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From men to the media and back again:

An analysis of mediated help-seeking

David Anstiss

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Abstract

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Life-expectancy and mortality statistics position the health of western men as in crisis. Not only has popular media facilitated this notion of crisis, the media has played an active role in creating the views that this crisis is 'fact,' that men are unwilling to accept responsibility for their own health, and that change is inconceivable. However, although many men have indeed been found to be reluctant to seek help from these services despite wanting to, instances of seeking help do exist and even occur against a social backdrop that seems to actively deter it. In response, this thesis sought and examined a sample of help-seeking texts, written by men, with the aim of uncovering discourses that might be empowering to men in regards to their health and healthy lifestyles.

Two discourses emerged that reflect predominant enactments of western versions of masculinities, particularly hegemonic masculinity. Firstly, the biomedical discourse allows men to position themselves, relative to experts, in a way that appears to elicit health information and control consultation directions. Secondly, the (re)establishing masculinity discourse allows men to position themselves as masculine where their masculinity might be threatened. Implications of these discourses are discussed.

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Chapter One: Men, masculinity and magazines

This thesis examines help-seeking in men and focuses on rare instances of seeking help that occur against a social backdrop that seems to actively deter it. Its purpose is to contribute to the efforts of health promoters to encourage more men to seek help for health issues. As such, this thesis plans to build on previous suggestions by examining male help-seeking discourses to align health promotion with enactments and expectations of western masculinities. To begin, this introductory chapter reviews the long standing notion of ‘men in crisis’ which arises from men’s shorter life-expectancy and over-representation in mortality statistics. This crisis is the foundation and justification on which much of the research on men’s health stands. The chapter explores the idea that popular media has not only facilitated this notion of men in crisis, but has played an active role in creating the views that this crisis is ‘fact,’ that men are unwilling to accept responsibility for their own health, and that change is inconceivable. It argues that since the media has been so effective in constructing men as inevitably in crisis, then it could also be used to create more empowering constructions of men’s roles in regards to health, and of men’s health as a whole. Upon consideration of the suggestion that male socialisation should be the target of change, this chapter argues, instead, that it would be much more feasible to change available services to fit the needs of men as they exist now. However, as will be revealed, men have been found to be reluctant to seek help from these services despite wanting to. This highlights the importance of encouraging men to seek help for health issues while also acknowledging western male ways of being.

Men’s health in crisis

The concept of men’s health as in crisis has become something of a cliché within the psychological, sociological and public health literature; summary statistics are used to observe that men are more likely to die, and at younger ages, of cardiovascular disease, cancer, suicide, violent injury and car accidents the world over (Aoun, Donovan, Johnson, & Egger, 2002; Brooks & Good, 2001; Hall, 2003; Lee & Owens, 2002). In New Zealand, men can be expected to live shorter lives overall than women (Ministry of Health, 2007b), with

mortality trends demonstrating that women have outlived men by 4.1 years between 1950 and 1952, 6.5 years between 1975 and 1977, 4 years in 2002 (McKinlay, 2005) and 4.2 years between 2005 and 2007 (Statistics New Zealand, 2009). Specifically, New Zealand men have been found to be more likely than women to die from coronary heart disease, cancers, and violent injury (Ministry of Health, 2006a, 2006b, 2007b; North Regional Health Authority, 1996). Suicide deaths, too, have claimed the lives of more New Zealand males than females for more than two decades, and although the number of male suicide deaths has decreased significantly from its peak in 1995 (from 29.3 suicide deaths per 100,000 population in 1995 to 17.4 suicide deaths per 100,000 in 2007), the rate of male suicide deaths still outstrips that of females by a ratio of 3.6:1 (Ministry of Health, 2007b). Rates of diagnosis for human immunodeficiency virus (HIV) infection (Ministry of Health, 2008) and of drug and alcohol related admissions (Ministry of Health, 2007a) are also skewed toward men. The common factor which emerges here is that the culprits apparently responsible for dissimilarities in mortality rates between men and women are largely preventable. Heart disease, for example, has been associated with risk factors of high blood cholesterol, high blood pressure, tobacco smoking, obesity, physical inactivity and inadequate diet (McKinlay, 2005), all modifiable via behavioural intervention. Many cancers have been linked to modifiable risk factors such as smoking (Gun, Pratt, Ryan, Gordon, & Roder, 2006; Ota, Mino, Mikouchi, & Kawakami, 2002), infection (Lin & Karin, 2007), diet (Paterson & Lawrence, 2001) and physical inactivity (Friedenreich & Orenstein, 2002); and suicide to both depression (Brent et al., 1994; Friedman, Aronoff, Clarkin, Corn, & Hurt, 1983; Yen et al., 2003) and alcohol use (Ramstedt, 2001; Stack & Wasserman, 1993).

The problem with men

Explanations for this crisis position men as being more likely to engage in behaviours such as drinking, risk-taking, unprotected sex, and violence thus men are exposed to greater levels of various health risks than are women (Brooks & Good, 2001; Hall, 2003; Lee & Owens, 2002). The driving mechanisms behind such behaviours are believed to lay deeply rooted within western principles of masculinities (Aoun et al., 2002; Bem, 1974; Brooks & Good, 2001; Charmaz, 1995; Lee & Owens, 2002; O'Neil, 1981). Specifically, men's gender role socialisation doctrines and masculine ideological norms are theorised to raise 'real men' who

pursue masculinity by establishing that they are powerful, competitive, dominant, in control, and sexually gifted while utilising only logic and rationalisation as their cognitive tools (O'Neil, 1981). Unfortunately, as will be demonstrated over the following pages, the lifestyles men are theorised to be living in order to achieve masculinity via these tenets also expose them to health risks and to reject health-oriented regimes. What is more, men's gender role socialisation doctrines and masculine ideological norms are also said to instil a fear of femininity. Through fear of association, femininity is devalued and rejected and along with it, positive attitudes toward seeking help. The pursuit of masculinity and the fear of femininity will thus be examined in turn to explore their effect on the health of men.

The pursuit of masculinity

As a prime example of the detrimental effects of the pursuit of masculinity, Scottish men (aged 15 to 72) who were interviewed by O'Brien, Hunt, and Hart (2009), revealed a prioritisation of enactments of masculinities, via alcohol consumption, over health. As such, drinking was not so much about the consumption of alcohol per se, but an enactment of a local version of masculinity through which men could compete to establish their place within an informal masculine hierarchy. Higher places in this hierarchy were said to be held by those who could drink the most alcohol whilst remaining in control of his faculties and not being sick. Those who failed were otherwise described as weak, less masculine and subject to criticism (O'Brien et al., 2009), and therefore relegated lower status as men. This pursuit coincides with the notion of hegemonic masculinity, a popular theoretical conception of masculinity, enacted in western countries, in which men are said to be encouraged to position: themselves as superior to other men; men, as a whole, as superior to women; and masculinity as superior to femininity (Courtney, 2000; O'Neil, 1981). Many of O'Brien et al.'s (2009) participants thus commented on the pressures they felt to drink to excess (O'Brien et al., 2009). Participants who actively avoided heavy drinking for weight and health reasons felt that they were constantly under attack from peers who used alcohol as a yard stick for their masculinity – being health-conscious, they felt continually pressured to drop their health-oriented decisions. Some younger participants linked being tough to an ideal of Glasgow-past in which the city was heavily industrialised, and masculinity achieved through manual labour. These participants believed Glasgow to have retained this expectancy, although a decline in physical labour industries left them, as white collar workers, with limited opportunities to act out this toughness. Heavy drinking and disregard for dietary

health was thus considered to be a way for participants to act out their masculinity without the use of tough physical labour (O'Brien et al., 2009).

The masculinity-alcohol association is worrying given the link between heavy drinking and health issues such as vitamin deficiency, liver cirrhosis, impairment of immune system response and susceptibility to disease (Szabo, 1999). Also linked to excessive consumption are physical illnesses and hangovers, injuries, blackouts, suicide, academic impairment, fighting, damage to self and/or property, impaired driving, legal repercussions (Perkins, 2002), unintended and unprotected sexual activity (and therefore to HIV), sexual coercion and sexual harassment (Bacharach, Bamberger, & McKinney, 2007).

What is more, O'Brien et al.'s (2009) participants felt that dieting and exercise were seen by their peer groups to be challenging dominant enactments of masculinity, commenting that peers saw participants as less masculine due to their 'unnecessary' regard for their bodies. Participants also disclosed that they even felt pressure to present themselves as uncaring about their health during conversation with other men. So, not only may many men feel they have to consume large quantities of alcohol to compete for their self-worth as men, but social pressures appear to exist that lead men to feel discomfort in actively engaging in, or even talking about, health-conscious practices. It should be no surprise, then, to find men dominating disease and fatality statistics given the link between enactments of masculinities and men's participation in excess consumption of alcohol combined with the rejection of healthy eating and exercise.

The fear of femininity

Unfortunately, what exacerbates this situation is the well documented reluctance of men to utilise health services when signs of disease and ill-health do appear. For example, studies from the United States, Canada and Holland have found men to be less likely to seek help from medical services than women (Gijbbers van Wijk, Kolk, van dem Bosch, & van dem Hoogen, 1992; Green & Pope, 1999; Kandrack, Grant, & Segall, 1991). While introducing diabetes education to rural industries in Western Australia, Aoun and Johnson (2002) had general practitioners perform diabetes screening sessions on employees. These practitioners found that a significant number of the men were at high risk of developing diabetes (48% between 40-49 years of age, 85% between 50-65 years of age). In New Zealand, the results of the 2004 New Zealand Behaviours Survey revealed that male respondents were more likely

than women to want help in regards to alcohol consumption but not receive it (Ministry of Health, 2007a). The fact that these figures arose from home and workplace studies, and not from health care centre or practitioner data, illustrates the issue that many men are either not actively seeking or not receiving help from health services despite the existence, or high risk, of health issues.

