twenty-six of the 55 participants discussed having a serious health concern at some stage in their lives; most groups included at least one such man. Unsurprisingly past experience of ill health was less common in groups comprising mainly younger men and those who were currently employed, and their descriptions of help-seeking were mainly confined to discussion of consulting with 'minor' symptoms. As four groups (Cardiac Rehabilitation, Mental Health, M.E., and Prostate Cancer) were recruited because of past experience of ill health to allow a more specific focus on its relationship with masculinity, it is perhaps no surprise that recogni-

tion of symptoms and experiences of help seeking featured strongly in these discussions. However, issues around help seeking were of concern to the majority of participants, even when their identities had not been challenged by serious ill health. Most participants were able to reflect on their approach to help seeking in response to questions or others' contributions, whether they described non-attendance, an occasional presentation with 'trivial' complaints, or frequent visits to their doctor for regular treatment. In the remainder of the Findings we present, first, general attitudes towards consulting for 'minor' symptoms, largely as expressed by the younger men and those with no major health problems. We then look at how men who have experienced major heart problems and mental health problems discuss consulting. Finally, we document a greater willingness to consult in particular groups of men (those with prostate cancer and ME, and men working as firefighters), or different kinds of putative health problems (those affecting sexual performance).

### *Men's unwillingness to consult their GP with 'minor' complaints*

Although occasionally participants who had not experienced serious illness said that they would be willing to visit their doctor if something was "really wrong" (Nathan, Slimming Group), it was more common for participants to describe how they avoided seeking help and tolerated 'minor' symptoms. Common reasons given were that they might waste the doctor's time or be seen to making "a fuss about nothing". It was clear that many considered it a weakness to pay attention to 'minor' symptoms and that the ideal of being "strong and silent" (Steve, Health Change Group) about 'trivial' symptoms was a widely espoused practice of masculinity.

Such views were particularly dominant in the younger groups. The majority of younger men emphasised the rarity of their visits to their doctor. They stressed the need to be obviously injured, seriously ill or pressured to attend before they would consider seeking medical attention. The few examples of help seeking provided by younger participants emphasised how their symptoms derived from acceptably masculine pursuits. As one stated:

the only time I have (gone) to hospital or seen a doctor...was when I had been punched in the face (and)...I needed stitches...or a relative tells you that you've got to go... even then I've been reluctant to go, it's other people...tells you 'you've got to go and get that seen to' (Aidan, Student Group).

He related this reluctance to "the whole idea about what constitutes a man. A real man puts up with pain

<sup>2</sup>The issues raised by a female researcher facilitating group discussions on masculinity with male participants is explored elsewhere.

and doesn't complain". He, like others, reinforced his reluctance to consult by stating "I'm not even registered [with a GP practice]".

Men in the Health Change Group shared similar beliefs and explained in more detail why they considered the ability to endure pain or illness to be a key practice of masculinity, one that would be seriously undermined by help seeking before a problem reached an acceptably 'serious' stage:

- Steve: You don't like to make a fuss because it's a macho thing just to say you're being the strong silent type... You'll endure it, you can take it. So if there is something wrong you won't talk to anyone about it. You have to be bed-ridden or half dead before you'll go (to the doctor's).
- RO: Why would you leave it until that stage?
- Steve: That's what being a man is
- Ross: Aye. You can't really describe it. But most guys are like that.
- Health Change Group*

Similarly, a discussion in the Slimming Group revealed similar beliefs that men should endure illness and injury as a mark of masculinity:

- Rory: I broke my thumb and it took me two days before I went to see a doctor... It was going septic, going green and purple and black and I was like 'I'm not going to bother them'.
- Jake: I think that's just a male trait.
- Nathan: Aye it's (puts on very deep voice) 'I am man the hunter'. I think it's that.
- Rory: I don't even think it's that... It's just I couldnae go to the doctor's with that.
- Nathan: If a woman cut themselves they'd be away to the doctor. A guy'd be like 'I'll just go and get myself a bit of Sellotape and wrap it up'.
- Rory: Aye. I put a bit of a tape on it and carried on.
- Nathan: That's just a man thing though isn't it
- Rory: Aye that's just a man thing. 'I'm hard, I'm daft, I'll cut my arm off and just grow another one back'.
- Slimming Group*

Many described tolerating 'minor' symptoms in this way. However, there was considerable elasticity in what men understood by 'trivial' and how much they were willing to tolerate before seeking help. While some like George were describing "normal aches and pains, a sore throat" when they spoke about 'trivial' complaints

(George, Prostate Cancer Group), others framed most things as 'trivial'. When one participant was asked how he decided what was or was not trivial he responded: "you wait 'til you take a heart attack" (Nathan, Slimming Group); another constructed symptoms as trivial "unless you're dying" (Jake, Slimming Group). Thus, there was not only the suggestion that participants were describing delaying or avoiding treatment for 'minor' symptoms, but also that serious symptoms might be trivialised (or overlooked) in order to avoid challenges to masculinity.

