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Men, Masculine Identities, and Healthcare Utilisation

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

Master of Science  
In  
Psychology

At Massey University, Palmerston North,  
New Zealand.

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2006

I would like to say thank you to the seven men of the Ida Valley who participated in this study. It was a pleasure to work with you all. I would also like to give thanks to my supervisor, Dr Christine Stephens. The guidance and advice you have given me throughout the year will undoubtedly assist me in my future endeavours and I look forward to working with you in the future. To Charlotte, thank you for being a 'sounding board' for my ideas and for being an excellent office-mate. Coffee will not be the same without you. Thank you to my mother, for proof reading the first draft and for your support over the year. To Cristina, thank you for all you love and support, and for telling me "you can do it!"

## Abstract

Seeking medical help early in a disease process is critical for recovery, yet empirical evidence indicates that men do not utilise general practitioner services as often as women. In explaining these findings, the focus has now shifted away from the biological differences between men and women to examine popular beliefs about masculine identities and their influence on help seeking behaviour. This paper incorporates a critical analysis of Connell's (1995) theory of hegemonic masculinity to examine how men's relative under-utilisation of medical services, as negative health behaviour, can be influenced by the social construction of masculine identities. Interviews discussing the help seeking attitudes and behaviours of seven older rural men used a short movie clip and hypothetical scenarios as stimulants to discussion. The transcribed data was analysed using discursive analysis techniques, which resulted in the identification of three interpretative repertoires labelled: 'The Medical', 'The Natural Body', and 'Health Behaviours'. Many men faced a dilemma between identifying as a regular health care user, a morally virtuous position for all individuals, and identifying as an infrequent user of health care services, a virtuous position for men. They solved this dilemma by using the health behaviours repertoire to position women as the frequent and trivial users of health care whilst using the medical repertoire to position themselves as the legitimate users of health care. Furthermore, a number of respondents used the medical and natural body repertoires to construct a powerful masculine identity in relation to men that do not seek help and in relation to doctors. By using the three repertoires in this way these men could maintain a masculine identity whilst identifying as a regular and virtuous user of healthcare services. These results highlight the existence and complexity of multiple masculine identities and, in doing so, challenge theories that consistently polarise masculinity and help seeking health behaviours. These results therefore support hegemonic masculinity as a theory for examining the construction and maintenance of gendered identities.



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## Introduction: Health Care Utilisation

An abundance of medical research has demonstrated that seeking medical help early in a disease process, can lead to a greater chance of survival, a less intensive treatment regimen, and a reduction in cost to the public health system (Dracup, McKinley, & Moser, 1997; Taplin et al., 1995). For example, the incidence of cancer is one well-publicised example whereby the chance of survival is often directly proportional to the speed with which the cancer is identified and treated. According to the United States Cancer Society (USCS), the five-year survival rate for patients presenting with stage one breast cancer is approximately 99%, yet if the cancer remains undetected and metastasises, (stage three), the survival rate drops to 14% over the same time period (USCS, 2005a). Testicular cancer, the most common cancer among 18 to 35 year old males, is one of the most rapidly dividing and aggressive of all cancers (USCS, 2004). Nevertheless, when a patient presents at an early stage, they can expect a five-year survival rate of 99% and a treatment regimen restricted to orchidectomy and light radiation therapy of the localised lymph nodes. However, if presentation is delayed, as it often is, and the cancer develops to an advanced stage, heavy doses of chemotherapy are also required, and the five-year survival rate drops to 74% (USCS, 2005b). The benefits of seeking help early are by no means restricted to recovery from cancer. An early diagnosis of diabetes can prevent organ damage and the onset of chronic disease with similar outcomes in many other areas ranging from heart disease and meningitis to sexually transmitted diseases (Gerstein & Meltzer, 1999; Leslie, Urie, Hooper, & Morrison, 2000; Ward, Mertens, & Tomas, 1997). Although the evidence in favour of seeking medical help early is striking, research indicates that many people will delay going to see their doctor, and more specifically, that men tend to delay more and visit their doctor less often than women.

Numerous population based (Boros, Grajczjar, Szeles, & Vitrai, 2000; Ladwig, Marten-Mittag, Formanek, & Dammann, 2000; Mustard, Kaufert, Kozyrskyj, & Mayer, 1998; United Kingdom General Household Survey [UKGHS], 2003), Longitudinal, (Green & Pope, 1999) and smaller scale studies of health care utilisation (Bertakis, Azari, Helms, Callahan, & Robbins, 2000; Briscoe, 1987) have indicated that men of many different cultures in the western world tend to delay

visiting their General Practitioner (GP) for longer and use their services less often than women. The most prominent evidence is often found in larger scale surveys where, in some cases, women between the ages of 16 and 44 had almost twice as many medical consultations per year than men. For example, results from the UKGHS (2003) indicated that women in this age group had visited their GP approximately five times per year whereas men averaged just three. In a further large-scale survey based on a Hungarian population, approximately 65% of women aged 18-34 were found to have had visited a GP at least once in the last 12 months compared to 58% of males. In the 35-64 age group, approximately 78% of women had been at least once in the last year compared to only 65% of men (Boros et al., 2000). Green and Pope (1999) found that when factors such as age, education, and social class were controlled for, gender remained an independent predictor of health care utilisation. Furthermore, these differences remained significant even when sex specific utilisation, such as cervical screenings, mammograms, and pregnancy related consultations were taken into account. They found that the predictive capacity of gender for health care utilisation increased as respondents grew older, accounting for between four and ten percent of the variance explained by their model. Finally, in a study performed almost 20 years ago, Briscoe (1987) found that even with sex specific factors taken out of the model, women consulted a doctor almost twice as often as men (3.8 versus 2.0 visits per year respectively). In explanation, Briscoe stated, "women are more predisposed to consult, especially with vague symptoms or for reassurance, perhaps because they are more interested in health matters and more aware of day to day fluctuations about which they seek reassurance from their Doctor." (Briscoe, 1987, p. 511)

Results like these support a widely held assumption that men are less likely than women to seek help. However, a growing number of exceptions have indicated that the relationship between gender and help seeking is more complex than once thought (Fernandez, Schiaffino, Rajmil, Badia, & Segura, 1999; Macintyre, Hunt, & Sweeting, 1996; New Zealand Ministry of Health [NZMOH], 1997; Settertobulte & Kolip, 1997; Wyke, Hunt, & Ford, 1998). For example, a recent NZMOH survey (1997) initially showed that women were significantly more likely to seek help than men. However, when sex specific reasons for seeking help were taken out of the model, the sex differences in utilisation disappeared. For example, women aged 15-

34 were approximately ten percent more likely than men to have visited a GP once in the previous year and slightly over ten percent more likely to visit their doctor more than six times over that same time period. Yet, when these sex specific factors were controlled for, women were found to be slightly *less* likely than men to visit their doctor for short or long-term conditions, routine check ups, and immunisation. Furthermore, men were found to be twice as likely as women to seek help for injuries or poisonings (NZMOH, 1997). As a further example, Wyke et al. (1998) presented a checklist to participants who were required to indicate which symptoms they had experienced in the last month and whether or not they had consulted their GP in regard to that symptom. Although they found that women reported significantly more symptoms than men, when only those who had reported at least one symptom in the past month were included in the analysis, they found no sex differences in health care utilisation. In a large scale, cross sectional study, Fernandez et al. (1999) found that although Catalanian women reported a lower level of self perceived health than men, they were only slightly more likely to have sought medical help once in the previous two weeks. Finally, in a study of adolescent boys and girls, (Settertobulte & Kolip, 1997) found no gender differences in consultation rates for seven of the eight medical conditions they identified. Furthermore, when the boys and girls reported similar symptom severity any differences in help seeking between the sexes also disappeared.

In summary, these studies highlight the ambiguities and inconsistencies in traditional or reductionist health care utilisation research. Addis and Mahalik (2003) suggest that these inconsistencies are least partially due to the theoretically misguided categorisation of men and women into two homogenous and mutually exclusive groups. More specifically, they argue that because this type of research categorises men and women in this way, it is unable to adequately explain why certain men visit their doctor more often than others, why some groups of women may be reluctant to seek help, or why the same individual will visit their GP in some circumstances but not in others. Although a great deal of research has identified significant differences in utilisation rates between men and women, the growing body of exceptions to these findings suggests that an alternative approach to studying help seeking behaviours is warranted. One avenue that can begin to explain these variations is an analysis of individuals' gendered beliefs, which examines how *social influences*,

rather than innate or biological differences, can constrain beliefs about how men and women should behave.

### *Gender and Health*

Bohan (1993) argues that the behaviours deemed to be masculine or feminine are socially constructed *gender roles* that are agreed upon, maintained and/or reformulated by men and women in a historically situated context. Thus, it is not the sex of the individual that define behaviours as masculine or feminine but the situational context in which the behaviours are performed (Bohan, 1993).

Traditionally masculine behaviours are perhaps most succinctly defined by Brannon's (1976) conception of the learned male sex role. Brannon identifies four dimensions of traditional masculinity: 'No Sissy Stuff' marking a stigma against anything feminine; 'The Big Wheel' denoting the need for success and high status; 'The Sturdy Oak' which encompasses toughness, confidence, and self reliance; and 'Give Em Hell' which refers to aggressiveness, violence, and daring.

West and Zimmerman (1987) contend that gender is best conceived as an achievement rather than what one possesses; it is something that one does in order to maintain one's competence as worthy member of society. When a young man at a bar boasts to his friends about his capacity for alcohol, he is 'doing' masculinity by promoting or maintaining his status as a 'lad' in that particular context. However, to maintain overall competency as a man, he must behave in a way that is both consistent with the behaviours deemed appropriate to his sex category and appropriate to the current point in time and place (Hart, 1996). For example, boasting about one's alcohol consumption will only display competence when it is undertaken in the appropriate context. Other situations will require different ways of doing masculinity such as displays of physical strength and agility during sporting activities or emotional stoicism when coping with personal problems (Courtenay, 2000a).

Bohan (1993) contends that the actual process of gender role construction is highly circular in nature because the 'doing' of one's gender 'correctly' reinforces and legitimises the 'gendering' of that particular situation as either masculine or



feminine. Thus, the more that groups of men (and women) emphasise the importance of, for example, lack of emotion and invulnerability in men, the more these become considered masculine qualities. The result of this process is a divergence between the genders where appropriate masculine behaviours are created in direct *opposition* to what are considered to be appropriate feminine behaviours (Bohan, 1993).

Day's (2001) research provides a good example of how gendered identities are constructed in opposition. She found that although many of the respondents stated that their city had very low crime rates, most constructed female residents as fearful of public spaces, especially at night. Day identified the formation of two masculine identities: the 'badass man', which was characterised by accounts of their bravery and toughness (or lack of) and the 'chivalrous man', which emphasised the importance of providing protection for 'damsels in distress'. Day (2001) argues that although accounts of bad-ass masculinity were seen to be performed primarily for men, the respondents emphasised the importance of not 'frightening women' with these displays. She therefore argues that traditional gender constructions of women as fearful reinforce men's identities as strong and brave. Finally, the chivalrous male identity, found to be performed primarily for the benefit of women, was used by these men in an effort to avoid appearing too unmanly to be regarded as 'protection'. In such cases, men adopted chivalrous identities as protection against 'bad men', whom they constructed as a major reason for women's vulnerability. Thus, Day suggests that these men constructed masculine identities based on strength and invulnerability in opposition to the fearful and vulnerable identities they constructed for women.

### *Health Care Utilisation as Doing Gender*

Gender based theories posit that health care practices are aspects of gendered practices so that the 'doing' of health reflects the 'doing' of gender (Saltonstall, 1993). Thus, variations in help seeking behaviour amongst men are attributed to the level at which individuals endorse particular ways of being masculine or the practices of, for example, the 'real man' that Brannon (1976) identified. As a further illustration of this point, Courtenay (2000b, p. 10) argues that in order for a man to do masculinity he must "be relatively unconcerned about his health and well-being

in general and would place little value on health knowledge. He would see himself as stronger, both physically and emotionally, than most women.” Therefore, according to gender and health theories, the failure to seek medical help originates from the belief that real men do not ask for help and do not need to go to the doctor as this denotes vulnerability or weakness, concepts believed to be feminine in nature (Addis & Mahalik, 2003; Courtenay, 2000a, 2000b). From a social constructionist perspective Courtenay (2000a) argues that men and women are not simply victims of socialisation but are active agents in constructing and reconstructing dominant forms of their respective genders. In other words, as well as learning to adopt behaviours that demonstrate their respective genders, the undertaking of gendered behaviours actively reinforces and at times reconstructs specific behaviours as masculine or feminine.

The influence of gender roles on men’s help seeking behaviours have been well documented to date and suggest that many men have delayed seeking medical attention because ‘real men’ do not ask for help. A growing body of research is now examining not only the influence of gendered beliefs on help seeking attitudes and behaviours (Cameron & Bernardes, 1998; Chapple & Ziebland, 2002; O’Brien, Hunt, & Hart, 2005; White & Johnson, 2000) but also how health professionals’ constructions of their male and female patients can further reinforce this popular belief (Pitman, 1999; Seymour-Smith, Wetherell, & Phoenix, 2002; Tudiver & Talbot, 1999).