Again, some blame appears to lie embedded within western masculinities. Smith, Tran, and Thompson (2008), for example, found a significant negative correlation between men's negative attitudes toward psychological help-seeking and help-seeking intention, as well as an indirect effect of traditional masculinity ideology on help-seeking intentions in undergraduate men. This suggests that western masculine ideals impinge on men's attitudes toward psychological help-seeking and therefore on their intentions to engage in help-seeking behaviours in regards to psychological issues. Much research indicates that such a negative stance toward seeking help may be linked to a concept O'Neil has given the title: the 'fear of femininity'. This fear of femininity is said to arise also from men's gender role socialisation and masculine ideological norms in which, through fear of association, femininity and its associated stereotypes are devalued and rejected (O'Neil, 1981). Such stereotypes may include values of care and nurturance, attitudes toward intimacy, and behaviours like the expression of emotion and gentle physical contact (Courtney, 2000; O'Neil, 1981, 2008). To Courtney (2000) and O'Neil (1981), this fear exists through the juxtaposition of these stereotypes to the tenets of superiority inherent in enactments of hegemonic versions of masculinity. As masculinity is understood to be an on-going performance requiring constant enactment and defence, feminisation is used frequently, within hegemonic enactments, as a means for men to undermine other men's enactments of masculinity (Campbell, 2000). Given that it is not uncommon for men themselves to make no reference to masculinity itself while doing so, it appears that many men strive to reach a masculine ideal that is not always pre-defined, but is reached via distance from femininity (Campbell, 2000). Campbell (2000) suggests that masculinity is thus an 'unmarked' category and femininity a 'marked' category, one that is constantly policed and defines masculinity through its negation. Therefore, versions of masculinity need not rely solely on what a man should be (such as definitions of power, competition and dominance), but also, importantly, on what he should not. In short, western-socialised men are theorised to strive to distance themselves from associations with femininity in order to retain their masculinity. O'Neil (2008) insists that fears about being

associated with femininity are linked to the four patterns of his Gender Role Conflict paradigm (GRC – “a psychological state in which socialised gender roles have negative consequences for the person or others” (O’Neil, 2008, p. 362)): Success/power/competition (the pursuit of success via means of competition and power), restrictive emotionality (restricting and fearing expression of emotions), restrictive affectionate behaviour between men (restricting expression of thoughts and feelings to other men) and conflict between work and family relations, an insistence that is backed by much empirical data (O’Neil, 2008). Institutional sexism and sexist patriarchal structures in society then maintain a constant system of surveillance that continues to shape men’s acceptable identities (O’Neil, 2008).

Indeed, Courtney (2000) has argued that the male socialisation doctrines of restriction (both restrictive emotionality and restrictive affectionate behaviour between men) also play a large role in preventing men from seeking help. O’Neil proposed that because men liken help-seeking to femininity (via admitting weakness, revealing potentially intimate information and displaying emotion), then refusing to seek professional help is both an avoidance of associations with femininity (O’Neil, 1981), and an enactment of prevailing masculine norms through striving to meet a stoic ideal (Courtney, 2000; O’Neil, 1981). Addis and Mahalik (2003) argue that this problem may be compounded if men perceive others in their social networks to be equally, or more, critical of help-seeking or if men consider stoicism and restriction to be central facets of their self-identity.

In support of the notion of restriction as barrier, Good, Dell, and Mintz (1989) found anxiety toward both affectionate behaviours between men and the expression of emotion to be significantly associated with negative attitudes toward help-seeking in college men. More recently, Steinfeldt, Steinfeldt, England, and Speight (2009) found athletic identity to be significantly correlated with both GRC and help-seeking stigma in American college football players. This suggests that higher levels of athletic identity are associated with increased GRC and perceived stigma around seeking professional psychological help. GRC, too, was significantly correlated to stigma, indicating that as GRC increases, so too does the perceived stigma associated with professional psychological help-seeking, regardless of athletic identity. Moreover, Good and Wood (1995) found stoicism and restrictive affectionate behaviour between men to correlate negatively with recognising the need for professional help, with being open about the problem and with tolerance of the stigma they associated with help-seeking. These findings suggest that adherence to restrictive masculine values may

inhibit the recognition of needing help and then to reluctance in sharing this need once recognised. This is reflected in the findings of Anstiss (2008) who, in surveying the symptoms for which university students would seek help, found male students to be significantly less likely to endorse consulting a doctor for depression, night sweats and shortness of breath than female students (in addition to 23 further symptoms for which neither men nor women endorsed seeking help).

Due to the well-established link between depression and suicide (Brent et al., 1994; Friedman et al., 1983; Yen et al., 2003), it is not surprising, then, to find males outweighing females in incidence of suicide. Anstiss (2008) suggested that New Zealand men not seeking help for depressive symptoms may miss diagnosis, and therefore treatment, in turn preventing intervention before the onset of suicidal ideation. His suggestion is supported by Desaulniers and Daigle (2008) who have proposed that the ability of others to recognise men's suicidal warning signs and suffering is hampered by men's oppositional attitudes toward expressing pain. This proposition arose from their research in which male suicide rates across 17 regions of Canada were found to be inversely associated with men's attitudes toward pain expression in those regions (Desaulniers & Daigle, 2008). In conjunction with Good and Wood's (1995) findings that stoicism correlates with higher depression scores (indicating that avoidance of, and inability to communicate emotion is associated with greater incidence of depression), it appears that restriction, depression and suicide-risk appear to be circularly linked.

In summary, male socialisation policies both directly and indirectly encourage the adoption of detrimental behaviours and attitudes in regards to the excessive consumption of alcohol and the rejection of healthy eating, exercise regimes and help-seeking. Participating in such behaviours has been linked to striving to meet invisible societal masculine ideals while also avoiding masculine devaluation through feminisation. Combined, these contribute to men's over-representation in poor health statistics.

These findings should not, however, be interpreted to imply that men themselves are under the illusion that they do not need help. As the 2004 New Zealand Behaviours Survey has illustrated, male respondents are more likely than women to want help for alcohol consumption but not receive it (Ministry of Health, 2007a). It appears that many men may be suffering silently from problems such as depression or problematic alcohol consumption but not attaining help. This is concerning as it opens up dangerous possibilities such as suicidal

ideation, of which those around them may have little warning that intervention may be necessary.

Men in media (the construction of crisis)

The notion of men's health as in crisis is reiterated by popular media. In happenstance of examining dominant representations of men, masculinity and dietary associations in recent UK newspapers, Gough (2007) observed that all analysed articles linked men's eating habits to the prevalence of obesity, cancer and heart problems. What is more, these habits were also portrayed as being actively pursued by all men despite the consequences. In particular, while men were viewed as consuming too little in the way of fruit and vegetables, an inextricable link was also found by Gough (2007) to be assumed between men and red meat. The pursuit of unhealthy diets was also positioned as fixed and therefore unchangeable without intervention on the part of women and health professionals (Gough, 2007). This stance appears to have been taken on the grounds that men are viewed in the media as infantile and deficient when it comes to matters of domestic health and nutrition (Gough, 2007; Lyons & Griffin, 2003). According to the media, and in relative accordance with current scientist-practitioner literature, responsibility for the crisis lies with a homogenous male culture that revolves around unhealthy diets, lack of self-control, and help-seeking reluctance (Gough, 2006, 2007). In short, the media positions men as health and nutrition ignorant and disinterested, and not susceptible to change. Moreover, dieting is represented as irrational and extreme by masculine standards and therefore exclusive to the domain of femininity (Gough, 2007). In fact, articles exist that appear to be deterring men from dieting by insinuating that men who diet are 'as confused as women' which, in turn, alienates men from healthy diets (Gough, 2007). Ironically, the media portray men as health-negligent while at the same time chastising men who diet on the grounds of being emasculate.

Moreover, a critical appraisal of Men's Health magazines by Crawshaw (2007) found that articles from popular men's media not only construct, but encourage masculine lifestyles associated with poor health in men. For example, regular sex, particularly casual sex, was advocated as a means of maintaining health and youth (Crawshaw, 2007). Paradoxically, this also reinforces the use of risky behaviours and, in light of men's HIV statistics, contributes to the vulnerability of men to STI (Crawshaw, 2007). What is more, advice from the same

magazine, to drive fast in order to trigger the release of endorphins, is concerning given the predominance of men in car accident mortalities (Crawshaw, 2007). Crawshaw (2007) thus concluded that although men's magazines may appear to be concerned with achieving good health, they are, in actual fact, merely promoting their idealised versions of masculinity. In this way, healthy eating, when it does appear, is endorsed as a means of attaining an idealised muscular physique (as opposed to health in itself), and risk-taking is reinforced under the tenuous guise of healthy living.

Taken together, at the same time as the health of men appears to be in crisis when observing mortality statistics, the media appears to have been instrumental in the reiteration and maintenance of this notion. That is, while the media has acknowledged the impact of masculine lifestyles on health, it has, at the same time, unwittingly facilitated the construction of a crisis that is not amenable to change. The media has achieved this by constructing poor health in men as something that has arisen from men being 'the way they are' (Gough, 2006, 2007). This, in turn, works to establish the crisis as natural and fixed whereby change for the better seems doubtful. This construction has implied that the very behaviours contributing to the crisis are inherently masculine thus practices contradicting these behaviours, being now positioned as feminine, are constructed as unattractive or unavailable to men thus making it harder for men to change.

