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**A COMPARATIVE ANALYSIS OF MEN'S RELUCTANCE
TO SEEK HEALTH CARE: PERFORMING
MASCULINITY AND DEFLECTING BLAME**

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Abstract

Men have higher rates of premature mortality than women and may arguably have higher rates of morbidity. An explanation frequently offered to account for these gendered health differences is that men are reluctant to seek health care. This research, within a social constructionist framework, explores the discursive construction of men's reluctance to seek help by investigating through a comparative analysis the ways in which two small groups of men from different socio-economic locations make sense of the reluctance to seek help notion, as well as the implications of this discursive and social positioning for the enactment of their lives. Individual unstructured interviews with nine mid-aged New Zealand men were analysed using Foucauldian Discourse Analysis. Two dominant discourses were identified in the men's accounts. A discourse of masculinity, which constructs reluctance to seek health care as a form of idealised masculinity, was drawn upon by both working-class and professional men. In a contradictory account, working class men also drew on an impediment discourse, which constructs reluctance to seek help as a product of restrictive contextual factors that limit the health practices that men can undertake. Utilisation of the masculinity discourse enabled both groups of men to present themselves as masculine men and perform gender as socially prescribed. The impediment discourse also allowed working-class men to present themselves as victims of circumstance and deflect blame for their unwillingness to seek help from themselves to socio-structural restraints. Presenting themselves as masculine men and victims of circumstance was problematic for the men, as each of these positions was fraught with ambivalence. Their accounts reflect a series of unresolved tensions and dilemmas as they worked through the conflicts between the preservation of their social identity, acknowledging the need to seek help, and deflecting blame. They render overt the interplay between gender, power, and social class. These men's accounts are consistent with previous research that indicates that men are reluctant to seek help, but ascribe this to social expectations and socio-structural constraints, rather than individual choice. Reluctance to seek health care is thus reframed as a social issue.

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Chapter 1: Men's Reluctance to Seek Health Care

Intensifying interest in men's health issues highlights the fact that being a man in the 21st century is health threatening. Emerging from the exploration of a gendered approach to the nature of health and illness is a disquieting profile of men's health. Substantial evidence indicates men die younger than women, have higher mortality rates across all age categories and are at greater risk of ill health and death throughout their lifespan (Courtenay, 1998; 2000a). Further, although still at the nascent stage of research, it appears morbidity rates for men may also be higher (Hodgetts & Chamberlain, 2002; Van Buynder & Smith, 1995). Yet, paradoxically, given this portraiture, research indicates men assess their health status more positively (Boehm et al., 1993; Courtenay, 1998) and seek help for health problems less frequently than women (Gannon, Glover & Abel, 2005; Galdas, Cheater & Marshall, 2005; Ladwig, Marten-Mittag, Formanek & Dammann, 2000).

An explanation frequently offered to account for these gendered health differences is that men's poor health outcomes are linked to their reluctance to seek health care, since it is assumed that men's delay in accessing care may increase their susceptibility to illness and death. An increasing body of empirical research in the United States and the United Kingdom suggests that men are less likely than women to seek help from health professionals and use health care services. For instance, Sandman Simantov and An (2000) analysed data from the Commonwealth Fund Survey on American Men and the Health Care System and reported that 24% of men aged 45-65

years did not have a regular general practitioner, compared with 13% of woman of the same age group.

A National Health Survey (NHS) in the United Kingdom reported that only 58% of healthy men had visited a general practitioner, compared with 74% of women in good health, suggesting an under-use of preventative health services by men (NHS Executive, 1998). In New Zealand, analysis of national data from the Ministry of Health based on the 1996/1997 National Health Survey also indicated that men were less likely to visit their general practitioners than women (Ministry of Health, 1999). Moreover, amongst adults with health problems, men are significantly less likely than women to have had recent contact with a doctor, regardless of income or ethnicity (United States Department of Health and Human Services, 2002).

However, differences in the frequency of help-seeking between men and women are of limited value in helping to understand men's reluctance to seek help (Galdas et al., 2005). Gender-comparative research indicates little about the different biological or cultural processes involved in this health care practice (Galdas et al., 2005; Mechanic, 1978). It also fails to recognise the heterogeneity of men, and that individual men may behave differently in different help-seeking contexts. (Galdas et al., 2005).

Although the research on men's reluctance to seek help is sparse and sporadic, some explanations for men's reluctance to seek help from health professionals have been proposed. It has been suggested that this reticence is due to a lack of knowledge about health matters and a misinterpretation of symptoms (De Nooijer, Lechner & DeVries, 2001). Emphasis has also been placed on the perceived or real barriers,

involving the accessibility and the availability of health services (O'Brien, Hunt & Hart, 2005). For instance, Davies et al. (2000) reported a lack of time, doubts about the credibility of the health practitioners' competence, and a lack of knowledge and information about health services, as impediments to college men accessing care. While Tudiver and Talbot (1999) reported that long waiting periods before men get to see a doctor, limited surgery hours, the lack of male doctors, the inconvenient location of clinics, and the absence of physicians in the work place were perceived as some of the reasons males did not seek help. Furthermore, it has also been suggested that male unfriendly consulting rooms may inhibit men from seeking help (Banks, 2001).

However, many of these explanations are based on research that has inherent methodological limitations. For example, often this research is centred on male undergraduate university students as well as general practitioner populations (e.g. Davies et al., 2000; De Nooijer et al., 2000; Tudiver & Talbot, 1999). Seldom is it informed by the voices of older men, although these men are potentially at greater risk of health problems because of their age.

Some of the research is based on perceptions of men's unwillingness to seek help as opposed to men's own accounts of reluctance to seek help (e.g. De Nooijer et al., 2000; Tudiver & Talbot, 1999). Moreover, content analysis when used in text based analyses (e.g. Davies et al., 2000; De Nooijer et al., 2000), "reify the taken-for-granted understandings that individuals bring to words, terms, or experiences" (Denzin & Lincoln, 2000, p. 640). Given these limitations, these explanations must be seen as inadequate for drawing firm conclusions concerning men's reluctance to seek help (Galdas, et al., 2005).

In addition to these explanations, social theorists and researchers have sought to explain men's reticence in accessing help by relating it to men's social roles and cultural stereotypes (Gannon et al., 2005). One such explanation relates to the male gender role, which is taken to describe the "behaviors, expectations, and role sets defined by society as masculine or feminine which are embodied in the behavior of the individual man or woman and culturally regarded as appropriate to males or females" (O'Neil, 1981b, p. 203). Rigid conformity to this male gender role, learned during socialisation, is thought to have negative effects on men because it leads them to choose practices that potentially reduced their well-being and shortened their lives.

For instance, Nadler, Maler, and Friedman (1984) in research examining gender and gender role ideology, reported that gender-typed masculine men expressed less willingness to seek help than androgynous men. However, Connell (1995) contends that role theory fosters the notion of a singular male personality and so obscures the various forms of masculinities that men can and do demonstrate. Moreover, role theory ignores the part men play in producing effects in their lives (Courtenay, 2000a; Courtenay, 2000b).

Extending the notion that men's rigid adherence to the male gender role is dysfunctional for them (Wisch, Mahalik, Hayes, & Nutt, 1995), O'Neil (1981b) proposed that the male gender role produces messages for men that are contradictory and unrealistic, and leads to their experiencing a psychological state of gender role conflict that results in the personal restriction, devaluation, and violation of themselves, or of others. Gender role conflicts have been reported to being predictive of men's unwillingness to seek help from others.

Good, Dell and Mintz (1989) examined gender role conflict in relation to psychological help-seeking in undergraduate males and reported that men who endorsed the traditional male role regarding restrictive emotionality were more reluctant to seek help. Restrictive emotionality refers to a man's difficulty in expressing his vulnerability and feelings to other people, especially other men (David & Brannon, 1976; O'Neil, Helms, Gable, David & Wrightsman, 1986). The researchers noted that "As men's values regarding the male role became less traditional, their view of psychological help seeking became more positive" (Good et al., 1989, p. 299).

Robertson and Fitzgerald (1992) confirmed these results, reporting that the gender role conflict factors of restrictive emotionality, and power, success and competition were correlated with negative attitudes towards psychological help seeking. The gender role conflict factor of power, success, and competition is a measure of the emphasis a man places on power, control and achievement over others (Wisch et al., 1995). Help-seeking, in contrast, is associated with the qualities of weakness, helplessness, uncertainty, and submission to a more powerful individual (O'Neil, 1981b), all of which are contradictory to the traditional male gender role. Further research literature related to these conflict factors also reports that men are generally reticent in seeking out and accepting psychological help (Rice, 1978; Sher, 1979; Wisch et al., 1995).

However, gender role conflict, as a barrier to help-seeking, has not been investigated with regard to medical help-seeking practices. There is also a heavy reliance on measurement scales, such as the Gender Role Conflict scale (GRC; O'Neil et al., 1986) and the Masculine Gender Role Stress scale (MGRS; Eisler & Skidmore, 1987) to assess how men think and feel about their gender-typed practices and their

relative “degree of conflict and comfort in particular gender-role situations” (O’Neil et al., 1986, p. 338-339).

Many of these self-report instruments, however, reflect societal mores and expectations, which often pre-empt responses, and so perpetuate idealised notions of manhood (Moynihan, 1998). For instance, both the Gender Role Conflict scale (O’Neil et al., 1986) and the Masculine Gender Role Stress scale (Eisler & Skidmore, 1987) include an antifeminine factor and so maintain masculinity as partially opposed to femininity (Smiler, 2004). Masculine characteristics may also be concealed when men report on those they think they ‘should’ have, according to stereotypical notions of masculinity.

Another explanation advanced for men’s reluctance to seek help, based on men’s gender role, is the concept of hegemonic or traditional masculinity, which is taken to describe the culturally idealised form of masculinity at a given place and time (Courtenay, 2000a). It has been suggested that men’s adherence to stereotypical masculine ideals of physical toughness, self-reliance, rationality, and emotional stoicism, for example, translates into a reluctance to seek help (White, 2002), as these ideals are antithetical to many help-seeking activities such as admitting a need for help, relying on others, and discussing symptoms.

However, this concept of traditional masculinity, although it is presumed to be social in origin, represents these masculine ideals as an individual characteristic and personality disposition (Riska, 2002). Consequently, it obscures the various forms of masculinity that men can and do demonstrate (Connell, 1995). Moreover, despite social

theorists pointing towards traditional masculinity as a significant variable influencing men's help seeking practices (Galdas et al., 2005). little empirical research on masculinity and men's reluctance to seek health care has been done, as most research has tended to focus on masculinity and health (O'Brien et al., 2005).

Some researchers have also investigated the relationship between help-seeking and socio-economic status (SES), focusing on socio-economic status as a barrier in the utilisation of health services in terms of primary health services, secondary health services and preventative health practices, in nationally representative surveys. For instance, Mackenbach (1992) reported that higher SES people in the Netherlands made more preventive care visits and used more secondary services than people of lower SES.