#### *Patients’ accounts.*

In a study of men suffering from benign prostatic hyperplasia and prostatitis, Cameron and Bernardes (1998) identified a number of themes that highlighted the gendered nature of men’s health problems. Firstly, they found that many of the participants constructed general health concerns as women’s business and responsibility. This was exemplified by one respondent that was proud of how his wife ‘took charge’ of his health related needs including the making of appointments and ensuring that he attended them. In addition, this finding was further supported by a general lack of knowledge of men’s health and a need to keep quiet about their health related problems. One man in his 80’s had decided not to tell his wife of 60 years about his prostate problems, opting instead to suffer in silence. Finally,

Cameron and Bernardes found that the potential loss of sexual functioning was also a major threat to each man's masculine identity, which they argue to be a key reason why these men refrained from recognising the disease and seeking help.

Nevertheless, it is equally important to note the exceptions as not all of the participants held the same beliefs. Cultural ideals about appropriate masculine behaviours did not always disadvantage these men in regard to their health. In a number of cases some actually drew on metaphors of masculinity and war as a resource in dealing with their health problems by gathering enormous amounts of information about their illness to 'fight' the disorder (Cameron & Bernades, 1998).

In a further study examining men's experience of prostate cancer, Chapple and Ziebland (2002) found that many men were reluctant to consult a doctor for their problems due to a belief that 'boys don't cry'. A number of respondents also argued that women found it easier to consult a doctor than men as they were more used to seeking help for their children, pregnancy and menstrual problems. Similar results were found in a group of 25 men admitted to hospital with acute chest pain (White & Johnson, 2000). They found that virtually all the respondents had ignored their symptoms or considered them to be a minor concern and delayed seeking help as a result. For example, one participant had delayed seeking help for three months and had neglected to tell his wife about his symptoms out of a fear that she may think he was a 'wimp'. White and Johnson argue that these men went through a self-justification and self-surveillance process to make sense of their symptoms and to assess their performance against their own perceptions of how the 'real man' should behave. The result was an inability to conceive themselves as at risk to a heart attack, coupled with a fear of losing their social status through the transition from a well and productive body to the sick body.

In a further study, O'Brien et al. (2005) found that certain groups of men actually *emphasised* how little they went to the doctor. They also found that these men endorsed a masculine identity based on the ability to endure illness whilst implying that women are the 'weaker' sex. However, not all of the participants endorsed the same ideals. For example, a group of firemen actually highlighted the *importance* of seeking help early for medical problems by citing the fact that illness may affect their ability to stay fit and work. O'Brien et al. argue that these firemen were able to



reject what they considered to be 'old school mentality' because their own masculine identities were based on having a strong and healthy body not on rejecting the need for help. In this sense, their positive health seeking attitudes actually functioned as a way of protecting their own sense of masculinity as opposed to threatening it. For example, they gave accounts of sharing their health concerns with their colleagues, a stark contrast with traditional beliefs that men do not talk about their problems. For these firemen, the power of the masculine body and their status in a highly 'masculinised' occupation to all intents and purposes rendered them exempt from needing to maintain their masculinity, as many of the other men did, through negative health behaviours or the reluctance to seek help (O'Brien et al., 2005).

Robertson (2003) illustrated how respondents faced a dilemma between demonstrating they don't care about health, as is culturally appropriate for men, and showing that they should care about their health, as the good moral citizen should. Robertson argues that contemporary health carries a moral burden on individuals to identify as a 'good citizen' by regularly visiting their doctor and consequently, 'staying healthy'. This was reflected in the respondents' accounts of 'settling down' after getting married and having children. For example, because these men had undertaken new responsibilities such as providing for their families, many stated that they had left their 'wild days' of negative health behaviours, such as heavy drinking and smoking, behind them. These same connotations of health and morality have been widely acknowledged in research to date (Blaxter, 1997; Crawford, 1994; Crossley, 2003) and suggests that good health can ultimately represent a 'good person': one who is responsible, moral, and virtuous. For example, Crawford (1994, p. 1347) argues that good health is associated so strongly with moral virtue that "the pursuit of health is actually the pursuit of moral personhood." Indeed, Crossley (2003) found that although many of her respondents constructed themselves as individuals resistant to cultural norms of health, unhealthy behaviours such as excessive smoking and drinking had come to represent a lack of control or irresponsibility.

In summary these studies represent the accounts of both 'well men' and those that have faced illnesses that could damage or potentially damage their masculine identities. Culturally idealised forms of masculinity may have prevented many men

from either seeking help early or identifying as regular help seekers in an interview context. However, previous research has shown that moral connotations of the 'good citizen' can also impinge on the ways people make sense of health and identify as being healthy. In other words, although men are often seen as reluctant to seek help, there is also a social pressure on all people to be and identify as 'healthy'.

*Health professionals' accounts.*

Research has shown that, in addition to the general public, many health professionals reinforce the belief that men are reluctant to seek help in the way they construct their male and female patients. For example, Tudiver and Talbott (1999) identified a number of broad themes regarding men's help seeking behaviour through focus groups comprised of family physicians. They found that the majority of the physicians agreed that men seek help less often than women. These physicians also stated that their male patients were encouraged by their spouse to seek help and that their spouse was often present during the consultation. Men were constructed as having a higher pain threshold than women and this was reflected in a belief that when men did go to the doctor it was for a specific, tangible, or valid complaint. In contrast, they suggested that women sought help for more general complaints or complete check ups. In regard to this point, the physicians stated that their male patients felt that seeking help was not acceptable behaviour for men and that they should not be interested in health promotion and ill-health prevention.

As part of the Women, Health, and Development Program of the Pan American Health Organization, Pittman (1999) conducted a number of interviews with 27 male and female Argentinean diabetes patients and compared them to the focus group accounts of 18 health care workers of the same nationality. Pittman found that several physicians suggested many women sought health care when there was no real need. Of note, these statements corresponded to the accounts of their female clients, who were often concerned that their doctors were not validating their problems. Furthermore, the health providers stated that this was 'normal' because 'men work' and do not like to reveal their illnesses. Again, these statements corresponded with the male patients accounts, many of whom considered that health clinics were primarily for the benefit of women and children. The correspondence between the physician and patient accounts was a central finding for Pittman's

study. More specifically, she found that the opinions and beliefs of the physicians were more similar to the views of the male clients than the females. For example, she found that women's reasons for seeking help were constructed by both physicians and male patients to be 'irritating' and sometimes 'ridiculous' (Pittman, 1999).

Finally, in a study of nurses and GPs, Seymour-Smith et al. (2002) identified three interpretative repertoires the health professionals drew upon when constructing accounts of their male patients. These repertoires constructed men and women as dichotomous but relational groups, indicating what is considered to be common sense or what health professionals 'know' about male and female patients. They found that the health professionals drew repeatedly on discursive resources that positioned women as health conscious and responsible (and men as not), men as unemotional, and men again as the serious users of health services. Most importantly, they identified a common pattern that illustrated how the doctors and nurses simultaneously criticised the ideals of traditional masculinity for its part in men's lack of help seeking behaviour but also valorised or celebrated it at the same time. This could be seen in the way that women's problems were constructed as more trivial compared to men and how men's reluctance to visit the doctor was often considered amusing or even entertaining. They suggest that, "because masculinity is culturally hegemonic, already positively constructed in relation to femininity, many of the things that men do which are constructed as negative also retain an ambivalently positive flavour" (Seymour-Smith et al., 2002, p. 264).

In summary, the gendered health beliefs of male patients, health care professionals and the public in general effectively define, construct, and reinforce strongly held stereotypes that differentiate health care utilisation for men and women. These stereotypes construct women as the *over users* of health care services and men as the *serious* users. The result is reluctance by men to seek medical attention as seeking help is stereotypically considered feminine behaviour. From the three studies examining health professionals accounts, one can begin to visualise an unequal power relationship between men and women whereby male stubbornness and stoicism is tolerated yet women's 'weaknesses' are not (Seymour-Smith et al., 2002). These authors argue that this reflects how dominant forms of masculinity are

performed and the “continuing over-valuation of masculinity relative to femininity” (Seymour-Smith et al., 2002, p. 263).

### *Men and Hegemonic Masculinity*

The power imbalances that exist between men and women are a central tenet to Connell’s theory of hegemonic masculinity (Connell, 1995). Connell also constructs masculinity and femininity as relational concepts but he goes beyond the examination of gender roles to encompass aspects such as *power*, *multiple masculinities* and masculinity as an *embodied gender project*.

#### *Power.*

Firstly, hegemonic masculinity is described as, “the configuration of gender practice which embodies the currently accepted answer to the problem of the legitimacy of patriarchy, which guarantees (or is taken to guarantee) the dominant position of men and the subordination of women” (Connell, 1995, p. 77). From this definition one can see that hegemonic masculinity is not a stable trait or reachable goal per se, but a historically embedded way of being masculine that justifies men’s power over women. However, Connell also contends that when social conditions change and the dominance of a particular masculinity is diminished, “new groups may challenge old solutions and construct a new hegemony” (Connell, 1995, p. 77). In perhaps a more explicit explanation, Donaldson (1993, p.645) suggests that hegemonic masculinity is

a culturally idealized form, it is both a personal and collective project, and is the common sense about breadwinning and manhood. It is exclusive, anxiety-provoking, internally and hierarchically differentiated, brutal and violent. It is pseudo-natural, tough, contradictory, crisis prone, rich and socially constrained...it concerns the dread of and the flight from women.

In regard to the construction and maintenance of gendered identities, Connell (1995) states that hegemonic masculinity or the ideals of the ‘real man’ can impinge on the way men can identify as masculine. For example, although many men may

undertake behaviours traditionally seen as feminine such as cooking, cleaning, and child rearing, they may still consider it important or feel compelled to identify as the provider for and protector of their wife and children. Therefore, although very few men can embody all the currently accepted qualities attributed to hegemonic masculinity, many still endorse a number of its principles and reap the rewards from the 'patriarchal dividend' or men's dominance over women. (Donaldson, 1993; Connell, 1995). Although this has been a point of criticism to date (see Wetherell & Edley, 1999) it provides the basis for one of Connell's major contributions in this area: the existence of multiple masculinities.

### *Multiple masculinities.*

Connell (1995) claims that hegemonic ideals not only generate power over women but power over less dominant groups of men. For example, Connell suggests that gay masculinities are subordinated masculinities in that their power as a group is diminished by more powerful heterosexual masculine identities. Connell argues that is evidenced by the political, cultural, economic, legal, and religious discrimination that homosexual men experience at the hands of heterosexual males. Thus, he claims that there is no single masculinity as such, but a multitude of different masculinities bound in a power relationship. These power dynamics have been identified between many different groups of men based on race, sexual orientation, and class, each with their own unique masculinities but marginalized or subordinated by current hegemonic ideals (Connell, 1995).

In terms of health care, the evidence of power dynamics between different groups of men can be found in the discourses of prostate and testicular cancer survivors and the way they reconstruct alternative masculine identities following surgery-induced impotency (Chapple & Ziebland, 2002; Gascoigne, Mason, & Roberts, 1999; Gray, Fitch, Fergus, Mykhalovskiy, & Church, 2002; Oliffe, 2005). For example, Oliffe (2005) found that although the prostate cancer survivors he interviewed endorsed hegemonic prescriptions of sex as erection, penetration, and climax, they found new ways to redefine their masculine sexual identity by focusing instead on shared interests, physical touch, and intimacy. Nevertheless, the lengths these men went to in an attempt to regain an erection indicates the power that hegemonic ideals of a functional penis and hyper sex drive have over less dominant, impotent, and

consequently marginalized masculinities (Oliffe, 2005). A similar theme arose for a group of testicular cancer survivors whilst describing the reasons why they delayed seeking help (Gascoigne et al., 1999). For these men the fear of being marginalized to a group that appeared “not up to scratch” or being seen as “less of a man” to their wives played a significant role in the delay of seeking help (Gascoigne et al., 1999, p. 149). As a final illustration, Gray et al. (2002) found that although a number of prostate cancer survivors, did not consider their impotence as an attack on their masculinity, all of them tried hard to hide their impotency, incontinence, and other cancer related problems from the men in their lives. These authors argue that this is a reflection of men’s competitive nature and the loss of power and control that admitting vulnerability to other men would ensure. Thus, power differentials between different groups of men do not simply reflect the loss or potential loss of sexuality but encompasses other aspects such as admissions of vulnerability and appearing ‘weak’ in front of other men and women in their lives (Gray et al., 2002).