Some participants seemed to test the limits of their masculinity through their ability to withstand severe symptoms that appeared to require urgent attention. The presence or absence of pain was seen as a key indicator of an underlying problem. One man articulated this by saying "you're always defining what ill health is by being in physical pain" (Steve, Health Change Group). Some believed that it was 'manly' to tolerate a high degree of pain and distinguished between levels of pain. Ross describes 'real pain' as:

Basically something that will stop you doing something. It's not the case of 'oh, I've got a wee sort of twinge'. You probably won't see a doctor if you've got a wee twinge. It probably won't stop you doing things so you tend not to mention it. *Ross, Health Change Group*

Paul described postponing getting help until his pain was unbearable.

I'd basically pulled a muscle in my groin and he (doctor) said just rest it... I waited four days and I called him back and I was in absolute agony. He (said) 'why didn't you say anything?' and I was like... 'You told me to rest it'. The ambulance had to come... I was in absolute agony... almost in tears before I called him again. *Paul, Health Change Group*

Thus, it seemed that when it came to 'minor' symptoms the majority of participants agreed that men "should be able to push things further" (Ross, Health Change Group) before taking any action.

However, some of the older participants had no choice but to think more critically of the way their own and others' masculinities had been monitored. When men did talk about past symptoms that had worried them (especially if they thought that others might see these as trivial), the pressure to "push things further" was ever present. Liam, for example, said that he would have liked to feel able to consult the doctor as concerns arose. However he described feeling pressured to consult with something "concrete" or "easy to see and to point to" for fear of being seen as a "time waster". His concern that symptoms might appear trivial seemed

rooted in what he had learnt early in his life about manhood:

I think a lot of men feel that they're expected to put up with it and not complain...when you're young there's an idea that you shouldn't complain or show that you're unwell or injured or upset. *Liam, Mental Health Group*

He goes on to describe his difficulties with seeking help with 'minor' symptoms and his concern about how this might appear to others if it was not obvious that his symptoms were 'serious':

Like a swollen knee I can say there's something wrong here, because I can see it and so can you. Whereas if you go along because you've got a...pain in your...head or you've got a cough or something it's...a little bit less concrete, a little bit less easy to see and to point to and identify (unfinished)...I think you'd be reluctant to go unless you've got something to point at that says this is something that is definitely wrong. You can touch it, it's there...as plain as the nose on your face. Whereas, if you're going with something that's internal...(unfinished)

He suggests that his wife's input was crucial in ensuring he eventually got help with a problem that had troubled him for a long time (he would not specify what this was but it eventually led to emergency hospital treatment).

I think it's interesting that somebody was saying earlier (about) getting your wife to suggest that you go to the doctor...I've heard that before from other men. That they let somebody else take the initiative for them to go...They almost have to get somebody else to confirm that there is something wrong and that it's worth their while to go to the doctor. It's the right thing to do. It's not a time wasting thing to do. It's like somebody else saying 'there, you've got to that point, now you can go to the doctor'. If it's suggested to you that you shouldn't be making an issue of your health, then you almost need somebody else to say to you 'right, you need to make sure of this. There is something wrong. It's a reasonable thing to do to come and have it checked out'.

This suggests that, even among men who appeared to be critical of the constraints of masculinity, the need to "push it further" remained. This was evident in the discussion of the two men in the ME group who spoke about their need to sometimes test the limits of their debilitating illness. Both experienced symptoms that most men might identify as 'trivial', with little or no physical signs or pain. One man compared himself (unfavourably) with other men in his life: "thinking about my Dad or my Uncle, men always struggled on. They wouldn't go to the doctor with anything". His

description illustrates that even chronically ill men were not immune from the pressures to test the limits of their masculinity, to "try and push yourself to see how far you can go" (Morris). He wrestled with a "feeling that you're letting yourself down ... if you're always unwell".

