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Men's Health – A couples' perspective in  
shared narrative

A thesis presented in partial fulfilment of  
the requirements for the degree of

Master of Science  
in  
Psychology

at Massey University, Albany,  
New Zealand.

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2013

## **Abstract**

Men's health is often studied in isolation of the supportive and caring relationships that have significant influence on their lives. This qualitative research employs joint interviews with heterosexual couples to explore the interworking between them in health. A narrative analysis approach is undertaken and the stories these couples construct analysed in a natural setting.

The couples' perspective is discussed in the context of two key structures; firstly, couples' shared narratives are explored to investigate the stories couples construct together in the context of the cultural narratives they are immersed in, and their unique ways of challenging these narratives. Secondly, a temporal view is presented across the participant group to describe their shared journey in health over time, and how their shared narratives evolve as they transition through formative, established and mature life phases.

The influence of parents is also discussed as they provide, along with other members of wider society, a reference group of less effective others for the participants to compare and contrast their success in health. The negative aspects of this other group are contrasted with hope for upcoming generations giving some indication of progress being made toward wider, positive cultural change in men's health.

Overall, the couples participating in this research are inspirational in the level of ownership and accountability they take in men's health and their sharing of life's burdens, and rewards as a couple.

## **Preface**

This thesis is located in a field of research that explores how men's health is influenced by being in a heterosexual relationship. A critical focus is placed on how couples create shared identities, in a semi-structured joint interview, within the constraints of culture and the couple's interactive frame.

What started as an inquiry into a field of interest has evolved to reveal something not only about men, their partners and the couple relationship; but also the work they perform through narrative and their expectations for the future of men's health.

### **Matters of ontology and epistemology**

This research is undertaken from a social constructionist ontological orientation where it is proposed that the social world is constructed through discourse, that truth and meaning are multiple, and the stories we tell are contextual. Further to this, the research is informed by an epistemological perspective where knowledge is shared between people and that which can be considered knowledge relates intimately to those using it and the context in which it is used (Tuffin, 2005). To that end, it is proposed that the study of the social world is best served through observation of people and their use of language in a natural setting, rather than through scientific intervention.

The joint interview context chosen for this research has had significant influence on the outcomes achieved in the study. In particular the participants and researcher commence interview sessions as strangers and then, through the course of the interview, work to construct identities that they wish to project and be recognised by. It is proposed that the primary tool available to participants, to enable this construction, is the act of talking together.

The interview structure also challenges participants by limiting the time they spend together on this activity. In order to make sense of each other, in this short period, it is proposed that participants employ culturally embedded rhetorical devices which allow them to shortcut their way to a joint understanding. This shared understanding is built on the cultural landscape they are bound to, although in New Zealand there may be significant leeway available for participants to express themselves within these bounds.

It is further proposed that culturally embedded stories, as employed by interview participants, can be surfaced by remaining sensitive to commonalities that span across a number of interviews. These cultural artefacts are contrasted by those constructs that make the couples individual and unique in their own right (Freeman, 2001).

### **The research journey in time - getting from then to now**

This research is founded on an iterative development of understanding, where an active navigation through participant interviews and associated theory, has culminated in an increased awareness of the discursive tools employed by couples when discussing men's health.

The preconceived view of the research landscape, held by the researcher at the start of this journey, was challenged using a critical approach that encouraged frequent reassessment of current in-use theory against the interview data collected. A number of assumptions and understandings employed in the structuring this research were invalidated during this process as new perspectives revealed more complex analytical relationships in the research data.

This thesis report is, therefore, the endpoint of a research effort that has taken many directions unforeseen at the start. It

is presented in a somewhat unconventional format that encourages readers to join this journey, to understand the evolution of analysis and a growing connection with the participants and their stories. In this regard an on-going review of literature is, in some places, interleaved with the presentation of findings reflecting the tight interlock between these two streams of the research process.

### **Structural considerations**

The transcription extracts presented in this thesis are exemplars of couple interviews employed to facilitate a discussion of narrative from across the interview set. These extracts are not the sole examples of the concept being discussed, but are relatively contained narrative segments that reflect the views of a number of couples. The extracts are presented in a non-edited state and should be read in the context of an interview setting. The key discourse in each extract, relating to the surrounding thesis findings, is bolded to ease location and reading.

Transcription extracts are identified in the first line by interview number and participant pseudonyms. All occurrences of interview content identified by participant 'M' reflect the interviewer (Murray) speaking.

Content within this report that is *italicised* consists of researcher reflections intended to assist with reader navigation of the report. And finally, following contemporary convention (Riessman, 2008b), the terms story and narrative are used interchangeably in this thesis.

## **Acknowledgements**

This research would not have been possible without the generous participation of couples who volunteered their time and spoke frankly and openly in interviews that were scheduled into busy days and evenings. Their contribution goes beyond the time invested and the disruption generated.

The support and guidance of my supervisor, Professor Kerry Chamberlain, who encouraged me to extend my interests in men's health beyond the individual into the couple context, was invaluable. His extensive knowledge of qualitative research approaches, theories and methods provides a backdrop to this thesis research.

A timely approval from the Massey University Human Ethics Committee (Northern) ensured the thesis project started early with sufficient runway to allow for the evolution of thinking required.

And finally, I would like to thank my partner Paula and my friends and family, who have navigated this journey with me. They have provided shoulders to lean on, along with intelligent reflection, in my many hours of need.

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## **Chapter One: Introducing the thesis**

Men's health is often studied in isolation of the supportive and caring relationships that have significant influence on their lives. This qualitative research employs joint interviews with heterosexual couples to explore the interworking between them in health. A narrative analysis approach is undertaken and the stories these couples construct analysed in a natural setting.

### **Setting a context for men's health in New Zealand**

In 2012 the New Zealand Ministry of Health released key findings from the New Zealand Health Survey (Ministry of Health, 2012) reporting increased levels of depression, bipolar disorders and anxiety disorders, along with growing obesity rates in the New Zealand population. Additionally, over half a million New Zealanders were reported as taking medication for high blood pressure and, or high cholesterol.

Further to this, at a macro level, New Zealand is identified in OECD health reporting as rating in some of the worst member countries in a number of key health indicators. In particular OECD statistics place New Zealand as the 3<sup>rd</sup> highest population for reported levels of overweight and obese adults with over 50% of the population meeting the OECD definitions for these categories; worryingly this number has doubled in the last 20 years (OECD, 2011).

Unfortunately the significant financial costs of health reported by the New Zealand Ministry of Health in 2006 have continued to grow leading to a call for policy change, along with other forms of intervention, to reduce the prevalence of poor health in New Zealand (Lal, Moodie, Ashton, Siahpush, & Swinburn, 2012).

## **Gender and health policy**

Anderson and Frogner (2008) propose that an effective response in this environment, with the goal of improving general population health, when there is significant variability across health indicators reported, requires focus. These authors posit that increased funding is not necessarily an answer to the challenges faced as reflected in the United States of America, where the spend on healthcare is double that of the OECD country median, yet value for dollar spent is reported as being inconsistent across OECD indicators.

Understanding and responding in this health landscape is further complicated by gender differences reported at the OECD indicator level. Heart attack rates in New Zealand men, for example, are reported as being at a level twice that as for women. Whilst mortality rates for cancer are 10% higher for women than men in OECD countries, and 20% higher for New Zealand women specifically (OECD, 2011). Overall, the premature mortality rate for men, a key indicator for the present study, is reported in the OECD findings as being twice that of women, reflecting the findings of studies that have reported men live shorter lives, and do worse on many health measures, than women (Karoski, 2011; McVittie & McKinlay, 2010; Oksuzyan, Juel, Vaupel, & Christensen, 2008).

In response to the significant variation in gender needs for health the Australian Department for Health and Aging has published separate policy frameworks for male and female health so that the specific needs of both men and women may be addressed (Department of Health and Aging, 2010). It is proposed that health policy for men in Australia may then be more effectively enacted as it may focus on prioritising the multi-dimensional, functional, action orientated approaches to health

favoured by men (Karoski, 2011; Sloan, Gough, & Conner, 2010).

This refocusing of health policy reflects a positive step forward for men's health in Australia, possibly in response to earlier calls for policy and programmes tailored to the health needs of boys and men when these were considered to be non-existent or of limited use (Monaem, Woods, Macdonald, Hughes, & Orchard, 2007).

### **Masculinities and health**

The OECD (2011) and New Zealand Ministry of Health (2012) reports indicate significant differences between men's and women's morbidity and mortality but the source of these differences remains in dispute (Bird & Rieker, 1999). Health related behaviours and social factors have, however, been located as important contributors to gender differences in this arena (Courtenay, 2000; Rieker & Bird, 2005). Health behaviours, like other social practices men and women engage in, have been identified as a means of developing and demonstrating femininity and masculinity identity (de Visser & McDonnell, 2013), but for the most part studies have failed to ascertain why rational men are not making their health more of a priority in their lives (Rieker & Bird, 2005).

This is a complex landscape and simply confronting men's poor health status, where some health behaviours may be perceived as feminine activities (Cameron & Bernardes, 1998; Evans, Frank, Oliffe, & Gregory, 2011; Thompson, Reeder, & Abel, 2012), may undermine and threaten the power and authority men perceive they hold in this context (Courtenay, 2000) with subsequent detrimental effects to their health.

Traditional masculine gender norms, in the form of the hegemonic male, may encourage men to put their health at risk (Mahalik, Burns, & Syzdek, 2007) with the signifiers of

masculinity being largely unhealthy (Courtenay, 2000). This pathologisation of masculinity, within one dominant hegemonic form may, however, mask the complex and sometimes contradictory masculinities as experienced by men (Gough, 2013). A number of researchers propose a multiplicity of masculinities where there is a wide range of possibilities for men to live out and perform their maleness (Cameron & Bernardes, 1998; Thompson et al., 2012). What is defined as hegemonic is made relevant, in this stream of theoretical reasoning, by men living in everyday contexts under the influence of wider social norms (Sloan et al., 2010).

The social forces of masculinity do not just have effect on men with poor health behaviours however; Sloan, Gough and Conner's (2010) study found evidence of healthy men also framing their health behaviours in ways that allowed them to maintain their alignment with a hegemonic masculinity. These authors reported that healthy men were concerned with their showing weakness and being subordinated to a less privileged position by other men despite, or because of, their good health behaviours (Courtenay, 2000).

Adding further complexity in the relationship between masculinity and health, men are reported to be more constrained by these gender ideologies than women (Evans et al., 2011) with the stereotypical stoic, macho, image being evident in the maintenance of bodily boundaries for men (Thompson et al., 2012). Crossing these boundaries to access health services may be seen as a threat to this identity, although this may be managed by men accumulating masculine capital over time (de Visser & McDonnell, 2013). Men may exhibit behaviours aligned with a hegemonic ideal and then, once a buffer of masculine capital is developed, undertake behaviours associated with a feminine identity, such as a focus on good health. This balancing

of masculine and feminine behaviours allows the men to maintain a desired masculine identity with their individual context.

### **Women's influence on men's health**

Women play a key role in men's health acting as a normative reference point for good health (Courtenay, 2000; Mahalik et al., 2007) and providing a social context to influence men's health behaviours. In this respect men are reported to be 2.7 times more likely than women to be influenced by the opposite sex to seek health care (Norcross, Ramirez, & Palinkas, 1996) with women's roles in the family unit being seen as more responsible for health promotion and providers of health information than men (Gough & Conner, 2006; Oksuzyan et al., 2008; Westmaas, Wild, & Ferrence, 2002).

A key indicator of women's influence on men's health, is evidenced where men consider it unacceptable to express emotion or pain with their male peers, yet they are more likely consider doing so with their spouse or girlfriend (Courtenay, 2000). This reflects the importance of these relationships to men and indicates a subsequent positive influence on their health.

### **Researching men's health in this context**

The complexity identified in masculinities and health research is also reflected in the evolving methodology and approach for men's health research in general. Traditional research in men's health has had a tendency to investigate stereotypical observations of gender with a single, idealised, hegemonic model of masculinity being the predominant context (Gough, 2006; Sloan et al., 2010). This has led health researchers to focus on identifying differences between genders, with the goal of understanding more about extreme cases that define and delineate masculinity and femininity.

One challenge facing researchers in men's health, when taking this approach, is that studies of extreme cases often encourage a language of separation, creating dichotomy which ignores the diversity of positions held both within, and between extreme gender locations (Hankivsky, 2012). Unfortunately these traditional approaches also ignore the relational aspects of gender (McVittie & McKinlay, 2010), that men and women work together as couples, and that men and masculinity are socially embedded (Lohan, 2007).

Although an individual perspective has proven useful in establishing a body of knowledge in men's health, it is proposed there is significant value to be uncovered in the middle ground, between the extremes of dichotomy. That is, where men exist on a day to day basis, working with their partners in couple relationships, to achieve their desired outcomes in health.

In this relationship based model men's health decisions are made at a complex intersection of gender, identity and social context (Broom & Tovey, 2009) encouraging a move away from the essentialist hegemonic lens to one that is more inclusive, fluid and contextually dependant. To this end, Sloan, Gough and Conner (2010) call for further research investigating the complex relationships in men's health to extend understanding of how masculinity is deployed by men in both healthy and unhealthy lifestyles.

### **A couples' perspective**

It is proposed, in this thesis, that viewing men's health from a couples' perspective may improve researcher sensitivity to the social and cultural pressures acting on men along with contextual factors such as history, relationships and locale. Further to this, there may be higher visibility of both partners as they perform in multiple, contested and dynamic roles that are culturally

embedded (Courtenay, 2000; Evans et al., 2011; O'Brien, Hunt, & Hart, 2005).