*Embodied gender projects – body reflexive practices.*

Connell (1995) is highly critical of both biological based and gender roles theories. He argues that in order to examine gender effectively, one must focus on the subjective experience of the body and the embodiment of masculinity. Gender is not a social practice reduced to the body nor is it a neutral landscape ready to be socialised. Instead, gender is envisaged as an ongoing project or a “social practice that constantly refers to bodies and what bodies do” (Connell, 1995, p. 71). He suggests that while the biological approach ignores the importance of social life, the social approach has ignored the fact that we are embodied, thus reinforcing a dualistic division between body and self. Connell argues for an understanding of practice in terms of reflexive embodiment. In other words, our physical selves are constructive and ‘agentic’. Men are embodied with particular physical characteristics and physically based experiences and desires. These embodied experiences are shaped by our reflexive sense of ourselves in relation to others. Our behaviours and practices and the ways in which we include or respond to our embodied experiences are an integral part of our social lives (Personal communications, C. Stephens, 2005).



### *Criticisms of Hegemonic Masculinity.*

Although the concept of hegemonic masculinity has been used extensively in previous research, it is not without its critics. A growing body of literature now argues against the relevance of hegemonic masculinity for contemporary males or even the utility of the concept for examining masculine identities (Demetriou, 2001; Jefferson, 2002; Wetherell & Edley, 1999). For example, Wetherell and Edley (1999) argue that because few men can embody all the ideals of hegemonic masculinity and because these ideals are themselves unclear, the value of the concept as a definition or tool for analysing masculinities is questionable. They contend that the concept is insufficient to understand the complexities of a negotiating a masculine identity, as it is difficult to comprehend what hegemonic masculinity looks like in practice (Wetherell & Edley, 1999).

In addition, Wetherell and Edley (1999) argue that it is unclear whether there is a single hegemonic masculinity as such, or whether hegemonic strategies can vary according to time and place. Jefferson (2002) builds on this argument by claiming that Connell's (1995) theory and its relational approach to gender suggests that there are multiple, context-specific strategies yet, Connell uses the term 'hegemonic masculinity' to denote a single dominant way of being masculine. Furthermore, Phoenix and Frosh (2001) state that, in current research, it is rare for hegemonic masculinity to be conceived in a unitary way. Thus, in order to remain useful as an analytical tool, these authors claim that hegemonic masculinity must be recognised as plural or multifaceted and in a constant state of change. Yet, regardless of these criticisms, Connell's theory of hegemonic masculinity has been used in a multitude of gender based research ranging from men's health (Courtenay, 2000a, 2000b; Gray et al., 2002) to the construction of masculine identities for men 'online' and for men who do 'women's work' (Kendall, 2000; Lupton, 2000).

Throughout this review I have argued that the methodologies used in traditional health psychology are ill equipped to explain the complexities of health care utilisation due to the assumption that 'men' and 'women' are two homogenous and mutually exclusive groups (Addis & Mahalik, 2003). I have then described how research that examines gendered beliefs may be able to account for the variations in

men and women's help seeking behaviours that realist epistemologies cannot. In making this argument, I suggest that the use of social constructionist methodologies may provide a richer understanding of health care utilisation including the ways people 'construct' or make sense of gender and the appropriate ways that men and women should 'do health'. Connell's (1995) 'hegemonic masculinity' is one such theory that promotes a relativist approach to studying gender, and it has been drawn upon frequently in health-based research. Connell's theory is different to traditional, reductionist approaches in that it considers gender to be an ongoing project rather than the possession of fixed qualities or traits. It takes into account both the ways gender is constructed in society and one's own experiences with their body. Furthermore, Connell places an emphasis on the power dynamics that exist not only between men and women but also between different groups of men.

This study aims to determine whether the criticisms made against hegemonic masculinity are warranted in this particular context. Or in other words, to examine whether hegemonic masculinity is relevant for contemporary men and whether it is a useful theory for understanding the ways men construct masculine identities. To achieve this aim, I will identify and describe the interpretative repertoires these men drew upon and illustrate how they used these repertoires to construct health and health care utilisation whilst maintaining a gendered identity.



## Methods

### *Methodology*

One assumption of mainstream or realist health psychology is that meaning resides within the object and is waiting to be discovered by 'objective observers'. In this sense language is assumed to reflect what individuals 'believe', 'perceive', or 'think' about the object under study. However this assumption has been criticised in recent times with regard to the status of knowledge or truth and who can hold such information. From a social constructionist standpoint, Burr (2003) argues that, rather than objective truth, knowledge reflects the currently acceptable way of understanding the world, a status determined by social processes and interaction. In other words, people form understandings, make objects meaningful, or construct reality, between each other. Furthermore, the categories and concepts people use to currently understand the world are historically and culturally specific. Thus, what is considered to be knowledge depends on one's place in time and the beliefs and attitudes of their culture. In this sense Burr suggests that there can be no single 'truth' waiting to be discovered but a multitude of different understandings and ways of 'knowing' the world that are created, maintained and reconstructed in interaction.

Language provides the categories and concepts people use to construct objects or to understand their environments. Consequently, the way people use language to make objects meaningful has been widely studied in psychological research (Burr, 2003). For example, many authors have argued for the utilisation of relativist epistemologies in the study of gender (Addis & Mahalik, 2003; Courtenay, 2000a, 2000b; Petersen, 2003). Discourse analysis is a commonly used methodology for studying the way people use language to 'make sense' of objects such as health and work, and to negotiate masculine and feminine identities. According to Wetherell and Potter (1988) discourse analysis involves the development of specific hypotheses that indicate the purposes and consequences of language. They state that because discourse is orientated towards different functions, the way people use discourse will vary based on what they are doing or trying, consciously or unconsciously, to achieve in their discursive acts. Although discourses vary according to their function there are commonalities in these variations. These

variations are characterised by linguistic patterns and metaphors, which they label as *interpretative repertoires* (Potter & Wetherell, 1987; Wetherell & Potter, 1988). It is these interpretative repertoires or discursive resources that respondents draw upon to make sense of or construct objects such as 'health' and 'health care'.

### *Respondents*

The respondents were a convenience sample of seven late-mid-aged men drawn from a community situated in Central Otago, New Zealand. Of these seven men, six were long-term farmers and one was working outside the industry. Five out of the seven men were personal acquaintances of the researcher, a former resident of the community under study. All the respondents were given pseudonyms to protect their identity and any of their talk that could potentially identify them was removed from the analysis.

Although this study makes no claims of generalisation, it will identify and examine the seldom-studied masculine identities of rural men. Much of the research to date that examines masculinity has focused on the identities of young urban males, and as a result a great deal of theorising on help seeking behaviour is based on *urban masculinities*. Therefore this study will identify and examine alternative masculine identities and to illustrate how this may impact on the help seeking attitudes for these seven men.

### *Procedures*

Details of the study were peer reviewed by Massey University staff and no ethical considerations were raised, thus approval was not sought from the Massey University Ethics Committee. Information sheets containing the broad aims of the study, the researchers contact details, and an invitation to ask any questions were attached to and sent out with the local school newsletter to 124 households (see Appendix A). Approximately one month later, the full details of the study (Appendix B) and a formal invitation to participate (Appendix C) were sent out to those same households via the local rural mail delivery service. Within this invitation potential respondents were given the option to receive a summary of the results and were

encouraged to ask any further questions regarding the study. The respondents that replied to the invitation were then contacted by phone and arrangements for interview dates and times were made. Each individual or 'one on one' interview took place at the each respondent's home. Copies of the transcriptions were returned to the respondents who then had the option of either taking no action or adding or deleting text as they saw fit (see Appendix D). The respondents were not required to return the transcripts and no changes to the transcripts were made. Before the semi-structured interview began (see Appendix E for the interview protocol), information about the study was repeated and the respondents' rights were discussed. The respondents were encouraged to ask any further questions and informed consent forms (Appendix F) were signed.

At the beginning of each interview a laptop computer was used to present approximately ten minutes of video clips compiled from a movie titled "Something's Gotta Give". The short segments were compiled using Massey University equipment in line with current copy write laws. Each 25-45 minute interview was recorded on an Olympus digital voice recorder, backed up onto a Massey University laptop computer. In this movie, Jack Nicholson plays the part of 'Harry', a successful, suave, 63-year-old businessman who has spent a happy life as a bachelor. Harry is weekendending with his young girlfriend when they unintentionally meet up with her mother and Aunt at their holiday home. Throughout this weekend, Harry experiences the warning signs of a heart attack but chooses to ignore the symptoms instead of seeking medical attention. Eventually he experiences a heart attack. This movie clip served two important purposes: To set the context for the rest of the interview and to provide a character that the participants could relate to (or not), thus stimulating further discussion.

The respondents were initially asked describe Harry's character and to discuss the possible reasons why he ignored his symptoms. In the second part of the interview I described two hypothetical health scenarios to each respondent. The first scenario involved a man with stomach problems called 'Pat' and the second scenario introduced 'Doug', a man that had found blood in his urine. They were asked if they would go to the doctor in each situation and to explain their response. They were also asked to describe the reasons why each man would not go to the doctor and the

role the man's wife may play in this type of situation. The third part of the interview involved a discussion about a former resident of the Ida Valley community that had recently died of pneumonia. The respondents were asked to give their own version of what had happened to this man leading up to his death including their own thoughts on why he had not sought medical attention earlier. Finally, they were asked to describe a time in their life when they had not been to the doctor, despite experiencing symptoms that they knew should have been checked out. In addition to these predetermined questions, many respondents spontaneously raised issues about their own medical experiences. I encouraged these discussions and they often explained how their own experiences might relate to the topics that were discussed throughout the interview. Their experiences often became the focal point of our discussion and in these cases the structure of the interview was adjusted accordingly. Each interview concluded with a full debriefing of the study and any further questions were answered.

The transcribing of the interviews proceeded in line with the recommendations of Potter and Wetherall (1987) (see Appendix G: Notes on transcription). They argue that for the majority of research, the exact details of timing and intonation are not necessary and can actually make it more difficult for the reader to disseminate. For this reason details such as increases or decreases in voice intonation were not identified and any pauses during our conversation were rounded to the nearest second. The completed transcriptions were then coded using the software programme "Atlas Ti". This involved the reading and rereading the transcripts to identify and categorise specific speech units based on commonalities, themes or patterns of talk. This enabled the researcher to produce a number of broad, "manageable chunks" of data for ease of further analysis (Potter & Wetherell, 1987, p. 167). For example, all references to 'the Body' were categorised together as were all references to 'partner or wife', 'medical knowledge', 'the doctor', and their own 'health experiences'. All references to concepts such as 'masculinity', 'morality', and 'faith in medicine' were also identified.

The data was analysed using discursive analysis techniques as described by Potter and Wetherell (1987). Firstly, the Coded data was reread a number of times in order to determine the *function* of the men's language or what they were doing with their

talk. This was achieved by carefully examining the data to identify and categorise any *variations* or *contradictions* in the men's accounts of health seeking attitudes and behaviours. For example, the types of language or linguistic units that the respondents used to construct their own help seeking behaviours was found to be different to the language they used to describe the help seeking behaviours of other men. The previously identified codes were then imposed manually onto these variations in the discourse as an aid for the researcher to identify the types of language respondents were using. For example, I found that the language the respondents used to describe their own health behaviours was specific to medicine, whilst the references they made to *other* men's help seeking were characterised by language that differentiated 'doing health' for men and women. With the aid of the coded data, these patterns were then analysed to identify the different types of linguistic units and metaphors within the discourses that these men drew on to construct their own and other men's help seeking behaviours and attitudes. Finally a period of hypothesising was undertaken to determine the function of these variations, or what these men were achieving by constructing their own and other men's health in different ways. As a result of this process, three dominant interpretive repertoires were identified: 'Health Behaviours', 'Medical', and the 'Natural Body'.

Although this procedure appears straight forward, the actual process of identifying and determining the functionality of these three repertoires required constant 're-hypothesising' throughout the process to account for the inevitable 'exceptions' that arose in the respondents' discourses. Furthermore, although these men drew on a range of discursive resources the three interpretative repertoires I have identified represent the most dominant of these.

## Results and Discussion

In this section I will firstly discuss the social context of the interview and the influence it may have had on how these men could identify as health care users. With the social context of the interview in mind, I will then identify and describe the three interpretative repertoires these men drew upon to construct their accounts of health care utilisation. To describe these repertoires I will firstly explain what each 'does' or how it constructs objects. I will then identify the metaphors and linguistic units that characterise each repertoire and the subject positions they give rise to. From within each subject position I will provide discursive evidence from the interviews to illustrate how respondents used the repertoire, or how the repertoires function in the interview context. Finally, I will discuss how the findings from previous research relate to the interpretative repertoires I have identified. The interpretative repertoires are labelled 'Medical', 'Natural Body', and 'Health Behaviours.'

### *The Social Context of the Interview*

Identifying and analysing the social context of any situation enables the researcher to determine how specific circumstances can influence the way participants are positioned, how they construct objects, and to help discover the functionality of the variations in their accounts (Addis & Mahalik, 2003; Lee & Owens, 2002; Yoder & Kahn, 2003). The term 'social context' refers to any constituent in an individual's social environment that can either constrain or generate behaviour (Yoder & Kahn, 2003). I have identified three characteristics in this study that together created a unique context from which the respondents could provide accounts of their help seeking attitudes and behaviours. Although the characteristics I have identified are not an exhaustive list, I suggest that the social context they created constrained how these men could identify as health care users. These characteristics were the respondents' own knowledge they brought to the interview, the type of information that was provided in the invitation to participate, and my own involvement throughout the interview.



