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

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## Abstract

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

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## Chapter 1: Men's Reluctance to Seek Health Care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### *An Overview of the Thesis Chapters*

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

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