Morris, Sutton and Gravelle (2005) reported that lower SES people in England had a higher use of primary care health services, and a lower use of secondary health care services. While Habicht & Kunst (2005) reported that visits to general practitioners in Estonia appeared to positively relate to higher incomes. The inconsistency in this research literature is unsurprising given differences in the markers of SES used in the research, as well as the effects of health reforms in some of these countries in which structural barriers to help-seeking have been investigated. Furthermore, little is known about the influence of other factors, such as, gender, ethnicity, and age within this research.

In summary, the reviewed research literature has identified a number of factors that act as barriers to help-seeking in an attempt to understand and explain why men are reluctant to seek health care. The primary focus of this research has been on men's

traditional male gender role and cultural stereotypes that exert their influence through the personalities of individual men. In this context, responsibility for men's reluctance to seek help is located within individual men. The factors external to men that act as barriers to help-seeking have been given less research emphasis, but those that have been explored, have focused on the functioning of health care services. While research on structural barriers to help-seeking has paid little attention to how they impinge on men's help-seeking practices, concentrating instead on nationally representative populations.

Although these previous research insights are helpful in trying to understand the reasons for men's reluctance to seek help, they provide only part of the picture, as they largely lack sensitivity to the cultural, historical, and social contexts that have the power to shape, maintain, and constrain men's help-seeking practices. As Backett (1989, p.141) contends, "health behaviours should be studied not simply as individually determined, but rather as social products which are subject to complex structural and interactionist constraints".

Yet, very little is known about the nature of men's experiences in relation to this health practice, or the multiple meanings they may have attached to their own practices within particular contexts (Chamberlain, 1997; Leininger, 1992; Lincoln, 1992). To achieve these understandings requires a research approach that is based on a different conceptual framework to that of past research. The reason for this is that the conceptual framework influences the research questions asked, the research methods that are used, and the possible and acceptable sources of knowledge that are gained (Chamberlain, Stephens & Lyons, 1997; Willig, 2001).

This research, therefore, presents an alternative approach to the study of men's reluctance to seek health care by bedding itself on a social constructionist epistemology and a discourse analytic methodology. This conceptual framework provides a research focus that seeks to include the social world of men who are reluctant to seek help and so it allows a different type of research question to be answered. It also provides an opportunity for a comparative analysis of the views of two groups of men from different socio-economic positions, so that the implications of not only their discursive positioning can be explored, but also that of their social positioning

Consequently, the purpose of this research within a social constructionist framework is to explore the discursive construction of men's reluctance to seek help by investigating through a comparative analysis the ways in which two small groups of men from different socio-economic locations make sense of the reluctance to seek help notion. This will elucidate how these men account for their reluctance to seek help, how this affects their subjectivities and the consequent conflict and contradictions they face, when the reality of their lives is taken into account.

As is common in qualitative research, I did not rigidly establish the research question prior to under-taking the research process, as this facilitates the development of a flexible interpretation of men's reluctance to seek help (Cullen & Hodgetts, 2001). Consequently, my provisional question, how do men talk about their reluctance to seek health care, became refined through the research process to:

- How do men from two different socio-economic backgrounds construct reluctance to seek health care and make sense of their unwillingness to seek help?
- Do these discursive constructions of reluctance to seek help differ between these two groups of men?
- What are these men doing with their talk – what functions does their talk serve?
- What do these constructions mean for their everyday lives?

Overall, the goal of my research is to contribute to new insights into why men are reluctant to seek health care.

An Overview of the Thesis Chapters

This first chapter of the thesis has outlined and critiqued previous research that has focused on men's help-seeking practices and has indicated the significant limitations within these studies. This has been followed by a rationale for an alternative approach to studying men's reluctance to seek help that is based on a social constructionist epistemology and a discourse methodology, and then the research questions that this study seeks to answer were presented. In Chapter Two, I discuss the epistemological and methodological underpinnings of this research and in Chapter Three the methods of inquiry used in conducting the research were described. This includes descriptions of the type of inquiry methods used, the selection of participants, how the data was collected, and the ways in which the interview data were analysed, as well as reflexive and ethical issues. In Chapter Four, I present an interpretative account

of the working-class and professional men's reluctance to seek health care. The focus here, through a comparative perspective, is on the discourses the men used in their accounts of reluctance to seek help, the subject positions that they accepted or resisted, as well as the implications of both discursive and social positionings for the men's everyday lives. Finally, in Chapter Five, I offer some observations and directions for further research.

Chapter 2: The Conceptual Framework of the Research

There are various assumptions associated with a social constructionist epistemology and a discourse analytic methodology that afford a fundamentally different approach to understanding men's reluctance to seek help. This section outlines and discusses these assumptions. First, it considers the central epistemological assumptions of social constructionism, and then the methodological assumptions of a discourse analytic approach.

Social Constructionist Epistemology

The research on men's reluctance to seek health care has largely focused on men's gender role, as a key factor in men's reticence to seek medical care. Within this research it is assumed that men have an inherent masculine nature (an essential self) that can be discovered, measured and described by accessing their thoughts and attitudes through the medium of language. This realist approach to language use assumes that men's talk of reluctance to seek help reflects more or less transparently their private world (Bolam, Hodgetts, Chamberlain, Murphy & Gleeson, 2003).

However, such an approach overlooks the social, performative, and constructive aspects of language use (Bolam et al., 2003; Radley & Billig, 1996). By contrast, research underpinned by a social constructionist epistemology is based on different

assumptions that take account of these aspects of language use and thus, provide an alternative explanation of men's reluctance to seek health care.

A social constructionist perspective assumes that the people we are, and the world we experience, are primarily the product of social processes, particularly language (Cromby & Nightingale, 1999). Our knowledge of ourselves and the world is not considered a direct perception of reality, as reality may only ever be experienced through our constructions and interactions with it (Flaskas, 1994). Our interactions (e.g. spoken interchanges) with other people in the course of our lives construct our versions of knowledge (Burr, 2003).

For example, a man may cry in one encounter and then stoically withdraw in another. Such fluidity constructs different versions of masculinity that varies with the context of these socially shared interactions. Hence, masculinity is not an inherent trait, belief or attitude that is discoverable and definable. Masculinity is socially constructed by men in their interactions with others, according to the different contexts in which these interactions occur.

If the nature of the world is a constructed reality, then meaning-making systems, such as language, are more than a way of reflecting and transmitting our world and our thoughts. Instead, language is a form of action that has a variety of functions and consequences (Potter & Wetherell, 1987). Language has explicit social functions. We use it to pass on information, to make excuses, to lay blame, and so on (Chamberlain et al., 1997). Language also functions to position us and others in different ways, it reproduces meanings, and it reinforces existing social structures (Chamberlain et al.,

1997). Through language, we draw upon a range of culturally bound and readily available linguistic resources to construct our world. As people see their world differently, alternative versions of reality are constructed.

This implies that our understanding of our world is historically and culturally specific, depending on where and when in the world we live (Burr, 2003). History provides extensive evidence that cultural understandings change over time. How society defines masculinity, for example, is dependent on the era and the socio-political history (Burr, 2003; Liu, 2005). As Stearns (1994, cited in Smiler, 2004) notes masculinity in Victorian times was passionate compared to the masculinity of today, which he describes as emotionally inexpressive.

Similarly, social anthropology demonstrates that our understandings vary from place to place (Cromby & Nightingale, 1999). Truths, facts, and 'common-sense' are simply perspectival interpretations (Durrheim, 1997). They emerge against a backdrop of socially shared understandings that are culturally and historically relative; a product of a particular place and time, dependent upon the prevailing economic and social conditions (Burr, 2003). Psychological explanations and theories are not conclusive descriptions of human nature and experience. Instead, they are artefacts of a particular culture and time, and as such, they are neither disinterested nor politically neutral (Burr, 2003).

Hence, the social constructionist underpinning of this research problematises the individualistic and acontextual approach of previous research and the understanding that men's reluctance to seek help is simply a matter of individual agency. It provides an

opportunity to challenge the common sense knowledge surrounding this health care practice that contributes to the notion that men are individually responsible for their own health problems and to blame for men's poor health status (Lee & Owens, 2002).

Discourse Analytic Methodology

The constitutive effect of language is best understood through a methodology that focuses on an exploration of the discourses men use in their talk of this health practice. A discourse analytic approach to the research represents a methodology that embodies a 'strong' social constructionist view of the social world (Gergen, 1999), the Foucauldian idea that language is always located in discourse (Willig, 2001), and the assumption that language is a social practice. Discourse is described by Parker (1992, p. 3) as "patterns of meaning which organise the various symbolic systems human beings inhabit and which are necessary for us to make sense to each other".

Discourse is embodied and enacted in a variety of texts. These texts may take a multiplicity of forms, such as spoken words (e.g. interviews), written material (Burr, 2003), artefacts, symbols, and so on. Discourses are multiple, competing, and offer potentially contradictory ways of giving meaning to the world (Burr, 2003; Gavey, 1989). As alternative versions of events or objects are potentially available through language, this means there are a variety of different discourses surrounding an object, such as men's reluctance to seek help, each of which has a different story to tell about it, and a different way of representing it to the social world (Burr, 2003).

Discourses offer subject positions, ways-of-being, for people to take up that provide a basis for their identity and experience (Burr, 2003; Parker, 1992). The subject positions of either masculine male or feminised male are made available in the masculinity discourse, for instance. Individuals may challenge and resist these subject positions but they cannot avoid them (Burr, 2003). Once having taken up a position, the person is tied to the repertoire of rights and obligations that are carried with that position, and they inexorably experience themselves and their world from the vantage point of that perspective (Burr, 2003; Davies & Harré, 1990). Subject positions fluctuate with the varying social contexts that people find themselves in (Harré & van Langenhove, 1999) and also differ in terms of the power they offer individuals (Gavey, 1989; Willig, 2001).

Discourses are implicated in the exercise of power, since they vary in their authority (Willig, 2001). Dominant discourses can function as truths by denying their own partiality (Gavey, 1989). They appear natural and so gain their authority by appealing to common sense (Garvey, 1989; Willig, 2001). These dominant discourses support and perpetuate existing power relations and social structures (Willig, 2001) and “tend to constitute the subjectivity of most people most of the time (in a given place and time)” (Garvey, 1989, p. 464). For example, a system of meanings, such as hegemonic masculinity is unlimited in its power, because it is privileged and available to the majority of men (Gavey, 1989).

Individuals are active and have choice when positioning themselves in relation to various discourses (Davies & Harré, 1990; Garvey, 1989). For instance, men can identify with and conform to discursive constructions of masculinity, or they can resist

or challenge them (Garvey, 1989). This is not simply a matter of rational choice, however. According to Davies and Harré (1990), competing discourses generate the potential for contradiction in men's experiences that may result in a sense of self that is contradictory and fragmented, rather than unified and coherent. These authors suggest that if a person is to act rationally, the person must be aware of, remedy, transcend, resolve, or ignore these contradictions (Davies & Harré, 1990). This situation provides the person with the possibility of choice and acting agentically (Davies & Harré, 1990) and of challenging and resisting subject positions.