Firstly, the knowledge that these men possessed clearly indicated they were aware of the issues surrounding men and help seeking before the interview began, which is not surprising considering the increase in publicity that men's health is receiving. For example, before we had started the interview formally Warren stated:

Warren: So I mean this is probably why men don't or won't or don't always run off to a doctor straight away because (mmm) who can help you? What can they help you with? What's wrong?"

This statement indicates that Warren had brought his own preconceptions about men and going to the doctor to the interview and that he was not reluctant to express his opinions on this matter. Jacob was another man that was aware of the issues, as indicated in the passage below:

Jack: Um, (3) at this stage I am sure you can guess that we are sort of looking at the reasons why men=

Jacob: =Yes, I, I know what you are about (yeah) and its all to do with the thing that's on top of the shoulders (mmm) um, and the male ego I think to a larger degree.

Statements like these were common to all the interviews and strongly suggest that the respondents were aware of the issues surrounding masculinity and health care utilisation before the interview.

The second identifiable characteristic, the information that was provided in the invitation to participate, effectively reaffirmed the participants' own knowledge about men's health. In fact, the invitation itself inadvertently and openly implied that men are bad patients and that this is a problem that needs to be solved:

"As part of my course, I have been looking at the rather unfortunate health status of men in our society and this is particularly the case for rural men. One of the issues that comes up often is the fact that, for a number of reasons, men tend to not go at all (or) delay going to their doctor when they have a medical problem."

Finally, my own participation in each conversation can be seen to influence the social context of the interview. Any interviewer is subject to certain social requirements of that particular situation, thus my role as interviewer or the 'potential saviour' of the men's health crisis strongly influenced how I could construct myself and respond to each participant. This is evidenced by my openness in explaining the problematic nature of men's reluctance to seek help and in reinforcing the instances when the respondents stated that they would go to the doctor for help:

Jack: I am sure you can gather by now we are talking about men and them sort of not being inclined to go to the doctor when they should.

And:

Jack: So, would you stop and go to the doctor, if you were in his situation and your experiencing pains like that?

Phil: I would.

Jack: Yeah?

Phil: I would.

Jack: *No, that's good* (emphasis added).

And finally:

Brian: No I don't think, I think heart pains I would take pretty seriously (yep) whether it was outside or inside and most probably anybody that was around you would pack you off to the doctor [laughs] before you could yeah, pronto anyway yeah.

Jack: *Sure, sure no that's good* (emphasis added).

As mentioned above, there is a moral pressure on all individuals to be 'good, healthy citizens' and, as a result, ill health is often constructed as a mark of irresponsibility and individual moral failure (Blaxter, 1997; Crawford, 1994; Crossley, 2003). Therefore, it is likely that the invitation to participate, the respondents' prior awareness, and my own utterances essentially reinforced the moral pressure placed on all people to identify as 'healthy'. In other words, it was likely that the social context of the interview influenced the way these men could identify as health care users, to the extent that each had very little choice but identify as virtuous and moral citizens that sought help regularly. But rather than posing a problem for the analysis,



the social context provides a framework for understanding the contradictions and variations in participant accounts as a potential dilemma between the moral position as a regular help seeker and a masculine position, which according to theory, rejects the need for help.

### *The Medical Interpretative Repertoire*

The medical interpretative repertoire is a widely available and powerful discursive resource often drawn on by individuals when making sense of their health. Linked directly to scientific discourse, the medical repertoire constructs the human body as a machine. For example the human heart is often construed as a 'pump', exercise is concerned with 'biomechanics' and 'improving oxygen intake', Bodies are 'maintained', and food is the 'fuel' for the body (Gray et al., 2002; Saltonstall, 1993). The medical repertoire firstly constructed the respondents as knowledgeable 'lay experts' of matters related to health and medicine. For example, many respondents drew on the medical repertoire to position themselves as experts of health and medicine and in some cases to challenge the status of doctors as 'medical professionals'. A number of respondents also used the medical repertoire to construct their health behaviours as 'legitimate' or warranted by providing a medical rationale for both their help seeking delays and for the times when they had sought help.

The respondents use of the medical interpretative repertoire was characterised by a number of descriptors including "diagnosis", "symptoms", "signals", "second opinion", "precautions", "observation", "system", "warning", and the frequent use of disease labels such as "septicaemia" and "peritonitis." Respondents used these descriptors to construct health and health care from two subject positions: The 'lay expert' and the 'legitimate user' of health care, each of which will be described in detail below.

#### *The lay expert.*

The lay expert is one that possesses 'lay knowledge' specific to his or her own medical problems or of medicine in general. Although this knowledge is often discredited and considered inferior to that of the medical professional, it can allow

the lay expert more leverage during medical consultations in regard to options such as their treatment regime (Beisecker, 1990). Respondents often used the medical repertoire from this position to construct themselves as knowledgeable of health related matters including their own particular medical problems. For example, in the following passage Kelvin uses the medical repertoire to construct an account of peritonitis that illustrates his medical knowledge of disease processes, despite stating that he is not a doctor:

Kelvin: Peritonitis or something wasn't it at the finish? But (1) but that is (1), was bought about by delay really. Peritonitis can, I'm no doctor but, appendicitis can become peritonitis too and obviously pneumonia (1) can as well. But you know, they were talking, he was three or four days in bed or something.

In the following passage, Brian draws on the medical repertoire, using terminology specific to medicine such as 'septicaemia' and 'blood poisoning' to describe why the man that had died of pneumonia had not sought medical help earlier:

Jack: I wondered if we could talk a little bit about [the deceased resident] (mmm) and what lead up to his passing away (yeah). Um did you hear about what happened sort of leading up to that?

Brian: Well just that he had the flu and he um (2) yeah he didn't, didn't actually go to the doctor and then the flu must have just suddenly developed into septicaemia type thing and when you that there's no way back (mmm). Your blood's poisoned isn't it? Its a blood poisoning. Yes I think that's what it was that finished him.

Andy used medical terms such as 'observation' and 'pills' to show that although he does not know the name of the drug used for treating pneumonia, he does have an understanding of how long the drugs need to be taken in order to be effective:

Andy: If he'd got some help, (1) even if it had only been a week's supply of pills, and that isn't enough as it takes a fortnight. Even if he'd only got those, at least he would have been under observation and the doctor would have listened to his chest.

Whilst many respondents drew on the medical repertoire to position themselves as lay experts, some went further to openly challenge the capabilities of their doctor and the decisions they had made. Therefore, I argue that the relationships between these men and doctors in general are, in this context, embedded in issues of *power* and *status*. For example, in the following excerpt Warren uses the medical repertoire to explain that some doctors specialise in specific fields but GPs have to deal with a wide array of medical problems. He argues that because GPs deal with such a wide array of problems they often make mistakes:

Warren: Doctors, GPs are only (2) you know, general practitioners over a wide area (mmm). People make professions over a wide area: dealing solely with the eye, ear nose and throat (sure), whatever it might be, and you know, specialise in specific fields. So doctors (GP) have a difficult job, they are a Jack-of-all-trades.

Jack: They are not infallible?

Warren: And they don't get it right half the time anyway, Well those are my thoughts.

Previous research has also identified power imbalances in the doctor-patient relationship and has shown how patients have empowered themselves by gaining medical knowledge about their illnesses. For example, Ziebland et al. (2004) found that the Internet was a commonly used source of information for cancer sufferers seeking information about their illness. They argue that many of their respondents had used the Internet to covertly check up on their doctors' responses and to display a measure of expertise with relevant medical and experiential knowledge. Cameron and Bernades (1998) found similar results in men diagnosed with prostate cancer. In this case many men had become proactive in gaining information from a range of sources including the results from new drug trials. Of note, they found that many of the men believed they had more knowledge of their disease than their GP and that their specialists had generally not welcomed their lay expertise. In this sense the traditional doctor-patient relationship, characterised by the powerful, 'expert' doctor and the submissive 'lay patient', is under negotiation. Cameron and Bernades argue that the desire for knowledge displayed in these studies is a reflection of traditional masculine assertiveness. The results from the current study support this argument as I suggest that by displaying their knowledge of medicine the respondents were, in this particular context, constructing a powerful masculine identity for themselves.

*The legitimate user of health care.*

The 'legitimate-user' of health care is one who will willingly use health care services but only when they have a genuine, valid, or legitimate condition. The legitimate-user does not seek help for 'trivial' problems or problems that will 'cure themselves' without medical intervention. From this subject position respondents used the medical repertoire to construct themselves as the legitimate or valid users of health care services. Thus, when respondents provided accounts of their positive help seeking behaviours they did so in a way that indicated their problem was genuine and that they were not wasting the doctor's time or public funds. For example, in the following passage Warren positions himself as a legitimate-user by constructing his stomach pains as an established or diagnosable medical condition. He argues that while many people think they have a stomach ulcer most actually do not but in his case he *did* have an ulcer diagnosed and consequently his problem becomes 'genuine':

Warren: You know most of the people who complain of having or who they suspect of having the stomach ulcer or who suspects they have an ulcer and most of them don't have one... I went in and they gave me something to relieve the stomach ulcer I think (1) and I later had an ulcer diagnosed.

In the excerpt below, Howard uses the medical repertoire to provide an account of going to the doctor for more than one reason to, in effect, make the consultation worthwhile. By constructing his health account in this way the relatively minor illness can be checked by the doctor under the pretext of a more 'serious' lung examination. Finally, he also legitimises the need for a lung examination and x-ray by stating that his lungs had been a problem in the past:

Howard: I've been a couple of times, um these last few years seem to have bought on those coughing bugs quite a lot, so I thought "oh well, it's a good opportunity to get your lungs looked at". And um, so I've had an x-ray once umm, [ ] Yeah, well two or three years ago a problem and that's when they took the x-ray and they said no it's still just that viral thing (ah Ok yep).

Later in the interview, Howard positions himself in the same way by indicating that, although he has gone to the doctor for the same symptoms we were discussing, he

had not sought help until he believed that it was warranted. In other words, his problem becomes legitimate and worthy of a doctors visit only when it is of concern to him:

Jack: Um, if you were in his, not his exact situation, like if you were experiencing the same sort of pains, how would you explain that to yourself do you think?

Howard: Um, oh it would be a worry. I have had similar things and I have, so I followed it through. So but only when I've got to the stage, you know, that it was worrying, then I went and sorted it out.

As a final illustration, Brian used the medical repertoire to provide a rationale for not seeking help regarding an ongoing problem he had been experiencing. For two reasons his talk constructs his health problem as not yet serious enough to warrant further attention. Firstly he can predict what medications his doctor will prescribe and secondly his talk suggests that this particular drug will not sufficiently help his condition:

Jack: Any other reasons why you chose not to go?

Brian: Ah, well I think, I think he'll just probably say "well just some more of those Voltaren pills" or something like that (mmm). (2) and um (2) at some stage the [problem will need attention]. But how bad it is before they do that.

Previous research (Clark & Gong, 2000; Pollock, Grime, & Mechanic, 2002) has shown that the fear of wasting a doctor's time is a major reason why both men and women may delay seeking medical help for their symptoms. Studies like these indicate that although one is under social pressure to remain healthy (Crawford, 1994; Crossley, 2003), one is also required not to waste the doctor's time and public funds with trivial problems. As Pollock et al. (2002) point out, this is most evident in collectivist health schemes such as England's National Health Service. They found that participants, who had experienced moderate depression, held an internalised belief that each consultation should take less than ten minutes regardless of the medical problem. These patients also believed that professional help should be sought only for extreme and genuine need. Indeed, many participants worried when their consultations took longer than they expected with many patients voicing concerns about wasting the doctor's time and leaving consultations with unasked

questions. Previous research along with the results from the current study suggest that the need to have a legitimate problem so one is not 'wasting the doctor's time' is an important factor in a decision to seek medical attention.

### *The Natural Body Interpretative Repertoire*

The natural body is one that thrives best when unpolluted by drugs or medicines and is capable of healing itself. Constructions of the natural body often conflict with powerful medical models of the mechanical body: the body that can be 'repaired' by medical science. However, in the current study this was not always the case as some men drew on the natural body and medical repertoires together to validate their health behaviours as genuine and, on occasion, to construct themselves as experts of both medicine and their own bodies. Although the two repertoires appear to function in a similar way, there is a critical distinction between the two. The medical repertoire legitimates health behaviours and constructs men as experts through the use of discourses related to science, medicine and biomechanics. The natural body repertoire also constructs men as experts but is based on their subjective embodied experiences including the experiences they have had with their body healing itself without medical intervention.

Respondents use of the natural body repertoire was characterised by commonly used descriptors such as "It'll come right", "pass through the system", "you know your body", "magic period", "It'll go away", and "let the body recover." The natural body repertoire gave rise to a single subject position, the 'embodied self', which will be described below.