Under this critical lens the male identity is volatile and is consumed and redefined in the couple relationship. From this perspective the couple's position on men's health is negotiated between them in response to the dynamics of the specific context in which they find themselves (Courtenay, 2000).

### **Interviewing couples**

Interviews employing traditional methods, where members of a couple are separated and interviewed apart from one another, are an assumed norm for couples' research. Joint interviews on the other hand, where the members of a couple are interviewed together, are infrequently mentioned as a valid approach (Morris, 2001; Torgé, 2013). Individual interviews in a couple environment can however be problematic, introducing ethical issues relating to intrusion, inclusion and difference (Morris, 2001). Individual interviews also favour individualistic views which present the members of a couple as autonomous individuals (Bjornholt & Farstad, 2012) when it may be more appropriate to reflect the mutual dimensions of a couple's relationship more directly (Taylor & de Vocht, 2011; Torgé, 2013).

Joint interviews, on the other hand, have been advocated when a socially defined relationship or situation, such as that between the couple in their joint construction of health, is to be explored (Morris, 2001; Taylor & de Vocht, 2011; Torgé, 2013). These joint interviews have proven useful for investigating the common experience and endeavours of couples along with the sense of we-ness common to these couples as they share time and space together (Eisikovits & Koren, 2010). Bjornholt and Farstad conclude in their 2012 review of the joint interview methodology that more elaborate, contested and multifaceted

stories and narratives, reflecting the couples real life context, are produced with this method than by using an individual approach with each member of a couple alone.

The support for joint interviewing is not, however, universal with Seale, Chatteris-Black, Dumelow, Locock and Ziebland (2008) reporting that women generally speak more than men in shared forums and warning that researchers wanting to investigate men's experience in health in detail may be best to employ individual interviews. These authors recognise, however, that their study was focused on women in childbirth and their male carer, a context where women's roles are culturally defined as highly dominant and not necessarily representative of other couple relationships in health.

### **The goal of this thesis**

This thesis is focused on developing an understanding of how couples construct shared stories in relation to men's health and what purpose these stories serve for them.

## **Chapter Two: Researching men's health from a couples' perspective**

### **Research approach**

This research is an exploratory, qualitative study, using semi-structured, conversational, joint interviews for data collection. A set of themes were developed to guide the initial interview process and it was proposed that these themes be subsequently informed and tuned as part of the research process. These themes were modified as new areas of interest were identified whilst transcribing the interview recordings, or as part of the incremental analysis of the interview data.

### **Participants and recruitment**

Friends and acquaintances of the researcher's friends who were living together in a heterosexual, couple relationship, were invited to participate in this research. Ten couples volunteered and were interviewed over a three month period in the first half of 2013 forming a convenience sample for this study. All participant couples live in the greater Auckland region, are from predominantly middleclass backgrounds, and are over 18 years of age.

Nine out of the ten couples have children as part of their family unit and in seven out of the ten couples both partners were born in New Zealand. The majority of participant couples identify a high level of interest in health, with a number of couples having one or both members working in the health field or having studied health in some dimension such as fitness or food technology.

### **Procedure and materials**

Participant couples were contacted, and interview times coordinated, primarily through email. A shared, face to face,

joint interview was organised to occur at a time convenient to the participants. In the majority of cases interviews were conducted at the couple's residence, after the evening meal, once their children were in bed. This approach minimised interruptions to family life in the household and allowed the participants to concentrate more fully on the interview activity.

All interviews were voice recorded and subsequently transcribed; these transcriptions were coded with key themes and dimensions using MaxQDA11, a qualitative analysis tool on the researcher's computer. Each interview was transcribed, coded and the interview theme set updated, if required, before subsequent interviews were commenced. This iterative tuning, during the interview process, extended the time required to complete this phase of the research, but proved invaluable as it ensured an ongoing closeness to the participant interview data whilst supporting the evolving researcher understanding of the research area.

### **Security and ethics**

Interview data was transcribed by the researcher with participants identified by a randomly assigned pseudonym in a password protected database. All personal names used by participants in their interview were also replaced with pseudonyms to protect the identity of these other parties. Participant names and other personal details will not be published or made available in any external data source or report.

Ethics approval was obtained from the Massey University Human Ethics Committee (Northern) in March 2013 - Application 12/092. All participants completed an ethics consent form before their interview. In doing so both members of the couple confirmed that they had read and understood the research information sheet. This ensured that both members were aware

of the goals of the study and how they could withdraw from the study if desired. No couple withdrew from the study after their joint interview had commenced.

### *Ethics in action*

The ethics approval process for this research provided a key foundation for the interview interactions with scenarios identified in the ethics application being experienced with some participant couples. Most couples had not, for example, read the research information sheet prior to their interview. This was identified early in the interview as part of the consent process and provided a useful opportunity to orientate the participants to the interview proper. Couples were provided with hard copies of the participant information sheet and guided through the detail on this document. The interview only commenced once the couple confirmed they understood the participant information sheet, were provided with an opportunity to withdraw from the study, and both members signed the consent form agreeing to participate.

Further to this, a number of couples, after being advised in the interview opening that the interviewer was not medically trained, asked questions or sought guidance of a medical nature. It is believed that these questions were posed in innocence due to the medical orientation of the research topic and the participants were reminded that the interviewer was not medically trained and that these questions should be directed to the couple's general practitioner. This response followed an action plan outlined in the ethics application and was generally accepted by the participants as reasonable without undue impact on the interview proceedings.

A scenario occurring in a number of interviews, which was not identified during the ethics application, was the emotional implications of questions relating to the participant's children's

health. All of the couples interviewed closely associated their children's health with that of the wider family group; dietary constraints due to children's intolerance of certain food groups, for example, would have effect on the whole family diet and health. This interview topic proved to be a sensitive area with some discussions on childhood illness having an emotional impact on the participants.

The action plan developed for this scenario, after the initial interviews, centred on reminding the participants that they could close a line of discussion at any time. Further to this, questions relating to children's health were subsequently prefixed with explicitly seeking permission from the couple to continue the line of discussion should that topic be initiated by the couple. Importantly, these two actions provided a logical and low stress point for the couple to move on to another area of discussion if they desired.

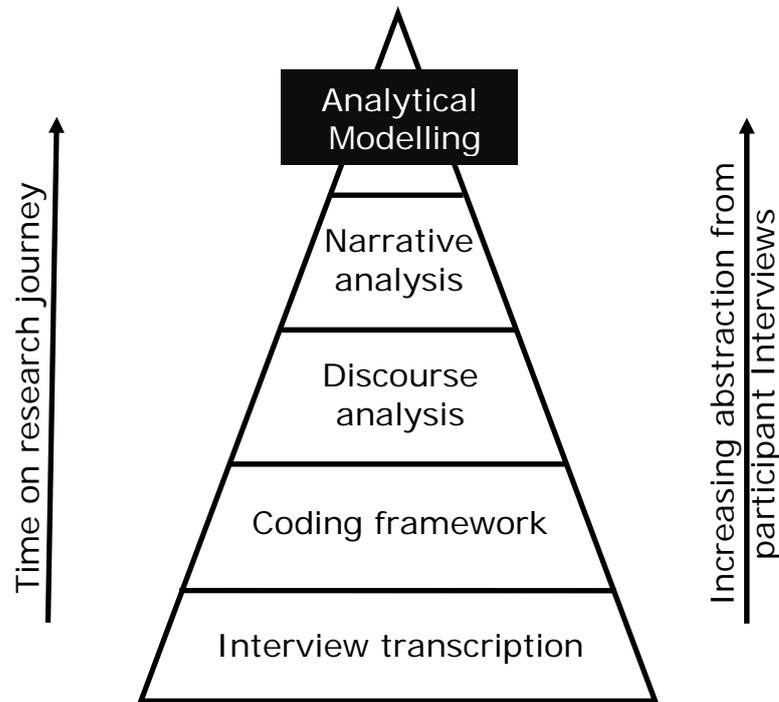
### **Chapter Three: Investigating men's health - An evolving understanding of couples' shared stories**

*This chapter presents an evolving, iterative approach to investigating men's health that respects the dynamic nature of critical qualitative research. My starting point was located in my ongoing interest in health psychology and also my own personal view of the world. This was challenged in the participant interviews when the couples provided new dimensions to the topic of men's health that I had not previously considered.*

*My initial thoughts on research methodology needed iterative modification to meet the new directions of the participant data so that their stories could be told both individually as a couple, and collectively as a group of couples.*

This thesis explores how men and their partners work together, in couple relationships, to achieve shared outcomes in men's health. An exploratory, qualitative approach is undertaken to work with couples as they co-construct narrative about men's health, in their words, in the context of their world view. To this end, the analysis of participant interviews generates a deeper understanding of men's health in the couples' context whilst a parallel journey through relevant qualitative health psychology literature has enabled these interviews to be analysed in new and challenging ways. This dynamic landscape has encouraged a research model that is flexible and able to evolve as knowledge is built.

In essence, the theoretical lens, with which to view participant data, has been informed by an evolving understanding of the associated literature. This research approach is depicted in Figure 1, which represents the research journey as it relates to increasing levels of abstraction from the participant interviews. Analytical modelling is proposed as a final phase of investigation where a model is generated to support the presentation of the research findings.



**Figure 1. Investigating men’s health – a couples perspective**

This research respects the strengths and weaknesses of the theories and frameworks in use, whilst remaining flexible in how the participant interviews inform the research undertaking. To this end, the research effort is as much about revealing new relationships in the interview data, as it is developing an understanding of relevant literature.

### **Interview transcription**

Each of the participant interviews was audio recorded and transcribed forming a data pool of 116,778 words for subsequent analysis. During each transcription session research memos were generated to set a reference point for more detailed coding once the transcription was loaded to the MaxQDA qualitative data analysis tool.

## **Building a coding framework**

A qualitative, open coding approach was employed to provide a framework for analysis. This approach provided research tools to allow input from a number of sources, consolidate them, and then identify similarities and differences in these data (Corbin & Strauss, 1990; Suddaby, 2006). The goal of employing this systematic approach was to find patterns in, and give order across, the couple interviews where possible.

The initial participant interview was structured around a preliminary set of core themes and areas of interest identified by the researcher's own experiences in men's health. These codes and themes were subsequently updated after the interview transcription and coding process, to reflect the researcher's growing understanding of the thesis landscape. The coding scheme continued to evolve throughout the interview phase and became increasingly abstracted from the individual couple interviews. Codes and categories which span across the interview data, from the ten participant couples, reflect the growing focus on the interviews as a set of data.

This coding effort was influenced by a second research stream which focused on developing theoretical understanding from an ongoing literature investigation.

## **Micro level discourse analysis**

The concepts and tools of micro level discourse analysis (Potter & Wetherell, 1990) were employed in the opening stages of analysis to surface the action orientation of the discourse used by couples during their interview (Tuffin, 2005). This approach aligned well with the coding framework and provided valuable insight when identifying how couples may be using discursive resources to actively perform work for them in their interview (Riessman, 2002).

The appearance of the same discursive structures in multiple interviews signalled the presence of interpretive repertoires where couples may be relying on culturally imbedded metaphor to shortcut their story telling (Potter & Wetherell, 1990). Applying a discourse analysis perspective resulted in a useful interpretation of the participant interviews; however it was felt that the analytical toolset offered by discourse analysis did not capture a wider view of the couple interactions which were identified as spanning across the interview set.

Further to this, a major limitation being experienced at this level of analysis was considered to be related to the efforts of the micro level discourse analysis tools to fragment the interviews into discursive artefacts (Burr, 2003; Stephens & Breheny, 2013). Some of the rich and insightful interplay between the participants during their interview was being lost. To this end the sum of the discursive parts did not equal the whole.

### **Narrative analysis**

A growing interest in the interaction between the members of the couple, and a view of their discourse across relatively long periods of the interview transcription, sponsored a literature search for a set of tools to support the elevation of the current analysis to a higher level of abstraction. This need was satiated with a temporary diversion into thematic analysis where patterns and themes are identified and reported within a set of data (Braun & Clarke, 2006). Thematic analysis allowed for a wider, macro view of interview data, but there remained some discomfort in the level of visibility of the interactions taking place between the couples as they storied their perspective on men's health.

These jointly constructed stories became the focus of a final literature investigation which identified narrative analysis as a body of theory that would have significant impact on the

subsequent research outcomes. Narrative, as a construct, has been used synonymously with storytelling and is employed by individuals in strategic and purposeful ways to achieve some end (Riessman, 2008b). It is defined by a temporal and sequential ordering of dialogue (Andrews, Squire, & Tamboukou, 2008) which takes it beyond description to the convey and reveal the narrator's inner social world (Koenig Kellas, 2012).

Speakers impose this order, in their speech, to reveal preferred and volatile versions of the self which they deem appropriate for the current social context (Riessman, 2008b; Stephens, 2011). This identity is fluid, it is assembled and disassembled, accepted, contested and performed within narrative as their story evolves through time and place revealing how health is lived and responded to (Cohen, 2010; Langellier, 2001; Riessman, 2008b).

Most importantly stories are kept intact in this methodology, with researchers excavating the relationships in narrative (Riessman, 2008b) and preserving this structure as a unit of analysis.

### ***Shared dialogic narrative***

Bringing a couples perspective to research requires an extension of individual narrative beyond the autobiographical, to be sensitive to how shared, dialogic, narrative is constructed (Riessman, 2008b). The joint aspect of family storytelling, where narrative is a relational activity (Gubrium & Holstein, 2002; Koenig Kellas, Trees, Schrodt, LeClair-Underberg, & Willer, 2012) is relevant to this shared endeavour, with members of a couple working collaboratively in vicarious support of each other (Hydén, 2008; Hydén & Örvulv, 2010; Trees & Kellas, 2009). The ongoing negotiation of content and turn-taking in shared narrative sees the storytellers reach agreement, and the story

told reflects the cultural and historical milieu in which they live (Mandelbaum, 2010; Riessman, 2002).