According to Willig (2001), discourses are also grounded in social and material structures. This means they are bound up with the structure of institutions and their practices (Willig, 1999; 2001). Discourses reproduce the material basis of social and institutional structures and reinforce their power (Willig, 1999; 2001). These social and institutional structures, in turn, also legitimate and validate discourses (Willig, 1999; 2001). The health care system, for example, is a particularly important structural influence that is bound up with the discourse of masculinity, as it cultivates idealised forms of gender enactments that foster unhealthy health care practices among men (Courtenay, 2000a).

The discourses used by the men in their accounts provide a rich source of the meanings that they bring to their experiences of reluctance to seek health care, as well as the discursive resources within their culture that are available to construct those meanings. A focus on these discourses provides an understanding of how men are positioned in relation to them and how they enable or constrain what men can think.

what they can say, and how they can act in relation to this health care practice (Willig, 2001).

Chapter Overview

All research rests on assumptions that underlie and drive the practices that are undertaken in any research endeavour. In this chapter I have focused on the conceptual framework underpinning this research by outlining and discussing the assumptions that relate to a social constructionist epistemology and a discourse analytic methodology so as to provide the reader with an understanding of the nature of this research and the type of knowledge that it produces. The following chapter outlines the research process that was followed in undertaking this study.

Chapter 3: The Research Process

“The process of research is . . . not a simple recording of something which is there to be found with more or less reliability and validity, but is asking respondents to engage actively in the construction of their ideas and the presentation of their social identity” (Blaxter, 1997, p. 755).

In this chapter, I detail the methods of inquiry used in conducting this research. This includes descriptions of the type of inquiry methods used, the selection of participants, how the data was collected, and the ways in which the interview data were analysed, as well as reflexive and ethical issues.

The Inquiry Methods

This research used methods of inquiry that involved purposive sampling, inductive data analysis and contextual interpretations associated with the non-relativist constructionist-interpretative assumptions underlying it (Denzin, 1994). These were selected, because the men’s understandings of reluctance to seek help are constructed within social interaction and these methods allow for a focus on the language used by the men in their interview accounts. They also provide an interpretative account of seeking help. In addition, since the social world is interpreted in a multiplicity of different ways, the use of these methods affords insights that incorporate the wider socio-historical context in which the men are situated and ‘play’ a part (Chamberlain et al., 1997; Stainton Rogers, 1996).

Selection of Participants

Between August 2002 and September 2003, nine men were recruited for the research. In most discursive studies the size of the sample tends to be small, owing to the relatively intensive time and labour nature of data collection and data analysis (Minichiello, Aroni, Timewell & Alexander, 1995; Willig, 2001). However, this is not regarded as a methodological issue, as the aim of the analyses is not to make statistically reliable or generalised claims (Bolam et al., 2003). Rather, it is an in-depth exploration of the discursive construction of men's reluctance to seek health care, in order to facilitate new insights concerning this practice (Bolam et al., 2003; Chamberlain, 1997).

The men were New Zealanders of European origin and all confirmed that they had never undertaken annual health checks. Their ages at the time of interview ranged from mid-forties to mid-fifties. I judiciously selected men at this stage of life, as researchers have identified this period as a time that involves a growing recognition of advancing age, physical vulnerability and mortality (Burke & Nelson, 1998; Levinson, 1978). Four men worked in manual occupations (salesman, labourer, store-man, and garage attendant) and identified themselves as of lower, socio-economic status. Five men were engaged in professional employment (accountants, consultant and lawyer) and classed themselves as of higher socio-economic status. This social positioning of the participants essentially formed a white-collar/blue-collar distinction that allowed the implications of this positioning for the enactment of the men's lives to be explored.

Data Collection

“If you want to know how people understand their world and their life, why not talk with them?” (Kvale, 1996, p. 1).

Intermediaries (friends and acquaintances) approached prospective participants with an Information Sheet for them to read (see Appendix A). Those men who were interested in taking part in the research returned the accompanying interest form (refer to Appendix B) in the freepost envelope. Upon my receipt of this form, I contacted these men to discuss the details of the study and arrange an interview date, time, and place that best suited them. Just over two thirds of the men, who expressed an initial interest, did not however, participate in the research. Some men cited work commitments for their non-participation, others could not be reached at the contact number they gave, and it subsequently turned out that three had undertaken regular health-checks.

Interviews were conducted within a number of settings where participants could talk privately. Four men asked to be interviewed in private rooms at their corporate offices. A further three interviews took place in private rooms within community facilities. One man’s interview was held at an intermediary’s home and another occurred at the researcher’s home. The interviews lasted from 30 to 55 minutes, with each interview time guided by the participant. All interviews were audiotape recorded. This allowed more of the data to be captured than would have been possible if I had simply relied on memory and so enabled a fuller analysis of the men’s accounts.

Data was collected using an individual interview method. This method was selected, because it provided an opportunity to access the men's talk about their experiences of seeking help within a conversational relationship (Kvale, 1996). The interviews were also unstructured. This permitted more information to be gathered, as the conversational flow of the interview allowed the men to talk freely and spontaneously about issues they considered meaningful (Minichiello et al., 1995). An unstructured interview format was also used with a view to influencing the quality of the conversational interaction by building rapport quickly (Kvale, 1996).

General conversations with the men preceded audiotaping of the interviews in the interest of establishing rapport and making the interviewing process as comfortable as possible. During this time, the structure of the interview was explained to the men and it was emphasised that there were no right or wrong responses to any issues that might be discussed. It was their experiences in which I was interested. The men's research rights (see Appendix A for these) were also outlined at this time. For the men, this was a time for completing biographical details, such as age, occupation, and address for receiving the research summary information sheet, clarifying any issues they may have had regarding the interview, and signing the Consent Form (refer to Appendix C).

Each interview began with the question "Thinking back, can you tell me about the last time you visited a doctor for either a health problem or a health check?" This inquiry typically elicited an extended response about a particular health experience and was the only pre-determined and standardised question throughout the interview process. I thought this initial inquiry would increase the men's comfort in being

interviewed, as it simply required them to describe an experience. At the same time, these experiences would provide insights into the men's accounts of reluctance to seek help (Sword, 1999). Beyond this, the interview proceeded in different directions according to the natural flow of conversation between the men and me, with what was said in the interview determining or defining further questioning.

Throughout the interview I encouraged the men to comment expansively about their experiences and what these may have meant for them. Clarifying questions, both open and closed, such as "can you tell me a bit more about that" were used at times to elicit information more comprehensively (Minichiello et al., 1995). More often than not, however, reflections, simple statements such as "right" and "yeah", and non-verbal gestures, such as head nods, were sufficient to gain further elaboration. The nature of an unstructured interview meant that I also expressed and shared occasionally my own views and experiences of issues that were discussed.

Equally, I was careful the men had the opportunity to respond as they wished, as I was aware of the sensitivity that surrounds sharing medical information. For the most part, participants readily entered into conversation and shared quite personal details. The relatively meandering character of an unstructured interview meant I also had a list of topics to cover and used this as a prompt (refer to Appendix D for this *aide-mémoire*), if a topic was not broached during the conversation.

After the men indicated they had finished, they were given the opportunity to raise any matters that they thought had been missed or not adequately addressed in the interview. If there was nothing further for discussion, as in nearly all cases, the

audiotape recorder was turned off and the men were thanked for taking part in the research. On completion of the interviews, I routinely talked with them about matters in general. This served as a disengagement phase prior to their departure.

Field notes were completed at the end of each interview and used during data analysis as a reminder of the assumptions that I brought to the interview process. This information included details about the setting, my impressions and observations regarding the interview as a whole, as well as my reflections about the conversation. Overall, the interviewing process proceeded reasonably well, given that this was my first experience of conducting any type of formal interview. On one occasion, however, I omitted to switch the audiotape recorder back on after turning the tape over. The result of this was that only thirty minutes of what otherwise would have been a fifty-five minute interview was recorded. On a second occasion the tape recorder malfunctioned. This required me to abandon the interview at that stage and undertake it afresh a few days later.

The men received a thank-you note and a \$20 voucher; petrol, supermarket or book, for their involvement in the research after the date for withdrawal from the research had expired. At the completion of the research process, they received a summary of the research conclusions.

Transcription of Interviews

I transcribed the audiotapes nearly verbatim to remain close to the data. A simplified transcription notation (see Appendix E for this) derived from that developed by Jefferson (1985, cited in Potter & Wetherell, 1987) and guided by the principles of transcription by O'Connell & Kowal (1995) was used in the transcripts. Transcribing involved close and repeated listening of the audiotapes (Silverman, 2000). Given the focus of the analysis, pauses and tone were omitted from the transcripts. Care was taken to protect the men's anonymity and confidentiality. This included the use of pseudonyms to identify the talk extracted from their accounts and the deletion of any potentially identifying details from the transcripts.

Data Analysis Overview

The data for analysis were the transcripts generated by the interviews with the men. Analysis of the transcripts was influenced by existing literature and the texts themselves and involved working back and forth through the transcripts, revisiting phases of analysis, and reworking the data throughout the development of the final account (Potter & Wetherell, 1987). The interview data were not treated as reflections of the men's 'true' experiences, but as discursive productions of these. Moreover, since my construction of the issues, my own discourse, and my influence in the transcription and analysis processes were influential factors during the research process, the men's accounts are presented as an interpretative construction of seeking help, (Lupton, 1997; Wetherell & Edley, 1999).

Throughout the analysis of the data, I focused on identifying the dominant discourses on which the men drew in their conversations about reluctance to seek help, as well as the subject positions the discourses afforded the men, whether they drew on or resisted these positions, and the implications of both discursive and social positioning for the enactment of the men's lives.

Initial Data Analysis

Analysis commenced at the first interview and was ongoing throughout the interview process as each interview was transcribed. Initially, the transcript was read and re-read, firstly, to develop a sense of awareness of what the talk was doing. Then, in subsequent readings, the transcript was broadly analysed for recurrent terms or phrases, metaphors or other imagery that referred to reluctance to seek help (Willig, 2001). Notes about meanings and content were made on the transcript and these were then introduced into later interview conversations.

This was followed by a thematic categorisation of the men's talk in order to establish recurring and collectively shared general patterns about the way reluctance to seek help was constructed in the transcripts. At the start of this categorisation process, the transcripts of lower and higher SES participants were organised into two separate sets. Then for each set of transcripts, all similar instances of talk were selected and grouped together in the same category under an emerging theme. By way of illustration, instances of talk such as: "mainly, because I suppose I can't be bothered, mainly, or I don't think it's important, you know, important" and "I suppose it's being pig-headed,

but can't see any reason why I should go to anyone" were placed together under an emerging disinterest theme. This process was made as inclusive as possible with even vaguely relevant instances of talk included in the category (Potter & Wetherell, 1987). When the talk had features similar to more than one category, it was included in both.

Following this, each category was examined to determine whether it was well supported by extracts of talk and whether it overlapped with other categories. Where there was insufficient support for a category to be analysed in-depth, it was either discarded from the analysis, or as was the case in three instances, amalgamated with another category. The search for emerging patterns in the transcripts resulted in the identification of a number of discursive themes: *disinterest, toughness, minor ailments, serious ailments, financial restraints, commercialisation of healthcare, and a lack of confidence in the medical profession*. Some themes were common to both groups of men and some were unique to only one group.