*The shift from minimising 'in extremis' to more immediate response: the impact of heart problems*

Nine of the men had survived a heart attack, undergone bypass surgery, or sought emergency treatment for chest pain or other heart problems. Most of these men described having very little contact with their doctor prior to their attack, stressing that it was the seriousness of their symptoms on that one occasion that "made" them go to the doctor. Thus, it seemed that even when men had a clear medical emergency (severe chest pain) some still worried that they were making a fuss over nothing or being 'daft'. One man described his difficulty in believing that his symptoms were dramatic enough to warrant medical attention:

I broke out in a sweat and my cure for anything like that is go to your bed. Then I found I was up through the night drinking milk...I thought it was indigestion...So my wife was up and down Friday night so she says 'you've got to go to the doctor'. So I was hoping that I'd go in on the Saturday morning and...he'd say 'aye, everything's alright'...The next thing I was whipped up the (hospital) and they reckon there'd been a heart condition.... I never had any of the symptoms that you hear people normally associating with heart attacks, no strange pains. So I found the biggest problem was accepting the fact that I had a heart attack to be quite honest...the symptoms I had I thought I had terrific flu. ...There were people there getting urgent attention and they had revival kits and everything and I was thinking 'what the hell am I doing here?'

*Alf, Cardiac Group*

Others echoed similar feelings. Barry said "I was really shocked when they told me that...(I needed a) quadruple bypass because...up until that time...I felt that I was wasting their time" (Barry, Unemployed Group); and Danny said:

I couldn't believe it was a heart attack... By the time I got to the infirmary I had no pain, so I just jumped off the trolley and said 'sorry it must be muscular tension' and made my way to the door...(A) doctor said 'Mr A, get in that bed!'

*Danny, Cardiac Group*

The belief that a symptom would "probably go away" (Bernard, Cardiac Group) was commonly expressed and again some men talked of the role their wife played in

encouraging them to get advice with symptoms they would have otherwise dismissed as 'minor'. Some appeared to find it impossible to shake off feelings that to be bothered by 'a bit of pain' was to go against their own beliefs about what it is to be a man. Like the younger participants, Mike (who had had a bypass) referred frequently to the belief that the ability to tolerate pain without immediately seeking help was a mark of masculinity:

A man is not likely to go to the doctor as readily as a woman is. You might get a pain and say 'well I'll not bother going to a doctor'. That's what a man is more inclined to do. He'll not say until it's really bad 'look, I've got a pain. There's something wrong here'. ...Now if we feel a bit of pain there we'll go and see a doctor but before...we just accepted the thing.

*Mike, Unemployed Group.*

Although men in the Cardiac Group described how being helped and 'watched' by others was something of an affront to their masculinity, the majority who had had heart disease acknowledged that their health crisis was a sign that certain practices of masculinity might have to be adapted to prevent the recurrence of life-threatening symptoms. They seemed more willing to accept that seeking help at the first sign of a problem, a practice they previously would have rejected, was now crucial following their 'scare':

- Jack: I don't hesitate to go  
 Bernard: If you're unwell go to your GP straight away  
 Jack: After I took the heart attack I would agree with that. Prior to that I would have said I'll work it off  
 RO: What do you mean by 'work it off'?  
 Jack: Well...like I said when I was taking aspirin I knew there was something brewing in my tummy. Normally I would have just said 'ah, I'll let it go', but I was along there like a flash. Normally when I went to the doctor's he'd say 'you should have been here a fortnight ago'... That's the macho male coming out. You can take it.

*Cardiac Group*

One man described becoming very conscientious following his diagnosis: "I go and see a doctor, a consultant every three months. I have to pay for that, but it sets my mind at ease...he gives me a check-up right through" (Danny, Cardiac Group). Similarly, another reflected on his views on help seeking prior to his heart attack and contrasted that with the approach he said he would take in future:

Before I'd say 'alright I'll just go on and not see anyone'. As a matter of fact the doctor I had when I went to see him I wasn't on his books.... You didn't tend to go to the doctors you know, well I didn't... It was only when I got the pains in my heart that made me go to the doctor... I wouldn't hesitate now if I had to go to the doctor's if I felt anything was wrong  
*Barry, Unemployed Group*

Barry described how he "never felt ill enough" to seek help prior to his bypass operation. As he said "the only times I went to the doctor I used to be kind of apologetic. 'I hate to be using up your time doctor' (laughs)".