Each member of the couple has, for example, a historically located understanding of their partner's direction and goals for the interview, having formed these narrative structures in previous forums. Further to this, based on their history together, the couple likely have well practiced strategies ready to navigate any new challenges raised during current or future social interaction between them (Andrews et al., 2008; Harre, 2001; A. Phoenix, 2008).

A key contribution to the interview process from this shared forum, that exceeds the outcomes of interviewing men separately from their partners, is that both members of the couple bring their memory and recollection of events to the interview. Together they may construct a more complete picture of men's health than if interviewing one member alone, providing a richness of data that allows additional stories to be built by the couples (Mellor, Slaymaker, & Cleland, 2013). Often the members of a couple will take turns in discussing men's health or defer to their partner to fill in the gaps in their knowledge extending the completeness of information presented to the listener (Koenig Kellas, 2012; Koenig Kellas et al., 2012).

What one member of the couple forgets may be remembered by the other (Bjornholt & Farstad, 2012; Morris, 2001), an example of which occurs when men are unable to recall the date of the last time they were ill and went to the doctor, but the couple between them are able recount their history through share narrative to locate this event in the couple's shared timeline.

Further to this coordination of turns to speak and joint building of knowledge, the couple sense-check their contributions during the interview. Input that doesn't ring true with one partner's

recollection may be challenged in the interview process and corrected if necessary (Koenig Kellas et al., 2012). This ensures that the couple's story is not only complete, but is as accurate as can be negotiated between them (Bjornholt & Farstad, 2012).

The additional richness of information in shared narrative appears particularly important in ensuring that new generations are aware of their genetic lineage, where the family health history is handed down through multiple generations (Koenig Kellas, 2012). In most cases, the mechanism enabling this is the shared narrative constructed by parents and grandparents. This historical information then becomes part of the evolving family health legacy for telling to future generations (Manoogian, Harter, & Denham, 2012).

### ***Cultural narrative***

A couple's shared narrative is not generated in a vacuum; it is located temporally, and influenced by the highly patterned cultural narratives active in the couple's world, helping the couple interpret events in a cultural frame (Feldman, 2001). When discussing health a couple may employ cultural narratives of health that reflect the norms and expectations within their environment (Bruner, 2010; Riessman, 2008b). Further to this, how a couple tell their story, and how it is received by an audience will often depend on the cultural context of the narrative event (Thornborrow & Coates, 2005). Their stories should, therefore, be viewed in the context of these culturally defined structures.

An assumption of this current research is that cultural narratives are pervasive across a relatively homogeneous participant population and should be evidenced in interviews from a number of the participant couples. That is, these cultural narratives are assumed to be reasonably consistent across this group. Further to this, it is proposed that couples work together

to locate themselves as being both in alignment with these cultural narratives, but also in conflict as they form unique stories which challenge and contrast with their projection of the culturally accepted state (Freeman, 2001).

### **Unique stories and turning points**

Whilst a couple's journey through narrative is shared and may conform to cultural expectation, couples also inject a level of uniqueness into their stories in an attempt to distinguish themselves as a couple and remain interesting to the listener (Freeman, 2001). For a story to be tellable it must involve a breach in the ordinary script of life and in doing so "reach a moment where the unexpected and unusual erupts from out of the mundane and predictable" (Thornborrow & Coates, 2005, p. 11).

A couple's unique stories represent the differentiators that allow the couple to tell their own story, in their own words. The boundaries of how far a couple can diverge from cultural expectation are negotiated in unique stories that may, with regular retelling, become well structured, polished, and readied for future presentation (Andrews et al., 2008). In some cases these unique stories describe turning points in the couple's life together where significant outcomes are discussed that represent new directions for the couple (Bruner, 2001; Riessman, 2002; Squire, 2008).

It is proposed that the analysis of these turning points may provide clues on how to effect change in men's lives as these events signal a new way of being for a couple and mark their transition to a new identity.

### **Performed identity**

The research interview process creates an environment where the couple and interviewer meet as strangers and are challenged

to quickly construct an identity through the opportunities offered to them in the interview process. In effect all that an interviewer can reasonably know about the couple, outside of their cultural and environmental context, is that which the couple choose to share during the interview - a mimesis constructed by, and mediated through, their stories (Hydén & Brockmeier, 2008).

Sensitivity to this performed identity and how it has been constructed in narrative is particularly important in the analysis of a shared interview (Riessman, 2008a) where both members of a couple are working to construct not only their individual identity, but also that of the couple unit together. Subsequent analysis should recognise this mediated representation of the couple's identity, a performed version that the couple construe as being appropriate to the context of the interview (Bruner, 2004; Riessman, 2002, 2008b; Stephens, 2011).

### **A natural setting**

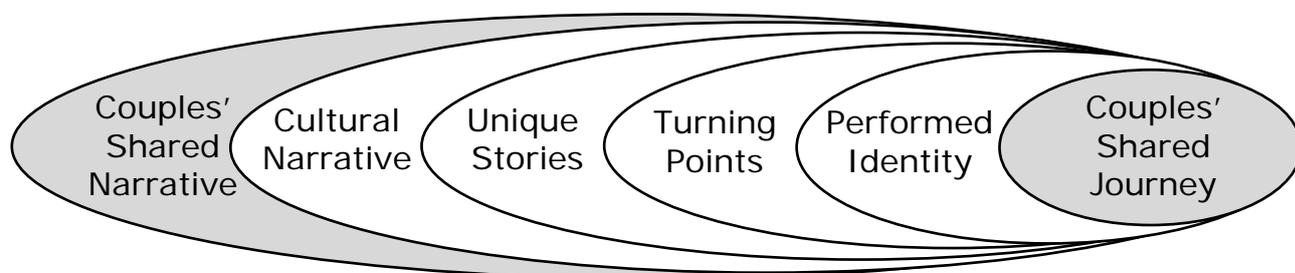
A positive outcome, proposed as being inherent in narrative based analysis, is that interviews formed around narrative encouraged the participants to discuss health in a more natural setting. This is further encouraged by the joint interview format where there is immediacy in the couples telling their shared story together (Morris, 2001). Couples in joint interviews are afforded significant leeway to story men's health, in their own words, whilst receiving little direction from the interviewer.

To this end, once narrative analysis was identified as a key approach for this thesis the themes forming the basis of the interviews were greatly simplified from those originating from the discourse analysis phase. It is proposed that this removal of structure in the interviews encouraged the couples to discuss men's health in a context more natural to them. The simplified theme set focused on demographic information gathering, the couples' personal history in men's health, the challenges the

couple foresee in men's health today, and finally the challenges and opportunities the couple envisaged for the future of men's health in New Zealand.

### **A model for exploring men's health in a couples' context**

The outcome of this investigation, using insight in the interviews to generate new perspectives in theory that subsequently informed further analysis, is a model to guide the exploration and discussion of men's health in a couples' context. This model is presented in Figure 2 and is closely related to the theory and concepts of narrative analysis.



**Figure 2. Model for exploring men's health in a couples' context**

This model provides a working framework for the remainder of this thesis document. It is structured so that when moving left to right in the model, each oval is generally a logical subset of the one prior and provides context for the oval following.

## **Chapter Four: Exploring couples' shared narratives in men's health**

*The aim of this chapter is to describe the findings of this research, using the prevalent cultural narratives identified in the couples' interviews, to frame a discussion of how the couples both align with and challenge these cultural narratives.*

This thesis now moves to exploring men's health as it is constructed by the participant couples. Where the previous current chapter presented an evolving investigation into how the thesis is structured from a methodological perspective, the next two chapters explore what the application of these methodological tools has uncovered.

This current chapter employs the concepts of couples' shared narratives to investigate how couples worked together within a cultural discursive frame to create a shared identity during the interview, whilst chapter five explores the couple interviews as a group within a temporal frame, to observe the couples' shared journeys in health over time.

It is proposed that exploring men's health from these perspectives supports the goal of this thesis by developing an understanding of how and why couples tell their stories, and what purposes these discursive artefacts serve for them.

### **Introducing the cultural narratives**

Five cultural narratives identified in this research provide a framework for this chapter. It is proposed they have a significant influence on men's health and will be explored through a narrative lens; a) freedom and consumerism, b) the right to relax, and c) couples' roles in men's health d) narrative founded in comparison to others e) looking to the future for men: education and role models for change. Each of these cultural narratives is summarised and the unique stories told by the couples presented to provide context for the couples' shared

narratives in health. In essence the cultural narratives provide a framework for presenting the associated unique stories and turning points that bring visibility to the couples performed identities in these areas (Freeman, 2001; Langellier, 2001; Riessman, 2008b).

### **Freedom and consumerism**

It is proposed that consumerism plays a significant socio-political role in the west. Passini (2013) posits that this way of living is a common denominator of western life and that globalisation is having an effect of increasing the relevance of luxury goods in the everyday life of people in the west. Discretionary consumption is anchored in needs that have been culturally produced in western society (Leahy, 2013; Miller, 2012) and paradoxically an increased freedom to consume may turn people into slaves to consumption who are, in effect, less free.

Further to this, Passini likens consumerism to the binge cultures inherent in addiction and poor health behaviours where instead of empowering and liberating people, through freedom of choice, a consumer culture also infers entrapment where people may be unaware of the pervasive forces at play around them (Dittmar, 2007; Passini, 2013). In this context overconsumption becomes understood in terms of new thresholds being reached in the maintenance of wellbeing that may exact a significant psychological disturbance on family life (Humphery, 2010).

The participant couples in the current study identify challenges associated with this in the context of men's health, particularly as it relates to the excessive consumption of fast, cheap, nutritionally deficient foods and their impacts on diet. Participants also relate this cultural artefact to the accumulation of discretionary items as visual indicators of success, and the financial and mental stresses these purchases generate.

In most cases the participant couples tell unique stories in order to construct healthier, active identities, with lower levels of ongoing stress than those of average New Zealand couples, embracing a slow-living alternate to the wider cult of speed where consumerism is deeply implicated in poor family health (Humphery, 2010).

### ***Diseases of prosperity***

High levels of discretionary consumption and its influence on diet is linked by participants to major illness that have become predominant in the current age including heart disease, cancer, diabetes and obesity. In the narrative extract that follows these illnesses are referred to, in-vivo, as “diseases of prosperity”. Together Raquel and Wilbur construct a narrative that is located in Wilbur’s recovery from cancer and how the couple have responded to a non-operational diagnosis with a significant shift in the way they perceive and interact with their world.

#### Interview 9 – Raquel(R) and Wilbur(W)

- 74 W I was diagnosed with bladder cancer in August of 2009, I weighed about 115 kilos, 110, 115 kilos
- 75 R mmm, that’s quite a lot
- 76 M mmm
- 77 W that was in August, **6 months later they found a second tumour**, the doctor, after they had removed it, they always remove the tumour and have treatments but after the second tumour, where it was located they couldn’t effectively, **there was no post operative treatments for it and so she said well we’ll just have to take a wait and see approach** to this
- 78 M right
- 79 W which is never encouraging
- 80 R and come back and see every 3 months
- 81 W **basically they are saying there is nothing we can do for you**, you know
- 82 R yeah, but there wasn’t like any chemo or radiation or anything like that

83 M mm

84 W so at that time, for probably 3 or 4 days, it was, it was pretty dark times, because I was very concerned

85 M mm

86 W and, **so, I made a decision to change my diet, start exercising regularly**, for, from April, late April of 2010 to November 2010 I was, we were raw vegans

87 M oh ok

88 W yeah, and started exercising 4 or 5 days a week and I went from, I dropped a 3rd of my body weight in about, 90days

89 M crikey

90 R well, something like that, yeah

91 W 90 to 120, most of it

92 R of course it tends to drop of men pretty quickly, but yeah and then it tapered off

93 W yeah, the first 90 days was pretty dramatic and I started and it was just a combination of diet and exercise and plus I started reading and doing my own research read some online medical forums and things like that

94 M right

95 W **and they all say the same thing, the best thing you can do**

96 R **diet and exercise**

97 W well back up a little bit, you know in America the biggest health concerns are heart disease is number 1 killer of US population, as far as disease goes, cancer is number 2, diabetes 3rd, the obesity, now they rank obesity as a disease

98 R because of the complications

99 M mm

100 W these are all, essentially could probably be classified as, **diseases of prosperity**

101 R mm

102 M right, yeah

103 W **I mean you don't exercise as much, you over eat, you eat the wrong foods, things like this you are going to get fat, you are going to**

104 R **cancer is growing to**

105 W **cancer and where I was going with this is that with all of these if you change your diet you start eating better you**

**know, and exercising on a regular basis you know, these instances are going to dramatically decrease**

106 M mmm

107 W I do firmly believe that

108 R mmm

In this narrative sequence Wilbur is the primary speaker with Raquel being a co-author in the construction of their shared story. The roles played by the couple in this narrative are well practiced, and their turn-taking seamless, as story details are layered upon a timeline that extends four years, from 2009 to the present day. Raquel supports the wider narrative constructed by Wilbur and provides clarification whilst volunteering information that she considers pertinent to the evolving story. The resulting shared narrative is collaboratively generated and reflective of their identity as a couple, providing some insight into what they consider important enough for inclusion in their story (Koenig Kellas et al., 2012; Mellor et al., 2013).