When will men listen?

Many men may be unlikely to consider health messages given that the goals and values of potential interventions may not be compatible with the values associated with men's notions of what is acceptable, enjoyable or even relevant (as per the pursuit of masculinity and the fear of femininity). As such, one way in which concerned parties have tried to get health messages across to men has been through women. In suggesting practical ways to overcome barriers that may prevent men seeking help, Hall (2003) has emphasised providing female patients with information about men's health which they can then give to their partners or family members. Likewise, articles related to men's health in the media have portrayed health as 'women's responsibility' by giving women instruction on how to stealthily improve their partner's health (Lyons & Willot, 1999). Although these may be potential ways in which to reach men indirectly, they also (re)produce constructions of men as 'infantile' and inept in

regard to health responsibility (Gough, 2007; Lyons & Willot, 1999) and deemphasise the potential for men's empowerment over their own health (Lyons & Willot, 1999). This approach also risks omitting single men, gay men and widowers from receiving health information.

It is also possible that men may resist attempts at promoting their health and, instead, actively participate in detrimental behaviours in retaliation to health promotion, no matter how well intentioned. Crossley (2002) has proposed that educational approaches that impose pre-defined concepts of health ignore and deny the psychosocial meanings of unhealthy practices. For example, subgroups of gay activists have reportedly attempted to eroticise unsafe sex associated with consciously and purposefully, although not maliciously, infecting willing men with HIV (Crossley, 2002). Crossley (2002) attributes this movement to symbolic meanings of rebellion and transgression. On conducting focus groups with these men, Crossley (2002) found that risk was believed to heighten the pleasure, value and enjoyment associated with unsafe sexual practices. Moreover, some men in Crossley's (2002) interviews resented the attempts of health promoters to make everything safe for society, and expressed the need to rebel against those practices they felt were being dictated to them (Crossley, 2002). The culmination of these led Crossley (2002) to the conclusion that risky behaviours, such as unprotected sex with HIV positive men, provide individuals with a way to rebel against dominant values in order to feel and express freedom, independence, autonomy and protest, particularly against the authority of mainstream health professionals. Crossley (2002) explains this need in terms of psychological reactance theory in which threats to an individual's important free-behaviours will be met with equally high reactance to persuasion attempts. Given the importance of unsafe sex to the expression of some gay liberalist movements, high reactance should be expected (Crossley, 2002). Health promoters have therefore exacerbated the situation by creating a taboo around unsafe sex, thus making it more desirable to high risk, reactive subpopulations (Crossley, 2002).

Crossley (2002) has thus recommended avoiding a 'commercial sense' approach, suggesting, instead, a focus on community values or issues that may surround the health topic such as self-esteem, mental health, relationship issues and personal skills that are also deeply embedded in men's lifestyle choices. Indeed, it seems plausible that examining the shared psychological attributes of men may be advantageous in enabling health promotions to be compatible with the expectations of men. This could increase the likelihood of reaching men

directly and reduce the need for subversive intervention by women. For example, after a review of the literature, Addis and Mahalik (2003) have suggested that perceptions of normativeness, reciprocity and constructions of masculinity each moderate the likelihood of help-seeking and should be considered when targeting men. Specifically, if individual men are unaware that other men struggle with a similar problem as they do, they may perceive a problem as abnormal (Addis & Mahalik, 2003). The abnormality of depression, for example, is to be expected given that values of restriction (that is, the restriction of emotional expression, intimacy and affection, particularly toward other men) (Courtney, 2000; O'Neil, 1981) mean that symptoms of depression may not often be observed by men in other men or by men themselves. Addis and Mahalik (2003) suggest that role models of successful, wealthy and confident male figures may exacerbate the supposed abnormality of being unsuccessful, depressed or lacking self-confidence. Therefore, it may be beneficial for health promoters to seek to get men to understand that they are not alone in struggling with the issue. By getting men to acknowledge that the problem may in fact be one that is more common than they had initially thought, health promoters are effectively normalising the issue and increasing the chances that men will speak openly about it. Indeed, the National Depression Initiative employed this technique in 2006 by launching an advertising campaign in which John Kirwan, an ex-rugby representative and New Zealand male role-model, spoke of his struggle with depression and of seeking help. As such, a remarkable increase in the number of New Zealand men contacting phone-help service Lifeline was observed (McKenzie-Minifie, 2006), illustrating the effectiveness of this approach.

What is more, problems perceived as non-normative also reduce a man's opportunity to reciprocate help which, according to Wills (1992, cited in Addis & Mahalik, 2003), is also important in men's help-seeking. According to Addis and Mahalik (2003), reciprocation operates as a means to evade indebtedness while also preserving one's status as strong and competent. Whatever the reason, if men are aware that they will be offered the opportunity to reciprocate the help given to them, they may be more likely to seek help in the first place and continue on to help others.

Lastly, adopting and inverting meanings of masculinity may be helpful in conveying health messages. Addis and Mahalik (2003) use the example of a television commercial advertising medication for erectile dysfunction in which a popular professional baseball player performs a series of impressive plays and informs viewers that he uses both practice and the

medication. He then encourages men to 'step up to the plate' and seek help for erectile dysfunction. To Addis and Mahalik (2003), the stigma surrounding acknowledging sexual difficulties is undermined by likening help-seeking to 'manning up' and having the courage to increase performance such as would an athlete. Likewise, Johnson, Field, and Stephenson (2006) advocate the Men's Health Forum's use of the 'Man Manual' in which car maintenance manual publishers were worked with to produce health manuals analogising men's bodies to cars. A Heavy Goods Vehicle manual was also produced for overweight men. Such an approach utilises the stereotypical priorities of men and, indeed, Johnson, Field, and Stephenson (2006) report that over 100,000 copies of the Man Manual were sold, attesting to the popularity and reception of this approach. By approaching men's health campaigns from angles that reflect the ways in which men approach their lives, health promoters may have a better chance of aligning their health messages with the priorities of men.

In stark contrast to this assumption, however, Gough (2006) criticises a special, men's health edition of *The Observer* for conceiving of men as a single homogenous group. Because the issue in question gives little regard to diversity as may arise from socio-economic status, ethnicity, sexuality or age divisions, Gough (2006) claims that it erases differences between men (Gough, 2006). By extension, it also, therefore, argues against the assertion put forward in the next section of this chapter that suggests that men should be viewed as a culture which shares norms, values and practices. However, while it is very true that using an all-encompassing notion of men's health does obscure the finer details of men's ill-health statistics (poorer health in Maori men may warrant special attention and may benefit from different health promotion techniques, for example), it also reduces the risk of stigmatising particular groups of males (the association of gay men with STI and HIV, or positioning Maori men as of poorer health and therefore less interested in it, for example). There is also the possibility that singling out a particular group may incur a higher chance of reactance given that being removed from other men may signify them as 'other' or allocate them a further marginalised masculine status. Moreover, the inclusion of all men may be essential in establishing normativity and for introducing chances for reciprocation. In saying this, Gough's (2006) recommendation of extending promotion methods, in order to reach males that lie outside an adherence to stereotypical masculinities that are associated with vehicle-

like manuals, is well worth heeding. Health promotion should therefore consider alternative methods for reaching men who are aligned with alternative or marginalised masculinities.

From men to the media and back again

On the grounds that the media have been influential in circulating constructions of masculinity as creating and perpetuating the crisis in men's health, the media may again be useful in investigating the possibility of disseminating alternative constructions within which men may operate. Rather than focussing on discourses that position the state of men's health as natural and inevitable, it would be beneficial to explore discourses, and arenas, in which men actively and successfully navigate the health domain. By examining the ways in which men seek health information in the public media, alternative discourses may be identified which encourage and facilitate the adoption of help-seeking strategies. This caters to both Gough's (2006) suggestion that health care services should evolve in order to reach men in ways that leave masculinity relatively intact, and Addis and Mahalik's (2003) proposal that constructions of masculinity should be used to health promoters' advantage.

That being said, such an approach to health promotion could also be used to make health messages more accessible to target male populations via effective communication (Kreuter, Lukwage, Bucholts, Clark, & Sanders-Thompson, 2002). According to Kreuter et al. (2002), people of a culture share values, norms, practices, systems of meaning, ways of life and other social regularities. As such, men could be viewed as a culture and, therefore, be targeted in ways that are culturally appropriate by using promotional strategies that are congruent with men's values and norms. Thus western male idioms could be effective not only in facilitating the embedding of male worldviews into health messages to make them more personally compelling, but in developing promotions that employ the 'do's', fostered by western male socialisation to facilitate health promotion, and avoid the 'don'ts', that may hinder it. For example, in transcriptions of classroom discourses and interviews with their interlocutors, Sunderland (1995) discovered that the term 'girl' can be used as an insult for a boy, yet 'boy' is not taken as an insult for a girl. Sunderland (1995) gave this discourse the label 'boy as OK, girl as insult,' acknowledging the semantic asymmetry in which being given the status of the opposite sex was deprecating only to boys. This male-female opposition and derogatory use of feminine referents (Sunderland, 1995) (while also reflecting ideals of a hegemonic

version of masculinity and O'Neil's (1981) notion of the 'fear of femininity'), suggests that references to femininity, or associations with women, are more likely to be felt by men to be insulting than encouraging. Consequently, health promotions aimed at men should avoid associations of their target population, and of help-seeking, with what may be considered as feminine. While this example could be criticised for endorsing already endemic male-female oppositional constructions, more positive constructions may exist and are worthy of investigation.