### *The embodied self.*

The embodied self is an individual who is subjectively aware of their body with regard to how it functions and its ability to heal itself without medical interventions. One's previous bodily experiences therefore position the individual, not their doctor, as an expert of their body. From the embodied self position, many respondents used the natural body repertoire to argue that the body should be given a chance to heal itself first before seeking medical attention. For example, in the following passage Andy provides an account of the 'magic period', which he constructs as the period



of time in which the body can recover without medical intervention. However, once this period of time has passed with no improvement, he indicates that it would then require attention:

Jack: Um, do you think he should go to see a doctor?

Andy: Four or five days? Well the magic period is a week but yes I think I would if I happened to be going to town. But certainly at the end of the week I would.

....

Jack: Do you think you could expand on that [magic period] a little bit for me?

Andy: Well it applies to so many things, um, for instance wind, like that if it persists for a week then its serious, if its not wind, is something else, it might go away (yeah) but if it comes back you'd go. For instance, if you are taking painkillers and it persists for a week then you'd go. Yes (1) it applies to a lot, um, (2) you hurt your ankle or get kicked by a cow, whatever, and it's getting easier well that's OK. But if it's not getting easier and the weeks gone by then you go. Yes it is a sort of a magic period.

In the example above, Andy has used the natural body repertoire to construct 'stomach cramps' as either genuinely in need of medical attention or something that is not serious and will go away on its own. Like many other men, Andy's talk suggests that he knows when his body can fix itself and when it cannot as he 'knows his body'. As a further example of this, below Brian states that he knows when he needs to go to the doctor because he is aware of how his body feels when medical attention is needed:

Jack: Um, so this is just getting off the subject a little bit, but what symptoms do you personally think should be checked out by a doctor and which ones do you think shouldn't? Well not shouldn't but aren't quite so serious.

Brian: Quite so serious. Oh, (1) anything (3) I think you know yourself, you know, how you feel and if you, you know. When it gets to a stage where you just feel that you need to go I think (mmm).

Furthermore, Brian uses the descriptor 'it'll come right' from the natural body repertoire to argue that if the problem is not serious the body will repair itself. But again, Brian constructs the failure of the body to heal itself as an indication that medical help is necessary:

Brian: You tend to think: It'll come right, it'll come right...but when you see the red line go up your arm, you think well maybe its time to go (laughs).

As a final example, Howard draws on the natural body repertoire to argue that he would not seek help for stomach problems straight away because from his own experiences, symptoms such as gastritis can be experienced for four or five days before the body can heal itself. In this context, Howard's talk positions him as an expert of his own body or someone that knows when the body is incapable of fixing itself and therefore knows when it needs medical attention:

Jack: He's 50 plus years old and he's been experiencing stomach pains for four to five days (yeah). Um, do you think he should go to see the doctor?

Howard: (Laughs) If I put myself in his place I probably wouldn't, if they haven't got any worse. four to five days I, if it were longer than that I would, but it wouldn't have to be much longer than that (yeah). In my experience after four to five days if you've got some gastro or some sort of pain then it might take long to, to go (yeah). But if was five, six, seven days then I would go to the doctor.

Howard then uses the natural body repertoire to further strengthen his position as an expert of his body. His talk rejects medical science by resisting the unnaturalness of medication and constructing his body as a complex entity that must be given a chance to heal itself. Yet, as a good moral citizen should, Howard indicates that he would seek help if his body had not recovered itself:

Howard: S:::o um I resist taking anti-biotics and letting my body recover if it can, but, but if it drags on then I'll certainly go (mmm).

Jack: So would it be fair to say that you, for you, you tend to let your body have a go first to see if it can fix the problem=

Howard: =yeah.

Jack: And then if it can't=

Howard: =Yeah. I'm off, I'd go yeah. Which, isn't very often because you know, your body is pretty amazing. It does take care of those things (mmm) yeah (got you).

Previous research has shown that natural body discourses are often used in opposition to highly pervasive and powerful biomedical discourses. For example,



Lawton (2003) argues that lay perceptions of a healthy and natural body can potentially obstruct health promotion messages. Furthermore, Popay and Williams (1996) state that the difference between expert and lay knowledge of health is a widely established 'barrier' to good health in general. In other words, biomedical discourses construct lay perceptions of the natural body as inferior and a nuisance for more legitimate and powerful medical knowledge. Many studies have identified and examined the power that medical models have over natural understandings of the body, including understandings of contraception and menopause (Keogh, 2005; Lyons & Griffin, 2003). In a study of emergency contraceptive use by women, Keogh (2005) found that at least half of the respondents they interviewed resisted the daily use of a contraceptive pill due to its unnatural side effects such as interference with one's hormone levels and ovulation cycles. Yet, the health care professionals they interviewed used a medical discourse to construct the knowledge that these women had as 'bad knowledge'. When these health care workers drew on medical discourse to counteract and discredit patients' natural views of their body, they did so from the position of 'medical expert', both of medicine and women's bodies. As is the case in many health situations, the power of medicine and the medical discourse dominated lay perspectives of the natural body.

Lyons and Griffin (2003), in an examination of 'self help' texts for women experiencing menopause, identified five major discourses that constructed and polarised menopause as either a 'disease' or a 'natural' event in a woman's life. They found that all of the texts used the disease or medical discourse to construct menopausal 'patients' as 'deficient in oestrogen'. In contrast, three of the texts also constructed menopause as a natural part of a woman's life and therefore, no different from the changes experienced during puberty. Lyons and Griffin suggest that, to deal with this contradiction, the three texts drew on a third discourse: 'menopause as confusing'. The contradiction between natural and medical discourse was solved by frequent reference to menopause as inherently confusing and uncertain to both women and doctors. Women's bodies themselves were constructed as confusing, which further reinforces the belief that women are not experts of their own bodies. Lyons and Griffin therefore argue that this process both explicitly and implicitly gives health professionals expert status over women's bodies, which along with the polarisation of natural and medical discourse, does little to help women understand

changes related to menopause. The same issues of power that Keogh (2005) and Lyons and Griffin (2003) have identified between natural and biomedical accounts of health were also evident in the current study as men used the natural body repertoire construct themselves, rather than doctors, as experts of their bodies. For example, although these respondents stated that a doctor should check out certain symptoms, many implied that they knew when this was or was not necessary. Their talk therefore suggests that their own extensive subjective experiences with their body may play an important role in a decision to seek medical help.

### *The Health Behaviours Interpretative Repertoire*

The Health Behaviours Repertoire (HBR) constructs health care for men and women in different and opposing ways. It provides individuals with a discursive tool for discriminating between dominant masculine and feminine ways of 'doing health'. For example, the HBR constructs men as invulnerable to illness, stoic, and generally uninterested in matters related to health. Yet, in contrast, the HBR constructs women as the frequent users of health care, as responsible for family health matters, and constructs women's bodies as 'weaker' than men's bodies.

Respondents' use of the HBR was characterised by a number of descriptors that they used to provide a rationale for both men's help seeking delays and for women's willingness to seek help. For example, they used descriptors such as "macho", "get over it", "bullet-proof", "hard nosed", and "stubborn" when describing men's negative help seeking behaviours and "they like to go", "more together", "they wouldn't put up with the pain", "they talk about their problems" and "she'd pack you off" to describe women's positive help seeking behaviours. The HBR therefore provides two subject positions: The 'frequent-user' of health care, which is characterised as a feminine subject position, and the 'seldom user' of health care, which is characterised as a masculine position.

#### *The frequent-user of health care - a feminine subject position.*

The 'frequent-user' of health care services typically takes responsibility for the health of her immediate family including the health concerns of her husband. When a family member has a health problem, she is the first person they approach and she

determines whether the problem warrants a visit to the doctor. The frequent-user visits the doctor habitually and often for reasons that could be considered trivial in nature. She openly discusses her problems with her friends and is widely involved in preventative health including immunisation and screening for disease.

Many of the respondents drew on the HBR to position women as frequent-users of health care by constructing them as responsible for their husbands' health concerns. For example, many men suggested that, in a married couple, it was the wife's role to determine if their husband's problem was serious enough to warrant medical attention. In the following passage, Kelvin's account of Pat's wife indicates that she would make the decision for Pat to go to the doctor. Indeed, he constructs Pat's wife as possessing enough knowledge of health to be able to provide a second opinion, which he argues would be the catalyst for Pat to seek help:

Jack: Um, what would you see like yourself or Pats, how would you see their wife's role as far as like health goes?

Kelvin: Well they, yeah, well they probably (1), they'd make the decision for him. (2) I think its hard to say (2). Probably he might be thinking "I wonder if I should go to the doctor" (yeah) and a second opinion from her or somebody else, yeah "I think you should."

Jack: Ah I see, like a justification? =

Kelvin: =Yeah.

Jack: Oh okay.

Kelvin: Yeah, you're more um, yeah (2) "do you think I should go?" sort of thing (mmm) and she would say "yeah" and that would be the (2) thing that would probably get him to the doctor (got you) yeah.

Other men suggested that it is their wife that sends them to the doctor. For example, Warren uses the HBR to construct his wife as his confidant and manager of his health concerns:

Jack: Yeah so my next question was going to be, would you stop and go to the doctor if you experienced chest pains like that but you sort of answered that one really.

Warren: Well, yeah I probably would (2) no I would confide in my partner [name] I suppose and she would rush you off to the doctor pretty quickly probably.

Later in the interview Brian also uses the HBR to construct women's bodies as more complex and problematic than men's bodies and therefore, more in need of medical attention:

Jack: Now, if, at this stage Pat's been a man, what if Pat were a woman? Do you think (1) she would go to the doctor any earlier, than a man?

Brian: Um, Probably their stomach, or their stomach area is more complex, they do have other things that go wrong in their stomachs don't they? Maybe they would, yeah.

As a further illustration, Howard draws on the HBR to position women as frequent-users by pointing out that women are more willing than men to discuss both their medical and general worries with another person:

Jack: Do you think that she, Pat as a woman, would be more likely to talk to someone else about it?

Howard: Yeah Probably.

Jack: And why do you think that would be the case?

Howard: Yeah, I am not too sure why, but, you know, those difference are often pointed out between men and women, their willingness to share those inner or worries.

In the passage below, Warren indicates that his wife talks about her problems with her friends and that they are often going to the doctor to get medications:

Warren: If they've got a problem they share it with, with a lady friend or I don't know why it is but they talk about their problems to one another in a big way. I know my wife does and she has friends and they all talk about their problems, difficulties and (1) what they are doing about it. And you know they're invariably going to doctors and having treatment.

As a final illustration, Andy suggests that women go to the doctor more often than men because men's psyches prevent them from seeking help:

Jack: This is an interesting one, up until this point we said, well we've said that Pat is a man. What if pat was a woman, do you think she would go see a doctor?=  
=

Andy: =More likely, much more likely.

Jack. Why would that be do you think?

Andy: They don't have problems with their psyche like males do. Um (1) even if she lived on her own she would talk to her niece or her sisters or somebody, (2) from my experience that is. (3) They, yeah, do:::n't seem to have any hang-ups about discussing (1) things like that.

The pervasiveness of the frequent-user position has been widely identified and acknowledged in both qualitative and quantitative research (Lyons & Griffin, 2003; Lyons & Willott, 1999; Norcross, Ramirez, & Palinkas, 1996). For example, in a study examining patients' reasons for consulting a GP, Norcross, Ramirez, and Palinkas (1996) found that married men were twice as likely as married women to identify 'encouragement from the opposite sex' as the reason why they had seen their doctor (39.5% and 18.5% respectively). Although other conclusions are possible, Norcross et al. suggest that these findings are indicative of the wife's role as the manager of their family's health. Consequently, they argue that health promotion campaigns aimed at improving men's health in particular should be directed at women. Although they did not draw the same conclusions, Lyons and Willcott (1999) found related results in an analysis of media representations of men's health where health issues and concerns were constructed as women's affairs. Women were positioned as 'naturally' concerned about health whereas men were not. Thus, the media's health promotion messages for men's health were targeted at the women in their lives or that women should be responsible for the health of their husband and family. One way this was achieved was through media constructions that portrayed men as infantile. Lyons and Willott argue that the texts constructed men as infantile, unrealistic, and ignorant thus requiring special care and handling, from their wife, to improve their health. Although the men in the current study did not construct themselves as infants that need help, the same themes of 'health managers', 'responsible wives', and frequent visits to the doctor were still applied to the women in their own lives and the lives of other men.

*The seldom-user of health care - a masculine subject position.*

The 'seldom-user' of health care refrains from showing pain. He is invulnerable and typically disassociates with anything considered feminine or homosexual in nature

including health in general and staying healthy. In this sense, the seldom-user is disinterested in and has little knowledge of health and medicine.

Because the respondents could have interpreted the social context of the interview as a critical examination of their health behaviours, it was perhaps not surprising that each rejected taking up the seldom-user position. Instead, respondents used the HBR to position *other men*, those that do not seek help, as seldom-users. For example, in the following excerpt Kelvin provides an account of the reasons why a recently deceased resident of the community had not sought help for his illness. In this excerpt he draws on the HBR, using the descriptors “hard nosed” and “I’ll get over it” to position the former resident as a seldom-user of health care:

Kelvin: Oh well, that he [the former resident] was obviously bloody sick (mmm) and nobody realized how sick he was but he (1), like I knew [the former resident] pretty well, he was probably the hard nosed fulla, you know “I’ll get over it, couple of (2) disprins or whatever they are and I’ll come right”.