The narrative also describes a turning point for the couple as they work together to challenge the dominant, consumerist, cultural forces in their environment and remind us that not only is there freedom to consume, but also freedom to abstain. The couple find this second path is more difficult to traverse than the first requiring significant changes in their lives. By reporting their decisions to improve their exercise regime, improve diet and reduce intake, the couple perform an identity that is proactive with a shared interest in Wilbur's health.

Morris (2001) reported similar discursive work being undertaken in joint interviews for her study of women cancer sufferers and their carer. In that study mothers and daughters were interviewed and collaboratively built shared narratives that challenged a dominant cultural narrative influencing their relationship. Their shared narrative prepared ground for the

daughters to construct a life independent of their caring relationship for their mothers, when an unspoken cultural imperative would see the daughters fully dedicated to their duties of care (Morris, 2001).

Where Rachel supports Wilbur, in the current study, to allow him to co-construct a narrative challenging consumerism, the daughter's stories were supported by their mother's narrative. This shared narrative enabled the daughters to tell stories of independence, where they had some freedom to work and live, as well as care for their mothers in the face of cultural pressure to do otherwise.

### ***An accumulation of wealth***

Couples identify the drive to accumulate wealth as an indicator of success to be problematic for health, especially with respect to the stress that this can introduce into the family home. The stressors that this can place on men and women as earners, who must service associated debt and the high expectations of ongoing accumulation, can have a fundamental impact on the health of the family unit (Humphery, 2010; Passini, 2013). Paradoxically this accumulation cycle can generate a high level of stress in family and work life when the additional income required to support higher levels of spend, is earned at the cost of the leisure time required to enjoy the fruits of this labour (Humphery, 2010).

In the narrative that follows Erin and Hamish have just discussed the impacts of extreme fitness regimes on family life and turn to the implications of wealth accumulation.

#### Interview 6 – Erin(E) and Hamish(H)

821 E or if, like **a girl I knew, her 6 year old daughter said to her dad one day, do you live here**

822 H oh no, who said that

823 E MD said to her dad

824 H MD, who's MD  
825 E you know MD who use to go to kindy  
826 H no, well where was he  
827 E working hard  
828 H oh  
829 M right  
830 E working like a dog, and I could imagine if you were (into)  
extreme fitness that could be the case  
831 M mmm  
832 E just never home  
833 M never home yeah  
834 H see that's probably worse than a fitness fanatic  
835 E well she said, do you sleep here, that's right  
836 H **those are the people I reckon have the problem, the  
workaholics, the corporate guys who**  
837 E **miss out on the fitness**  
838 M **yeah**  
839 H **who miss out on the fitness but also miss out on their  
family**  
840 M yeah, and this huge stress of  
841 E yeah  
842 M supposedly power jobs to deal with  
843 H yeah **and the powerful jobs give them heaps of money**  
844 M yeah  
845 H **they get massive benefits**  
846 M yeah  
847 H **and they can't, they feel they can't leave**, cause if they leave  
they have got all the way  
848 M mm  
849 H and I have worked with, I have supplied services to a lot of those  
sorts of people, mainly American software companies,  
850 M yeah  
851 H and when they spend all their time on a plane they look like crap  
852 M yeah  
853 H **they just, and ah, but that's their life, they spend weeks  
away from home, from their kids, it's like**  
854 M **they have got the old golden handcuffs**  
855 H **yeah, ok yeah you're earning 5 times more than I am but,**

**wow in 10 years, was that worth it**

856 M yeah that's right

857 E mm

Erin provides the basis for the unique story that is co-constructed with Hamish, a relatively serious scenario is introduced in a humorous way that then allows the couple to tell their unique story, as it relates to this cultural narrative and the stressors associated with it. With Hamish this is facilitated through the proactive management of his work and family life to ensure he spends time in the family home with their children.

The construction of the couples' stories in this area is relatively consistent across the interview set with the couples interviewed identifying the systemic implications associated with this cultural narrative and the survival strategies they have implemented to manage this effectively in their household. Other participant couples propose a growing level of financial independence and the prioritisation of health above asset accumulation as key strategies to reducing and managing the stress generated in this area.

**The right-to-relax**

The participant couples locate themselves in a cultural narrative focused on the inactivity of men and their resistance to change as they age. This narrative has implications for the health of men, forms a reference point for family members and is constructed as a stereotype for the state of older men's health as observed generally.

A high proportion of adults are reported as leading sedentary lives (World Health Organization, 2002) and despite the variability of definitions employed by researchers a literature review of 28 studies in aging found only one third of elderly were classified as aging successfully (Depp & Jeste, 2006). Much

illness and disability in older age is related to risk factors present at midlife (Reed & Foley, 1998), but the rate of decline of functioning, due to age, is largely determined by behavioural factors related to adult lifestyle (World Health Organization, 2002).

Unfortunately, when a release of control on diet and alcohol consumption is combined with a reduced level of physical activity, men may experience a chronic deterioration in their health. The participants in the current study propose that this is evidenced visually, by a growing population of overweight men who may have had histories as being active sportsmen when younger.

The right-to-relax cultural narrative is constructed by participants in the current study as a general malaise that befalls some men as they enter middle age and then retirement. These men are constructed as having been successful in fulfilling their roles as providers of financial stability in the household and believe that by doing this they have earned the right to relax in their later years.

An Australian study by Nicole Asquith in 2009 reports a similar phenomenon within the social contracts that workers construct between themselves, their employer and the state. The expectation of these workers is that the state will support them in their final years as a reward for the hard work performed throughout their working life (Asquith, 2009). The Australian workers are reported to believe that they have contributed to the state finances, and society in general, throughout their working lives and so have earned the right to relax and enjoy the perceived benefits of their retirement.

### ***Demanding control of the aging body***

Although the struggle by some men to be responsible for their health, in practice, may be undermined by the natural aging of

their physical body, health doesn't inevitably decline with age and many advance to old age in good health (Richardson, 2010). To this end, being an active participant in the aging process may enhance the quality of life experience as men age (Umberson, Crosnoe, & Reczek, 2010; World Health Organization, 2002).

A number of couples in the current study construct unique stories that challenge the right-to-relax cultural narrative by reporting an ongoing rebellion against the aging process and the health issues that may be associated with it. These couples take active control of the aging process and challenge the cultural stereotypes assigned to men in this area.

In the following extract Francis and Ned talk of deterioration as part of the aging process, where some of the body's bio-mechanical capability such as quality of eyesight and hearing, declines naturally with aging. Although this reduced functioning is a source of disappointment for Ned (60 years young), who is actively opposed to the agency assigned to aging in this context, he continues to challenge himself and remain active in other areas of his health.

Interview 5 – Francis(F) and Ned (N)

291 N .... I believe that I am sort of getting to an ideal weight for a person of my height but I have still believe that, 5foot7 or 1.7m and 58 to 60 kilograms I am still carrying fat

292 M right

293 N in my gut area that I would like to get rid of, partly to bring my state back to what I believe a person should be able to maintain for whole, all of life. I think I have said to F a few times **I want to die like an old dog, I want to look the same, until the day I die, and I want to be running around chasing sheep till the day I suddenly just die**

294 M yeah yeah

295 N **I don't want that long lingering deterioration of overweight and under powered and all that.**

- 296 M mm
- 297 N I believe, I also hear a lot of talking about deterioration due to age, everybody says to me stuff like, oh you can't do that cause you know you are getting older you know. My dad says it to me, people I work with say it to me, people who are otherwise involved in sport who are my age or thereabouts are out walking marathons
- 298 M yeah
- 299 N and all this sort of stuff, and saying oh well at our age you have just gotta be careful and all that sort of stuff, and **I am vigorously opposed to ageism think**
- 300 M yes
- 301 N I don't believe that ageism has got anything to do with a person's ability to stay as fit as they were when they were 18 to 24, like in their prime, and I still am
- 302 M Yeah
- 303 N **about the same level of fitness as I was then**
- 304 F **you are probably better**
- 305 N could be
- 306 F I would say, in some ways, you have probably got better endurance
- 307 N yeah
- 308 F and you are probably just as strong if not even more, a bit stronger
- 309 N **in certain dimensions I certainly am stronger than I was then.** And F is quite right I never did, at that stage I never did anything more than a run around the block, I thought that was run training, I had no idea that you could run 10kms, in those days you just didn't do that

Together the couple form a narrative that describes their shared resistance to the processes of aging in the context of an active fight against aging and ageism, standing against the prevailing western notion of negative aging (C. Phoenix & Sparkes, 2009). The analogy of the faithful dog that lives a full active life plays a strong role in this narrative, allowing the couple to locate their story effectively, so they can then quickly move to their unique story. For this couple there is no relaxation

earned by age, and Ned proactively challenges himself to retain a level of fitness that equals and sometimes exceeds that of when he was a younger man.

This is tempered in subsequent discussion on the challenges facing men's health where Ned describes a systemic social construct that will require significant effort to change.

Interview 5 – Francis(F)and Ned(N)

393 M so do you have any thoughts on the challenges facing men's health and 1 or 2 things that might be done to improve men's health generally

394 N **I think that the challenge for men's health is to actually move people psychologically out of their huge comfort zone that they have built up over the years** and some of that comfort zone comes from the fact that they have had all of their life believing when they get to be older, when men's health really counts that they should be entitled to this big rest and indulgence

The psychological challenge, identified by Ned, of moving men from their comfort zones to become more focused on their own health is a consistent message from the study participants. Unfortunately it seems that a major health event may be required in the men's lives to make this transition a priority for them.

***Major events as turning points***

Men participating in this research, who have experienced a turning point in health (Bruner, 2001; Riessman, 2002; Squire, 2008), where a major change in their approach to health is undertaken to realign with a healthier lifestyle, report successfully recovering their health and transitioning to a healthier identity. Unfortunately, most successful turning points reported were triggered by major medical incidents in the men's health, such as episodes of cancer or heart disease.

This need for significant events to trigger change is reflected in a recent Canadian study where adults, who had experienced a major heart event or the threat of one, positioned subsequent turning points as transformational events. These events provided a wakeup call for the participants and challenged their taken for granted assumptions of good health (Coady, 2013). By their choices of how to respond to these events and the environments they subsequently became active in, they set their life path and their future in health (Bandura, 2012).

Ideally men would change their behaviour and take proactive action prior to being in these life threatening situations, but this rebellion is not easy for men. The complexity of this negotiation and the inner turmoil men experience is described in the following narrative where Victoria and Oliver reflect on the interview process and how this may have influenced their outlook on men's health.

Interview 10 – Victoria(V) and Oliver(O)

- 989 M have you guys, just a last question, have you guys learnt anything about yourselves during this last hour
- 990 V I probably haven't because it's about him, but I'm already reasonably health conscious and wary anyway,
- 991 M yeah
- 992 V but **I think it's been good for O to sit, because I see him sit back and think about where he actually is**
- 993 O mmm
- 994 V where he is, when he says he's a 5,
- 995 M mmm
- 996 V you know really ideally he should be a 7 or an 8, where I am, but how is he going to deal with that
- 997 M yeah
- 998 V but you might make him, he might go away tonight and think about it
- 999 O so it's good you, **you subconsciously do it and go through it but you don't sit and talk about it**

- 1000 M mmm
- 1001 O **unless there is a calamity, for instance if I had a heart attack then it would be an open discussion, why don't you, your diet you should change it, or you should do this, you should do that**
- 1002 M yeah yeah
- 1003 O **so you know when you have an event that triggers a discussion**, so quite interesting to have a discussion without an event

The interview process is reported as valuable to the couple as an opportunity to discuss Oliver's health in a shared forum. One concerning feature of the narrative presented by this couple, however, is the proposed strategy of waiting for a calamity event, as a turning point, in order to trigger them to make changes in Oliver's lifestyle and health behaviours. This seems in conflict with their earlier confirmation of the poor statistical chances of surviving a major health event such as a heart attack and reflects the transformational events required for this level of change as reported in the Coady (2013) study.

One implication of this narrative may be that Oliver's health may decline if unmanaged, as per the right-to-relax cultural narrative, until this major event takes place. Prevention may, however, be better than cure as recovery from these major events is reported by participants as a stressful, time consuming, painful, complex and protracted process with possible long term chronic side effects. Assuming of course the event is not terminal for the men. On a positive note it has been reported that men can recover from health problems and experience improved health, if they take positive action, at any age (Umberson et al., 2010).

### ***Dead man walking***

One story of a couple successfully traversing a critical turning point is presented by Kelly and Graham, who has previously

suffered a major heart attack. This couple employ a metaphor of “Dead Man walking” to tell a story that locates them as members of a rebellion against the right-to-relax narrative and any associated admission of defeat to the aging process.

The narrative interworking between Graham and Kelly reflects that found between some stroke survivors and their spouses. Radcliffe, Lowton and Morgan (2013) identify in their study of stroke survivors that couples who pulled together and emphasised their accommodation of the stroke outcomes as part of their normal lives, despite associated disability, were presenting themselves as united and worked together to minimise the impact of the stroke on their lives. In this context stroke is narrated as a manageable event within the framework of the couple’s life history (Radcliffe et al., 2013), a discursive structure we observe in the current study.

In the current study Graham is storied as being an active person and the couple actively construct a history of health across a range of dimensions including diet, exercise, and strategies for managing mental health in the form of stress. Graham does however discuss a genetic disposition for high cholesterol and complications in the form of heart disease. This “chink in his armour” leads to a major event that forces the couple to construct a narrative of proactive rebellion against the cultural narrative of aging, contingent on their experiences with others, who have been unsuccessful in their attempted to constrain the couple’s life.