Put simply, if the techniques used by health campaigns reflect the efforts of men who have successfully sought help in a context that seems to actively deter it, men may be more likely, and perhaps better able, to consider health messages. As such, this study examines the language used by men when they are prepared to seek help. It is hoped that the use of this language can be used to further facilitate action in regards to help-seeking. The same language, then, may also be advantageous in encouraging deeper consideration of specific health issues by future health promoters who might enable men's health campaigns that reproduce the ways in which men *do* ask for help.

The current study

In order to obtain such language, and in conjunction with the medias' involvement not only in (re)constructing men's crisis but also in the circulation of predominant discourses, the current study examined widely circulated instances of mediated help-seeking, specifically instances of seeking help in popular men's magazines. Such a medium was chosen not only because men's magazines the likes of Men's Health have been instrumental in establishing a collective understanding of men's health in the public domain (Stibbe, 2004), but also because recent research has demonstrated that health-oriented help-seekers are turning toward media such as the internet and magazines instead of GPs as their first source of health information. For example, using data from the 2002-2003 Health Information Trends Survey (Nelson et al., 2004), Hesse et al. (2005) found that although 49.5 percent of the 6369 United States' respondents reported wanting to seek advice from their GPs first, as many as 48.6 percent admitted that they would initially consult the internet before going to their physician. Only 10.9 percent reported that they would actually attend a health service as a first resort. This suggests that to-be-patients are seeking health information in advance of contacting

health services. Moreover, while 64.8 percent of respondents reported ‘a lot’ or ‘some’ trust (as opposed to options of ‘a little’ and ‘not at all’) in internet sources of health information, a larger 66.2 percent reported ‘a lot’ or ‘some’ trust in magazines. What is more, in their study examining differences between online and offline health information seekers in the United States, Cotton and Gupta (2004) used data from the 2000 General Social Survey to find that as many as 61 percent of offline help-seekers (n = 158) viewed magazines as potential and legitimate sources of health information. On these grounds, this study focussed on letters published in the advice sections of men’s magazines, and any other excerpt that evidenced readers’ help-seeking from the magazine or from other readers. This particular format and location appears to be a socially acceptable platform on which men are able to (anonymously) ask for and receive help. The aim was to systematically analyse ways in which men ask for help when they readily and actively do so.

In summary: Men, masculinity and magazines

In summary, Western men appear to be in crisis given shorter life-expectancies than women and an over-representation in preventable mortality statistics. Media coverage of this crisis has positioned men as engaging in behaviours that lead to preventable mortalities because this is ‘the way they are’. In other words, this crisis is a result of the supposedly ‘true’ nature of men and thus unchangeable without intervention from women. In response, it is suggested, here, that the best way to reach men is directly and via communicative pathways to which men may best respond. Thus, the current study investigates the ways in which men write about health and illness when they are ready and actively seek to do so. The medium chosen for this was the advice columns of men’s magazines on the grounds that men appear to successfully navigate the health domain within this arena despite discouraging media portrayals. It is hoped that the discourses that emerge from this medium will be beneficial in highlighting positive help-seeking strategies in men and may be employed usefully in male-oriented health promotion.

Chapter Two: Analysing mediated help-seeking

Texts

Magazines were selected on the basis of their popularity with, and availability to, a New Zealand readership as well as the presence of letters to the editor (or to columnists). According to Magnetix.co.nz, the website for Magnetix Magazines - a National New Zealand magazine outlet, New Zealand's top selling men's magazines are Arena, GQ, Ralph and FHM. On inspection of book shops, convenience stores and supermarkets in Auckland, the men's magazines that were most widely available, at the time of collection, were M2, Arena, Ralph, FHM, GQ and Men's Health. However, letters to the editor or any sections where readers received feedback from columnists were not available in M2 or Arena magazines. Men's Health, GQ, FHM and Ralph magazines were thus chosen for review. Magazines were collected over the months of November and December of 2009, and January and February of 2010 so that four issues of each magazine were acquired for analysis, providing 16 magazine issues in total. Each magazine is described in detail below.

Men's Health

Men's Health is the Australian version of an international magazine brand that presents articles on many facets of men's lives and health, including fitness, nutrition, sexuality and lifestyle. It has an Australian readership of 75,579 a month ("Men's Health," n.d.). In the November issue of Men's Health, the editor, Bruce Ritchie, discusses a competition in which readers have the opportunity to win a place on Men's Health's cover. He explains that the crucial criteria for entrants was that they are able to provide evidence of balancing "a normal work and home lifestyle while also achieving the kind of physical results that merit being showcased on the cover of the country's No.1 men's lifestyle magazine." This suggests that the aim of this magazine is to model a high standard of physical attractiveness while also encouraging the maintenance of all-round healthy lifestyles. Consequently, while receiving praise for being a top-selling men's magazine without having to print semi-naked women on its cover to attract an extensive readership, Men's Health has been criticised for potentially encouraging anxiety, eating disorders, compulsive exercising (Corner, 2000) and notions of hegemonic masculinity in men (Crawshaw, 2007).

GQ

GQ (Gentlemen's Quarterly) is the British version of a magazine franchise produced also in the United States. Figures from the United Kingdom's Audit Bureau of Circulations puts GQ's readership at an average of 120,057 a month in the U.K. (Ponsford, 2010). The spotlight of this magazine is on fashion, style and grooming. Tables of contents' generally also include articles on politics, food, cars, travel, technology, sports, media and sex. While considered to be one of the classier, more elegant men's magazines by reviewers for being politically and socially informative (Jacob, 2008; Magazine City," n.d.; Review Centre," 2008), GQ has been criticized for lacking social responsibility in that it promotes the idea that expensive top brand suits are an everyday norm for the average gentleman, in order to enhance perceptions of its own sophistication ("Review Centre," 2008).

FHM

Despite starting out as a magazine oriented towards contemporary fashion, Australia's FHM (For Him Magazine) has earned itself the label of 'lad's mag', focusing now on women, drinking, sport and humour (Woods, 2009). FHM has reportedly taken efforts to distance itself from more 'top shelf' magazines by using images of women as its primary selling point, making material more 'accessible' to their target audience and enabling more interaction between readers and the magazine itself (Woods, 2009). In Woods' (2009) words, "FHM is clearly not a 'shy' magazine. This perhaps sums up the lads mag culture; it is loud, rude, likes beautiful women and enjoys having a laugh. FHM reflects the men that read it and this has been key to its success." According to ACP Media, FHM reaches 121,000 readers a month in New Zealand, 50 percent of whom are aged 20-29, and a further 26 percent aged 30-39 ("FHM. Detailed readership," n.d.).

Ralph

In much the same vein as FHM, Ralph has been described as "purely Australian", with readers likening the publication to "a conversation with one of their mates" (Falzon, 2008). Focussing somewhat more on women than FHM, Ralph also features articles on sport, technology, travel, fashion, celebrities, entertainment and fashion. First published in August, 1997, Ralph was discontinued in July, 2010, despite a monthly Australian readership of 267,000 (Washbrook, 2010). Its discontinuation followed a 4.7 percent decline in readership,

which put it well behind its main Australian competitors. Plans of discontinuation were unknown to the researcher at the onset of this study.

Ethics

Although no human participants were directly involved in this research, there were still potential ethical issues that warranted consideration. The first was informed consent; the second, anonymity.

Informed consent

Excerpts that are cited in this study have been written by people who have not given explicit permission for their communications to be discursively analysed. However, this was not considered a violation of ethics given that the writers have implicitly consented to the use of their communications on the grounds that these have been submitted for widespread distribution by popular media. This argument reflects the declarations of the Massey University Human Ethics Committee concerning consent regarding anonymous questionnaires. Committee guidelines assert that by returning an anonymous questionnaire, participants are consenting to the use of their information by researchers (Massey University Human Ethics Committee). Likewise, readers seeking advice from magazines can be considered as consenting to the widespread circulation and use of their requests by submitting their requests for publication.

Anonymity

Secondly, the barrier that prevents obtaining informed consent, at the same time, protects contributors on the grounds that the letters themselves are written with the intention of anonymity. This implies that readers have written into magazines using minimal personal details or identifiable characteristics in order to remain anonymous among other help-seekers. This suggests also that aliases need not be allocated in the final write-up of this research. This implication is assumed on the basis that either their real name was not used in the original submission or that authors will not be identifiable by their first name given the general nature of the exert content. However, despite this assumption, the names given by help-seekers are not used in this thesis, on the happenstance that the author did in fact submit their real name.

Analytic technique: Discourse analysis

What is discourse analysis?

The analytic technique of choice for this study was discourse analysis, the goal of which is to comprehend peoples' collective constructions of self, of others, of the world and their place in it, and of social action (Potter & Wetherell, 1995). According to Potter and Wetherell (1995), individuals construct, develop and negotiate their versions of the world through interaction with others with the help of various resources. Discourse analysis thus focuses on the content and processes of social interaction as well as the resources participants make use of in developing this content (Potter & Wetherell, 1995), such as commonplace 'lay' ideas or broader explanatory systems (Potter, 2003).

Discourse analysis differs from traditional approaches to social psychology in that fitting cognitive underpinnings to human talk is discouraged (Potter & Wetherell, 1995). Instead, the language itself, and use of it, is the focus of analysis given that it is within this talk that participants negotiate understandings and viewpoints with other participants (Potter & Wetherell, 1995). It is this unique approach to psychology that has earned discourse analysis the description of 'anti-cognitivist' in that it rejects the use of popular psychological mechanism theorisation to understand social cognition, thus avoiding cognitive reductionism (Potter & Wetherell, 1995). Willot and Griffin (1997) reiterate the importance of focusing on language in its own right - recognising that word use does not necessarily arise solely from underlying cognitions but rather reflects uniformity in phenomena construction. This can be taken to mean that discursive patterns are used to convey and circulate communal understandings of phenomena. Acknowledging such understandings may help health campaigns to evolve by enabling deliveries of health messages in ways that are compatible with dominant discursive patterns.