In the following passage Phil draws on the HBR to construct Harry’s negative health behaviours as a consequence of ‘machoism’. When queried about what his own response would be in the same situation, Phil, like many others, constructed his own health behaviours as positive, rejecting the uptake of the seldom-user position in the process:

Jack: So do you think it was sensible response? To um [ignore the problem]

Phil: No I think he’s got a problem and I think he’s got to face up to it.

Jack: So why do you think he acted in that way?

Phil: I think he just didn’t want to um, (2) let himself down in front of the female company.

Jack: So what do you, what do you personally think his chest and shoulder pains mean? What would be your explanation if say you had the same symptoms yourself? What would you think it would be?

Phil: I would be looking at a heart, a heart trouble and I’d be going to see, do something about it (mmm).

As a final illustration, Brian has just been asked why he thought Harry had ignored his symptoms. In response he uses the HBR to position Harry as a seldom-user



whose admission of suffering from a medical problem would hinder his ability to 'be with the girls'. Yet his talk suggests that, if in the same position, this would be a serious problem for him:

- Jack: So why do you think he acted the way he did? The way he ignored his symptoms and just passed it on, why do you think he did that?
- Brian: Probably because he well, (2) he didn't want it to be happening right then and he was probably um (2) thought he was still young enough and good looking enough to be with girls and yeah, I don't know about his health history but he wasn't keen, (1) you sort of put things off don't you? (yep)
- Jack: How you would respond and how, how would you see it? Like would you see it as a major problem or would you see it as something not too much to be concerned about.
- Brian: Oh no, if it were me I'd be, if it were me I'd be quite concerned if I thought it was a heart problem or something serious because I mean if you heart plays up it generally gives a warning and um (2) you hope that it will give a warning before it stops or something drastic happens.

Men's resistance to what have been identified as dominant masculine attitudes towards health have been identified in previous studies of hegemonic masculinity (Wetherell & Edley, 1999) and masculinity in men's health (Robertson, 2003). For example, Robertson (2003) found that although his respondents believed that most men did not care about their health, they were also resistant to this masculine image, claiming instead that as an individual one should be more responsible for their health. Robertson found that most men solved this potential dilemma by making a distinction between health and illness. For example, many men openly discussed the times they sought help for injuries or illness yet resisted the need for preventative health care by citing it as a waste of the doctor's time (Robertson, 2003). Results from these and the current study show how some men, although resistant to certain forms of masculinity that have been identified as dominant in previous research, are still negotiating other ways of being masculine.

## Masculine Identities

In the following three sections I argue that the way these men constructed their own health behaviours and the health behaviours of others, were influenced by ideals of hegemonic masculinity both in terms of the rejection of femininity and power over other groups of men.

In the first section I describe how these men faced a dilemma between identifying as a regular and moral user of health care whilst still maintaining a masculine identity. In solving this dilemma, I argue that these men were compelled by culturally idealised or hegemonic forms of masculinity to construct their health behaviours as 'not feminine'. In the second section I propose that men's uptake of the 'lay expert' and 'embodied self' positions are context-dependent ways of doing hegemonic masculinity. I will show how many of the respondents constructed a powerful identity for themselves by firstly using the HBR to construct men that do not seek help as ignorant and powerless whilst, secondly, using the medical and natural body repertoires to challenge the status of doctors as medical experts. Finally, I present a single case study, which follows my discussion with 'Jacob' throughout our interview. This section provides further support to the arguments I have made to this point, but also demonstrates how the interpretative repertoires, and the subject positions they offer, do not function in isolation.

### *Hegemonic Masculinity and the Flight From Feminism*

Connell (1995) argues that at the core of hegemonic masculinity is the rejection of anything considered feminine in nature. This includes health in general and health behaviours such as regular check ups, screening and prevention in particular (Courtenay, 2000a). In support of this argument, previous research (Cameron & Bernardes, 1998; Chapple & Ziebland, 2002; Gray et al., 2002; O'Brien et al., 2005; White & Johnson, 2000) has shown that many men have delayed seeking medical attention out of fear of appearing feminine or 'weak' and that many people including health professionals believe this to be part of 'human nature' (Pitman, 1999; Seymour-Smith et al., 2002; Tudiver & Talbot, 1999). In this section I describe how the ideals of hegemonic masculinity have created a dilemma for these men as they

provide accounts of their help seeking behaviours. I will then discuss how they used the interpretative repertoires to solve this problem.

Many of the respondents faced a dilemma between identifying as a seldom-user of health care, as is culturally appropriate for men, and identifying as a regular help seeker, a moral, virtuous position for all members of society. This dilemma arose because to identify as a man who is willing to seek help risked damaging their masculine identity because the 'help seeker' position is one they had constructed for women. Yet, to admit that one does not seek medical help risks being positioned as an immoral member of our society or one that does not take responsibility for their health. I argue that many of the respondents solved this dilemma by drawing on the medical repertoire to position themselves as *legitimate-users* of health care, whilst using the HBR to position women as the 'trivial' or 'frequent-users' of health care. By positioning themselves in this way, the respondents were effectively identifying as regular and moral users of health care whilst constructing their own positive health behaviours as 'not feminine' but serious or legitimate in nature.

Throughout this section, I argue that these men were compelled by culturally idealised (Donaldson, 1993) or hegemonic forms of masculinity to construct their own positive health behaviours as legitimate, warranted, and masculine in *opposition* to trivial, unnecessary, or feminine reasons for seeking help. I will firstly discuss how Brian's and my own use of laughter effectively constructed men's negative health behaviours as acceptable. I will then demonstrate how Kelvin used the HBR to maintain a masculine identity whilst identifying as a regular user of health care services. As a final illustration, I will describe how Warren negotiated between the negative health behaviours he associates with dominant forms of masculinity and his own positive help seeking strategies.

In the excerpt below, Brian provides an account of why the men we had discussed in the interview may delay seeking help. When he admits himself that he disregards his symptoms, he is positioned by the HBR as a seldom-user. However this is dilemmatic for him, as he had previously rejected this position earlier in the interview as evidenced by the way he humorously attributes his delays to inconvenience. I argue that Brian's use of laughter effectively solved this dilemma

for him because it reconstructs his negative health behaviours as 'acceptable' for the typical man:

- Jack: What factors, and this is for Pat or Doug, or Harry even, what do you think would, could potentially prevent them from going to the doctor?
- Brian: Oh, too busy, yeah like the guy in the film, yeah its inconvenient, disregard it for as long as you can (yep) we probably all do that a bit {laughs} when you get desperate you go...And I know I should go (mmm) yeah, but its inconvenient.
- Both: (laughter).

The same discursive patterns arose at the end of the interview when Brian was asked to describe a time in his life where he had delayed seeking help. He returns to the same issue of inconvenience and our laughter again suggests that this is normal for men:

- Jack: Can you think of a time in your life when you put off going to the doctor (1) when you really know that you should have? And this can be a sports injury or anything, is there anything that jumps to mind? (laughs) That you'd like to share at all?
- Both: (laughter)
- Jack: Lucky [the respondents wife] isn't here perhaps?
- Brian: (3) Oh yeah, um, yeah well I've got a [medical condition] and I've been putting it off and um, as its turned out there was a shed full of sheep to crutch and [person's name] yeah an I thought I would get in and give him a hand but its not very good for me. And I know I should go [to the doctor].
- Jack: Mmm yeah.
- Brian: But it's inconvenient (laughs).

My own comments and our use of laughter continues to construct negative health behaviours as somehow acceptable for men, which suggests that at some level both he and I 'knew' that this is what typical men do and is 'expected' and 'acceptable'. Seymour-Smith *et al.* (2002) argue that this reflects the dominance of certain ways of being masculine and the overvaluation of masculine, stoic health practices relative to women's frequent and trivial use of health care. Because masculinity is the dominant gender and positively constructed relative to femininity, many of men's negative health behaviours are still regarded in a positive light (Seymour-Smith *et*

*al.*, 2002). Therefore I suggest that although Brian previously rejected the seldom-user position, ideals of stoicism and being able to ‘fight through the pain’, still impinged on the way he could construct his own health accounts and consequently how he identified as a man in this particular context.

In the excerpt below, the consequences of going to the doctor without a legitimate medical problem becomes apparent for Kelvin as his talk reflects on appearing ‘silly’ in front of his doctor, a high status male:

Kelvin: I think I would feel silly if I went to the doctor thinking (1) I was dying and he told me I only had the flu. I'd think I'd just wasted his time.

Of note, Kelvin used the HBR in a later passage to position women as the frequent-users of health care by suggesting that nobody likes going to the doctor except for elderly women. My own laughter and comments also further reinforced Kelvin’s positioning of women in this way:

Kelvin: But its (1) yeah, I don't think anyone likes going to the doctor, well some people.

Jack: (laughs)

Kelvin: Old ladies do.

Jack: A bit lonely?

Kelvin: (laughs) yeah.

Jack: No it's not something you look forward to obviously.

Although Kelvin, with my assistance, rejected the seldom-user position by identifying as a regular help seeker earlier in the interview, he equally rejects the alternative, feminine position taken up by elderly women who he constructs as frequent and trivial users of health care.

Hall (1996) points out that identities, including gender identities, are constructed through difference or the relation to the ‘other’. Thus in order to determine what one is, one must also determine what one is not. With this in mind, I suggest that the respondents used the repertoires in this way to construct and maintain a masculine identity in opposition to a feminine identity. For example, while Kelvin does not take up the masculine or seldom user position, his talk indicates that his identity as a

man hinges on not appearing feminine, or 'old lady' like, especially in front of his doctor, a high status male. Thus, the hegemonic nature of dominant masculine ideals, namely to reject anything deemed feminine, impinged on the way he could construct himself as a regular health care user whilst still maintaining a masculine identity. Just as the men in Day's (2001) study constructed their bravery in opposition to women's fear of public spaces, many respondents maintained a masculine identity by constructing their health accounts as 'legitimate' in *opposition* to the 'trivial' reasons they identify with femininity.

As a final illustration of this argument, Warren takes up three different subject positions to ultimately identify as a regular and legitimate health care user. Warren initially draws on the HBR to position himself as a seldom-user of health care. However, the way Warren laughs to himself suggests that this particular position is equally problematic for him and he immediately goes on to construct himself as a help seeker for 'everything in general'. However, this is a position that he had previously constructed for women and again his laughter suggests that this position is also problematic for him. He solves this dilemma by repositioning himself as a legitimate-user, one that *does not* seek help for everything but goes when it is necessary:

Jack: That pretty much answers my next question actually=

Warren: =So I am not really in a position to know because, you know, I don't know how I would react (2). You know I'd be probably a typical male guy [chuckles to self] and not too ready to run off to doctors. But you know, I attend my doctor reasonably regularly, not for anything in particular but for everything in general basically [laughs]=

Jack: =sure, yeah.

Warren: I don't go running to the doctor for everything, but, I'll go see her now and again.

In this particular context, Warren has effectively maintained a masculine identity by reconstructing his health behaviours as 'not feminine' in nature. It is at this point that Warren, as indicated in a previous example, provides a rhetorical account of his stomach ulcer and past help seeking behaviours to further validate his position as the legitimate-user of health care.



In summary, the way these men constructed their positive health behaviours as 'not feminine' reflects the hegemonic nature that dominant forms of masculinity have over the way men can identify as health care users whilst maintaining a masculine identity. For example, although many men rejected the seldom-user position, a position they had constructed for men, they still orientated their accounts away from what they constructed as feminine health behaviours. Just as those identified in previous research (Cameron & Bernardes, 1998; Chapple & Ziebland, 2002; White & Johnson, 2000) were compelled by hegemonic ideals to not appear weak or effeminate in front of their wife or male colleagues, I suggest that the respondents in the current study were compelled to identify as 'not feminine' because to do otherwise would likely damage their masculine identities and their status as men. Although hegemonic masculinity has been described as a 'slippery notion' (Wetherell & Edley, 1999), the discursive evidence from this study suggests that as a concept, hegemonic masculinity is a valuable tool for examining the 'fine grained' and detailed construction of masculine identities in opposition to feminine identities. Therefore, I suggest that Wetherell & Edley's criticisms regarding the need to examine specific hegemonic traits are not relevant in this context as this study has identified and described the fine-grained ways that these men constructed and maintained a masculine identity *without* defining hegemonic traits.

### *Strategies for 'Doing' Hegemonic Masculinity*

As mentioned above, previous authors have argued that in order to understand the influence that social context can have on the way men can identify as masculine, one must conceptualise hegemonic masculinity in its plural form (Jefferson, 2002; Wetherell & Edley, 1999). They suggest that because the strategies considered dominant at any point in time are determined by factors including age, socio-economic status, and social context, the strategies for doing masculinity will be hegemonic in certain situations but not in others and for certain groups of men but not all groups. The results from this study support this argument. For example, by positioning themselves as lay experts of health, these men have constructed a powerful masculine identity for themselves in relation to other men, those they construct as *ignorant* of health concerns and reliant on their wives for help.