Interview 1 – Kelly(K) and Graham(G)

995 G ... **I also find that, once you’ve had something wrong like I’ve had a heart attack but I can outpace some of the guys at work**

996 K mmm

997 G **but when you start talking to medical place, medical**

**insurance, professional health, oh anything, they then all of a sudden, you're in a square box,**

998 M right

999 G **you're, you're terrible , you've had a heart attack, you're gonna die, you're un-fit**

1000 M yeah yeah

1001 K you see the health that the, the fit men

1002 G I had mine 9 years ago this, 9 years ago this January, and I mean

1003 K you what he says, you know what he says he is, **dead man walking**

1004 G well that's basically what it is, you know, like, like you get a health insurance people ring up here and I love them, oh you know, and insurance people, especially in health

1005 M like life insurance

1006 G life insurance

1007 K he winds them up

1008 G we can, you know, and I sit there you know, we can guarantee this and I say yeah you can guarantee that for me, this is what you are gonna supply, yes yip, this is what we are gonna do for you, and I say well can I have your name, and who you are, and who your boss is, and they go oh why, I said well you've just made a statement, this is what you are gonna guarantee me, yes, we are, I said well then I need your name and I need who your boss is

1009 M yeah

1010 G and they go, oh why, oh because I've had a heart attack, click, bang

1011 M mmm

1012 G and **that's it you're in a box, bang**

1013 M yeah

1014 G you know it's like Southern Cross, travel insurance, you're in a box you know

1015 K yeah

1016 G you know you can't go anywhere cause you're gonna have this and you're gonna have that, well I mean,

1017 K healthy, healthy men though

1018 G **I sit here today and feel really really good, you know, I could be dead tomorrow**

In this narrative Graham identifies how he is quickly assigned by others to the role of being a high medical risk and put in a “box” as a powerless victim who has no control over his future health. Graham challenges this labelling and recovers his personal agency when proudly telling us that despite suffering a heart attack he can still outpace some of his workmates. Further to this he proactively “winds up” life insurance agents when they call.

Kelly supports this narrative, constructing Graham as a “dead man walking”, a term that they have negotiated previously and is highly contextual. The use of this term evokes a background of implicit mutual knowledge and shared experience for the couple that they subsequently make explicit within the interview narrative (Edwards & Middleton, 1986). This well versed and established narrative provides the environment where the couple can tell their story of survival against the odds.

Despite this major medical event they consider themselves to be healthy and proactive in the management of their lives scoring themselves highly in the overall health demographic. The approach taken by the couple when assessing their health, where Kelly comments that Graham is “so healthy he’s dangerous”, is reflective of them being optimistic about Graham’s health when they have little power change the current physical realities of his heart condition (Warner, Schwarzer, Schüz, Wurm, & Tesch-Römer, 2012), that is, they just get on with life in a positive way.

### **Couples’ roles in men’s health**

The roles assigned to, and performed by, members of a couple in relation to health have a significant influence on men’s health making this an important area of focus for this study. Women have been identified as having positive roles in the cessation of smoking in men (Westmaas et al., 2002) and mortality rates for

non-married men are reported to be higher than those living in couple relationships (Umberson, 1987; Umberson & Montez, 2010). Further to this, marital disruption and divorce have been associated to negative influences on the health of both partners in these failing relationships (Hughes & Waite, 2009).

The roles played by couple members, in this current study, will be explored from three lines of enquiry, a) the role of women as family health consultants, b) men as resistive parties in their health, and finally c) men are investigated as caregivers.

### ***Women as family health consultants***

Men often identify their spouses as the exclusive agents of family health care (Westmaas et al., 2002) with health traditionally being seen as “women’s business” (Richardson, 2010, p. 420). Women are regularly positioned in narrative as the family experts in health (Oksuzyan et al., 2008) with an extended knowledge of health, a context that is reflected in the current study where female participants report significant influence on the health of men and the family unit in general. In four of the couples women are working directly in health or fitness orientated roles, three have tertiary level knowledge of food technology and all report a life experience of raising families in healthy environments.

Richardson (2010) found in a study of 24 men that these men would often minimise their own needs and defer responsibility for health to their partners. This negotiation of responsibility for men’s health is reflected in the current study where women often provide the first level of care for men, supporting decisions on the need for primary practitioner level medical care, control the family diet when there may be a level of intolerance to certain food types, and are proactive in the definition of survival strategies for the couple when navigating their way through the stresses of modern life.

These role assignments may be reflective of how work is distributed within the family unit, with mothers taking an active interest in the ongoing health of children when, for example, they are at home during the child's early years. Gender stereotypes and social norms (Oksuzyan et al., 2008) in this area are not however universal, with some men assuming a highly active role in family health. This seems particularly evident when the couple are required to interact with the male dominated world of medical specialists and surgeons where more aggressive approaches have proven successful. In these cases men may use their assigned roles to fight the medical system and secure high levels of medical care for their children.

There has been a relatively consistent narrative presented by the participants regarding the division of roles in the management of a healthy family diet. Women play a significant role in promoting healthy eating practices for men (Gough & Conner, 2006), managing the planning, cooking and allocating portion sizes of meals eaten in the participant family households. Although there may be some allowance for 'special treats' for men in these relationships, the main meals are not democratically defined. In this instance, the men's diets and subsequently their health are greatly influenced by their partner's knowledge and experiences in selecting and preparing healthy meals.

Social forces acting on women may see them benefit from taking a consultative role in family health with the Western cultural model arguably favouring women to engage in primarily healthy behaviours (Courtenay, 2000), whereas for men this idealisation is presented by the participant couples as being orientated toward the accumulation of wealth and power. Further to this the longer life spans experienced by women may endow them with motivation to extend the time they may spend with

their partners in older age by actively engaging in issues related to their partners health.

This active role for women may, however, prove difficult as reflected in discussions of participant mothers, who are described in some cases as enduring the idiosyncratic nature of their partners when they prove difficult to navigate through life's changes.

### ***Men as resistive forces in health***

The focus of contemporary healthcare tends to be on the individual assuming responsibility for modifying their health behaviours with men's health practice focusing on behavioural risk management (Richardson, 2010). This does not reflect well in an environment where men take health for granted and continue in unhealthy ways until they are faced with a health threat (Gough & Conner, 2006) and there is a general reluctance on the part of men to seek and comply with medical treatment (Oksuzyan et al., 2008). Richardson (2010) proposes that acting irresponsibly in health may in fact be men's expression of defiance, a way of defining themselves in an environment that they consider to be feminine and in danger of challenging their masculinity.

The complex relationship men have with health is reflected in the current study; Victoria and Oliver navigate this difficult ground and identify stubbornness and ego as sources of men's resistance to taking action when ill. These two constructs are culturally laden and embedded not only in the way the couple tell their story, but also fundamentally at the core of the discursive tools available to the couple when constructing these stories.

#### Interview 10 – Victoria(V) and Oliver(O)

845 O ... so we are talking about men's health and how couples approach it

846 M yeah

847 O yeah, so, you didn't go down the line of, **it's quite interesting how my wife will intervene because sometimes as a male when you get sick, besides my leg, but sometimes you won't cry wolf with man-flu**

848 M right

849 O but sometimes, you will as male figure in the house, just not say when you have a health issue

850 M mm

851 O so quite often, a couple of times, V has gone you should really go and get that checked out, you know

852 M yeah

853 O **and I go oh no I'll be right, and that male ego comes through**

854 M mm

855 O and I think that is still prevalent

856 V **the male stubbornness**

857 O **yeah the stubbornness to go, like, I'm just making this up, but this is the sort of example, a man will sit there and pee blood, and literally be going oh yeah it must be something I ate last night** or

858 M yeah

859 O literally at that stage go oh I'll give it a few days, **where a woman will go, that's not right**

860 M right

861 O **you need to get up and see about that now**

862 M go to the quack

863 O yeah go and sort that out

864 M yeah,

865 O but it is quite amazing with problems, yeah predominantly a male will just sort of

866 V oh **you'll ponder on it for ages before you will actually do anything about it**

867 O yeah

In this shared narrative the current state of men's health is constructed within the context of extremes where men will 'pee blood' and still not actively respond to their potential health

need. The couple subsequently move to solve this dilemma by discussing the barriers to health that are slowly being broken down so that men have an enhanced health vocabulary and platform for good health.

Interview 10 – Victoria(V) and Oliver(O)

- 939 V so would you think that in another 5 years with all that, that if then you pee'd blood, you'd think, oh shit I should go do something about that tomorrow
- 904 O yeah yeah

The couple propose that in five years, a relatively short timeframe for change in this environment, men will be more proactive in their response to poor health symptoms. Mechanisms to achieve this change, proposed by the participant couples, are discussed in the - Looking to the future for men: education and role models for change – section later in this thesis document.

***Men as care givers***

The focus of literature on men's lack of responsibility for health (Oksuzyan et al., 2008) contrasts greatly with their reported action when their partners are ill. Participant couples report that during this time men may take on roles in the shared household that would not normally be culturally assigned to them in Western society. In many cases these men take on the role of health consultant for children and other family members filling the role as carer and primary health provider for the family until their partner is able to return to this position.

Sharing these roles is an important family dynamic (Schulz & Sherwood, 2008), Umberson and Montez (2010) propose the prevalence of men moving into these caring roles may become more frequent as families become smaller and the population

age rises. In this respect family health becomes an intra-couple project (Bjørnholt, 2011) where the care giving role becomes shared between the couple.

In extremely unfortunate cases the participants report that men may become the primary care giver for their partners during times of long-term decline due to chronic or terminal illness. These men become advocates for their partners when they are unable to represent their own needs. These experiences may become turning points for the men and are interwoven into the couple's shared narrative for health. Contrary to a Western cultural narrative that positions men as non-responsive in health, when the need arises these men take action beyond that which wider society may generally expect of them.

The level of variability identified in the couples' approaches to family health suggest that their assigning of roles is contextual and situational, being highly dependent on how individual couples have responded to the health challenges and experiences in their environment. A couple's solution to these challenges is negotiated between them, over time, and projected to others as the identity they collaboratively construct in their shared narratives.

### **Narrative founded in comparison to others**

*A common narrative identified in the participant interviews is the mechanism these couples employ to create a level of separation from a group of unhealthy others they see in wider society.*

*The reference to parents as role models of this lesser group of others was almost universal and forms an interesting contrast to the participant couples also in this mature age group.*

*Note: in the following chapter participant couples discuss their father's health. These fathers are identified as the 'fathers-of-the-participants' to save confusing them with the participants, who may also be fathers.*

It has been theorised that when people report their wellbeing and fitness they do not rely solely on objective information, social context also has influence on their judgement (Glanz, Rimer, & Viswanath, 2008; Warner et al., 2012). To this end Albert Bandura (1999) proposed, in his seminal work on social cognitive theory, that individual actions and reactions, including behaviours, are influenced by the actions that individuals observe in others. In effect people learn by experiencing the effects of their actions through the power of social modelling. Human functioning in this context is a product of the interplay of intra-personal influences, that is, how people work together to shape the events in their life course (Bandura, 2012).

The relationships established in the construction of these social networks carry some risk as they apply direct and indirect influence on the health behaviours of the network members (Umberson, 1987). The social support provided by the network is often critical to the way illness is negotiated and lived in people's lives (Radcliffe et al., 2013), but this must be tempered by the possibility of social contagion from negative health behaviours operating in social norms and unsupportive social ties (Umberson & Montez, 2010).

The couples interviewed position themselves as making sensible decisions in health by remaining independent from the negative social relationships in their lives that are not aligned with their beliefs and/or approaches to health (Sloan et al., 2010). Couples generally construct two images of men's activity and level of ownership in health, firstly men in the wider populace are positioned by the couples as being less active and in poorer health overall than the participants.

Secondly, men in the couples interviewed are constructed as being separate from this group and projected as being more proactive and responsive to health related subjects than these

external lesser others. This discussion of other men's unhealthy practices as a mechanism to locate the participants as relatively healthy, rather than necessarily discuss their health practices directly, is reflected in the Sloan et al. (2010) study where healthy men were found to use similar constructs during their individual interviews.

The couple's narratives, when comparing themselves to others, are generally founded on how the couple locate themselves in relation to their parents and/or the average man in the street. They construct stories to contrast and separate themselves from the unhealthy activities they report in these others. It is proposed that this separation is an important tool for the couples as they work to perform a socially acceptable form of success for the interview session, which they consider may be in conflict with the unhealthy cultural narratives they report in the social networks around them.

***Fathers-of-the-participants as role models for resistance to change***

The participant efforts to compare and contrast their lifestyle and health decisions with others are highly visible when the couples talk about their fathers, the relationship these fathers-of-the-participants have with health, and their almost universal resistance to change. In most cases the dietary range of fathers-of-the-participants is, for example, storied as being limited to those foods that have been consumed in the past, perhaps in conflict of recent findings that these foods are now considered unhealthy. Further to this, fathers-of-the-participants are frequently constructed as having levels of fitness that are in decline as they become inactive and unwilling to exercise, or they have accumulated a number of possibly preventable chronic illnesses that have an ongoing detrimental influence on their health.

A possible source of the systematic decline in the health of fathers-of-the-participants, identified by the participant couples, is their performing roles of powerless victims. It is proposed that these men assign agency to negative health factors and then consider themselves to be trapped and unable to change. Their perceived self-efficacy to make positive change in their health is low (Bandura, 2012) as they see themselves held in the grip of powerful forces that are outside of their control.

Unfortunately, despite efforts to modify the fathers-of-the-participants behaviours in this regard, their wives may be defeated by the fathers-of-the-participants resistance to change and the cultural forces influencing their environment (Radcliffe et al., 2013). There is evidence of these women attempting to improve the health of fathers-of-the-participants, but they make little headway until a significant event occurs in the men's lives, a 'wakeup call', that spurns them into action. This may however occur at a time when significant damage has already been done to the fathers-of-the-participants health and they are physically unable to adapt, or they may simply choose to ignore these events and continue on as they always have.