Thus, most men who had survived some form of heart disease changed their perspective on consulting to some degree and were apparently prepared to consult more readily. However, it may be that their earlier response to symptoms may derive at least in part from the common perception that heart disease is a 'man's' disease. This raises questions about how prior experience of less 'macho' illnesses, such as depression, may affect attitudes to consulting.

#### *Consulting the GP with depression*

The subject of help seeking with depression was raised frequently by participants and seemed to be an area that presented men with particular challenges to masculinity. This subject was discussed freely in the Gas Workers and Mental Health groups where the majority of participants shared common experiences of mental health problems. However, it was very difficult to penetrate the machismo that greeted this subject in other groups and explore how men might go about getting help if they experienced such problems. The main problem was in establishing who had suffered from depression, as men would merely suggest that they might have experienced emotional difficulties or "stress" in the past, but were unwilling to elaborate, or to define their problem as 'depression'.

Some of the interactions within the younger groups were particularly illuminating with regard to the particular challenges men might have with seeking help with depression. The Youth, Health Change and Asian groups all seemed to share rigid views of how men should behave if they experienced personal problems. Non-disclosure of emotions and self-sufficiency were emphasised. For example, Rajiv explained that:

the more masculine man is defined by a man who doesn't share stuff with other people. He can sort it out himself. He's totally in control. He doesn't need anyone else (Rajiv, Asian Group).

And another group member said, "males don't tend to talk about what's bothering them or why they're depressed because they're all man-like (smirking). It's

true though, they tend to keep quiet about it" (Sam, Asian Group). Another talked of his experience of being depressed and how he did not seek support during his bouts of depression:

The very idea of going to the doctor if I feel, you know from personal experience, if I feel in any way down or in a depressed mood... If I was a woman I'd probably go to the doctor and get some...anti-depressants... But as a man you just pull your socks up (Aidan, Student Group).

In a few of the groups there was a strong resistance to exploring issues relating to depression on a personal level, even when there had been hints that one or more members of the group had experienced this problem. This is evident in the hostility shown in the Youth Group when Martin revealed that his brother, Rick, had attempted suicide:

Martin: Tell her about the powder  
Rick: Am I fuck! (Shouting very loudly)  
*Youth Group*

The pressure which men felt from other men was apparent in some of their exchanges. When Ross discussed an incident when he was depressed and "should have talked to someone" he was met with the following reaction:

Ross: There's just something in our make-up that you just don't talk to other guys about it  
Tony: Aye well if it's total lads they're going to rip the pish out of you for it anyway  
Paul: Don't you forget it (mock threatening tone and group laughter)  
*Health Change Group*

Within this group, this apparently humorous exchange between friends, served as a reminder that Paul was a 'total lad' and willing to 'rip the pish' out of men who departed from his model of masculinity, and was effective in moving the discussion away from personal experiences of depression.

Those who did feel able to discuss their problems in greater detail often couched their experience in more acceptably masculine terms. Some preferred to refer to their depression as 'stress': as Phil (Carer's Group) said, "we don't call it depression we just call it stress" and there were a number of references to visiting the doctor for "work related stress". Stress was described as "a mental thing. It's a real macho thing", although the 'inability' to cope alone with 'stress' was seen as a weakness (and hence a direct challenge to masculinity) by some.

Thus, it would also seem that there is not only the need for men to test the limits of their masculinity by

enduring physical pain (as was observed earlier), but some men felt similar pressures to practice masculinity through demonstrating their ability to cope uncomplainingly with emotional difficulties. This is exemplified by Colm who described the symptoms of severe depression (which he interpreted as work-related 'stress') and referred to a past suicide attempt. In the following extract he describes why he feels that as a man he should be able to cope better with 'stress':

Colm: It's absolutely terrible. I mean I go in and the door's shut behind me and I just felt that I never wanted to do anything. I didn't want to see any of my friends. I felt isolated from my friends as well as my family.  
RO: That's how you feel at the moment?  
Colm: Ongoing for about eighteen months. It's just the whole stress environment... I think some men see it as a weakness and some of us, well, I certainly don't want to be seen to have any weaknesses. Not to myself and not to anyone else. I think that's the perception... 'What's he going to the doctor's about and complaining about a minor thing' and stress is just a weakness  
*Gas Workers Group*