Why discourse analysis?

The predominant justification for discourse analysis lays in the central tenets of discourse: action orientation, situation and construction (Potter, 2003). The first implies that not only does discourse facilitate human action, but is the predominant mode of human interaction (Potter, 2003). This interaction and action intent entails the use of language to achieve certain

ends, not just to purchase items or to arrange appointments, but to persuade and legitimise (Elliot, 1996). This use of language is therefore strategic, although not necessarily conscious, and useful in actively constructing singular or mutual world understandings. The second denotes discourses dependency on situation, thus what is said is embedded within the context in which it is said (Potter, 2003). It also means that discourse is sequential – what is said has grounds in what was said before and sets up what has yet to be said (Potter, 2003). The third acknowledges that world views are actively constructed and solidified through talk (Potter, 2003). Parker (2005) asserts that such discursive patterns sustain social bonds and power structures that confirm and reconfirm to discourse participants that the world is *the way it is*. This eventuates from the circulation and repetition of discursive patterns and messages within everyday talk until they come to be believed (Parker, 2005).

Likewise, Willig (1999) explains that individuals assume discursive positions that are relative to others, to the world and to events. These discursive positions ‘pre-exist’ the individual, whose self-understandings and identity are dictated by available discourses (Willig, 1999). Willig (1999) asserts that discourses also operate voluntarily whereby participants freely, actively and purposefully position themselves in order to achieve certain goals. Therefore, discourses too have implications for help-seeking by offering limited options for men and constraining their actions to what is acceptable in accordance with dominant discourses of masculinity.

The use of discourses to position one’s self is useful also in manipulating how one is viewed by others. For example, medical and scientific discourses are typically reserved for medical and scientific ‘experts’ thus the desire to be positioned and thought of as knowledgeable may involve the employment of medico-scientific discourses (Parker, 1990). Discourse analysis, then, is ideal for investigating how discursive patterns and accompanying images of the self and of the world circulate and construct realities within society (Parker, 2005).

Procedure

This project employs a ‘bottom-up’ approach whereby the textual material data is used to work toward more social meanings. The focus is not on the words in isolation, but rather, the part these words play in the creation and maintenance of practices. The process with which

this was done was conducted with the techniques of Potter and Wetherell (1995), and Willot and Griffin (1997) in mind.

After purchase, each magazine was searched for any instances where readers had written in to the magazine and had been replied to. Each letter and its reply were copied word-for-word into Microsoft Word. The texts were then grouped according to their content in order to divide the data into more manageable clusters. These clusters were pain and injury, mental health, general health, fitness, nutrition, grooming and presentation, sex, relationships, friendships, and fashion. The data within each cluster was read and reread; the researcher writing critical comments in the margins of the texts about the themes of each text, how writers chose to position themselves, what the writers tried to achieve through their text, and the assumptions that underlay their text.

As Potter and Wetherell (1995) suggested, looking for collections of sayings, figures of speech, and common phrases or descriptions that accompanied constructs, helped to identify not only the content of text, but how the content of text was organised. Having gained a collection of recurring predominant themes, the data and criticisms were again reread and the ways in which men talked about each theme were identified. The existent literature was extremely helpful, at this stage, to make sense of how themes form discourses and how interlocutors are directed by discourses. Discursive patterns and positions were examined across the themes, and are discussed in the following chapter.

Chapter Three: From the pens of men

Although all instances of help-seeking were inspected, the focus of this analysis turned specifically to health-oriented discourses, given this study's foremost emphasis on combating men's predominance in ill-health statistics. For example, although an interesting discourse relating to sexual entitlement emerged from the texts regarding sexual advice, it was not directly applicable to the study's purpose and so has been omitted from this report. It is thus that the clusters unrelated to health (grooming and presentation, sex, relationships, friendships, and fashion) have been excluded from further reporting. In consequence, texts from *Ralph* and *GQ* magazines are unrepresented in the final results, given their attention to sexual performance and fashion.

Health-oriented texts emerged, instead, from *FHM*'s 'Sports Doc' and *Men's Health*'s 'Bionic Health' sections. The former is a single column dedicated to injury advice given by Dr John Orchard, a physician who works closely with the Sydney Roosters (a professional Australian rugby league football club), the Australian Football League and Cricket Australia. The latter typically occupies a double-page spread and publishes text about topics ranging from health to general workings of the body (such as vision in the dark), to dreaming, to excessive sweating and acne in unusual places. Rather than having one dedicated expert to answer these queries, writers' questions are passed on to external experts, and replies published amongst the commentary of the page's editor.

The examined letters numbered twenty for pain and injury, thirteen for fitness, eleven for general health, three for psychological health, and three for nutrition; each with a reply. From these texts, two predominant discourses emerged. The first allows men to position themselves, relative to experts, in a way that appears to efficiently elicit health information and control consultation directions. The second allows men to position themselves as masculine where their masculinity might be threatened. Each discourse is described in detail below, using quotes from the texts.

Medico-scientific discourse

The defining characteristic of this discourse is the use of medical and science oriented technical jargon. This jargon is used to refer to parts of the body, medical conditions, problem locale, and rephrasing a problem in a medical or scientific way.

Within the text, medico-scientific jargon appears to be an effective way for men to communicate problems to experts, while also providing men with a vehicle to demonstrate that they are knowledgeable. Use of medico-scientific jargon thus seems to enable men to converse with experts more as equals; as opposed to naïve, lay help-seekers seeking advice from powerful, all-knowing experts. Experts' replies tended to respond directly to the jargon; hence men actively adopting medico-scientific jargon appear better able to engage with health professionals in ways that aid the formulation and delivery of advice.

What is more, jargoned queries tended also to provide evidence of consulting more than one source for information. This suggests that the men in this review actively sought not one, but multiple sources when actively seeking help, possibly to obtain verification via confirmation of the sources previously consulted. Compounded encounters with various sources of information appear to be the enabling factor in the use of technical jargon and thus the adoption of the medico-scientific discourse.

The paragraphs that follow will demonstrate: the purpose of the medico-scientific discourse; how this discourse functions to serve this purpose; and the medium that enables this discourse.

Purpose: giving direction

Medico-scientific jargon was used to convey problems to experts; problems that could otherwise be conveyed in everyday terms. As evidenced by the next two excerpts, the use of jargon draws attention to problem areas and elicits specific advice in regards to that area. For example, the following excerpt illustrates the reframing of a problem that could have been relayed in everyday terms into a biological query using medico-scientific jargon (“rectus femoris”):

I am a 22-year-old who has torn rectus femoris muscles twice, despite not playing sports. Is there anything I can do to prevent this occurring again, and what caused this?

In return, the response focuses initially on the jargon:

Rectus femoris (one of the four muscles in the quadriceps) strains are caused by slowing down movements. It's true that kicking is the most common cause, as you slow down the step before you kick the ball. If you don't kick, there's a good chance that if you give the injury a rest period, it will heal stronger and won't do it again. Beware when slowing down, though, which is when the muscle is at risk.

- Sports Doc (Dr John Orchard), Men's health, December 2009

In the next excerpt, the details of an injury are stated in a technical fashion (rotator-cuff tear, external rotation) thus directing the reader straight to the problem area:

I underwent a shoulder reconstruction nine months ago to repair a massive rotator-cuff tear. External rotation is limited. How long until my full range of motion returns and when will I be able to play contact sports and lift heavy weights again?

Given this direction, the reply relates specifically to the issue of the torn rotator-cuff:

What you get in terms of range of motion depends on the integrity of the repair. If the surgeon got in almost immediately after the tear occurred, you can sometimes get a near perfect result and be back to unrestricted lifting. If the problem was more chronic, then shoulder power may be permanently reduced despite the best repair job. You should be very careful when returning to contact sports and heavy lifting after such a major operation.

- Sports Doc (Dr John Orchard), Men's Health, November 2009

In the following piece, not only does the jargon direct the expert's response, it also guides the editor's choice of expert. That is, the text indicates that an expert (of the Down's syndrome association) has been sought in direct response to the jargon (Down's syndrome) used in the help-seeker's text:

A member of my girlfriend's family has Down's syndrome. How likely is it that any kids we have will have it?

"This is unlikely to have any bearing on whether or not she has an increased risk of having a child with Down's syndrome," says John Smithies of the Down's syndrome

Association. In fact, Down's is one of life's crueller lotteries, with 99 per cent of cases the result of a spontaneous occurrence at the time of conception. While it is possible to inherit a form of Down's syndrome, says Smithies, your girlfriend's family would probably know about it. "If your girlfriend is still worried, she can ask her GP for a chromosome test on a blood sample."

-Bionic health, FHM, November, 2009

The use of medico-scientific jargon, then, enables help-seekers to communicate with experts in the experts' own language (or, rather, a language that could be expected of experts), with the purpose of drawing experts' attention to specific problem areas. This, in turn, achieves a piece of advice specific to the problem.

Function: self-positioning, relative to experts

By communicating problems in language that might be expected of experts, texts appear to frame writers as on par with experts. That is, the use of medico-scientific jargon allows the demonstration of knowledge, which in turn positions help-seekers also as experts. In the following extract, the use of technical terms to describe the injury (tendonitis) and its location (lateral and medial tendonitis), inform the expert of what the help-seeker has already deduced. The only question left, then, is what the best treatment might be. Moreover, despite no explicit reference to previous consultation with a health expert, the help-seeker's text indicates that he knows what he is talking about. Via the use of jargon, the help-seeker's text evades speculation about the accuracy of his diagnosis. Use of medico-scientific jargon may therefore operate as an indicator of knowledge or expertise, one which may go unquestioned:

I have chronic lateral (a decade) and medial (two years) tendonitis in both elbows as a result of weight training and mountain biking. How do I resolve this issue?