Furthermore, the results illustrate how these men used the medical and natural body repertoires to construct a powerful masculine identity by positioning themselves, not doctors, as the experts of their bodies. The following section will therefore detail how the respondents' displays of medical knowledge and their subjective experiences with their bodies together function as different strategies for 'doing' hegemonic masculinity, firstly, in relation to other men and secondly, in relation to doctors.

*Powerful identities and other men.*

In the passage below, Andy uses the HBR to construct other men, the seldom-users of health care, as ignorant of medical issues and scared or fearful as a result. From the position of lay expert, he claims that most people think that chest pains are simply heartburn rather than a signal of a heart attack. Yet he implies that if it were to happen to him, he would not make that same mistake:

- Jack: So, why in that situation, you've pretty much answered it through the way, but just to get it down, why do you think Doug or Pat would put off going to the doctor? For a long time, for a week or so, like if you had blood in your urine.
- Andy: I can't imagine why (laughs) but fear I would imagine, I would think their primary cause would be fear. Not necessarily brought on by knowledge, it can be brought on by ignorance. Could be either.
- Jack: So do you think that was a reasonable response, to sort of ignore the=
- Andy: =Oh I gather, not really, but I gather that's what happens. I gather that's what people do, (1) um ignore it. Um, to be fair though to some people I think that they think its indigestion probably because it can be hard for an unprofessional person to pick the difference between the two.

Later in the interview he provides an account of dealing with acquaintances who have experienced similar chest problems and have ignored the problem. He illustrates how he has had to take a friend to the hospital in such a case. The important point to note is that Andy uses the medical repertoire to construct other people, but primarily men in this example, as ignorant of this particular health concern. The way he uses the repertoire suggests that he does not belong to this group of seldom-users as it is *other* men who believe that their chest pains are simply heartburn and *he* has to take *them* to the doctor:

Andy: Seen it among friends and react pretty much the way he did (yeah) You've just got to pick them up and drag them=

Jack: Is that right?

Andy: You've got to get 'em there.

Jack: Have you had to do that before?

Andy: Yeah.

As a further example Warren draws on the medical repertoire to construct or make sense of the recent advancements in medical science. In this instance Warren's talk resonates with terminology specific to medicine as he constructs the human body as a machine that can be 'repaired' with modern surgery techniques and 'maintained' by more efficient disease screening programmes:

Warren: So you know, while we've got some advancement in medicines these days (1), we've got scans and you know, things that can, pop things up, down your neck, in your veins. Place stacks=

Jack: =Or whatever=

Warren: =In your arteries and things like this. That's a lot more, you know, things are a lot more advanced these days, they can do a lot more things without open surgery (1). We w::e can detect things a lot better today than we could 20 years ago.

Warren's talk suggests that he is the holder of this knowledge and he uses it to position himself as a lay expert of medicine, one who *knows* about stacks, open surgery, and medical advancements. Soon afterwards, Warren goes on to argue that men's health is in crisis. To form this argument Warren uses the HBR to position men that do not seek help as ignorant seldom-users and as victims of a traditional masculinity he relates to his own generation. From here he proceeds to draw on the medical repertoire to construct the status of men's health as improving with the introduction of 'men's nights'. In a profoundly subtle way Warren has used the medical repertoire to position himself as a lay expert who is aware of these changing issues whilst using the HBR to position other men, those whose 'days are numbered', as macho and ignorant:

Warren: But a lot of the guys you are looking at are fullas in their sixties or fifties and sixties and they're probably still living in the age, still haven't been brought

up to realise that (1) a lot of these things can be identified more quickly and its (2) I think its an educational thing. I think men will, wont perhaps go the doctors as much as ladies but I think their numbers are probably (1)

Jack: Changing?=-

Warren: =Changing, I see they had a men's night in Alexandra six years ago and I see they were having one in Balclutha recently=-

Jack: A men's night, what=-

Warren: =Oh to discuss men's problems {ahh} prostate problems, cancer problems (1), blood pressure and pains, you know, encouraging people to go to a doctor.

The validity of Warren's argument is irrelevant but by positioning himself and other men in this way he, in this particular context, constructs a powerful masculine identity for himself in relation to these other, ignorant, groups of men. In summary, I argue that Warren's displays of knowledge reflect a context-specific strategy for doing hegemonic masculinity as he 'de-powers' men who are uninterested in health as ignorant and macho.

#### *Powerful identities and general practitioners.*

A number of men also drew on the medical and natural body repertoires to construct a powerful masculine identity in relation to doctors. They did this by challenging the status of GPs as medical experts and as experts of peoples' bodies. I argue that this is also one particular strategy for doing hegemonic masculinity. For example, at the end of our interview Warren reinforced the powerful identity he had constructed for himself earlier, by using the medical repertoire to argue that doctors often get it wrong and are too reliant on their patients for information. Thus, not only does Warren use the medical repertoire to construct other men as ignorant of medical issues he also uses it, from the position of lay expert, to reduce the status of doctors as health professionals:

Warren: I started to tell you earlier about a fellow who came out of a doctor's office after a medical exam and said he was fit as a trout and he died within nine or ten weeks with cancer. So you know, doctors can't tell you everything. That was 20 years ago anyway. A doctor can only diagnose if you can give him special information he can probably tell you pretty much what might be wrong with you but it doesn't mean to say (1), because, you might have

discussed some particular type of pain you might have. And cancer is something that doesn't give a lot of symptoms sometimes anyway, probably.

Jack: Yeah or symptoms for other things as well.

As a further illustration, Howard uses the medical repertoire through descriptors such as 'muscle damage' and the natural body repertoire ('how I felt') to construct himself as more knowledgeable of his body than his doctor. In this case, Howard's doctor had suggested that he should stay in hospital overnight as a precautionary measure regarding his symptoms but Howard ignores this advice, rationalising this decision from the lay expert and embodied self positions. He had already decided himself that he did not need to go to hospital because he felt he had sufficiently recovered:

Howard: And then when I went back to the hospital and had them the doctor said, "I was looking at them and they are OK." But he'd sent an extra lot of blood tests away, you know five different sections there. And when it came back he was quite surprised so he'd rung me at [work] by the time I had got to [work] and saying "look, I think we should put you in hospital over night". And um, and I didn't because I was feeling good (mmm, mmm) and then it was only after that we started to sift through and find that there was other muscle damage (aaah) cause I'd still been jogging (sure)

Jack: So when, that's interesting that he said, the doctor said that "I think that we should, I think that you should stay in for a night" (yeah) and then you decided that "I don't need to." How did you come to make that decision?

Howard: Um because I'd probably made it the night before I went to the doctor, because its, mmm, [ ] I was running most nights probably, just a short jog, and um so when that was going on, I was just a bit unsure because you know, I was thinking [the problem] myself you know, so, but in the end I was feeling good and I thought "oh well, I'll go for a jog anyway and we'll, I figured oh well we'll test it out anyway" (yeah, mmm) so, in a way I think I had proven to myself that you know, you know, pulse, the way I was feeling was perfect (yeah, yeah).

At the end of the interview Howard indicates that he has little faith in a doctor's ability to cure his medical problems because so much depends on a doctor's experience with peoples' bodies. He suggests that the many experiences he has had

with his body and the knowledge he has of its ability to heal itself rivals the medical expertise of a doctor. Directly after this passage Howard draws on rhetorical resources to support his argument but for privacy reasons this has been omitted from the analysis:

Jack: Alright, I've got two more questions to ask you. This ones a little bit, (3) a little bit different. But um, when you have a problem and your body hasn't fixed it (yep) and you decide to go to the doctor, how much, how much faith do you have that the doctors actually going to be able to fix your problem?

Howard: Um, not a great deal, that I, I think they are very much like us, even though they are trained, its still going on a range of experiences and if yours falls within their range of experiences, its beyond yours, these are the things I've, then as it falls within theirs. But they do, yeah, so not a great deal of faith (mmm) because having plenty of experiences in life where they've failed the family or friends, and not blaming them, it's just that you know, we are such an unknown.

In summary, a number of respondents drew on the medical and natural body repertoires to construct 'seldom-using' men as ignorant and to reduce the status of doctors as medical experts. By positioning themselves in this way these men have constructed a powerful masculine identity in relation to ignorant, seldom-using men and in relation to doctors.

These results support Wetherell and Edley's (1999) argument that there is no single hegemonic masculinity per se, but multiple context dependent strategies for doing hegemonic masculinity. I have argued that the respondents' use of the medical and natural body repertoire to position themselves as experts of health were highly contextual strategies for doing hegemonic masculinity. However, because the powerful masculine identities these men have constructed are highly context dependant I do not claim that these respondents have physical or mental power over men that do not seek help. For example, outside of the interview context these men may construct powerful masculine identities in other ways and in relation to other groups of men and women. Nevertheless, based on this discursive evidence, I suggest that hegemonic masculinity, when conceived in its plural sense, is not only a



useful tool for understanding the power inequalities between men and women but also between different groups of men.

### *A Case Study – Jacob*

Although I have demonstrated how the respondents used the three repertoires to construct health and health care utilisation, the ways that the three repertoires interacted and came together throughout the interview are still unclear. The subsequent section will therefore follow Jacob through the course of the interview to demonstrate how the three repertoires function in distinctive yet related ways and to provide further support for the arguments made in the previous sections. I have divided our interview into four different sections each with a summary of the main points. I also continue on from the discussions in the previous section to describe how Jacob's talk reflects hegemonic principles of rejecting femininity and power over other groups of men.

#### *Part one.*

At the beginning of the interview Jacob immediately drew on the HBR to position Harry as a seldom-user who is invulnerable to illness and therefore unconcerned about his health:

Jack: Rightyhoo, I'll stop it there.

Jacob: For a start he's bloody bullet-proof.

Both: (laughs)

Jack: Yeah, exactly, so how would you describe him, in like, like your first impressions? (mmm) like what sort of person do you think he is?

Jacob: He goes wherever, he's out for the good times, he smokes, he drinks, over weight and um, he's bullet-proof (yep).

When asked to describe the reasons why Harry ignored his symptoms Jacob continues to use the HBR to construct him as a seldom-user a position he associates with 'macho' masculinity. Jacob then suggests that if Harry were to admit he was ill, he would be less attractive to the women, something that does not match his personality. When Jacob is asked if he would go to the doctor in a similar situation he is quick to reply that he would. This statement is the first instance that Jacob

rejects taking up the seldom-user position to construct his own health behaviours. Instead he identifies as a regular and moral help seeker by suggesting that he would go to the doctor straight away if was experiencing chest pains:

Jack: And why do you think he would try and ignore it?

Jacob: Um, well I suppose it would um, how do I put it, um (2) ruin his chances of doing what he wanted to do that night for one thing. (1) an:::d, it wouldn't be in his style to have a crook heart (yeah) he's still bullet-proof.

Jack: Um, if you were in his situation, well not exactly the same situation=

Jacob: Yeah, I know what you mean.

Jack: How would you sort of explain those symptoms to yourself? Like what would you be saying to yourself if=

Jacob: =Get to the doctor Quick (yeah, mmm).

Jack: Um, so do you think that you would wait and see for a while or stop and go straight away=

Jacob: =I'd go straight away.

Jack: Straight away, yeah. OK.

In the following passage, Jacob's use of the medical repertoire gives rise to two subject positions; the lay expert and the legitimate-user. From the expert patient position, Jacob uses terminology specific to medicine such as 'cardiographs', 'triple bipass', and 'shunt' to construct himself as an expert of medical problems related to the heart. However, Jacob also takes up the legitimate-user position to argue that because there is a family history of cardiac complications he has a genuine reason to go to the doctor:

Jacob: I've been and had, not that I've got any problems, but I've, there's a family history there and I've had cardiographs and such like taken since the age of about [deleted] odd (oh yeah, ok). Just to keep checking on things and everything, and every time I go it seems to be OK. I've had a [deleted] that's had a triple bypass and one that's had a shunt put in his heart, and there both younger than me (laughs).

Jack: Oh I see! Yep, yep, that's fair enough.

Jacob: And then [deleted] that died with heart problems.

Jack: Ah I see, warning bells.

Jacob: So I am well aware of it and I keep an eye on things.

In this initial stage of the interview Jacob has rejected taking up the seldom-user position and has instead identified as a legitimate-user of health care. This effectively set the context for remainder of our conversation as a critique of traditional masculinity and the associated negative help behaviours.

*Part two.*

In the next stage of the interview Jacob is introduced to Pat and Doug and is asked if he would go to the doctor if he were in their situation. He uses descriptors from the medical repertoire such as 'meningitis', 'temperature', and 'symptoms' to construct the status of the health concern as either trivial or something that warrants further attention. Jacob also briefly draws on the natural body repertoire to construct the body as a system that can heal itself. Interestingly Jacob, like Andy, used the medical and natural body repertoires together, indicating that if the body has not healed itself after five days then a visit to the doctor is needed.

Jack: And if it were say for one or two days?

Jacob: Depends on the severity of it and it depends on a lot of other things: If he's eaten some unusual foods that he isn't used to or something like that then perhaps not but if was just the ordinary run of the mill, you'd had no cause to suspect anything else, yes he should go

Jack: So if I could expand that out a little bit more, what do you think would be the difference between having stomach pains for one day and having stomach pains for five days?