Colm seemed particularly concerned about other men's talk about his problem. He seemed conscious of other men's power to define and police his masculinity and to fear being exposed as 'weak'. As the discussion continued he seemed to acknowledge that he had experienced genuine distress and no longer referred to seeing himself as unable to cope or 'weak'. However, the perception of how 'stress' was viewed by other men remained the dominant concern:

RO: So would what you describe [as] a minor thing?  
Colm: Well I've never sought any help for anything I went through in the last eighteen months. Although I've been told that I should have and that I should have gone and spoken to somebody and spoken to them to get it all out and I never have... I tend to... speak to my Mum... I tend to do that when I'm out drinking at two o'clock in the morning and my Mum's in bed... and I'm on the mobile phone crying as I'm walking along the road because it gets too much for me... I think it's because stress is seen as a mental thing... It's a real macho thing, they (men) will not admit to it.

He described how he eventually visited his doctor and was given treatment for depression, although he did not

feel able to continue taking his antidepressants. It seems that even though the tablets 'didn't really work' they also seemed to reinforce his fears that he was not able to 'put up with the stress' without support. For Colm this posed too great a challenge to his masculinity and he did not return to his GP to try other treatment. It appears that his fears about how he and others would redefine his masculinity in light of a depressive illness were too great to face the challenge of accepting help.

However, a minority described seeking help with depression in spite of the perceived consequences for their masculinity. Ted, who sought help following bereavement, described himself as "proactive" when something was wrong and seemed very positive about his experience of receiving help:

I went last year to the doctor actually. It got so bad I actually asked for help, for tablets. Had a long conversation ten, fifteen minutes talking it through and I found that very useful. I met with a counsellor weekly for oh it must have been four or five months...I don't think I would have got through it without it...So I am very proactive if I've got something wrong with me. ...It worked for me and I think it's important but other people are different.  
*Ted, Gas Worker's Group* (emphasis added)

It could be that coming to terms with a death has little to do with measuring masculinity or the associated ability to withstand stress, or that bereavement is accepted as a more 'legitimate' reason for experiencing depression. For another man the stress of caring for his chronically ill wife took a toll and he eventually sought help. He explained that concerns about his masculinity played some part in delaying getting help (he suffered for a number of years before seeing his doctor). As he said:

It takes you a long time to understand, just to think about your emotions. ...Maybe it's because we bottle it up. We don't frequent the doctors when we do feel unwell...It's sort of the macho thing isn't it?...I suppose you find it difficult asking for help really.  
*Phil, Carers Group*.

Similarly, Jerry described his reluctance to seek help:

I was involved in talking and lecturing on mental health for twenty years but when the ball was on the other foot and I started to go down the sort of mental health area I didn't want to (pause). I knew it was there, but I didn't want to accept it. I didn't want to admit it...It would take my wife to turn around and say 'Jerry, GO and see a doctor'.  
*Jerry, Mental Health Group*

Both Phil and Jerry felt they had a responsibility to their wives (particularly Phil as his wife's carer) to seek

help and this was a strong motivation to put aside what seeking help might mean for their masculinity. However, the crucial thing in understanding why these three men (Ted, Phil and Jerry) did not appear to find help-seeking as challenging to their identity as other participants, is how their long standing depressive illness made them feel as men. All described feelings of isolation and 'otherness'; of being apart both from other men and the man they used to be. It may be that their experience distanced them from the masculine culture in which they felt they had to measure their behaviour against other men.

#### *Exceptions to the norm: accounts of greater willingness to consult*

Not all participants described a reluctance to consult or accepted the need to "push it further" so uncritically. One exception to the predominant reluctance to consult was provided by the men in the prostate cancer group. These men were all in the advanced stages of the disease and in some cases had been following treatment for many years. They were also very proactive in getting appropriate support and treatment. Typically they had experienced a less dramatic onset of symptoms than the men with cardiac symptoms. One man described how his diagnosis emerged during a consultation for flu, and another eventually consulted his doctor after experiencing severe pain in his groin ("lying on the floor stuff"). Although he was uncertain about how to interpret his symptoms and was unaware of the symptoms of prostate cancer, he said that the possibility of having cancer "was in the back of my head". He partly blamed his slowness to consult on his own lack of knowledge, as a man, about the workings of his body. Others in the group agreed about their previous lack of knowledge about their bodies. They discussed how a 'feminine' culture encouraged women to scrutinise their own and other female bodies and felt that women were more adept at recognising subtle signs of change in their bodies as a consequence. Callum believed that men were actively dissuaded from taking an interest in their bodies for fear of appearing feminine to their peers and that his socialisation into manhood did not require the same kind of vigilance about his body.