Continuing Data Analysis

Subsequent analysis drew on aspects of Foucauldian Discourse Analysis to provide an overall interpretation of the men's accounts of reluctance to seek help. This was guided by Parker's (1992) discourse analytic method and Willig's (2001) procedural guidelines for analysing discourse (the respective twenty and six steps are presented in Appendix F), both of which drew on Foucauldian theory. Foucauldian Discourse Analysis is based on the assumption that discourse plays a fundamental role

in the construction of meaning and that the way in which people think, feel, and act (subjectivity) is structured through language (Willig, 2001).

This type of analysis looks critically at the use of language in social discourses and the way in which it constructs different versions of social reality (Willig, 2001). It enables the researcher to go beyond the immediate contexts within which language may be used and explore the relationship between language and subjectivity, institutional practices, and the conditions within which these experiences take place (Willig, 2001).

Foucauldian Discourse Analysis focuses on the availability of discursive resources (discourses) within a culture, in order to identify the way in which language functions to position people in different ways (Willig, 2001). It enables dominant discourses to be highlighted so that their role in the wider social processes of legitimation and power may be examined (Willig, 2001). Thus, a focus on the discourses that men use in their interview accounts provides a rich source of the meanings that they bring to their experiences of reluctance to seek help, as well as identifying those discourses available within their culture to construct those meanings, and the consequences of this.

This phase of the analysis consisted of examining the different ways in which reluctance to seek help was constructed in each discursive theme by highlighting any implicit or explicit references to this. In the discursive theme of disinterest, for example, talk about reluctance to seek help was associated with “don’t give a toss” and “can’t be bothered”, so that theme became part of the construction *fortitude and indifference*. As this examination progressed, the other discursive themes of toughness, minor ailments,

serious ailments, financial restraints, commercialisation, and lack of confidence, became more clearly defined as discursive constructions of *fortitude and indifference* (toughness and disinterest), *self-reliance and rationality* (minor ailments and serious ailments), and *circumstantial barriers* (financial restraints, commercialisation, and lack of confidence).

Further analysis consisted of locating these constructions within wider discourses. A discourse, according to Parker (1992, p. 5), is “a system of statements which construct an object”. Analysis therefore involved ascertaining what was talked into existence in the men’s talk of reluctance (Willig, 1999). For example, the men’s statements of toughness and disinterest in the construction of fortitude and indifference contained talk about “its more apathy”, “I can’t be bothered”, “battle on” and “I’ll put up with it for a while”. This constructed a ‘macho attitude’ towards help-seeking and so became part of a wider discourse of masculinity. Two clear discourses were identified in the analysis, *a masculinity discourse and an impediment discourse*.

Following this, the analysis involved exploring the subject positions, “a conceptual repertoire and a location for persons within the structure of rights for those that use that repertoire” (Davies & Harré, 1990, p. 46) that the discourses offered and the context within which they were mobilised. For example, the masculinity discourse positions men as ‘naturally’ strong and indifferent to pain and physical distress (White, 2002) and offered the men the subject position of *masculine male*. Those men who rejected the subject position of masculine male were offered the positioned of *feminised male*. Similarly, the impediment discourse offered men the subject position of the *victims of circumstance*. Then, the ways in which the subject positions the men took up potentially enabled or constrained individual practices were explored. Finally, the implications of the men’s social class positioning were examined.

Presentation of the Analysed Data

In the following chapter, I have combined the analysis and discussion sections to render a more comprehensive interpretation of how men of different social locations make sense of the reluctance to seek help notion. Extracts presented in this section are drawn from the men's accounts and are included to demonstrate specific points. These were selected from the interview transcripts, because they were representative of the themes of the data set as a whole. In these extracts, the men are referred to by their pseudonyms and the researcher is referred to as 'Kate'. Pseudonyms were used in the analysis to identify the men's extracts, since they seemed to communicate most effectively the way in which variable and contradictory accounts were produced by individual men.

Reflexivity

Since this research process is both interactive and interpretative, it includes my personal values and assumptions. For that reason, a reflexive accounting is offered, so as to explore and lay open to scrutiny the nature and effect of my involvement within the research. I came to this study with a theoretical background largely premised on positivist scientist tenets, having recently completed an undergraduate degree in psychology and much earlier, having qualified as a registered nurse. It was only after an exposure to the qualitative research paradigm in postgraduate study that I learnt of its value for answering certain kinds of questions.

My research was an outcome of the unexpected deaths of two mid-age male friends and my subsequent concern that they were held responsible for their deaths, by their friends, including me, because they had failed to undertake regular health-checks. This was so on my part, even knowing that there is more to health than simply undertaking positive health care practices. Since this research, however, I have an entirely different perspective on 'men's reluctance to seek help' and I hope that this study may help others achieve a similar appreciation so that men will no longer be 'blamed' for their unwillingness to seek health care, or for men's poor health status and statistics.

In my role as researcher, I purposely did not identify myself as a nurse to the men. I thought that if I divulged my nursing background, the men may have revealed less about their experiences of their reluctance in seeking health care. With individuals now encouraged to take more personal responsibility for their health, I was aware that the men may have been uncomfortable talking to a health professional about their reticence in undertaking regular health-checks. I also thought it was important that I kept my researcher role separate from my clinical role. I did not want the men to view me as an expert and assume I had insights into the issues they would discuss. Particularly, as this analysis places the men's subjectivity at the center of the research. Accordingly, I regarded the interview as an opportunity to learn about how the men made sense of their experiences of reluctance to seek help.

Moreover, I have not nursed professionally since undertaking this course of study and so did not consider my practice knowledge sufficiently current, particularly in relation to pharmaceuticals and surgical procedures. Indeed, my re-entry to nursing at

this time would require my undertaking a refresher course. Despite this, I nevertheless felt that I had a professional and moral obligation to reveal my background in the face of a disclosure by a participant of a condition that required medical attention and had decided to do this, if such an occasion arose. Since this did not happen, I identified and positioned myself as a learner-researcher.

My outsider status, a female, middle-class university student, however, did mean that I positioned myself differently in relation to the men's talk along a gendered 'self-other' dimension through-out the research process. Whether a gender and socio-economic match would have enhanced the quality of the interviews is uncertain. Past research indicates that there are both strengths and weaknesses to matching interviewer with interviewee in this way (Sciarra, 1998).

It has been suggested that an interviewer who differs from the participants often has fewer preconceptions about the participants' experiences and consequently asks more questions and gets richer and more detailed accounts (Sciarra, 1998). By contrast, a match between interviewer and interviewee has been found to enhance the quality of the interview. Information shared by the participant with a matched interviewer may not be shared with an interviewer who differs from the interviewee (Sciarra, 1998).

Additionally, I was cognisant that my outsider status may have affected negatively the recruitment of participants to the research. For some men, the prospect of being interviewed by a woman about their unwillingness to undertake a practice that may enhance their health may have created a tension related to the preservation of their identity as 'masculine' males.

Ethical Considerations of the Research

All research always involves the researcher in judgments relating to the ethical practice of the research. In this undertaking, I was guided by the principles of the Massey University Ethics Committee Code and The Privacy Act, 1993. As this research was considered to be of low risk, approval from the Massey University Ethics Committee was not considered necessary. Instead, ethical evaluation and approval was sought and granted through a peer review procedure.

Informed consent for each participant was gained through the provision of an Information Sheet, when they were first approached as a prospective participant, and the formal signing of a Consent Form prior to the start of their interview. The information sheet, contained details, which introduced me and my thesis supervisor, my affiliation to the university, the nature and purpose of the study, the role of those taking part in the research, their rights as participants, the security and the future uses of the information gathered, and the acknowledgement of confidentiality and anonymity.

In the research, the men's welfare was of paramount concern. Care was taken to safeguard their anonymity and confidentiality by conducting interviews in private locations where there was little likelihood of our conversation being overheard by others. Further precautions included reviewing and transcribing audiotapes myself, using pseudonyms, excluding identifying information in the data, securely storing information and data, and planning for data to be destroyed when no longer required. In addition, access to the transcripts was restricted to me, my thesis supervisor, a

Discourse Analysis Group, comprising five other Massey students with whom my supervisor and I met regularly.

To counter any possible negative outcomes to the men associated with discussion around personal health issues, I employed an interview format that provided an environment where these could be discussed comfortably. For example, individual interviewing offered the men privacy and so minimised opportunities for possible embarrassment. Using an unstructured approach safeguarded the men's sense of self-determination. It allowed them to decide what aspects of a topic to discuss and afforded a forum where possible power differentials between the men and me would be limited.

Overview of Chapter

The various methods used in the conduct of this research have been outlined and discussed, together with pertinent ethical and reflexive issues. Following a thematic categorization process, Foucauldian discourse analysis was used to analyse the individual, unstructured interview accounts of nine men from two discrete socio-economic backgrounds to provide a comparative interpretative account of how these men made sense of their experiences of reluctance to seek help. During the analysis procedures, three discursive constructions of reluctance to seek health care, located within two wider discourses, were identified. Ongoing analysis elaborated the positioning of self evident in the use of these discourses and the dilemmas and tensions raised for the men as they negotiated the inconsistencies in their accounts of reluctance

to seek help (Seymour-Smith, Wetherell, & Phoenix, 2002), as well as the implications of their social class positioning.

Chapter 4: Analysis and Discussion

In this chapter I present an interpretative account of how reluctance to seek help was constructed by working-class and professional men in their interview accounts.

The Dilemmatic Nature of the Accounts of Reluctance to Seek Health Care

The men's accounts of reluctance to seek help demonstrated a considerable amount of variability. According to Billig (1996), everyday knowledge is dilemmatic. He contends that sense-making is complex and consists of competing claims and dilemmas around which people work to reach workable or tentative conclusions (Billig et al., 1988; Billig, 1996). Viewed from this perspective, it was anticipated that the men, when talking about reluctance to seek health care, worked through a range of dilemmas that resulted in a complex, contradictory, and discursively mediated construction of reluctance to seek help.

This inconsistency in the men's accounts was significant, as it identified the readily available, dominant, discourses the men had drawn upon in making sense of the reluctance to seek help notion and it also revealed the functions of each of these discourses. Dominant discourses are powerful (Seymour-Smith et al., 2002). They structure our identity and personal experience (Burr, 2003) by setting the framework for what can be thought, spoken, and done in a particular context (Seymour-Smith et al., 2002). Since these discourses prescribe or regulate our lives, they are highly invested, although they are also largely taken for granted (Wetherell & Edley, 1999).

Much of the men's talk about reluctance to seek health care centred on two dominant discourses: a masculinity discourse and an impediment discourse. The masculinity discourse constructs reluctance to seek health care as a form of idealised masculinity and was used by both working-class and professional men to demonstrate their gender identity. The use of this discourse affords men two subject positions, either that of masculine male or feminised male. Men who disclaim the need for help through the performance of a strong and powerful male exercising agency over his world are positioned as masculine males. This positioning allows these men to maintain their privileged status, relative to women and less powerful men and to avoid the strong social sanctions that accompany the failure to perform masculinity as socially prescribed.