Indeed, the expert's text gives no second opinion on diagnosis, but, instead, relies upon the patient's pre-diagnosis, suggesting that four operations would be needed (for both the lateral and medial tendons of each arm):

It certainly wouldn't be unreasonable to try surgery after all this time, but given that you could need four operations at two sittings a few months apart, even the most aggressive surgeon might be reluctant to cut you open. If you avoid surgery, the key is

to find out what load your tendon can just tolerate and do that amount of loading as much as possible, until your tolerance goes up. The good news is that tendons almost always have the ability to heal, even after years of failure to do so.

- Sports Doc (Dr John Orchard), Men's Health, December 2009

The learning and adoption of jargon thus appears to allow help-seekers to position themselves as knowledgeable and on par with health experts. This, in turn, enables them to actively engage with health professionals as equals. Doing so appears to facilitate biomedical diagnosis and treatment advice, and avoids second-guessing on the part of the expert.

Enabling medium: multiple sources

Yet, a repertoire of medico-scientific jargon is not something that is innate, thus it must be amassed via contact with medical or scientific contacts. As such, it is not surprising to find encounters with multiple sources of health information to be common in text that uses medico-scientific jargon. The next piece explicitly states that online information has been sought before consulting Men's Health magazine; the help-seeker's text comes armed with medico-scientific jargon:

I've sustained an ankle/arch injury playing cricket. I've self-diagnosed this online as tibialis posterior syndrome and have been wearing orthotics. Should I go to a podiatrist to get these updated or just buy some new runners and get physiotherapy instead?

Again, the jargoned diagnosis and attempt at remediation is the target of the expert's reply, much more so than the initial injury itself or preventative measures:

Orthotics will generally unload certain parts of the leg/foot during running movements, so they can cure many injuries. What is less admitted (at least by podiatrists) is that orthotics can possibly transfer load to other places. Generally, they unload the muscles and tendons that hold up the arch, including the tibialis posterior. So if this is indeed your diagnosis (it's worth having this checked), a full set of orthotics from the podiatrist will probably help.

- Sports Doc (Dr John Orchard), Men's Health, December 2009

Therefore, help-seekers may be likely to seek information from multiple sources, including pre- and post-consultation with experts. Function-wise, seeking multiple sources of information appears to serve the purpose of confirming alternative sources:

I'm a surfer suffering lower-back pain caused by the lower disc in my back being half as thick as the others. The chiropractor says I should avoid cobra-style back bends, while the physio disagrees. Who's right?

Notice that the expert's text, although not siding with either of the previous professionals thus not confirming nor disconfirming either source, seeks to equip the help-seeker with an alternative way to validate health information - self-evaluation. Regardless, his reply continues the help-seeker's theme of confirmation of sources:

It's common to have disc degeneration at the bottom level, but it will mean your back gets sore more easily with overload. Fortunately, surfing is a medium load at most, so you should hopefully be able to continue. There isn't a specific study on cobra-style exercises, so I would find out who is right by trying them gently and seeing whether your back seems to improve or get worse.

- Sports Doc (Dr John Orchard), Men's Health, February 2010

In the following excerpt, the help-seeker's text explicitly declares that not only has help been sought previously, but that the site of the issue has already been located, as indicated by the jargon ("sternum"). This gives the expert a medical reference point to begin giving advice. However, the text indicates that the help-seeker may be less than confident in his diagnosis to-date ("my GP *thinks*" [emphasis added]), thus this letter appears to be acting as his confirmation of sources:

I've injured my sternum after a chest workout. My GP thinks it's where the ribs meet the sternum and that the cartilage is inflamed/ damaged. Is there anything you recommend?

The expert's text responds to the diagnostic uncertainty and commences to dispense advice as directed by the help-seeker's query:

We see this injury occasionally in sports medicine and it is tough to treat. It's probably a type of stress fracture between the rib cage and sternum, which is bone.

It's more common in younger athletes when there are extra growth plates around the sternum. Longer term rest may fix it and active stimulatory treatments (ultrasounds and similar machines at the physio) may heal it. The best news is that it shouldn't get worse. If the pain is bearable, you can just train through it.

- Sports Doc (Dr John Orchard), Men's Health, January 2010

Not using the medico-scientific discourse

When the medico-scientific discourse is absent, however, enquiries appear passive, vague and tentative, as demonstrated in the query below, which does not articulate the problem well:

I've done something to my elbow and now the joint aches when I do things such as bicep curls. Any ideas on what it might be and how I can prevent it?

Indeed, without the purpose-driven direction of the medico-scientific discourse, the expert's text lists a number of possibilities (tennis elbow, golfer's elbow, biceps tendonopathy) that emerge from the sparse information supplied in the query. Vagueness is thus not only unhelpful for the expert, but suggests that the vague and uninformed help-seeker is unable to guide the expert or to elicit particular advice in the manner achieved by the active and informed help-seeker:

Tennis elbow affects the tendon on the outside of the joint and is most painful on wrist or finger extension movements. However, you can suffer overuse tendon injuries in the medial (inside) part of the elbow (golfer's elbow) or deep in the front part of the joint (biceps tendonopathy), especially at the gym. All tendon injuries respond best to moderate loading. Don't rest them totally but back off from fully loading and work up the load gradually. If it is a biceps tendon, try negative curls, where you lower the weight down against gravity but pick it up with the unaffected arm.

- Sports Doc (Dr John Orchard), Men's Health, January 2010

The same can be observed in the next extract, whereby the help-seeker's text asks a vague question, with no elaboration, that leads the expert to confusion, and inadvertently guides the quasi-consultation to an inconclusive end (with possibilities ranging from athletes foot to nerve damage, alcoholism to diabetes). The help-seeker's query is thus passed on; being advised to seek professional advice elsewhere and in person:

My right foot sometimes feels like it's on fire. Why?

You have Simply Feet's Jeanine Wilson so stumped she's spent the last few minutes contemplating a number of causes. "Athletes foot could cause a burning sensation. Some blood disorders, including anaemia, could also be the culprit. Hot, burning feet have also been associated with nerve damage, which is linked to conditions such as alcoholism or diabetes." And to clear it up, you'll have to hop straight down to your local podiatrist.

-Bionic health, FHM, February, 2010

Similar is seen in the following piece, in which the help-seeker's suggestions do not emerge from the medico-scientific discourse:

I play Aussie rules football and experience sore legs a couple of days after the match. What is the best method of recovery to reduce this – ice bath, a low impact activity or massage?

As such, although the help-seeker's query is purpose-driven (to choose the best recovery method from a list of possibilities), it lacks the support of the medico-scientific discourse. The help-seeker's 'diagnosis' (sore legs) seems vague, and his suggestions for recovery are referred to only in passing (and as merely 'probably helpful'), by the expert's text. This reply also advises seeking help elsewhere and in person:

Delayed-onset muscle soreness (DOMS) is very common, and all of your suggestions are probably helpful. Anti-inflammatory tablets reduce DOMS as well. If it is very severe and always in a specific part of your legs, you should get a professional consultation to assess for specific diagnosis (e.g., compartment syndrome of the calves, back-related hamstring pain).

- Sports Doc (Dr John Orchard), Men's Health, November 2009

While the brevity of information may at first glance appear to reflect an unwillingness to surrender information, it may be likely that this could represent the beginnings of help-seeking. By this assumption, help-seekers may start off as relatively naïve in terms of health expertise and thus be unable to articulate an issue or its features well. It may be likely, then, that those estranged from health information might be unable to prevent issue exacerbation

given an inability to communicate information about the problem. Consultation of health resources and adoption of diagnosis-guiding jargon of the medico-scientific discourse may represent a more effective way to seek help.

In summary, the use of jargon seems to have better enabled these men to engage in (written) consultation with health experts. There was often evidence of a pre-validated diagnosis and a repertoire of language with which to promote action in regards to engaging with health professionals and acquiring advice. This reflects the findings of Ollife and Thorne (2007) who found that self-directed investigation of prostate cancer allowed patients to be independent and actively involved in treatment decisions by allowing men to communicate with professionals via the use of biomedical language. This allows the help-seeker to position themselves as someone who is not only an active pursuer of good health, but is independently knowledgeable. Use of the medico-scientific discourse thus works to position help-seeking men as in the same league as experts, given that both are framed as knowledgeable about pain and injury. Men are then legitimately able to engage with health professionals as experts themselves. This discursive space has enabled the men in this study to better elicit diagnostic and treatment information from health professionals who have responded specifically to those aspects of the query that have been medically stated. As such, it has been the active help-seeker who has elicited health information from the practitioner in these quasi-consultations. This practise mimics that of the 'voice of medicine'. Elsewhere, scholars have declared that the 'voice of medicine' is a discursive technique used by general practitioners to exert control over interactions between biomedical expert and lay help-seeker, thereby manipulating consultation outcomes (Barry, Stevenson, Britten, Barber, & Bradley, 2001). As such, the voice of medicine is said to be results-driven and motivated by scientific and technical interests (Barry et al., 2001). In the present cases, however, it is the active help-seeker who controls the encounter by employing the medico-scientific discourse, thus dictating the direction and outcome of the conversation.