Because the experience of prostate cancer had presented many challenges to these men's sense of masculinity (such as impotence consequent on treatment, and the worry that they might die and leave their family insufficiently provided for), they seemed well placed to critically examine the constraints of masculinity. The fact that these men were also actively monitoring their bodies as part of a 'watchful waiting' management strategy for their cancer encouraged them to educate themselves about what they should look out for and to monitor themselves for any changes.

However, whilst these men had changed their own practices of self-monitoring and help seeking in the light of their illnesses, they recognised that other men would avoid seeking help with similar problems:

If they feel that they're too macho they will not come forward...or will not admit that they think they have prostate cancer—something which would affect their sex life. I think there's a danger in that. It's maybe inhibiting some men from coming forward. Men who think they've got it but they're not going to do anything about it.

*Murray, Prostate Cancer Group*

These men, who had consulted many times as a consequence of their illness, talked less extensively about help seeking and its challenge to masculinity, perhaps because by this stage they had experienced many other such challenges. As Ben stated: “they've stuck tubes up your penis, hands up your backside. In many ways you go through degrading things, you've just got to do it” (Ben, Prostate Cancer Group).

The threat of testicular cancer also had resonance with some participants concerned about potential challenges to their masculinity, although only one participant, Angus, had ever detected a lump in his testicle. Although in other circumstances he said “If I felt ill and everything, I just don't bother [going to the doctor] really” when he detected changes in the size of one of his testicles it prompted immediate action:

I found a lump in my nether regions...Obviously it didn't develop overnight because there was such a big lump and I went and I made an appointment that day...the next night I ended up in the (hospital) having an operation...

*Angus, Gas workers group*

He did not seem to dwell on the challenge, if any, that help seeking on this occasion might have created for him. Rather, he described how he visited his doctor a number of times over a period of days until he was given an emergency referral instead of having to “wait seven weeks” with a lump in his testicles.

A further situation in which men seemed less reluctant to consult was provided by the two men with ME. It seemed that both had a lot invested in seeking help to enable them to get medical confirmation that they had legitimate grounds for rejecting other conventional practices of masculinity (working and ‘providing’ for a family), even though both initially had some difficulties convincing their doctor that they were chronically ill. Both appeared to feel that their masculine identity was threatened by their illness. Donald felt that the reason it took so long to get to the root of his problem was that “the series of GPs” he had seen had “never been very interested in the feelings side of things...You had to

have something *wrong*” (Donald, ME Group) (his emphasis). Morris expressed concerns that other people would doubt that he had genuine reasons to ‘shirk’ his responsibilities as breadwinner and had made several attempts to resume work (which he saw as a ‘duty’ to his family) in spite of his illness. For Morris help seeking was crucial to *affirm* he had a legitimate illness:

I thought I really must be mentally ill, (that) I really can't have all these symptoms and I can't feel this way...You start doubting...even my own feelings, how I felt. ‘Maybe I am a charlatan. Maybe I should have done this. Maybe I should be able to work’... If someone does believe that you have it, then it ... makes a difference.

*Morris, ME Group*

Another scenario in which men rejected their otherwise well-entrenched reluctance to seek help was in relation to symptoms that might hinder their sexual performance. As Steve said, “if you have a problem that gets in the way of sex, you get it sorted pretty quick” (Steve, Health Change Group). Similar views were expressed about sexual health in the Youth Group from participants who were otherwise extremely hostile to the idea of getting help or advice. Although a few in the Health Change group admitted it might be embarrassing to seek help with such problems, they were agreed that it would be “the first thing a guy would go for, probably top of the list” (Tony, Health Change Group). Ross added “aye. You don't wait. It's not a case of ‘no, no, I feel OK’. It's like ‘I can't have sex!’. Neeeeeeow!” (Sound of him speeding to the doctor) (Ross, Health Change Group).

Perhaps the most strikingly different view (and one which was not connected with significant prior health problems) was articulated by men in the fire-fighters group. They described this kind of attitude as the “old school” of masculinity: “the old school—[being] a man's man.... ‘I've a wee pain in my heart today but I'll be alright, nae bother’” (Stuart). However, the fire-fighters suggested that “the average man” would not tolerate pain to that degree. Bobby stated:

Men are getting more aware of their health with the media....If we feel a little bit of pain we'll go and see a doctor...but before...we just accepted it...you'd hope these things go away

One fire-fighter (Stuart) viewed men who trivialised symptoms and diminished their need for help as “naïve. I wouldn't say that's masculine”, but the group acknowledged that it still happened: “unfortunately...I know it's completely moronic, I mean, it's caveman stuff, but that is to a certain extent how guys still operate” (Denny).