The masculinity discourse also constructs positive health practices as forms of idealised femininity (Courtenay, 2000a). Men who engage in health promoting practices, through the performance of a dependent and vulnerable male, are positioned as feminised males. Although these men are performing a form of masculinity, it is not among the dominant forms of masculinities, nor is it adopted by the majority of men (Courtenay, 2000b). This positioning, therefore, undermines a man's ranking among men and relegates him to a subordinated and less powerful status (Courtenay, 2000a).

An impediment discourse was also drawn on by working-class men. This discourse constructs men's reluctance to seek health care as a product of restrictive contextual factors, such as financial constraints that prevent them from accessing help. It functions to deflect blame for men's reticence to seek help from the individual level to contextual influences outside of a man's control, by offering these men the subject

position of victims of circumstance. This enables these working-class men to question the ramifications of their social-class positioning (Hodgetts & Chamberlain, 2000).

Overall, the men's accounts of reluctance to seek health care are consistent with previous research that indicates that men are reluctant to seek help for their health problems (see Davies, 2000; Tudiver & Talbot, 1999). However, rather than this reluctance resulting from a masculine gender role, imposed on men through structured forms of socialisation (Sabo & Gordon, 1995) and exerting its influence through the personalities of individual men, reluctance to seek health care is presented as the product of socio-cultural expectations about masculinity that men enact in order to demonstrate correctly their masculine identity. As Courtenay (2000b, p. 11) points out, "unhealthy behaviors often serve as cultural signifiers of 'true' masculinity". Reluctance to seek help is also presented by lower SES men as the product of socio-structural factors that limit the health practices they can undertake.

The use of both these discourses in the men's interview accounts moves the explanation for men's reluctance to seek health care away from an individualistic framework and reframes it as a social issue beyond the control of the individual (Hodgetts & Chamberlain, 2002). The following sections highlight how this reframing occurs by examining the men's use of these discourses and the implications of the discursive paths that they followed (Wetherell & Edley, 1999), as well as the role socio-economic contexts play in shaping the meanings the men associate with this practice (Chamberlain, 1997).

Reluctance to Seek Health Care and Performing Masculinity

In their interview accounts the men construct reluctance to seek health care by drawing upon a masculinity discourse that situates them in a masculine arena and demonstrates their gender identity as socially prescribed. The men place considerable emphasis on personal fortitude, indifference, self-reliance, and rationality as key factors in men's reluctance to seek help. In this way, they enact and strongly reinforce societal expectations about what it means to be a man and how one is expected to behave. These include the assumptions that "men are more powerful and less vulnerable than women; that men's bodies are structurally more efficient than and superior to women's bodies; that asking for help and caring for one's health are feminine; and that the most powerful men among men are those for whom health and safety are irrelevant" (Courtenay, 2000a, p. 1390). For instance, in the following extract the men indicate a willingness to ignore or suppress pain and discomfort and not give in to adversity. In doing so, they invoke the notion that a man has a responsibility to marshal fortitude and use his own internal resources to resist and cope with adversity:

- Kate: Would you talk about health matters, like screening and that with friends or work mates?
- Ron (LSES): Na, just if someone's got a problem. Like, you know, this thing here [points to elbow], I suppose I should go to the doctor with that, cos it's slightly bigger than the other one and it's quite tender. I don't know what I've done. I'll probably leave it and hope it goes away
- Kate: How long have you had that for?
- Ron: I don't remember. I don't remember banging it, it was just there. I just noticed it one day and when I went [lifts arm] agh, cos it's not sore to touch
- Kate: No?
- Ron: Put some weight on it wooah!
-
- Kate: And did you go the doctor with the knee when it was painful?
- Tim (HSES): No, no. It was just, umm, you know, sort of stiff knee and wouldn't

straighten out sometimes. but it was sort of spasmodic, so I thought, 'well, I've probably injured it', umm. I thought, 'I've twisted it or done something playing golf or playing tennis, or whatever and it'll go away'

Even when the men are encouraged to seek help by others, as exemplified in Steve's extract below, they disclaim the need to seek help and so define their masculinity against positive health practices:

- Kate: Can you tell me if you think someone encouraging you to go to the doctor, umm, would make a difference to you going?
- Steve (LSES): Umm, I've had people say that I should get things done or looked at, even my boss has said it at times, but I just, 'yeah, yeah, yeah, no worries I'll do it ()', but anything that's physical, you can fix it, you can mend it, patch it up and keep going. That's like when I took the fingerprint off my finger, it took all the skin off both my fingers. It was just meat. I ran it under a tap, bandaged it and back at work

The use of masculinity discourse, such as "I'll probably leave it and hope it goes away" and "I ran it under a tap, bandaged it and back at work" constructs help-seeking as a practice that is avoidable since it acts to minimise a man's health problems and invoke the notion that his body is robust and invulnerable that he is uncomplaining and gusty, and able to withstand injury and illness.

While military imagery in phrases and words, such as "battle on through", "Davey Crockett" (a hero of the battle of the Alamo) and "heroic" as evidenced in Tony's and Dave's extracts are used to imply that a man who fights on and resists adversity is strong, brave, and manly:

Tony (HSES): My father was always of the view, if you cut your hand, you sucked the blood until it stopped bleeding and then you went on with it, and umm, I'm very much, sort of think that's the sort of right thing to do without being Davey Crocket or heroic. It's just, you know, it's the way I sort of think about things

Kate: Right

Tony: Well, I went to an all boys' school and the same thing, the same thing was there, you know, I mean, you umm, fell over and skinned ya knees, you weren't supposed to sit there and cry about it, you were, you brushed the bigger rocks off and got on with it

Kate: When you have gone, has [wife] encouraged you to go?

Dave (HSES): Hard to, sometimes it's a, sometimes she encourages me, other times I think I should go. Yeah, as I say, because I haven't, I hope this doesn't sound arrogant or anything, but because I haven't had a condition or an illness that's really laid me low, just haven't had one for years, 20 years probably, I, you can then think, 'well, I can battle on through today, you know, its not as though I can't move, I've gotta do something about this to get myself up and going again'. It's just a matter of saying, 'well, I'm comfortable' and keep going as opposed to 'I really can't, I've got a blazing migraine, I can't move'

Similarly, phrases such as “It’s just a matter of saying, ‘well, I’m comfortable’ and keep going” and “you sucked the blood until it stopped bleeding and then you went on with it” reflect a disregard for the health consequences of one’s actions.

Within their accounts, these men enact a traditional notion of manhood that allows them to preserve their image as strong and resilient men (Hodgetts & Chamberlain, 2002). Fortitude is functional for them, as it enables them to resist adversity and avoid being labelled as in need of help. This interpretation is supported by the men interviewed by Hodgetts and Chamberlain (2002) in research that explored the role of television in the construction of men’s views about health. Men in that study similarly voiced reluctance to seek treatment based on the idea that they had a responsibility to muster fortitude and use their personal resources to resist, cope with, and not give in to adversity (Hodgetts & Chamberlain, 2002).

Paradoxically, fortitude is also problematic for these men. It is linked to their self-neglect, since it discourages them from seeking help. The men are not without some insight into this position, however. In particular, working-class men propose that such thinking can contribute to their health problems because it deters them from taking sufficient care of themselves (Hodgetts & Chamberlain, 2002). As Steve comments:

Steve (LSES): I remember there was one that I got, a very bad injury in my leg and I just left it, left it. I cleaned it and I got a huge infection there, and I, that was just, umm, that I suppose was just being macho

These lower SES men present themselves as hardy and self-sufficient men who can see through societal expectations. Hodgetts and Chamberlain (2002) describe this willingness of working-class men to reflect on traditional masculine ideals as noteworthy, as previous research has shown that these men are more likely to adopt uncritically these regulatory concepts of masculinity. However, Wetherell and Edley (1999, p. 351) contend that “in everyday talk, recognised social ideals . . . can act as both a source for invested identity and as an ‘Other’ to position oneself against”. Therefore, these lower SES men may not be just reflecting critically on this social ideal, but positioning themselves with and against this ideal at the same time.

According to Courtenay (2000a) the masculinity of lower-class men is subordinated by dominant masculinities of higher status males. While Edley and Wetherell (1995) note that some working-class men who apparently have hegemonic characteristics are much less socially powerful than middle-class men who apparently do not share those characteristics. Consequently, such simultaneous positioning may

function to compensate and strengthen lower SES men's subordinated masculine identity and resultant lack of social power associated with their working-class status. Demonstrating one's distance from traditional or hegemonic masculinity, the most honoured and desired of masculinities, as Wetherell and Edley (1999, p. 351) point out is "one of the most effective ways of being hegemonic". As such, this interpretation draws attention to how social class may intersect with masculinity and male power and to the way in which masculinity is not pre-given, but 'performed'.

The men not only construct reluctance to seek help as a result of one's personal fortitude, they also voice reluctance to seek health care based on the idea that help-seeking is a practice that men regard as both unimportant and unnecessary. This indifference is exemplified in the following remarks by Steve, Rick, and Dave:

Kate: Can you tell me, umm, why didn't you go to the doctor with that?
 Steve (LSES): I dunno, mainly, cos I suppose I can't be bothered, mainly, or I don't think it's an important, you know, important. I think I'm pretty blase about my health, I sometimes don't take it seriously.

Kate: Would you go to the doctor immediately for most things?
 Rick (LSES): No, cos I've actually had that crook knee, umm, for, agh, a couple of months now and I was tossing up whether to go to the doctor and I thought, 'no, I'd just do my own sort of work with it and monitor it'

Kate: And you still think that now?
 Dave (HSES): To a degree, yeah. I don't. I try not to run to the doctor at the slightest little twinge, well, you know, because I don't think it's necessary

In these extracts the men construct the practice of seeking health care in a negative way. For example, comments, such as “I can’t be bothered”, “I don’t think it’s necessary”, and “I don’t think it’s an important, you know, important” constructs going to the doctor as an activity that is of little concern to these men. This indifference is legitimated through the representation of this practice as a potentially feminising influence. That help-seeking is considered ‘sissy stuff’ (David & Brandon, 1976) is exemplified in the following comments by Tony when he implies that health visits are a practice mainly undertaken by women:

- Kate: Did you umm, initiate the appointment, or did, say like your wife do that?
- Tony (HSES): My wife, my wife certainly had discussions about it, umm, but umm, and my wife certainly goes to the doctor much more often than I do and so she’s much more used to taking up these issues with the doctor in a way that I’m probably not

It is also evidenced in talk that depicts others positioning men who seek help as feminised males. When Steve, for instance, ignores typical masculine gender expectations and goes to the doctor, he recalls being called a “wuss” by his work mates:

- Steve (LSES): I’d go to the doctor, I’ve heard guys in [...] say to ya when ya going to the doctor, ‘what the hell for, what’s wrong with ya’, and you get the odd comment like, ‘get over it ya wuss’ and they’re so blasé about it, you know

By repeatedly voicing the notion that men are uninterested in seeking help these men are able to actively oppose what is culturally regarded as a feminine practice and position themselves as masculine men. Traditional masculinity situates a concern for

one's health and asking for help as feminine characteristics that men should avoid (Courtenay, 2000a). As Steve's extract indicates, men who do defy societal expectations concerning masculinity and adopt positive healthcare practices, such as going to the doctor, cross over socially constructed gender boundaries. Consequently, they are devalued by others for failing to demonstrate their gender identity correctly (Courtenay, 2000a; Seymour-Smith et al., 2002). These men, therefore, work energetically to avoid being seen as subordinated and feminised males. Ron and Chris, for instance, voice their reluctance to go for health checks despite their willingness to admit that they are "a good idea":

Kate: Can you tell me, umm, how do feel about regular health checks, umm, are they a good idea or not such a good idea?