An interesting outcome of this current study has been identifying the resistance to change storied to describe fathers-of-the-participants and how this contrasts greatly with the men in mature couples participating in the research, who are of similar age to the parents of younger participants. Where fathers-of-the-participants are constructed as being resistant to change, set in their ways, and in most cases living unhealthy lifestyles; the mature participant couples paint a picture of proactive aging with unique stories that resist the unhealthy cultural narratives associated with this group.

In some respects the participant couples' identity, as being healthy and worthy of engagement in the interview process, is

validated by comparison to those others who are perhaps less so. In the context of an interview focused on men's health, the couples' ongoing participation as being proactive in health becomes contingent on their portrayal and subsequent comparison to these other, lesser performing characters in their stories.

### ***Doing well for your age***

The participants identify some challenges inherent in the relationships men hold with their general practitioner, the medical experts they have established trusted relationships with, over a period of years. The couples propose that unhealthy men are often contrasted with others in similar age groups and informed that "they are doing well for their age" despite the chronic effects on health associated with their poor health behaviours.

Participants report that doctors employing this approach validate the unhealthy lifestyle these men are living and normalise the outcomes on their health. As a by-product to this interaction with their doctors unhealthy men are then empowered to abdicate responsibility and control of their health by attributing their physical decline to the ageing process. Doctors who position an absolute minimum of physical activity, and poor dietary choices, as being consistent with the normal lifestyle for men as they age, are identified by the participant couples as being a significant contributing factor to the poor health outcomes for these men.

A number of couples propose scenarios for why this may be occurring, firstly and perhaps cynically, the commercial realities of making a local doctor's surgery financially viable was raised. It was proposed that being direct with these men may result in them seeking advice from another doctor who is less forthcoming with this bad news, thus impacting on the profitability of the

doctor's practice. And secondly, in some contradiction to the first, the process required to have these discussions with men, who may not generally be open to confrontation, would require time that is not available in the highly compressed, standard, fifteen minute doctor visit. Specifically, doctors are just too busy to make time to have these difficult discussions with men.

A further challenge, associated with general practitioners and their relationship with men, is highlighted when these health professionals under-deliver to men's expectations, particularly in the sharing of test results with these men, generating some confusion in the ongoing ownership of health. Copies of blood test results, for example, were often highlighted as being promised but not subsequently forthcoming from doctors. Men build expectation that these promises will be honoured and poor performance by doctors in this area generates resentment that may start the men questioning the value of regular doctor visits.

On a positive note, examples of situations where men participating in this research have regained control of, or are taking steps to proactively manage their health, are indicators of change possibilities for all men. Regular doctors checkups timed at least annually with their birthdays were reported by the majority of men participating in this research.

It seems imperative, however, that once men establish a routine to regularly visit their doctor, these health professionals set clear expectations with the men, follow through on any commitments made and provide honest, targeted feedback to them. Doing well for your age needs to be framed in the true status of men's health.

### **Looking to the future for men: education and role models for change**

*The effectiveness of education and the use of role models to support the messages being generated for men's health were consistently discussed in the interviews. Although there was strong support for education as a way to start the social change required one interview provided an interesting contrast*

Education, as it relates to improving men's health, is a major narrative identified in all of the interviews and there is significant support for improving school level access to information on health for boys as part of their core curriculum. This aligns well with recommendations from previous studies, that suggest if we are to get serious about creating healthier older men, we need to focus on creating good health practices in boys (Asquith, 2009). This change of health behaviour at a young age is the greatest hope in reducing the burden of preventable disease and death (Glanz et al., 2008) and some success in this area is reflected in participant narratives pertaining to the improvements to health seen in younger men when compared to fathers-of-the-participants.

The challenge of adult education remains however, as Hamish highlights in the following narrative section "do you know of anyone who hasn't heard of cancer". Unfortunately the complexity inherent in health literacy and the need to disentangle medical terminology to make sense of illness may generate confusion for adult learners (Schechter & Lynch, 2011). Further to this, the communities of practice (Schechter & Lynch, 2011) and informal group forums (Coady, 2013; Mezirow & Taylor, 2009) proposed as possible answers to this challenge seemed silent in the current study.

Improving education in isolation of modification to the cultural environment for men's health is highlighted by participants as difficult, if not impossible. They see wider systemic forces at play in health that need to be considered as Hamish highlights in the following extract. Providing context to this position on education is a strongly voiced view of individual responsibility in health,

that “it is incumbent on you as a person to minimise your risk” and that men who do not do this “have lost perspective” and turned into “these great big lard arses”.

Interview 6 – Erin(E) and Hamish(H)

- 645 E you gotta educate them when they are kids
- 646 M yeah
- 647 H **I think education is a waste of time** because people know, the people that are drinking it probably know they shouldn't be, I just think education, you know when they say, oh **we are growing awareness for cancer, it's like, do you know of anyone who hasn't heard of cancer**
- 648 M right
- 649 H **I just think this whole, oh we are raising awareness for this, I just think that's a cop out, I just think it's a waste**

The concept of waste raised by Hamish is founded on a view that the cost of poor health practices has become significant and that the growing rates of heart disease, obesity, cancer and other diseases of affluence cannot continue to be funded by traditional means. The epidemic of obesity in adults and children, for example, threatens a staggering global economic toll (Glanz et al., 2008), yet tax systems are not structured to ensure those who eat poorly also support the infrastructure to ensure their ongoing treatment. Hamish contrasts raising a tax on fat and sugar with smoking where the taxes collected provide some relief for the health systems that have been developed to support smokers with smoking related illness.

Within this context Hamish locates education as another wasteful process until there is sufficient social structure to enable positive outcomes. It should however be noted that after further discussion with Erin, who is working in the education sector, Hamish relaxes his approach to education in the following narrative and refers to the success of role models in health as a source of information and reference for men.

Interview 6 – Erin(E) and Hamish(H)

- 895 H I don't know whether they, and this relates back to the previous question about how improving men's health and I just thought of it before, and maybe it relates to this couch potato thing too. Is I think some of the best, and **I know I was dismissive of awareness and education**, but you talk to, John Kirwan on depression
- 896 M mm
- 897 H and how he sort of out'ed that as a, something acceptable to talk about
- 898 M yeah
- 899 H and you know, **you talk to John Kirwan and he says that he is approached by so many men who have said thank you so much you helped me get through this time and seek help or whatever**
- 900 M mmm
- 901 H **so that's obviously been, that's worked for a lot of people,**
- 902 M yeah
- 903 H similarly Buck Shelford, All Black hard man who go a lot of men off the couch to get proactively screened for prostate cancer because he got it
- 904 M mm
- 905 H so, even though they are a classic awareness campaign, it sort of, it worked, maybe they need to do that for the old couch potato, but I think, didn't Michael Jones and Inga Tugiamla
- 906 E whose going to front that
- 907 H yeah Michael Jones and Inga Tugiamla, I think cause it's a big problem in the Pacific community, fatties
- 908 E oh right
- 909 H and so they, I think they
- 910 E fatties
- 911 H well look at those 2, they are both 20stoners now
- 912 M yeah that's right
- 913 H and, **as I pointed out to E, Michael Jones, Pacific Island leader, and key shareholder in Carl's junior burgers**
- 914 M oh really
- 915 H way to go

916 M I see a small conflict there

917 E perhaps not him

### *Role models in men's health*

The success of role models in raising awareness for men's health issues is universally recognised by the participants as having a positive influence on health. The depression campaign presented by John Kirwan, in particular, has a very high level of recall in the research population and is positioned as a model for approaching other key areas in men's health.

However, as Hamish and Erin identify in the preceding narrative extract, these role models are only effective if they maintain their social mana and remain relevant to the population targeted by the campaign. In a study of 749 American adolescents Yancey, Siegel and McDaniel (2002) found that media entities accounted for 39% of the role models these young people associated with taking lower risks in their health care. One challenge of becoming reliant on these media role models as a major influence in health, is that they may become damaged heroes and be presented as villains in the very media that raised their visibility as role models in the first place (Lines, 2001).

Projecting forward into the future there is some concern for the current generation of boys and how they will manage their health as adults if the unhealthy cultural narratives remain in effect. Unfortunately the ongoing stability of these cultural narratives seems likely in the absence of major social upheaval although, in some respects, this cultural work is already underway with a number of couples proposing that the current generation of men have more knowledge about health than their fathers before them. Further to this, the couples indicate that boys, who will form the next generation, are receiving information on health at any early stage as part of an improving focus on health education.

The opportunities for men to make informed decisions in health are growing, as represented by the research population for this thesis. There are, however, a significant number of men who continue to conform to cultural expectation in this area. Unfortunately the mechanisms for change, such as education, are incremental and long term, so effective change may require a focused effort that spans generations.

### **Exploring couples' shared narratives in men's health - Summary**

Couples' shared narratives have been explored to investigate the stories couples construct together in context of the cultural narratives they are immersed in and their unique ways of challenging these narratives. Five cultural narratives have provided a framework for this investigation – a) freedom and consumerism, b) the right-to-relax, c) couples roles in men's health, d) narrative founded in comparison to others, and e) looking to the future for men: education and role models for change.

## **Chapter Five: Charting couples' shared journeys in men's health**

*Chapter five describes participant interviews in the context of a shared journey that is traversed by the couples. It is proposed that this journey is based on the challenges the couples face in men's health and how they, as couples, respond to these challenges as they navigate from one journey phase to the next.*

*The concept of a journey was born from analysis of the stories being presented by the couples and recognising that they were performing identities consistent with a cohort of other couples in similar locations in their shared journey.*

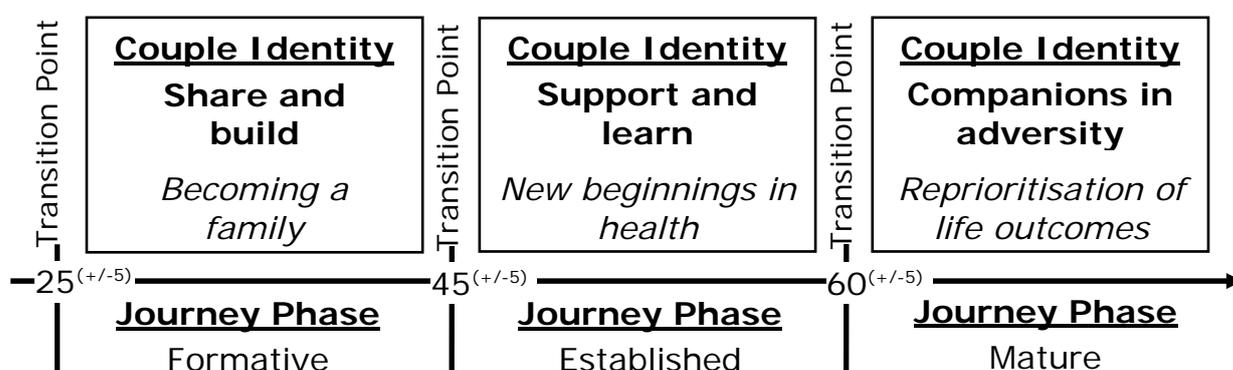
The convenience sampling method employed in this research formed a research population of couples from a range of life experiences, time together as a couple and age. This unplanned variability in the participant group provided visibility of men's health not only from an individual couple's perspective, but also from how couples differ in their approach to men's health based on their time together as a couple. To this end, participant couples who have been together for similar periods of time report relatively consistent experiences in their shared narratives on health.

This consistency is analogous to a recent study with stroke survivors and their partners, where narratives produced by these couples varied according to age, reflecting the couples' life experiences and circumstances (Radcliffe et al., 2013). In this respect it is proposed that shared narratives employed by the participant couples in the current study reflect the evolving social ties, health behaviours and risk factors that unfold over the couples' life course (Umberson et al., 2010).

Additionally, there is heightened recognition by men, as they get older, that their health is not a bottomless reservoir, that it needs to be actively managed and maintained, and that ageing may not be a linear process (Richardson, 2010). The couples in

the current study reflect this non-linear nature of ageing when they report long periods of stability in health, that are interrupted by turning points (Bruner, 2001; Riessman, 2002; Squire, 2008). These turning points may be in response to a need for change as the couple manage the dynamic conditions present in their lives. Some turning points may be so significant that the couple report a transition from one stage in their shared journey to the next. This transition requires couples to make major updates to their shared stories as the content of their current or old stories are no longer relevant to their new identity in health.

It is proposed that the participant couples can be formed into cohorts representing three stages of life, where the periods of stability are identified as journey phases which are subsequently interrupted by transition points as outlined in Figure 3. Evans, Frank Oliffe and Gregory (2011) propose a similar framework in their theorising of masculinity and health over the life course with three groups - young, middle and later life, forming their study cohorts.



**Figure 3. Couples shared journey in men's health**

Age is represented as an indicator of the transition point locations based on the participant demographics in the current study. It should, however, be noted that the model represents age ranges and that there is not one critical age where a couple may transition from one cohort to the next.

This thesis now discusses each of the couple identities located in the shared journey with respect to the related goals of the narrative used, transition points and the couples' location within phases of the shared journey.

### **Share and build couple identity**

This couple identity is constructed as the couple develop and build shared agreement of how they will work together in health. The transition point into this phase reflects their moving from an individual status to planning and living a shared life together, not only as a couple, but also as a young family. The dynamics introduced by their forming a couple are reflected in the narratives they use and subsequently the identity they construct in the context of cultural and social forces acting upon them.