The “old school mentality” did not fit with the fire-fighters' view of masculinity, as their gender identity rested

on having a fit, masculine body which enabled them to perform effectively at work. Indeed, all members of the group agreed that seeking help at the first sign of symptoms and asking for preventative health checks were key to ensuring that their ability to work effectively was not jeopardised. As Bobby stated “if I thought anything was wrong with me, say if I got ill next week, I’m straight down the doctor... I’ve got no problem”. Thus, unlike for other men, help seeking was a way of *preserving*, not threatening, masculinity for this group, a means of safeguarding their place in an archetypically masculine occupation. The fire-fighters were unique in having a supportive peer group who shared an interest in health matters and were similarly motivated to preserve health and their work identity. As Andy describes: “if you’re in a watch, a station, my philosophy is if there is something wrong you’d tell the men”. This was in stark contrast to the majority of groups who believed the subject of health and illness was “not men’s talk” (George, Prostate Cancer). This supportive climate was an environment in which the fire-fighters felt safe to critique the constraints of the “old school mentality”, even laugh at it, as they appeared able to reject it without consequence for their sense of masculinity.

## Discussion

It was clear from the accounts provided that there was a widespread reluctance to seek help (or to be seen to be seeking help) as such behaviour was seen as challenging to conventional notions of masculinity. This was particularly evident amongst the younger participants who adhered to a model of masculinity that men who had experienced serious illness had been forced to question. The younger ‘healthy’ participants appeared to have a lot invested in concurring with their peers’ views about what it was to be a man. It was rare for men in these contexts to critically examine these views and how they interfere with help seeking, unless this met with their group’s collective representation of masculine identity. It was apparent that to many participants to (be seen to) endure pain and to be “strong and silent” about ‘trivial’ symptoms, and especially about mental health or emotional problems, was a key practice of masculinity. Many healthy participants thus were eager to embrace a dominant culture of men’s slowness and reluctance to consult and to emphasise their lack of health service use, and were conscious that help seeking for minor symptoms might put their masculinity up for scrutiny. In their discussions men emphasised the importance of: having endured symptoms to some acceptable threshold; having physical and visible symptoms; and the influence of others (particularly spouses) in their decisions about help seeking. This mirrors findings from other research, both in men with

particular health problems (e.g. Chapple & Ziebland, 2002; Moller-Leimkuhler, 2002; Petchey, Farnsworth, & Williams, 2000; White, 1999; White & Johnson, 2000), and those without (e.g. Davies et al., 2000; Richardson & Rabiee, 2001; Robertson, 2003).

These accounts of help-seeking were all provided within exclusively male groups (with the exception of the facilitator) and are thus perhaps best viewed as being presentations of masculinity. Connell, like others (see, for example, West & Zimmerman, 1991), has claimed that “gender is social practice that constantly refers to bodies and what bodies do” (Connell, 1995, p. 71) and that “at any given time, one form of masculinity rather than others is culturally exalted”. In relation to sport, Connell comments that “the masculinity exalted through competitive sport is hegemonic: this means that sporting prowess is a test of masculinity even for boys who detest the locker room. Those who reject the hegemonic pattern have to fight or negotiate their way out” (Connell, 1995, p. 73). It could be argued that there are parallels for help-seeking behaviour, where the ‘exalted’ or hegemonic practice of masculinity, in contemporary urban Scotland at least, is one in which help-seeking is only contemplated following pain, endurance, stoicism and visible injury. The men who departed from this ‘hegemonic’ stance on masculinity and consulting all provided some negotiated reasoning for that departure.

Given that much of the “rich vocabulary of abuse [such as] wimp, ... turkey, sissy [and] lily liver...” that is used to mark out ‘subordinated’ masculinities (Connell, 1995, p. 79) can be closely and directly applied to men’s inability to tolerate, withstand or overcome physical pain, discomfort or disability, it is perhaps no surprise that it remains so important for men to be seen to be rejecting too ready a recourse to medical help or advice.