Ron (LSES): I would say, I would be the greatest one to talk on that subject, but I would say yes, definitely, but I'm a hypocrite in saying it

Kate: Right, umm, can you just explain that?

Ron: Well, cos I've never felt a reason to go

Kate: What about as you are getting older, umm, does that influence you at all or

Ron: No, not particularly. I suppose you're more conscious of the fact that you're getting older when you see your mates getting cancer chopped out and things like that. I suppose you're a bit more conscious of it

Kate: And that doesn't make you want to

Ron: No, cos this person with melanoma, he's only gone because he knows there's something wrong. If I don't know there's anything wrong with me, I suppose it's being pig-headed, but can't see any reason why I should go to anyone. If I'm dying, well everyone's dying, aren't they? Once you're born you're dying, but if I've got something radically wrong with me now that I'm not aware of, umm, and I went to the doctor for a check and he said 'there's something radically wrong with ya, you've got cancer', or something or rather like that, 'we're gonna have to cut it out', the number of stories I hear about people once they're cut open, they're gone once they're cut open, you know, it comes back twice as quick. Well, if I don't know I've got it, I think I'd rather stay sewn up until it got to the stage, well, okay stick the morphine in me and let me go to sleep peacefully

Kate: What do you think about regular health checks, umm, are they a bad or good idea?

Chris (LSES): No, no, it's a good idea, but I'll just wait until something happens. I'm not

- Kate: personally going out of my way to go to the doctor just to have a check up
So, you don't think that if you did go it might prevent something from occurring?
- Chris: Yeah, I see where you're coming from. Yeah, I suppose if I did go get it checked out, you know, it would help, but I'm just fine. I feel healthy now, so don't worry about it

What is clear in these extracts is that these men face a dilemma. While they acknowledge the value of having health checks, they nevertheless display a lack of interest in this practice in order to resist being rendered vulnerable, dependent, and feminised. Although this allows the men to preserve their image as invincible males, it also invokes the notion that they take deliberate risks with their health by ignoring a practice that may improve their health outcomes. As a result, this failure to under-take health checks is construed as a matter of personal choice and responsibility. Since the notion of self-responsibility invites an assumption of guilt, any health problems the men experience become their own fault (Blaxter, 1997).

Such 'victim blaming' arises from the individualisation of health (Blaxter, 1997) that has accompanied the rise of individualism within contemporary western societies (Hodgetts, Bolam & Stephens, 2005; Marks, 2002). Current social and medical dialogue advances the view that the prevention of illness and the promotion of health are associated with individual responsibility and personal choices (Blaxter, 1997; Hodgetts et al., 2005). The effect of this pervasive social prescription is that individuals are confronted with an obligation to take care of their health (Hodgetts et al., 2005). Consequently, health care practices, such as seeking help or health checks, become bound up with a morality of health that is associated with an intolerance of those who, through personal failings, deny the necessity of this healthcare activity and do not engage in it (Blaxter, 1997; Hodgetts et al., 2005).

The resulting understanding that men have freely chosen to make this risky choice and behave in a self-destructive way, has in effect, historically lead to a lack of effort to improve men's help-seeking practices, since it is assumed that such effort will inevitably be unsuccessful (Courtenay, 1998; Lee & Owens, 2002). These men, therefore, are not only seen as personally at fault for compromising their own health outcomes, they are also implicitly blamed for men's poor health status (Lee & Owens, 2002).

However, the western health care system has, in effect, traditionally not encouraged men to pay attention to their health care needs (Annandale & Clark, 1996; Courtenay, 2000b; Rafuse, 1993). Health care educational efforts have infrequently been directed at men (Rafuse, 1993; Regan, 1997) and health researchers and allied health professionals have contributed to the cultural portrayal "of men as healthy and women as the "sicker" gender" (Courtenay, 2000a, p. 1398).

This social perception of men's resiliency and health cultivates and helps sustain idealised forms of gender enactment that prevent men from taking care of their health. Therefore, this institutionalised structure contributes to the "invisibility" of men's poor health status (Annandale & Clark, 1996) by fostering stereotypic masculine demonstrations that undermine men's attempts to adopt positive health care practices, such as seeking help (Courtenay, 2000a).

The men also voice reluctance to seek health care as dependent on the assessment of the seriousness of a problem. The men repeatedly referred to the idea that a man should deal with minor ailments himself by giving his body the chance to cope

with the problem first. For example, Chris and Andy emphasise the need for self-reliance when treating health problems that are not serious:

Kate: So do you go to the doctor often?
 Chris (LSES): Na. I wouldn't go and see a doctor unless if I can't get rid of it by meself. Well, I'll try and sweat it out, or if I'm very crook I'll just stay in bed, try to maybe, you know, might have Lemsips or lemon drinks, or something like that
 Kate: Mmm
 Chris: If I'm really crook, I might have to go and see him

Andy (HSES): Well, colds are colds and flu's are flu's, we're all gonna get them and I think its only when it really gets you down and you really can't do something, that sometimes, yes, you might need an antibiotic, but at the end of the day, if you eat healthily, in the right proportions, I think, you know, a lot of these things can go away

Remarks, such as “Na. I wouldn't go and see a doctor unless if I can't get rid of it by meself” reflect the idea that men have a responsibility to take care of themselves. While phrases such as “if you eat healthily, in the right proportions, I think, you know, a lot of these things can go away” and “well, I'll try and sweat it out” promote the notion that a man's body is a self-regulating system that can respond to adversity and restore its self to order (Watson, 2000). Such talk renders a man's body as inherently resilient and efficient and a man, self-reliant and strong. As a consequence, these men resist being positioned as individuals who are vulnerable and dependent on others for help; characteristics typically associated with stereotypic femininity.

When men do display these feminine characteristics the gender ramifications are often significant (Courtenay, 2000a). Seeking help for a health problem “can reduce a man's status in masculine hierarchies, shift his power relations with women, and raise

his self-doubts about masculinity” (Charmaz 1995, p. 268). Self-reliance is functional for these men in that it enables them to dismiss their need to seek treatment and present themselves as robust and powerful men. As a result, they are compensated with social acceptance and diminished anxiety about their manhood (Courtenay, 2000a), even though they may be increasing the possibility of their health deteriorating even further.

Thus, a dilemma arises here for the men between the preservation of their gender identity and their negotiation of adequate health care. Presenting one’s self as willing to cope with minor ailments enables them to protect their identity as independent men, but it also means they are held responsible for taking insufficient action in looking after their health. This is because the practice of seeking help is often regarded as an important first step in resolving health problems and a critical link in effecting better health outcomes (Addis & Mahalik, 2003). Therefore, when a health problem develops and is allowed to progress, any serious ramifications that arise are attributed to the failure of the person to access help at an early stage (Hodgetts & Chamberlain, 2002).

However, the men diligently voice the notion that men’s help-seeking practices are based on well-considered and rational decision-making processes. When the problem becomes “serious” or the symptoms “too painful” the men recognise the need to see a health practitioner:

- Kate: Can you tell me the kind of things that would send you to the doctor?
 Steve (LSES): Things that would probably make me go to the doctor would be things I couldn’t fix myself, or by going to a chemist, or anything like that
 Kate: But you’d try and fix
 Steve: Sort of yeah, umm. if it was something serious, yeah, I would go to the doctor, umm. but I don’t seem to have too many problems like that. but that thing with my middle ear that was something serious

Kate: Mmm. and umm. you say you only go if you really have to?
 Chris (LSES): Yeah, yeah. I just go if I have to. agh. something's getting really annoying, it's just really bugging me, or it gets too painful. stuff like that. or if, you know, if I've been in bed still can't get rid of whatever I've got that's when I'll go and see a doctor

Kate: Are there situations or circumstances under which you wouldn't seek help?
 Nigel (HSES): No, well things that don't, you know. that aren't causing me a problem then fine. I wouldn't go and see anyone. I'll put up with it for a while, but if it doesn't go away then I'll go and see them. Everything has a chance to heal by itself and if it doesn't do that, then yeah
 Kate: Right
 Nigel: And you know it really depends what it is. If I had say a backache for a week, well I'd just take it easy for a week, you know. like just relax and do that sort of thing and if it stayed there then I'd go and see someone
 Kate: But, umm, you'd wait sometime before going to the doctor?
 Nigel: Yeah, well easily a week, yeah, I don't consider that to be excessive, but again that depends on, you know, if I was incapacitated then I wouldn't wait a week I'd go straight away

Comments, such as “if I've been in bed still can't get rid of whatever I've got that's when I'll go and see a doctor” or “if I was incapacitated then I wouldn't wait a week I'd go straight away” and “if it was something serious, yeah, I would go to the doctor” reflect the limits of a man's self-reliance and endurance. This ideal of rationality is clearly articulated and supported in Rick's talk, when he ranks help-seeking response times according to the different types of health problems he might experience:

Kate: How long would you wait before you went to the doctor?
 Rick (LSES): Well, there's different categories. Injury, you know, like a severe injury. I'd go straight away. Cut yourself, you need medical attention pretty quickly. I've damaged my back at different times, so I've needed to go straight away, so we can, but if it's, if it's an illness I would wait for up to a week before I'd go. A lot of it is just; it just goes away if you look after yourself, what it is and how it's progressing, over those four days

In addition phrases such as “severe injury”, or “too painful” and “really annoying” builds up the construction of help-seeking as a justified action given the severity of the problem and supports this practice as a reasoned choice. Presenting one’s self as prepared to access care when circumstances warrant such action implies that all men’s health care practices are based on careful and deliberate decision-making. This renders the men rational individuals whose health care practices are judiciously undertaken.

Although this safeguards the men’s masculine identity it also raises some crucial implications for the status of their morbidity and longevity. Failing to seek help until a health problem is severe may result in serious health consequences. Ignoring early signs and symptoms that all is not well with one’s body means that one can become a candidate for health concerns, such as cancer and heart attacks (see Cameron and Bernardes, 1998; De Nooijer, et al., 2001) that have the potential to lead to chronic illness and even early death. When these serious ramifications occur, they are most often attributed to the person’s failure to seek help early in the development of the health problem. They become the individual’s own fault - the character failings of a person who is not motivated enough to seek help at an early stage (Blaxter, 1997; Bolam et al., 2003; Lee & Owens, 2002).