The medico-scientific discourse has thus positioned not only these help-seeking men in a particular way, but also the experts they have sought help from. In striving to position themselves as equal to experts, these men are implicitly implying that they (and perhaps all lay people) are initially unequal to, or of lesser standing than experts. That is, the men may have anticipated an inequality of power in favour of experts in consultation. Adoption of the medico-scientific discourse, then, is a way to shift this power-disequilibrium. Employing the

medico-scientific discourse may be a vehicle through which men can enact a hegemonic version of masculinity by not only appearing on par with experts, but completely reversing power disparities so that help-seekers, rather than experts, hold consultation control.

(Re)establishing masculinity

Much of the self-positioning within the help-seekers' text can be linked to the western enactments of masculinity described in chapter one, particularly hegemonic enactments, the fear of femininity, and the pursuit of masculinity. As such, letters and their replies tended to mirror research postulations that men enacting hegemonic-type masculinities may strive to position: themselves as superior to other men; men, as a whole, as superior to women; and masculinity as superior to femininity (Courtney, 2000; O'Neil, 1981). Within the letters employing the (re)establishing masculinity discourse, the positioning of men relative to others, particularly women, is apparent.

Fear of femininity

As predicted by Courtney (2000), Campbell (2000), and O'Neil (1981), distancing one's self from women, and from femininity, appears to be one way in which writers (both help-seeking and expert) attempted to enact masculinities. For example, the following text attempts to distance its writer from femininity by implying that nail parlours are 'girly,' and that the help-seeker, being masculine, would prefer to settle the matter at home instead of at such a female oriented institution. Indeed, Motschenbacher's (2009) exploration of bodies in commercials found that linguistic representations of the human body tend to be gendered thus (re)constructing normative male and female bodies. That is, despite the fact that both men and women share body characteristics, many parts tend to be associated with either men *or* women (Motschenbacher, 2009). Here, the help-seeker's text illustrates the connection of hands to women and indicates that the writer's association with either is undesirable and something to be avoided:

The skin on the back of my hands is dry and painful. Do I need to take a trip to a girly nail parlour or are there some home remedies?

However, despite the attempt, the help-seeker is still chastised by FHM's 'Bionic Health' editor's text for complaining about a stereotypically female vanity (Motschenbacher, 2009). This persecution occurs despite the fact that salons exist for men. Although the 'trendy bloke's salon' is not, itself, rebuked, the men who attend are. By implying that the men who attend these salons leave their 'manhood at the door', such men are positioned as less than masculine due to their association with feminine concerns and institutions. In accordance with the phallo-centricity of masculinity (Khan et al., 2008; Motschenbacher, 2009; Nugteren et al., 2010), this implication is reiterated by the editor's reference to castration. Given the penis' symbolism of masculine strength, potency and power (Nugteren et al., 2010), the suggestion of castration represents not only an association to women, but a stripping of the help-seeker's male entitlement to superiority, particularly that over women:

Either way, prepare to leave your manhood at the door. "A good quality manicure will deal with cuticle dryness, as a nail technician will apply a hand moisturiser at the end," says Maria Epiphaniuo, therapist at a trendy bloke's grooming salon. But if you can't bear to leave the house on such a mission, have a go yourself, as Maria explains. "Use a homemade mask by slightly warming up some olive oil and soaking your hands in it. Follow this by wrapping the hands with cling film, and then wrap them in a damp, hot towel for 10 minutes." When you're done, why not chop your own gonads off?

-Bionic Health, FHM, November 2009

Pursuit of masculinity

Not only do attempts to establish distance from femininity emerge across many of the letters, but also ties to masculinity. Thus it seems important to be seen as seeking help for issues that are both divorced from perceptions of femininity and perceived of as masculine. As such, many texts, particularly in regards to pain and injury, make a point of mentioning that issues have arisen from stereotypically masculine physical activities. Activities include weight lifting, intense physical workouts and mountain biking:

I have chronic lateral (a decade) and medial (two years) tendonitis in both elbows as a result of weight training and mountain biking. How do I resolve this problem?

- Sports Doc (Dr John Orchard), Men's Health, January 2010

Though, it is not just through physical activity that texts claim participation in western masculinities. The following piece illustrates concern about a diminished ability to consume alcohol as well as the reduced ability to tolerate the painful consequences. Despite this diminishing ability, however, the help-seeker's text claims the writer's persistence in this activity:

When I was young, I used to be able to drink as much as I wanted, but now that I'm older, I'm finding my hangovers are much worse – and I'm not even drinking anywhere near what I used to. What's the deal?

“Dehydration and low blood sugar are what a hangover is,” explains GP Sarah Jarvis. The way alcohol generally works is it removes fluid from the body, as well as making it produce insulin, which reduces sugar from the blood – that's the reason a kebab is so damn appealing after a session. But why does it get worse the older you get? “A decrease in body water content and increase in body fat content, which comes with age, partly explains it,” says the good doctor. “Lean body mass also reduces as you get older, leading to higher blood alcohol concentration for the same amount of alcohol consumed.”

-Bionic health, FHM, January 2010

Many texts exemplified tolerating the pain associated with issues for extremely long periods of time, as well as a continued participation in the activities, despite. This is illustrated in the following excerpt where the help-seeker's text claims that although the writer experiences pain because of his activity, he has continued, regardless:

I've been running for four weeks and have had intense shin pain every day. What can I do to help recover from it?

If it's typical “shin splint” pain on the medial (inside) parts of the shin, the best treatment is arch supports in your shoes (orthotics, motion-control shoes or arch taping). If it's on the front or outside of the shin, it's more likely you might have

chronic compartment syndrome. In the first instance, this would be treated with short-term rest, then breaks in-between runs so you are not running continuously.

-Sports Doc (Dr John Orchard), Men's Health, January 2010

Help-seekers' adherence to masculinity via the fear of femininity and the pursuit of masculinity is reinforced by experts' text, which actively encourages help-seekers to tolerate pain and continue harmful activities:

I've injured my sternum after a chest workout. My GP thinks it's where the rib meets the sternum and that the cartilage is inflamed/ damaged. Is there anything you recommend?

We see this injury occasionally in sports medicine and it is tough to treat. It's probably a type of stress fracture between the rib cartilage and sternum, which is bone. It's more common in younger athletes when there are extra growth plates around the sternum. Longer term rest may fix it and active stimulatory treatments (ultrasounds and similar machines at the physio) may heal it. The best news is that it shouldn't get worse. If the pain is bearable, you can just train through it.

- Sports Doc (Dr John Orchard), Men's Health, January 2010

And just as these are reinforced by experts' replies, non-adherence is punished. For example, the following help-seeker is frowned upon when his text suggests giving in to pain by discontinuing his activity:

When I run long distances, my calves always get cramped, which means I can't run for a week after that. Why does this happen; am I doing something wrong? Should I just stop running altogether?

The expert's text not only implies displeasure at the help-seeker's intolerance to pain, but suggests that the pain resulting from muscle cramps does not provide sufficient enough

reason to prevent a man from running, as shown in the excerpt below. What is more, a feminine referent is used that works to associate the help-seeker with femininity. To explain, Bem's (1974) Sex Role Inventory consists of a list of personality attributes judged by multiple panels to be either masculine, feminine or androgynous. This inventory is used to label respondents accordingly. Of these attributes, 'gullible' and 'child-like' are among those rated as traditionally feminine. This suggests that to be silly is also to be feminine. Taken together, admonition of the help-seeker as silly suggests that he is being dissociated from masculinity due to his failure to adhere to its stoic tenets:

*Personal trainer Nick Mitchell is not a happy man. "Don't be silly," he says. Unless you have a pre-existing injury causing you to run incorrectly, there's absolutely no reason for you to not run because of muscle cramps." A cramp occurs when a contracted muscle fails to relax due to what is called "hyperexcitability of the nerves of the muscle" – basically when you subject the muscle to an undue level of stress of stimulation. "This is the most likely cause in ****'s [name withheld] case, although you also need to ensure adequate hydration and intake of potassium and magnesium salts. A good sports electrolyte drink can take care of this as a potentially limiting actor," he says. Mitchell also advises building up the distances and intensity of your runs slowly, as well as interval training – running for a few minutes, then walking – and stretching out your calves should the dreaded cramps occur again.*

-Bionic health, FHM, January, 2010

In summary, constructing one's self as masculine seems to be another feature of help-seeking exhibited by these men. Such constructions are established via emphasising participation in stereotypically masculine activities and through evidencing stoicism. Stoicism is illustrated by taking the position that not only can the help-seeker tolerate issues for long periods of time, but that he can continue on with activities despite these issues. Such stoic displays are reminiscent of popular 'men-as-machine' media portrayals of the 1980's (Messner, 2007). These depictions saw masculine archetypes, such as Arnold Schwarzenegger and Sylvester Stallone, evidencing their characters' masculinity via ignorance of their own pain or suffering. Research suggests that such stoic ideals exist as an important feature in many western masculinities (Addis & Mahalik, 2003; Courtney, 2000; O'Neil, 1981). Indeed, the

stoic position is one that seems to be taken up in the help-seekers' texts. Unfortunately, the reinforcement of this tenet by experts may lead help-seeking men to be vulnerable to exacerbated injuries by prolonging delays in help-seeking, or by following advice to continue clearly harmful activities despite pain.