Whilst, all men appeared to recognise this dominant or hegemonic script for the practice and performance of masculinity, some had chosen, or had been forced, to reject it in their own experience. Such exceptions rarely get considered, although Robertson has highlighted that how men actually behave in daily life may differ from how they say they will behave and that men struggle with balancing “a dilemma between ‘don’t care’ and ‘should care’”. In his in-depth interviews he found that “whilst men were aware of this ‘macho’ aspect of male identity [‘don’t care’], nearly all distanced themselves from it in direct discussion” (Robertson, 2003, p. 112). The exceptions in our own data are interesting because they too *reinforce* the interrelationship between help seeking and masculinity. Indeed, many of the exceptions to men’s reluctance to consult could be understood with reference to a ‘*hierarchy of threats*’ to masculinity. There were two clear scenarios in our data in which consultation could be seen to *preserve*, rather than threaten, masculinity. First, the fire-fighters, whose occupational role gave them access to a strong masculine identity,

appeared unusually open in their discussions about health and emphasised that consulting even for trivial problems or to prevent health problems was important in allowing them to maintain their health and thus retain their job. Secondly, the men who discussed putative problems with their sexual performance indicated that they would much rather 'risk' their masculine status by consulting for a sexual health problem than put it in greater jeopardy by not being able to have sex.

For the men with ME, it could be argued that consultation presented the prospect of *restoring* a masculine identity that was undermined by the nature of the symptoms of their illness. This depended on consultation resulting in a diagnosis that to some extent legitimated them being unable to fulfil roles (working, 'providing' for the family, keeping going) which they felt they were expected to meet as men.

Where men had survived episodes which they perceived to be life-threatening (cardiac problems, prostate cancer), it appeared that they had accepted, to some degree at least, that preservation of their future health assumed a higher priority than preservation of their masculinity. These men were more reflexive and sometimes critical about men's general reluctance to seek help.

The men who were perhaps most vulnerable were those with emotional or mental health problems, which they often construed as 'stress' rather than admit to the 'unmanly' diagnosis of depression. These men appeared very conscious of the unwelcome scrutiny of their male identities that they felt would result from consulting for depression. They had sometimes experienced serious, long-term problems with their mental health which they strove to conceal, and their reluctance to consult with such problems continues to contribute to the relative invisibility of men's mental health problems. Seymour-Smith and colleagues have suggested that "what health care professionals might see as most problematic for male patients is not 'behaving like a typical man' [i.e. constructing themselves as reluctant to consult] but behaving 'like a woman'" (Seymour-Smith et al., 2002, p. 264). It seems likely that consulting with emotional or mental health problems *as a man* may be construed as 'behaving like a woman' in both health care and everyday contexts.

As we noted earlier, these descriptions of attitudes to help-seeking may not reflect men's actual past actions, especially as they were given in group discussions with other men. However, they poignantly describe a culture, a 'practice of masculinity', which most men felt they were expected to conform to and reproduce, or to justify their rejection of such practices.

Addis has argued that:

"Men may experience barriers to seeking help from health professionals when they perceive other men in

their social networks as disparaging the process. This is especially so if (a) other men are perceived as unanimous in their attitudes, (b) a large number of men express similar attitudes, (c) men see themselves as quite similar to the members of the reference groups, and (d) the members of the men's reference groups are important to them" (Addis & Mahalik, 2003, p. 11)

Our study supports others in suggesting that these barriers remain relevant, and are a backdrop for men's illness behaviours. This is not, of course, to suggest that because men are reluctant to consult, women are not, an assumption that is widespread and often implicit. Rather these constructions of masculine 'practice' raise particular barriers for men to the effective and appropriate use of health services and other forms of help-seeking. The focus on physical manifestations of illness, injury or disability perhaps raises particular problems for men with mental health problems (see also Moller-Leimkuhler, 2002).

Robertson has considered the prospect of changing men's attitudes to consulting, and cautions that this should not rely too heavily on promoting men's health through female relatives as this serves "reinforce the impression that real men are not concerned about health matters". He argues that, rather than men being unwilling to go to the doctor, they may "need a means of legitimising their visit so that they can maintain face, or keep their male identity intact, by claiming to be pressured into attending" (Robertson, 2003, p. 113). Our own data show a multiplicity of views expressed by men in relation to help-seeking, and although all acknowledge the 'hegemonic' view that men 'should' be reluctant to consult, some quite clearly depart from this model. We would argue that future research should pay more attention to these departures to focus on the ways in which some men do justify consulting more freely.

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