Paradoxically, however, institutional structural influences, such as the health care system, compensate men with rewards, such as prestige and power, for such demonstrations of idealised masculinity. In illustration, Seymour-Smith et al. (2002), in their discursive analysis of doctors’ and nurses’ accounts of men’s use of general

practitioners, reported that the health practitioners respected their male patients for their stoicism and for only attending the doctor when they were 'really ill'.

In making sense of the reluctance to seek health care notion, these men invoke the restraining influence of societal expectations about gender and how one is expected to act, as influential in their disclaiming the need to seek help. The men's accounts reflect a series of unresolved tensions and dilemmas as they work through a conflict between the maintenance of their masculine identity and acknowledging the need to seek help. Presenting themselves as traditional masculine men not only allows these men to avoid the strong social sanctions that accompany the failure to demonstrate gender as socially prescribed, but it also enables them to maintain, relative to women, their positive and privileged position in society. Nevertheless, this performance of masculinity results in these men being held personally responsible for their reluctance to seek help, as well as implicitly blamed for men's poor health status (Lee & Owens, 2002).

However, working-class men with their subordinated masculine identity and less privileged socio-economic position in society, in contrast to professional men, do not simply accept responsibility for failing to seek help. Instead, they deflect this blame, by shifting responsibility to socio-structural constraints outside of their control that limit the health care practices that they can undertake.

Reluctance to Seek Health Care and Deflecting Blame

In an attempt to ward off blame and shift responsibility for their failure to seek help to external constraints, working-class men produce a contradictory account of reluctance to seek health care by placing considerable emphasis on circumstantial barriers in their interview accounts. The men repeatedly talk of being constrained in their help-seeking activities by external circumstances, over which they have limited control. They emphasise financial restraints as influencing their willingness and ability to access help. In typical examples of this, Chris and Ron talk about the financial cost of going to the doctor as preventing them from engaging in this practice:

Chris (LSES): You know, if you've gotta take two hours or three hours off to see a doctor and he's gonna charge you like a wounded bull, you know, why go to the doctors? I'm losing money going there, since I'm taking time off work and you most probably have to pay about twice as much as you get for your normal hourly rate at work. So, agh, I won't take time off work to go and see a doctor

Ron (LSES): After I broke my leg a few months ago, that was, umm, I ended up with athlete's foot, cos I hadn't been able to wash my foot. It was totally in plaster, hadn't been able, what a mess my skin was, but I didn't go to the doctor for that. I just went to the chemist first and they just gave me Daktarin, or all that sort of stuff, and covered meself with that, and that's as good as gold. Well, I mean it came right for the sake of a \$20 bottle of ointment and it would have cost me about \$100 for the doctor to get the same thing. I think there's a lot of people doing that now. It's probably false economy but people can't afford doctors and they tend to try and take short cuts. One of my offsidars down there [...], she's got major blood problems at the moment, I reckon. She keeps coming up in these big sores and god knows what, and she won't go to the doctor, she just keeps going into the chemist shop and it's sort of coming right

These extracts support previous research suggesting that financial restraints are influential in whether or not men seek help. Hodgetts and Chamberlain (2002)

investigating the ways in which working-class men drew upon their existing views and aspect of a men's health television programme as they worked through the reluctance to seek help notion, reported that the men referred to financial restraint as one of the barriers that prevent men from accessing care. Similarly, the working class men in this research talk of how the cost of seeking help curbs their own and other people's willingness and ability to engage in this activity. In doing so, they invoke the notion that reluctance to seek help is restrained by wider socio-economic influences and is not simply a matter of personal responsibility or failing.

By assigning responsibility to financial constraints these men link the practice of seeking help to one's SES level. They do not simply accept the notion that their unwillingness to seek help emanates from individual failure (Cullen & Hodgetts, 2001). If a person's material circumstances in life limit the choices and activities that are available, then responsibility for not accessing help can be transferred to socio-structural influences outside of their control.

In externalising responsibility in this way, these men invoke their social powerlessness and present themselves as victims of circumstance. This enables them to respond to the emphasis given to individual responsibility prevalent in social and health dialogue (Blaxter, 1997). These men are able to resist the potential stigma associated with this emphasis that assumes that personal characteristics, such as lack of motivation, laziness, as well as genetic inferiority, determine why working-class men are reluctant to go to the doctor (Hodgetts & Chamberlain, 2002).

However, presenting themselves as victims of circumstance invokes notions of dependency and powerlessness that reflects a shift in their masculine identity. Consequently, working-class men are obliged to negotiate a continual tension between needing to act in a socially prescribed masculine manner and preserve their masculine identity and an equally strong, but problematical need to act as victims of circumstance and deflect blame for their failure to seek help (Lupton, 1997). Since these two positions are each fraught with ambivalence, they are not without difficulty for these men (Stein, 1985, cited in Lupton, 1997).

The men extend this framing of reluctance to seek help as a socio-structural issue by linking their failure to access care to the commercialisation of the health care system (Hodgetts & Chamberlain, 2002). There is a concern throughout their accounts that the prevalence of a business ethos within this social structure prevents them from seeking help when it is needed (Hodgetts & Chamberlain, 2002). As Steve and Ron comment:

Steve (LSES): Doctors over there were so easy to get to, more accessible, the medical system there was quite different. You just signed a piece of paper and that was it, no money changed hands and it was added on to your tax at the end of the year. Here, if you haven't got the money to pay for the specialist fees up front, you have to go through the public system, which means you'll have to wait a long time. Your health suffers cos you're gotta wait

Ron (LSES): and he said, 'yeah, you go through the private system, you get it done straight away' and I said 'how much will it cost to get it straight away?' and I said, 'you're kidding'. I just thought that was over the top, you know, and I just said, 'put me through the system and I'll stay on the pills until there's space

As demonstrated in these two extracts, lower SES men voice a distinction between the availability of help-seeking opportunities provided to different socio-economic sections of society by a commercialised health care system (Hodgetts & Chamberlain, 2002). They emphasise that the existence of a two-tiered health system acts as a barrier to their help-seeking practices, as its private and public sectors provide different levels of access to help, depending upon one's financial position. With their limited financial resources, these men are excluded from a well-resourced private provider network where help is readily available. Instead, they are channeled into an under-resourced and overburdened public health sector. Consequently, they are obstructed in their help-seeking activities by their dependence on a commercially based system that penalises those with limited incomes.

By shifting responsibility for not seeking help to a health care system that maintains a gap between those with limited financial resources and those who are more affluent these men continue to renegotiate the notion that men's reluctance to seek help is an individual responsibility (Hodgetts & Chamberlain, 2000). They present themselves as the victims of an inequitable health system that not only limits their ability to utilise its health services due to its market-economy approach, but also acts to constrain them from being egalitarian members of society (Hodgetts & Chamberlain, 2002). In doing so, these men are effectively able to justify their failure to seek help and deflect blame from an individual level to socio-structural constraints.

The men also attempt to justify their reluctance to seek help through their criticism of the medical profession. The men are extremely negative in their comments about the way in which doctors interacted with them and tend to judge medical

practitioners harshly for their poor technical skills. For instance, Steve and Ron comment that the poor calibre of doctors currently practising is responsible for their reticence in seeking help:

Steve (LSES): I only go if I really have to and it's like I said, I don't like paying the money for it. I often think sometimes that doctors spend a lot of time, and I've had people been diagnosed wrongly, and I've come to the conclusion sometimes they're dispenses for drug companies and sometimes, there's like the old fashion doctors, you know, they check you over and do the whole bit and ask you all these questions. These days, you've gotta tell them, but umm, I don't know, I'm just wary about how things go, you know, like you're talking to them and they're looking at the computer and I kinda think that's either new age or they've just lost touch with how to deal with people, and so, umm, I'm a bit dubious about some doctors especially new and foreign ones, umm, I only go at the last minute if I really, really have to

Ron (LSES): I had to go for that ear and while he was checking my ear, he couldn't turn the switch on for the light probe thing they stick in ya ear and he didn't know how to turn it on, so he rang up on the phone and he got the nurse to come in and plug it in for him and switch it on underneath the table, the desk, and I thought 'either this doctors really helpless, hopeless, or he's just got no brains'. I thought it was pretty dammed silly, you know. It just didn't make any sense and I though 'is this the type of doctors we've got here?' 'What are they really like?' Pass that, like it was just, to sit there and watch him go through this, was like he seemed a bit hapless . . . I don't know if they lack experience, or they've been away from it, or what it is, but to sit there and watch this go on, I thought 'this was not what doctors are like', you know . . . and I suppose, it's one of the reasons that put me off. I suppose, going to the doctors

These men voice the idea that their lack of confidence in medical practitioners has a negative effect on their willingness to seek medical assistance. Lupton (1997) notes that expert knowledges, such as medicine, are now subject to skepticism and to challenge, because of increasing doubt and uncertainty about their claims. Furthermore, the current commercial approach to the delivery of health care services has resulted in medical services being deemed a commodity and the medical profession viewed "simply as suppliers of services, competing amongst themselves and seeking to

maximise their income by selling their professional expertise” (Blaxter, 1997, p, 373). Users of these services are now expected to evaluate doctors’ practices and go elsewhere if the commodity is unsatisfactory (Lupton, 1997).

Due to the influence of this commercialised approach, these men challenge the utility of seeking help from health professionals who offer an inferior service, particularly when financial issues are a consideration and going elsewhere may not be practicable when financial resources are limited. They do this by voicing criticism about the way in which doctors fail to act autonomously, their impersonal manner, their lack of proficiency with current technology, and their poor diagnostic skills.

Similar criticisms relating to the medical profession have been identified in other qualitative studies with lay people. Lupton (1997) explored people’s thoughts and feelings about medicine and medical professionals and reported that although individuals in the study were variable in their comments about the medical profession, their major criticisms related to the proficiency with which doctors used their medical knowledge and dealt with them on a personal level.

In their accounts, these working-class men use these criticisms of the medical profession, to shift responsibility for their failure to seek help to socio-structural restraints. Since the poor quality of the services offered by the medical fraternity constrains them from participating in this practice, it is the medical system that is responsible for their reticence to seek help. As they are the victims of a dysfunctional health care system the blame for their reticence in seeking help can be shifted to contextual restraints.

However, presenting themselves as victims of circumstance is problematic for these men and creates a further dilemma for them. Their accounts reflect a conflict between the need to fulfill societal expectations about idealised masculinity and preserve their identity as traditional masculine men, and the need to act as victims of circumstance so as to shift responsibility and deflect blame for not seeking help to socio-structural constraints.

Although positioning themselves as victims of socio-structural circumstance allows these men to challenge the notion that men's reluctance to seek health care is a matter of individual choice, it results in a shift in their masculine identity. Since western society values autonomy and powerfulness in men, lower SES men are obliged to negotiate an endless tension between preserving their masculine identity and preserving their social standing. Thus these lower SES men's accounts render overt the interplay between reluctance to seek care, masculinity, and social class position.

Chapter 5: Conclusions

In this discursive analysis, I have explored Caucasian mid-aged working-class and professional men's understandings of reluctance to seek health care and have demonstrated that this less than optimal health care practice is not simply a matter of individual agency, as popularly ascribed. Rather, I have shown, through an interpretative presentation of the men's interview material that accounting for reluctance to seek help is a complex and active process that is not only shaped by socially shared understandings, but is also intersected by social class and so differs between men from different socio-economic positions.