The participant couples in this journey phase tell stories of formation with health identities that are under construction as part of their becoming a couple. They positioned themselves as being flexible and open to change, well informed on the current state of men's health and on being a family in general, whilst being forward thinking and actively planning for their future.

The new, dynamic, shared environment requires the couple to negotiate a mutual understanding where the knowledge they bring to the couple unit is interleaved with that of their partner to form their current couple location in health (Bjornholt & Farstad, 2012). An example of this interworking by the members of a couple, as they share and build their identity, is storied by Lara and Jake.

58 Interview 8 – Lara(L) and Jake(J)

J yeah, I just know how I get sick, I know how I get the flu, I know how I get, even physical stuff to, like I know how I get body pain, physical pain

59 M yeah

60 J injuries and stuff, and so its, what I am doing at the moment

especially is (unintelligible) and damage that is being caused

61 M right

62 J whether it was getting L's cold, or like **I had a bit of an injury about a month ago**, so now I'm just trying to, now I've gotten back to a good place

63 M yeah

64 J **I'm being proactive in keeping it away**

65 M yeah, do you agree with that L, do you think that he is generally pretty healthy

66 L well, I mean you drink heavily, and you eat a lot of bad food, you do, but you manage all of the bad things really well because you know what you need, you do, you take a lot of vitamin c and you take a lot of other vitamins, and **no I don't think that you are very good at keeping up with your injuries, the back thing, it took you months of complaining about it every week**

67 J 3 weeks

68 L before actually going to the chiropractor

69 J 3 weeks you mean, when you say months you mean 3 weeks

70 L **no I mean months, the last time it was bad, no cause a year, a year and a bit ago** in Sydney it was bad, and you, you were getting massages for it, and we nagged you, I nagged you and my mother nagged you before you actually made an appointment with M the physio, and you're seeing her all the time

71 J mmm

72 L which is great

73 J mmm

74 L but

75 J so I saw M2 and M2 is not just a massage therapist, M2 does exactly the same thing as M does, but he does it in a much more expensive fashion. M is \$40 an hour and M2 is \$140 an hour

76 L but that wasn't really helping, **like you would go back to the pain every month or so. It felt like that to me**, if felt like

77 J no, I had a really bad injury for 3 weeks before I went and saw M, **it was 3 to 4 weeks**, and I saw M2 like 3 times over that period

78 L yeah

79 J yeah

80 L the back think kinda came and went

81 J it always does

82 L just the last time  
83 J no for the last 10 years, my back comes and goes  
84 L so yeah I think we're  
85 J **so you said months and for me it was 3 weeks**, cause I've got dates to verify that  
86 L **ok, for me it started last year in Sydney** and it got bad and better for a few times over the last year  
87 J mm, when was Sydney, was it before New York, aye  
88 L mmm  
89 J cause last year I had like, I had a massive injury like the day before I went to New York,  
90 L mmm  
91 J remember before I got on the plane to New York  
92 L yeah, yeah, you were in spasm, yeah  
93 J yeah, it happens all the time  
94 L yeah, well for me its like if I had that sort of injury I would want to find a permanent solution rather than just going back to what kinda semi fixed it cause it's not an injury, its not from an accident  
95 J no, and they are different every time, that injury was in a different spot on my body, last year  
96 L really  
97 J yeah  
98 L its always your lower back and always up through there  
99 J yeah, last year was the first time, but it was on the other side, last year it was completely the other side of my body,  
100 L ok  
101 J this year it was this side of my body  
102 L ok  
103 J but this year it started this side of my body, that fixed quickly when I saw M2  
104 L mm  
105 J and then  
106 L I don't know  
107 J we're not having a discussion with Murray, we're having an argument, how quickly things went badly  
108 M I'll just turn the stopwatch off  
109 J it was going ok until you started talking  
110 L yes, you are perfectly healthy

In this narrative the couple work toward a shared understanding of Jake's health status where each member of the couple presents their perspective of Jake's recurring injury. There is initially some confusion in the narrative constructed by the couple regarding the length of time that this injury has taken to heal and how proactive Jake has been in seeking medical support.

A major factor in this confusion appears to be the conflicting temporal scales in use in this discussion, with Jake focusing on a short-term injury and recovery cycle based on weeks (line 85 "so you said months and for me it was 3 weeks"), whilst Lara takes a longer term view of health from across the previous year where there have been ongoing injury issues for Jake's health over that time (Line 86 "ok, for me it started last year in Sydney").

Although the couple is attempting to build toward a shared understanding based on this narrative they are also aware of the interview environment in which they are performing and close off the negotiation early. They undertake a graceful exit from the topic with a negotiated agreement, using humour between them, to continue in the context previously framed in the interview where Jake rates himself as 9 or 10, out of 10 on a healthiness scale.

This insight into the couple actively constructing their shared story is reflective of the formative shared journey phase where the couple use these shared forums to learn about each other's ways of thinking and history whilst remaining flexible enough to modify their own perspective or negotiate a shared outcome if required (Morris, 2001). Other couples in this formative phase present narrative focused on preserving health as a way to ensure positive outcomes for the future, where the couples may employ tools to manage the risks associated with health. Stress

in the family environment may, for example, be managed by being sensitive to workloads and sharing family responsibilities.

Further to this, couples in this phase also proactively manage possible health risks where there is a known genetic disposition to illness or disorder by ensuring that they are informed about their family health history. Where possible proactive steps are taken to reduce risk with changes to diet and health practices, that are aligned with the couples approach to health overall.

### **Support and learn couple identity**

The narratives couples employ when forming their location in this identity differ subtly from those in share and build cohort. The transition to this shared journey phase is marked by a realisation that there are increasing health risks for men as they age and the couple must work together to manage the new dynamic this introduces to their relationship. Men find that in middle age bodily changes are more than transitory and they need to assume a higher sense of responsibility for their health and self care (Calasanti, Pietilä, Ojala, & King, 2013). Health risks at this time may be associated to the general deterioration of health over the years, the increasing prevalence of “old man stuff” (Interview 4, Line 69), or the men are finding themselves fighting for survival in “a young company” (Interview 10, Line 328).

The new beginnings undertaken by men in this group are facilitated within the couple framework with their partners. When, for example, increasingly invasive screening techniques for some of these new health risks raise concern for this group, their partners are able to provide a context to these discussions with reflection on their experiences with cervical and breast cancer screening, normalising this process (Mahalik et al., 2007) and developing the men’s understanding in this area.

Together the couples construct stories that describe them as acting responsibly in men's health, being aware of the challenges and risks factors that are being faced as they age, and caring for both their children and their parents. There is, however, some evidence that this may be a difficult and confusing time for men when they have insufficient understanding of the role they must play in order to proactively manage their own health. Sally and Chris surface this confusion when discussing the health of Chris's father whilst attempting to reconcile conflicting visual health indicators with his actual health.

Interview 3 – Sally(S) and Chris(C)

- 147 C you know, maybe it is a genetic thing, I don't know, and also my dad like I say he is a skinny guy, he's not, he's not, he's quite active, he eats pretty well
- 148 M yeah
- 149 S he's got diabetes as well
- 150 C **he has got diabetes, and like I say he's a skinny guy, he, you wouldn't think he was a risk at all, yet he has had a major heart attack so they gave, give him a, he went in for a double bypass wasn't it, and they end up giving him a quadruple bypass**
- 151 S yeah and that's when they found out that he was diabetic
- 152 C yeah and since then he has had another minor heart attack hasn't he
- 153 S **yeah, now he's just had his TURP done**
- 154 C yeah, so it worries me a little bit, I think, I don't, I don't have a healthy lifestyle what so ever. I don't do a lot of exercise, but in saying that I am active all day, I don't, I'm not sat down behind a desk all day
- 155 M right
- 156 C you know so, so you know, there is a little bit of that, **but I think I should be a bit more proactive about, approaching, well I don't actually know who to approach actually and asking do I need to do this, do I need to do that**
- 157 M mmm

- 158 C do I need to see the doctor every 6 months, you know
- 159 M what are the, you mentioned a couple times, like your dad, looks healthy, he's a skinny guy and he's relatively active, are there any other kinda key dimensions that you can think of that would indicate somebody's healthy to you, like if you saw somebody and heard their history and these 3 things or 4 things came up you would kinda say yeah that's the kind off a person who is living a healthy lifestyle. What kind of things would indicate that
- 160 C I don't know really, he's active, I know you are saying about other people but you know, they are active, their diet I suppose, **I don't really know really, I don't really know what constitutes a healthy lifestyle**
- 161 M right
- 162 C you can't restrict yourself to living like a monk I suppose
- 163 M mm
- 164 S mmm
- 165 C living of the land, we like a drink and stuff like that, we don't smoke, me dad
- 166 S **I think size is it, cause you keep going on about T and how big he is and stuff**, so I think size is an indicator for you isn't it
- 167 C well yeah, but see like one of the guys at the place I work for, he's a massive guy, he wobbles, he doesn't walk, he's kinda like a weeble, and he just manages to struggle along
- 168 M mm
- 169 C **and I don't know if he thinks this is ok or, and he smokes as well, so I don't know whether, you know, he's**
- 170 M sounds like a lot of risk factors there
- 171 C well it does. It does and I mean, **to tell you the truth I'm not too worried about him, it's myself I worry about, obviously I worry about S and my family who I don't see very often**
- 172 M mmmm

Chris's father is constructed by the couple as a man who has exercised regularly, eats well and is "a skinny guy"; all indicators that are traditionally associated with health and wellbeing. This visual assessment of health is challenged by Chris's father's medical health status where he is suffering from diabetes, heart disease and prostate enlargement; all indicators associated with

poor health. This generates confusion for Chris who thinks he should be more proactive in his own health, but is unsure what a state of healthiness may actually look like and the support structures available to him to achieve this state.

The extent of this confusion, between visual and medical representations of health, is reflected further in the couples' subsequent discussion of Chris's work colleague (identified in the narrative segment as T) who is visually overweight and smokes, two dimensions associated with an unhealthy lifestyle. Having invalidated the visual model for assessing health during the discussion relating to Chris's father, the couple struggle over the meaning this invalidation has to their story and the consequences of their constructing Chris's father in this particular way (Langellier, 2001). The couple are not able to make defining statements relating to T's actual health status due to this conflict and are left seeking further information before declaring him unhealthy or otherwise.

Irrespective of T's health, however, Chris ends this narrative segment with a declaration that he is more concerned about his own health, his partner's health, and that of his wider family, than trying to resolve this conflict; reflecting the family focus of couples in this shared journey stage.

### **Companions in adversity couple identity**

Couples transiting into the mature journey phase construct narratives of survival after a major health event, such as heart attack or cancer, that has significant impact on their life as a couple. These couples become companions in adversity as they fight for services in the health system and rally against the social stigma of being seen as part of an aging population.

The identity they construct is that of being wise to the ways of the world, having a high level of stability and as being survivors of these major events. Importantly this identity positions the

couple as continuing to contribute as valued members of society. The interaction within participant couples who are located in this shared journey phase is highly supportive, with both members collaboratively building shared, unique stories to construct their identity. Women in these relationships report a level in pride in both the survival of their partner and their on-going success as a couple to fight off the stigma associated with these events, that of being the “dead man walking”.

The reprioritisation of life outcomes, after a transitional event, is positioned positively in the narratives from participant couples with a reflection that the event is part of, and inseparable from, their lives as a whole (Radcliffe et al., 2013). An event such as cancer is not afforded its own agency and power in this relationship; instead it is consumed by the couple identity and integrated with their overall story. When transitory events are presented in this way the couple remain in proactive control of their destiny and are not constructed as passive victims of unfortunate circumstance where they have no capacity to elicit change.

In the following narrative extract Kim and Grant discuss this being-in-control in the context of proactively returning to work after an illness in a timeframe that is shorter than that recommended and, in some cases, shorter than others who have suffered similar ailments.

Interview 1 – Kim(K) and Grant(G)

- 339 G ...I'd had a couple of hernia operations and that sort of stuff and where I was supposed to be home for 10 days you know, I was only home for a few days, well it was like I , I had my spine fused, they cut thru here (pointing to front of neck)
- 340 M oh ok, yeah
- 341 G fused c5 6 and 7

- 342 K oh I don't know, numbers
- 343 G and, **I mean I was supposed to be off work for a month I mean I was only off work for 7 days and I was back at work** and, because at the end of the day I just fell like, you know like one lady at she, **she'd had the same thing done and she was off for a year, a I'd say well why would you be off for a year**, you know
- 344 K **we are all so grateful, but if you sit round feeling sorry for yourself**
- 345 M yeah yeah
- 346 K **you won't get any better, you get up off your butt and you go do**
- 347 G it's like K
- 348 K you stretch the boundaries, yeah I know
- 349 G **she was supposed to be off for 8 weeks for her hip**, she was back at work
- 350 K well 12days, **that's just that, if you sit, I feel, if you don't get up and get, get moving you are just going to sedate, you are just going to seize up and freeze up**
- 351 M yeah, yeah
- 352 K **you know, that old use it or lose it thing**

The couple construct their proactive efforts to return to an active lifestyle as being critical to their ongoing health so that they do not "seize up and freeze up". Further to this, Grant's story is fortified and supported by an example where Kim has also been proactive in her return to work following an issue with her hip, reflecting the relational and shared aspects of their joint story telling (Koenig Kellas, 2012). Koenig Kellas et al. (2012) propose that these collaborative narrative constructions allow couples to share the burdens related to the stressors of life as a couple, with a positive outcome on the health of both partners.