Not too different from hegemonic masculinities, Brannon's (1976) own formulation of the western male sex role positions men as needing to be: different from women; superior to others; independent and self-reliant; and more powerful than others. When help-seeking, the latter three are potentially violated, given that men may be relegated an inferior status to experts during consultation (as seen in the previous discourse whereby men tended to use a discursive technique to bring themselves *up* to par with experts), and that help-seeking may mean foregoing self-reliance since they must rely on others for guidance. The first may also be violated if help-seeking occurs in regards to a body-part normatively associated with the female body. The prior paragraphs, then, illustrate how these men negotiated a potential violation of male role tenets; violations they may have associated with help-seeking. In the examined letters, this was done by establishing that injuries were attained via men's involvement in traditionally male oriented activities, or by evidencing their adherence to masculine tenets, such as being stoic to long-term pain. Taken together, these men tended to construct themselves as masculine when they were seeking help for something that had the potential to otherwise position them as having violated expected societal sanctions of masculinity. The (re)establishing masculinity discourse, then, works to establish, or re-establish, writers' masculinity in the eyes of experts who may be expected to see them as less, given a potential violation of hegemonic masculine tenets. Again, there is evidence of power disequilibrium between expert and help-seeking men, as well as a means by which help-seeking men might attempt to limit this disparity.

However, the absence of the (re)establishing masculinity discourse, and thus the failure to evidence adherence to hegemonic masculine tenets, appeared to result in male experts attempting to retain the power difference. Experts thus not only reinforced hegemonic masculinities, but enacted them. By positioning help-seekers as feminine ('chop your gonads off,' 'don't be silly'), male expert's texts demonstrated the tendency, as pointed out by Campbell (2000), to enact and defend their masculinity by undermining other men's claims to masculinity, via feminine-association. As such, help-seeking men who transgressed male

socialised norms appeared to be relegated a lower status as men, by experts. In doing so, expert's texts constructed the superior position of their authors within masculine hierarchies by establishing their higher status, over the help-seeker, as a result of their active relegation of the help-seeker. In doing so, experts' texts reinforced the status quo of conformity to hegemonic masculine hierarchies.

Chapter Four: *Reconstructing crisis*

The medico-scientific and (re)establishing masculinity discourses allowed these men to position themselves in accordance with enactments of hegemonic versions of masculinity. Self-positioning relative to experts, then, could play an important role in male help-seeking, particularly where perceptions of power may be involved. The two discourses reflect the idea that masculinity involves a melee for superiority and power, and just as Campbell (2000) noted, seems to need continuous enactment and defence. As illustrated by the (re)establishing masculinity discourse, men writing in to Men's Health and FHM magazines sought to preserve their place in masculine hierarchies, possibly in defence of potentially violating hegemony tenets of superiority. Failure to defend their superiority resulted in criticism via associations with the assumed inferior - femininity. On the other hand, the medico-scientific discourse not only enabled men to lessen the potential to be perceived as inferior to experts, but achieved power through their ability to guide consultations.

The appearance of hegemonic-oriented discourses raises questions about how perceptions of power imbalances might prevent help-seeking and adoption of health practices in the first place. Given that O'Neil has hypothesised that men may liken help-seeking to femininity via admitting weakness and vulnerability, might men also avoid help-seeking based on apprehensions of power imbalances? To clarify, while the stigma associated with help-seeking has been correlated with O'Neil's concept of Gender Role Conflict, respondents evidencing higher levels of GRC have been those that score higher on the success/power/competition (SPC) subscale (Steinfeldt et al., 2009), suggesting that this subscale could be a fair indicator of overall GRC rating. Therefore, those with higher SPC socialisation could be expected to be more likely to associate stigma to seeking help. This makes sense when viewed in conjunction with the current results. That is, men socialised more in terms of SPC may be more likely to avoid help-seeking due to power disparities between them and experts. Therefore, not only is restriction a barrier to help-seeking, but so too could be the perceived loss of power and control to experts. Equipping men with empowering discourses such as the medico-scientific and/or (re)establishing masculinity discourses could thus be advantageous in overcoming this barrier. Future research might wish

to investigate the effectiveness of such an approach, as it has the potential to better enable men to seek help and to achieve good health.

Indeed, this thesis was aimed at achieving such ends by examining help-seeking discourses with which to align health promotion with enactments and expectations of western masculinities. Perhaps not surprisingly, the same masculinity tenets believed to be responsible for the crisis in men's health could also be used to counter it. While the pursuit of masculinity, the fear of femininity, and hegemonic masculinity are linked to the exposure of men to health risks and to the rejection of health regimes, they may also be useful in getting men to consider health messages. That is, while principles of superiority inherent in hegemonic enactments of masculinity could be scorned for their contribution to men's negative attitudes toward help-seeking, the repositioning of help-seeking as a way to establish control and power might otherwise encourage it.

Specifically, health promoters might wish to consider positioning their target men in ways that enables help-seeking to appear superior to not seeking help, or by positioning it as a vehicle for men to attain some superior masculine status. This repositioning might also be a way to avoid creating taboos and possible consequent backlashes. Rather than instructing men not to participate in detrimental behaviours (which, as noted by Crossley, might be met with reactance), promoters could encourage alternative masculine principles that counter detrimental behaviours. For example, a recent campaign against shaking babies in order to stop them from crying, used the slogans 'are you strong enough?' and 'you have the power to protect' (Ministry of Social Development, n.d.). In doing so, the campaigners have drawn on hegemonic versions of masculinity and the (re)establishing masculinity discourse, thereby associating caring fathers with strength, power and the duty to protect, rather than with feminine-associated values of caring and nurturing.

However, there are some ethical concerns inherent in this approach. Firstly, if men do not feel that they can live up to health-oriented masculine expectations, then they might resort to alternative, and quite possibly unhealthy, versions of masculinity. De Visser, Smith and McDonnell (2009) explain this phenomenon in terms of 'masculine capital', in which various enactments of masculinity can be traded for competence in other enactments. Indeed, as noted in chapter one, some of O'Brien's interview respondents felt that they were unable to pursue masculinity through physical labour. Instead, they turned to excess drinking.

Therefore, health promotion equating health with superiority may risk marginalising currently unhealthy men, men without health-competency with which to gain masculine capital, or men who have little access to healthy lifestyles. Secondly, encouraging hegemonic ideals might also contribute to already prevalent notions of masculine dominance and superiority. Health promotions reinforcing such belief systems thus risk undermining ideals of equality.

Alternatively, given that the medico-scientific discourse is one that seems promising in providing an efficient method of seeking and attaining advice in this context, health promoters could consider the benefits of equipping men with this discourse. This could entail providing men with easily understood information and links to further resources, while also encouraging them to use these links. Campaign messages thus ought not only encourage men to seek help for particular issues, such as prostate cancer and depression, but to understand symptoms, self-check techniques, and possible causes and ‘cures.’ Equipping men with information may facilitate the adoption of the medico-scientific discourse and allow them to better elicit advice from experts. The need for on-going performance and defence of masculinity suggests that these campaigns may also need to be on-going in order to continually support men in adopting health-oriented behaviours against social/societal environments that may actively discourage them.

Because the media have been so apt at reiterating and maintaining the notion of men in crisis, then perhaps the media could again be used to benefit men’s health. One option could be to encourage the publication of articles that carry the theme of empowerment of men over their own health. This could be one vehicle by which to de-establish the myth that poorer health in men comes as an inevitable result of men being ‘the way they are’. By refusing to justify this discourse through its propagation, there may be some hope of enabling change through the media by, instead, providing men with examples of successful change. A second option may be to attach existing enactments of prevailing masculinities to healthier lifestyles. The appearance of the medico-scientific discourse suggests that despite media portrayals, help-seeking men who draw on this discourse are far from infantile and disinterested when it comes to health. On the contrary, the discourse positions these men as interested in health while also so independently knowledgeable that they compete with experts for consultation power. Using the medico-scientific discourse, the media could be helpful in reconstructing men as able to be masculine through successfully pursuing healthier lifestyles.

Limitations and suggestions for future research

As per Gough's (2006) criticisms, this analysis gives little regard to diversity as may arise from socio-economic status, ethnicity, sexuality or age divisions, and erases differences between men. Instead, the current findings reflect the ontologies of the men who typically buy these magazines (or rather, a particular subsample of this group given that not all readers will be willing to write in). On one hand, FHM readers are most likely to be males aged 35-49, employed full-time as skilled workers and earn over \$60,000 (AUD) (Acp magazines, n.d.). This constitutes but a tiny sample with which to represent western men. On the other, it is not surprising that a biomedical discourse should emerge from a magazine that emphasises the physical male body (Men's Health). Taken together, the selection of magazine titles has in essence dictated, via their target audiences, certain discourses that might emerge. These discourses, in turn, may denote the world views and ways of being that are specific to the participants from which they arose.

A weakness thus exists in regards to the transferability of the current findings. That is, although the biomedical and (re)establishing masculinity discourses appear to have aided these men in seeking help, it cannot be said for sure that such discourses might actually empower men who currently refrain from help-seeking or from adopting health-oriented messages. It may be likely that this sample represents only a small subsample of men that may already be prepared to seek help or are already motivated to live healthy lifestyles. In each case, the discussed discourses might then be either specific to certain subgroups of men or might only facilitate help-seeking once men are motivated and already actively seeking advice. Alternatively, with De Visser, Smith and McDonnell's (2009) study in mind, it is also possible that these discourses may only apply to men who have attained masculine capital in other aspects of their lives, thus they may be able to negotiate threats to their masculinity more easily.

What is more, there is the possibility that columnists, or editors, of these magazines have chosen letters that reflect their own current version of masculinity. This may go some way to explain why only hegemonic-oriented discourses appear in this analysis; alternative versions may not have been given a voice. This examination, then, may be more of an exploration of discourses drawn on by men adhering to masculinities as held by FHM and Men's Health magazines. Basing health promotion solely on this analysis would therefore risk reproducing those ideals as found in FHM and Men's Health's magazines. As such, more research needs

to be done to collate a greater repertoire of inversed masculinity techniques, not just as they exist in popular magazines, but also in wider mediums and in arenas of alternative or marginalised masculinities.

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