In making sense of the reluctance to seek health care notion, these working-class and professional men present this practice as the product of societal expectations about manhood and how one is expected to act. They drew on a discourse of masculinity and voiced several explanations for their reluctance to seek help, ranging from fortitude and indifference to self-reliance and rationality. These explanations enabled the men to perform gender as socially prescribed and present themselves as masculine men. As such, they disclaimed the need to seek help, avoided the strong social sanctions that accompany the failure to demonstrate masculinity as prescribed by society, and maintained their positive and privileged position in society, relative to women.

Reluctance to seek help is also presented as the product of socio-structural constraints that limit the health care practices working-class men can undertake. In a contradictory account, lower SES men linked the practice of seeking help to their material circumstances in life that limited the choices and activities that were available

to them. They drew on an impediment discourse to talk of circumstantial barriers, such as financial restraints, the commercialisation of the health care system and their lack of confidence in the medical profession, to justify their reticence in seeking help. In externalising their responsibility in this way, these men invoked their social powerlessness and presented themselves as victims of circumstance. This allowed them to shift responsibility for not seeking help from an individual level to contextual factors outside of their control, and in doing so, deflect blame from themselves.

However, these two positions were not unproblematic for the men, as they were each fraught with ambivalence. Presenting themselves as masculine men meant these men were held responsible for not seeking help, as well as implicitly blamed for men's poor health status (Lee & Owens, 2002). Similarly, working-class men experienced a shift in their already subordinated masculine identity by presenting themselves as victims of circumstance. Clearly, these subject positions were relatively difficult for these men to manage, as they created a series of tensions and dilemmas for them, as they worked through the conflicts between acknowledging the need to seek help, the preservation of their masculine identity, and deflecting blame.

This analysis of working-class and professional men's accounts provides valuable insights into some of the linguistic resources that are available to men for constructing accounts of reluctance to seek help within contemporary New Zealand society. Significantly, it demonstrates that these men have not made a free and unconstrained choice to behave in a way that potentially compromises their health (Courtenay, 1998; Lee & Owens, 2002). This analysis, therefore, challenges the common-sense notion that men's reluctance to seek help is a matter of individual choice

and that men are to blame for making this unhealthy choice. Furthermore, it has also shown that although these discourses provide these men with many privileges associated with a patriarchal society and protect their social standing, they also disempower men by reducing their ability to lead long and healthy lives.

Simply encouraging men to take personal responsibility for improving their help seeking practices affords men a potentially uncomfortable and conflictual subjectivity that threatens their masculinity and their social standing. Thus, contemporary health messages that reinforce the notion that men should take care of their health by seeking help expeditiously, serve merely to threaten men's sense of self. Men's reluctance to seek medical care is, therefore, better understood as stemming from a socio-cultural context that offers men a highly restricted range of linguistic resources that undermine their ability and willingness to seek help.

Like Hodgetts and Chamberlain (2002) this research has demonstrated that reluctance to seek care is not simply a matter of individual agency, and similarly, this research has reframed reluctance to seek help as a social issue. This commonality suggests the pervasiveness and robustness (Seymour-Smith et al., 2002) of these discursive constructions of reluctance to seek health care, among men. However, not all men are the same nor should we assume that the socio-cultural context in which men make sense of the reluctance to seek help notion is similar for individual men (Galdas, et al., 2005). Consequently, it would also be of interest to conduct further research and examine how young adult men from differing socio-economic positions construct meaning in relation to reluctance to seek help and explore the extent to which they take

up and resist the subject positions afforded them by the discourses that surround this practice.

This is particularly important, as younger men have been raised in a socio-cultural environment where healthy practices are considered a moral duty and an individual responsibility. This would elucidate how these young men account for their reluctance to seek help, how this affects their subjectivities, and the consequent conflict and contradictions they face when the reality of their lives is taken into account. Moreover, as much current research on men's help-seeking practices is based on the lives and views of Caucasian men additional research that focuses on men from different ethnicities and various socio-economic levels would also enable us to learn more about this socially constructed practice and its implications for men's lived experiences.

Although these men's accounts of reluctance to seek help are open to a multiplicity of potential relationships to readers and may be interpreted in different ways, for different purposes (Madden & Chamberlain, 2004), I have attempted in my analysis of these accounts to identify the ambiguity and complexity of possible readings and have striven to represent the variety and complexity of interpretations that may be realised in these accounts (Madden & Chamberlain, 2004). Finally, this research on men's reluctance to seek help challenges the notion that men do not care about their health, and also the thinking that if men were educated about their potential health concerns they would willingly seek help (Hodgetts & Chamberlain, 2002). The research renders overt the socio-structural barriers faced by men of lower SES and so brings to the fore the need for us to recognise that health care practices exist within a social

context. Finally, but no less importantly, this research contributes to the dislodgement of the individualisation of men's health.

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Appendix A

Men's Health

INFORMATION SHEET FOR PARTICIPANTS

Hello, my name is Kate Fardell and I am a master's student at Massey University, Albany. I'm undertaking research to complete the requirements of my course of study, which involves my collecting information, analysing data and writing a report.

I am interested in men's health care practices, particularly men's help-seeking practices. To research this, I require the assistance of men, 45-55 years of age, who do not go to the doctor for regular check-ups.

Taking part in my research will involve you in an audio taped interview, which should take no longer than 40 to 60 minutes of your time. During the interview, I would like to talk with you about health care services, the medical profession, the health care system, accessing medical attention and the health care concerns of men.

This interview will be arranged at a time and place that is convenient for you. I will carry out the interview and transcribe the interview tape. The information given in the interview will be analysed by me, and this analysis will be written into a thesis and possibly published in an academic journal. It may also be used for research seminar presentations. With your permission, information given in the interview may be quoted in written work.

The tape and transcript will be stored in a locked cabinet that only I can access. At the completion of my research, you have the choice of either having your interview tape returned to you, or alternatively, held for five years and then destroyed. Transcripts and consent forms, will also be held for five years and then destroyed.

I asked the person, who gave you this information sheet to pass it on to someone they considered may be interested in being a participant in my research. If you are interested, I invite you to take part in the study. To do this, please write your name and contact

phone number on the attached sheet and mail to me in the enclosed freepost, self-addressed envelope.

Please note, that as a participant in this study

- Your participation is voluntary and you are under no obligation to be involved in this research.
- You may withdraw from the research up to three weeks after the interview.
- You may ask any questions about the research at any time during participation.
- You can refuse to discuss any areas of the research topic and you can turn the tape recorder off at any time during the interview.
- Any information you provide will not be identifiable as coming from you. I will be the only person to access the taped information. In the transcript, your name will not be used. My supervisor and research colleagues will have access to the transcribed information.
- Should you want it a summary of the research findings will be available to you at the conclusion of the study.

Prior to the start of the actual interview I will ask you to sign a consent form agreeing to participate in my research. If you have any questions or concerns about this study please do not hesitate to contact me on 09 445 7319, or my supervisor Kerry Chamberlain at the School of Psychology, Massey University, Albany on 09 443 9700 extension 9078.

Thank-you for giving this your time and consideration. Your support is greatly appreciated.

Kate Fardell

Appendix B

Interest Form For Taking Part In Men's Health Research

Name:

Contact phone number:

Appendix C

Men's Health

CONSENT FORM

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signed:

Name:

Date:

Age/Occupation:

If you would like a summary sheet of the research to be posted to you, please provide your address below.

.....

Appendix D

Aide-Mémoire

Opening Question

Thinking back, can you tell me about the last time you visited a doctor for either a health problem or a health check?

Help-seeking patterns

Circumstances under which men seek help

Circumstances under which men do not seek help

Perceptions of relationship with health professionals

Experience with health care services

Beliefs about health care practices

Health knowledge

Perceptions of vulnerability and invulnerability to health problems and relationship to seeking help

Closing enquiry

Appendix E

Transcription Convention

Single parentheses that are empty indicate that the material is inaudible or there is doubt about its accuracy.

Its kind of () I'll do that next year.

Material in square brackets clarifies information.

I lost some teeth, down here [points to position in mouth] and got to the stage where I couldn't chew on one side of my mouth

Square brackets indicate that material has been deliberately omitted.

If there's something specific that I, um, that I have a problem with, then I go to the doctor or talk to [...].

Appendix F

Procedural guidelines for the analysis of discourse as outlined by Parker, I. (1992)

Discourse Dynamics: Critical Analysis for Social and Individual Psychology.

Selection of a text for analysis

- **Step 1** Treat the objects of study as texts which are described; put into words.
- **Step 2** Explore connotations through free association.

The identification of the subjects and objects constructed in the text

- **Step 3** Ask what objects are referred to and describe them.
- **Step 4** Talk about the talk as if it were an object, a discourse.
- **Step 5** Specify what types of person are talked about in the discourse, some of which may have already been identified as objects.
- **Step 6** Speculate about what they can say in the discourse, and what you can say if identify with them.
- **Step 7** Map a picture of the world this discourse presents.
- **Step 8** Work out how a text using this discourse would deal with objections to the terminology.
- **Step 9** Set contrasting ways of speaking (discourses) against each other and look at the different objects they constitute.
- **Step 10** Identify points where they overlap, where they constitute what look like the 'same' objects in different ways.
- **Step 11** Refer to other texts to elaborate the discourse as it occurs, perhaps implicitly, and addresses different audiences.
- **Step 12** Reflect on the term used to describe the discourse, a matter which involves moral/political choices on the analyst's part.

The way discourses reproduce power relations

- **Step 13** Look at how and where the discourses emerged.
- **Step 14** Describe how they have changed and told a story, usually about how they refer to things, which were always there to be discovered.
- **Step 15** Identify institutions, which are reinforced when this or that discourse is used.
- **Step 16** Identify institutions that are attacked or subverted when this or that discourse appears.
- **Step 17** Look at which categories of person gain and lose from the employment of discourse.
- **Step 18** Look at who would want to promote and who would want to dissolve discourse.
- **Step 19** Show how a discourse connects with other discourses that sanction oppression.
- **Step 20** Show how the discourses allow dominant groups to tell their narratives about the past in order to justify the present, and prevent those who use subjugated discourses from making history.

Six stages in the analysis of discourse as outlined by Willig, C. (2001)

Introducing qualitative research in psychology: Adventures in theory and method.

1. **Stage 1.** Discursive constructions - the identification of the different ways in which the discursive object is constructed in the text.
2. **Stage 2.** Discourses - the location of the various discursive constructions of the object within wider discourses.
3. **Stage 3.** Action orientation - an examination of the discursive contexts within which the different constructions of the object are being deployed.
4. **Stage 4.** Positionings - an examination of the subject positions offered within a discourse.
5. **Stage 5.** Practice - a systematic exploration of the ways in which discursive constructions and the subject positions contained within them open up or close down opportunities for action.
6. **Stage 6.** Subjectivity - an exploration of the consequences of taking up various subject positions for the participant's subjective experiences.