## **Charting couples' shared journeys in men's health - Summary**

When viewed across time the participant couples' form cohorts performing in three couple identities - share and build, support and learn, and companions in adversity. Couples of similar journey phases experience men's health in similar ways and employed similar shared narrative to report how they manage the challenges they face in each journey phase.

Further to this, participant couples reported long periods of stability in the health of the male partner that are interrupted by transition points. These transition points reflect a changing health context that results in high levels of change in the couple's life together.

## **Chapter Six: Men's health - a couples' perspective** **discussed**

It is proposed that men's health and being in a couple are culturally located, and that the macro influences of culture are evidenced in the shared narratives constructed by participant couples in their interview sessions. Within this cultural frame the unique stories told by the couples reflect their shared alignment and conflict with the cultural narratives employed in their environment. Couples may, for example, employ unique stories to present an argument for their rebellion against those cultural norms that are not aligned with their definition of good health practice. Their stories, therefore, provide an important perspective on men's health as it is lived by them.

There is also a familial perspective to men's health in the context of the parents of the participants, the participants themselves and the next generation of young men and boys. In general the disappointment that participants reflect, when constructing their parents as the lost generation in health, is contrasted with equally positive stories of opportunity for developing and educating young men and boys. This next generation are positioned as being better prepared for their future in health than the current, signalling that work is underway to address some of the challenges inherent in the cultural models currently in effect.

Key shared narratives from across all participants, when viewed together as a set, indicate a sense of temporal alignment within a shared journey in health that reflects evolving risk factors for men. Younger couples form a cohort planning for and looking toward the future, those in their middle years begin to experience a change in the risks they face in health, whilst more mature couples reprioritise their lives to focus on what is really important to them at that moment in time.

This shared journey in men's health provides a framework for the discussion of important transition points that mark the passage of a couple from one journey phase to the next. An awareness of the movement and change inherent in this model may prove important to ensuring that health policy and support are flexible enough to focus on the needs of men as they navigate their shared journey.

### **Couples in men's health**

This research has identified a number of key tools that participant couples employ in their management of men's health. Shared narrative, where stories are constructed between the couple, ensures that a more complete story of health can be presented. This may be particularly valuable when recalling health experiences for medical consideration, and also to construct a more complete family history when stories are passed to a subsequent generation.

The additional knowledge of health sourced from two life experiences, the health orientation of partners in a couple and sharing the responsibilities for health through roles played in a couple are also important. It is proposed that these provide an extended set of options to men when making decisions relating to their health. Further to this, men in these couples are able to make decisions that challenge current cultural expectation with the support of their partners.

The shared stories told by the participant couples support a view that health in today's cultural climate places a high level of responsibility on men and the drive to succeed in health must ultimately rest with them. In order to be healthy men must recover the agency they have awarded to external forces. To this end, a change to healthier ways of living is incumbent on men, who must take responsibility and ownership for their lives. There is, however, significant value identified by the participant couples

from being in a caring relationship that will support this process for change.

Overall, the flexibility and change readiness reflected by participant couples in this study is a success story. The couples are inspirational in the level of proactive responsibility they take for their health, in the face of challenges that may force change in their lives together as a couple. Their tenacity and support of each other has a significant positive outcome on their health as they take these challenges head-on.

### **Beyond the research population**

The convenience sample method employed in this research generated a relatively homogeneous study population where both members of the participant couples were open to discussing men's health, were generally healthy, and were comfortable in developing credible healthy identities in their joint interview. The regular comparisons between the participant group and external others does, however, highlight that there are significant health challenges in wider New Zealand society that are not reported directly within the participant group.

Additionally, while participants in this research show some alignment in the way they construct their shared stories of health, they also display independent and unique problem solving approaches to the challenges they encounter. The solutions they employ are often bespoke and tailor-made to address the specific health challenges faced by them in a particular moment. To this end it is unlikely that a set of simple, one size fits all, rules for health can be successfully applied across all men, in all couples.

In some respects a key outcome of this study has been surfacing the proactive ownership of men's health projected by the participant couples and how this may, or may not, be reflective of the wider population at large.

### **A reflection on research goals**

This research was focused on developing an understanding of how couples construct shared stories in relation to men's health and what purpose these stories serve for them. As an exploratory investigation this has been successful and identified some value in extending the foci of research in men's health beyond the individual to a shared narrative context that more closely represents a natural setting for these men. That is, how men and their partners work together to achieve men's health.

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## Appendices

### Appendix A: Participant Information Sheet

#### *Men and health – a couples' perspective*

##### **INFORMATION SHEET**

Kia ora,

I am an adult student at Massey University, completing a Master in Science (Psychology). I am interested in men's health and the ways couple's relationships may influence male reporting of illness.

**I am seeking to personally interview couples to better understand men's health.** Research in this area is important as it has been found that some men delay reporting symptoms and seeking health advice when they are ill. Unfortunately such delays can reduce options available to health care providers and can result in poorer health outcomes for these men.

**Can you and your partner participate in an interview?** This would be a single interview between you and your partner, and me lasting around one and a half hours. The interview would be held at a time and location that is convenient for both of you.

I am really interested to hear what both you and your partner think about men's health and will be guiding the conversation around various topics relating to men's health.

The interview will be audio recorded, and this, along with recordings from other participants will be analysed, and the findings summarized in a thesis report.

**Your involvement in this research will be completely confidential.** I will use pseudonyms in the study so your identity will be protected and there won't be any direct reference to your name in any subsequent report. Only my supervisor and I will have access to records referencing your identify. For security all of the information collected will be kept safe by password protection.

**This is a voluntary study and you are under no obligation to accept this invitation.** If you do decide to participate you can decline to answer any question during the interview. You can also withdraw from the study at any time up to two weeks after our interview. If either you, or your partner, wish to withdraw in this timeframe I will remove all of your data from the research.

You do not have to discuss anything in the interview that you don't wish to. If during the interview you start to feel uncomfortable, or want to stop the interview for any reason, I

will suspend the interview and stop the recording until you are happy to continue.

**If you accept this invitation to participate you may request a summary of this research** that will outline the study findings (you can do this on the consent form). Alternatively you can read the thesis report which will be available from the Massey University library once it has been assessed.

**If you and your partner are interested in participating in this study please contact me, Murray Hetherington, using the contact details below.**

Please feel free to contact either me, or my supervisor, Professor Kerry Chamberlain if you have any questions relating to this project.

Thank you

Murray Hetherington  
e: murrayhx@ihug.co.nz  
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Supervisor  
Professor Kerry Chamberlain  
e: k.chamberlain@massey.ac.nz  
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*This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 12/092. If you have any concerns about the conduct of this research, please contact Dr Ralph Bathurst, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x 43404, email humanethicsnorth@massey.ac.nz*

**Appendix B: Participant Consent Form**  
***Men and health – a couples' perspective***

***PARTICIPANT CONSENT FORM***

We have read the 'Men and health – a couples' perspective' Information Sheet and have had the details of the study explained to us.

Our questions have been answered to our satisfaction, and we understand that we may ask further questions at any time.

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

**Signature1:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Full Name - printed** \_\_\_\_\_

**Signature2:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Full Name - printed** \_\_\_\_\_

**If you would like a summary of the research findings sent to you at the end of this research please provide your address details below.**

**Either,**

Email address 1: \_\_\_\_\_

Email address 2: *(Optional)* \_\_\_\_\_

**Or,**

Street Address:

Name \_\_\_\_\_

Street \_\_\_\_\_

Suburb \_\_\_\_\_

City \_\_\_\_\_

## **Appendix C: Interview Plan**

### ***Men and health – a couples' perspective***

#### **INTERVIEW PLAN**

##### **Process**

- Housekeeping
- Introductions
- Some guiding questions
- Reflections

##### **House keeping**

- First – thanks for agreeing to participate.
- Confirmation of understanding of the information sheet
- Confirmation consent sheet signed
- Confidentiality
- Introduce the voice recorder
- Do you have any initial questions on the process we will follow?
- At any time we can pause or stop the interview, just let me know.

##### **Introductions**

- Introductions - Me
- Introductions - You:

##### **The interview is conversational and based around following themes:**

- Demographics
  - Ethnicity
  - Age
  - Length of time that they have been a couple
  - Family members
- Couples relative assessment of health
- The couples' personal history in men's health,
- The challenges facing men's health today
- The challenges and opportunities the couple envisaged for the future of men's health in New Zealand.

## **Appendix D: Summary of Findings for Participants**

### ***Men and health – a couples' perspective***

#### **SUMMARY OF FINDINGS**

Kia ora,

At the beginning of 2013 we met for an interview where we discussed your thoughts and perspectives on men's health. As part of that interview you indicated that you would like to receive a summary of my research findings. This document summarises those findings.

#### **Introduction**

First, I would like to take the opportunity to thank you and your partner for investing time in the interview process. I did talk with 10 couples and this helped me to develop a view of the world from across a relatively wide perspective. This challenged my thinking in a lot of areas and improved the research outcomes beyond my initial expectations.

After much deliberation I began to see some commonalities in the way that you all were talking about men's health, both as a group of 10 couples, and as smaller groups. That is not to say that you are all alike across the board as you all have individual and unique views of the world and this was reflected in the stories that you told during the interview.

This summary discusses the key findings I reported, the full thesis will be available from the Massey University website if you search on my name in mid 2014.

#### **Summary of Findings**

The goals of this research were to explore how men and their partners work together, in couple relationships, to achieve shared outcomes in men's health. With this in mind our interview provided an opportunity to investigate how you and your partner worked together in the interview. This research is more interested in the stories that you told together, about men's health, and how these stories were told, than about things that make men unhealthy (although these are very important topics in their own right).

#### **Couples working together in men's health**

This research identified a number of key tools that you and your partner employ in the management of men's health. Firstly, the shared stories told by you as a couple seem to be particularly important. An example of these shared stories occurs when men

talk about a recent illness and additional detail for this story is provided by their partner. An outcome of this shared story telling is that a more complete story of health is presented. This may be particularly valuable when recalling health experiences for medical consideration, and also to construct a more complete family history when stories are passed to a subsequent generation.

The additional knowledge of health sourced from two life experiences, the health orientation of partners in a couple and sharing the responsibilities for health through roles played in a couple were also important. I have proposed that these ensure there is an extended set of options available to men in these couples when making decisions relating to their health. Further to this, men in these couples are able to make decisions that challenge current cultural expectation with the support of their partners.

Your stories supported a view that health in today's climate places a high level of individual responsibility on men. The ownership for a change to healthier ways of living is incumbent on men, who must ultimately take responsibility and ownership for their lives. There is, however, significant value identified by the participant couples from being in a caring relationship that supports the process for change.

Overall, the flexibility and readiness for change reflected by you and your partner is a success story. You are inspirational in the level of proactive responsibility you both take for health in the face of challenges that may force change in your lives together as a couple. Your tenacity and support of each other has a significant positive outcome on your health as you take these challenges head-on.

### **Some of the more detailed findings**

There were some common themes in the stories that you told. In psychology terms these may be called cultural narratives. The theory is that when a group of people, from a similar set of demographics, (in this case living in New Zealand in a heterosexual relationship) use common themes in their stories they are reflecting the culture in which they live.

Five common themes were highlighted in the way that you discussed men's health –

1. Freedom and consumerism – *this theme in your interviews is reflective of other studies on consumerism where we are all in danger of becoming trapped in a cycle of working to consume. The stress you identified and the actions you have taken as a couple provided an interesting contrast to the cultural narratives in this area.*

2. The right to relax – *there was much discussion on the inactivity of some men as they age. Some men appear to relax their control in a number of key health dimensions and starting a decline to an old age of illness and disability. Your narrative in this area describes how you have rebelled against this cultural norm.*
3. Couples roles in men's health – *men and women play different roles in a couple and this has a significant impact on men's health. Women are generally the health consultants in your families, play a strong role in the decisions around diet and food, and are the primary information source for illness and remedies. Interestingly there were a number occasions when men stepped into this role when, for example, their partners were ill.*
4. Narrative founded in comparison to others - *the health activities and current status of your parents along with other members of society were consistently contrasted with the way you were working together in health. Unfortunately your fathers, in most cases, seem to be less aware of their health needs and/or choose to ignore opportunities for positive change.*
5. Looking to the future for men: education and role models for change - *There was general agreement that the next generation of men are being better prepared to manage their health than the current. Health education and the employing role models with mana in the community were regularly discussed as ways that this change was occurring*

### **A shared Journey in health**

It was fortunate that couples from a range of ages and life experience participated in the interviews. This allowed a shared journey view of men's health as couples transitioned between life phases that I have termed – Formative, Established and Mature. This section of the thesis looks at how the focus of men's health evolves over time, as the various risk factors that men face change, and how this has implications to the couple's health stories.

As an example of how this is relevant to the studies of couples in men's health, it has been interesting to consider the impacts of the risk factors associated with prostate disorders that become more prevalent as men age. This has influence on the way couples work together to face new challenges in health that may not have previously been on their radar. Couples in the established life phase, for example, indicated there is increased discussion of how regular doctor's visits were important to ensure early detection of these types of risk factors.

## **In Summary**

The goal of this research was to explore how you and your partner work together, in a couple relationships, to achieve shared outcomes in men's health. As an exploratory investigation I believe this has been successful and identified some value in extending the foci of research in men's health beyond the individual to a shared context that more closely represents a natural setting for you. That is - how you and you partner work together to achieve men's health.

Thank you again for participating in this research and investing your time in the interview process. I personally have learnt a lot about research in a psychology context and the opportunity for me to hear 10 couples talk about men's health has been extremely valuable to me personally.

Please feel free to contact me directly if you have any questions relating to this project you would like to discuss.

Thank you

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