Jacob: Well, obviously there's something wrong if it lasts for five days. First day it might just be a minor upset in the digestive system something you've eaten or, you know something like that. Or it could be a flu that was going around. He should know if it's the flu though, yeah the temperature and he's probably having cold sweats and such like. It depends on what goes with it.

Jack: So you think he would know himself that something was=

Jacob: =should know.

Jack: Um, another difficult question: How would he know do you think?

Jacob: Well there should be other symptoms that go with it, the flu or something like that, meningitis or any of those types of things, not that meningitis would give you stomach. There should be other symptoms other than just um, the stomach pains (mmm)

From the position of lay expert, Jacob has used the medical repertoire to argue that one should *know* if a medical condition is serious or not, based on the symptoms they are experiencing and how long they have been experienced for. Jacob is then asked if he thought Pat would tell anyone about his stomach pains. However he misinterprets this question, confusing Pat for Harry:

Jack: And, do you think he would tell anybody that he was experiencing these stomach pains? Do you think he would tell anybody or just keep it to himself?

Jacob: Harry?

Jack: Pat, yeah sorry, forget about Harry.

Jacob: Harry wouldn't no.

Both: (laughter)

Jack: Harry wouldn't, no. What about Pat?

Jacob: Um, he may do. Probably not.

Jack: Would it depend on the person do you think?

Jacob: Depends on the person yes.

Interestingly, Jacob was not the only respondent to misinterpret the question in this way. Both he and Andy believed that Harry would keep the problem to himself and both found this humorous or perhaps acceptable for the seldom-using man. I play a part myself in reinforcing this macho image by agreeing with Jacob. In the following excerpt, Jacob continues to use the HBR to position Harry as a seldom-user. In this case he constructs Harry's negative health behaviours as consequence of not wanting to appear weak or vulnerable:

Jack: So how would you explain the, cause I understand what you mean. How would you explain the difference between Harry, as a person and this person that say would go to the doctor, or he would tell someone sorry. How would explain the difference between those to people? What's the major, sort of, thing between them?

Jacob: Um, one thinks he's bullet-proof, and there's nothing wrong with him, doesn't want to be shown up as a, I suppose a softie or you know, he's not, if he did something like that he's not part of the macho, macho bloody image.

Jack: And is that quite important for Harry?

Jacob: Umm, probably yes.

In the next part of the interview, Jacob draws on the HBR to position Pat's wife as a frequent user, someone that Pat can confide in and someone that will help Pat go to the doctor:

Jack: Um so if, back to Pat, if he was going to tell someone he was experiencing these stomach pains, who do you think he would be most likely to tell? Apart from the doctor obviously.

Jacob: His partner.

Jack: Yeah, why do you think that would be so?

Jacob: Um, well she'd probably confide, you know, someone to confide in and wouldn't go and tell too many others and probably help him with (2) the fact that he should go to see a doctor, these such things (yeah, yep).

Jacob then indicates that if Pat were a woman, she would be more likely to seek help than if Pat were a man. When Jacob is asked why he thought this to be the case he constructs men as having a problem with the way they think rather than a 'help seeking trait' possessed by women:

Jack: Um, now this is an interesting question: Up until, up until now we've said that Pat's a man, what if Pat was a woman, do you think she would be more likely to go to a doctor earlier?

Jacob: In most cases yes, I don't say all cases (no, no) but in most cases she would.

Jack: And why, why would you say that?

Jacob: I don't know (laughs) built in bloody male.

Both: (Laughs)

Jack: Tough question that one isn't it!

Jacob: It's the built in bloody male um, mind set I think (yep, yeah).

Jacob continues to position women in this way in following excerpt. When we talked about an acquaintance of Jacob's that had fallen ill, he attributed an element of responsibility for this illness to his acquaintances wife. He does this by using the HBR to construct the role of the wife, as someone that looks after her husband, is aware of his health problems, and sends him to the doctor when these problems become serious. Implicit here is the way Jacob constructs her as health conscious enough to know when he should be seeking help and when he should not:

Jacob: Um [the wife] should have been a wee bit more awake to what was happening as well. Um=

Jack: Do you think=

Jacob: Just a bit lax about looking after him (ah ok yep) yes, I think...he should have been there [to the doctor] (yep, yep). [She] should have picked it up and got him away too.

Soon afterwards Jacob, with my help, continues to use the HBR to construct men's negative health behaviours as a symptom of the male psyche or a feeling of invulnerability:

Jack: Um, I going to have to ask this, but a, bit of a pain but what do you mean by the male mindset? Because I understand but.

Jacob: Mmm, that's an awkward one (mmm) its um, (3) I don't know, lots of males and I don't say them all, but lots of males, um like to think that nothing will ever happen to them. Um, I don't know how exactly you would put it. Its part of the macho male (3)

Jack: Like psyche or something?

Jacob: Psyche yes.

In this section of the interview Jacob has repeatedly used the HBR to position other groups of men as seldom-users. However he has rejected taking up the seldom-user position himself to construct his own health behaviours. He has also briefly drawn on the HBR to position women as more 'health conscious' than men and more likely to seek help. Jacob has also begun to use the medical and natural body repertoire from the respective position of 'lay expert' and 'expert of the body' to construct macho men as ignorant of health concerns. I suggest that the way he constructs seldom-using men as macho and ignorant of health reflects a context-dependant strategy for doing hegemonic masculinity. When, Jacob uses the medical repertoire to construct himself as an expert, he constructs a powerful masculine identity for himself in relation to these less knowledgeable groups of 'macho men'.

### *Part three.*

In this part of the interview, Jacob has just been introduced to a scenario with 'Doug' a man who has just seen blood in his urine. Jacob continues to draw on the



HBR to reject taking up the seldom-user position whilst using the medical repertoire to construct his own positive health behaviours as legitimate:

- Jack: If he found out that some of his friends or his brother or something like that (yes) had been experiencing the same problems, do you think that would influence his decision to go to see the doctor?
- Jacob: Should do, should do, mightn't necessarily do so though. But um, I'd have certainly been there at the drop of the hat (mmm).
- Jack: But for someone that didn't want to go, why would sort of hearing that other people experiencing the same things sort of influence him? How would that?
- Jacob: (2) Dunno, don't really understand them (laughs).
- Jack: Yeah, yeah, no that's fair enough yeah.

At this point Jacob was given some information regarding the study and as a result his knowledge of issues surrounding masculinity and men's health become more evident. In the following passage Jacob uses the HBR to constructs men's health problems as imbedded in macho masculine ways of thinking:

- Jack: Um, (2) at this stage I am sure you can guess that we are sort of looking at the reasons why men=
- Jacob: =Yes, I, I know what you are about (yeah) and its all to do with the thing that's on top of the shoulders (mmm) um, and the male ego I think to a larger degree um.

Jacob was then asked how much faith he had that if he went to see a doctor, the doctor would be able to help him. In the following critical account of his GP, he uses the descriptors 'blood poisoning', 'antibiotics', and 'infection' from the medical repertoire to construct his health behaviours as legitimate or serious enough to warrant medical attention. Yet, from the lay expert position he also constructs himself as knowledgeable enough to *tell the doctor* what drugs *he* needs. He then challenges the GP's status further by blaming him for the death of an acquaintance:

- Jack: How much faith do you have personally when you go to see the doctor that they are going to be able to fix the problem (2) like do you go in there thinking "yep, they're going to fix it
- Jacob: Um not always, I had an experience once where I [deleted], obviously a wound I had had on my [deleted]. He picked it: blood poisoning. I

went to doctor [name] in Alexandra and he gave me some bloody um, ointment, drawing paste stuff to put on and told me to go home to bed and rot (oh?) And I thought, yeah that's exactly what I'm going to do. So I didn't even go home, I went straight to doctor [name] in [a nearby town] and told him I needed some antibiotics, I had this infection, this [problem] and I want to be [working] in four days (yeah). And he gave me the required antibiotics and fixed it (ah!). So yes I don't just rely on one doctors opinion (chuckles) (yeah).

Jack: So when you said that he said put the cream on and go home and rot, is that sort of the attitude he was putting across to you or=

Jacob: =Yeah, he had a problem too.

Jack: Oh did he?

Jacob: I would say he had a problem (oh) yes and the fact that um I don't know.

Jack: Like a similar sort of problem like?

Jacob: Yes something similar sort of problem I would think, I don't know. Um I blame him for [names] death, [name] shouldn't have died [like that] (ah)...In this day and age a doctor should be able to sort of pick those things up, fix that quicker than he did anyway. Or he should have realised that he was out of his depth and sent [the person] to a specialist before something happened.

Jacob then continues to downplay the status of doctors by arguing, from the lay expert position, that individuals must carry an element of responsibility for their own health by getting second opinions or by making sure the doctor is doing their job properly. Yet Jacob still indicates that people should still go to the doctor. Thus, the morality embedded in health or the need to identify, as a healthy, responsible citizen is also evident in Jacobs account:

Jack: So this like, cause obviously doctors do make mistakes and they don't always fix things (mmm). Do you think that that would sort of influence people not to go?

Jacob: Oh=

Jack: =He wont be able to fix it so there's not much point in going=

Jacob: =In the odd rare occasion it could do but in most place...cases it shouldn't do and if they are not happy with the first one they should go and get a second opinion or you know, second treatment (mm). Yes, doctors are human, they are not infallible (mmm) but on the same token you've got to sort of look after yourself and how do I put it (2).

Jack: Like it's your responsibility?

Jacob: Yes, and you've got to sort of um watch to see that, and admittedly in some cases, a surgery operation or something like that when they make a muck up, its very difficult for the patient to, to know whether they've done it [made a mistake] or not.

Throughout this section Jacob has continued to reject taking up the seldom-user position offered by the HBR. From the legitimate-user position Jacob has used the medical repertoire to construct his own positive help seeking behaviours as genuine or warranting attention. Finally, Jacob has used the medical repertoire to construct himself as knowledgeable of medical matters. He goes on to strengthen his position as a lay expert by constructing his knowledge of medicine against the debatable status of doctors as 'medical experts'. Again, I suggest that this was one context dependent strategy for doing hegemonic masculinity as Jacob has constructed a powerful masculine identity in relation to men that do not seek help and now, in relation to doctors.

#### *Part four.*

In this, the final part of the interview, Jacob was asked if there was a time in his life when he had not gone to the doctor when he felt that he really should have sought help earlier:

Jacob: (4) Well [ ] will probably tell you I should have gone to the doctor some time ago with my [condition], the way [it is] at times and it causes problems and um,

For privacy reasons the actual transcription has been omitted, but from here Jacob goes on to provide a highly detailed account of his medical problem and how he copes with the difficulties that it causes him. He talked of the medications he is taking, how this equates with the aging process, and finally how he envisaged that in the future he would have to get an operation. He ended the account with the statement by saying that his children would say he should have had surgery a long time ago and then laughs to himself:

Jack: (Laughs) now I am going to have to ask this question: Why weren't you there ages ago? Why, why do you reckon you sort of (2)

Jacob: Well one of the, yes, (2) I suppose it is part of this bloody male=

Jack: =(Laughs), yeah, well it might not, I mean in your words, like why do you personally, it might not have anything to do with the male psyche, you know there might be different reasons.

Although I unfortunately interrupted Jacob before he finished his statement, one can see that this situation has posed a dilemma for him. He has rejected taking up the seldom-user position throughout the interview by identifying as a moral and legitimate user of health care. But he has now arrived at a situation where his use of the HBR has positioned him as a seldom-user due his own admission that he has delayed seeking help. To solve this dilemma Jacob draws on the HBR and medical repertoires in a complex rhetorical account to reinforce his position as a moral and legitimate user of health care:

Jacob: Well, one of the things is that they can't do [the operation] until they are really bad, you only get one shot at the [operation] at this stage. They can replace a [deleted] several times but I believe at this stage the technology only allows them to do one shot at the [operation] (ahh). I'm definitely going to in the near future (yes) mmm.

In this passage, Jacob has used the medical repertoire to legitimise his delays in seeking help as a result of medical restrictions. For example, he argues that because the current surgery techniques are not advanced enough and because the condition has to be serious before the operation is performed, he has good reason to wait. Jacob then further legitimises his delays by indicating that the problem is not serious enough to be critical to his health, whereas if the problem were more serious he would have gone to the doctor straight away. From the position of legitimate-user Jacob has therefore constructed himself as a man that is willing to use general practitioner services but only when it is absolutely necessary:

Jacob: Yes, yes that's how I understand it at present. Yeah one day, when works not too busy I'm definitely going to get [the condition] seen to (mmm). It's not something that's critical to my health, that annoys me in not being able to get round and not being able to run as fast as I used to and things like that (mmm). But it's not as I see critical to you know, it's not a life and death situation (yep, yep). If it was a life and death situation I would have been there yesterday (yep, sure yep). But it's not, it's just something that slows me down getting around, a bit annoying, aggravating at times.

As mentioned earlier, all of the respondents, including Jacob, indicated that women are more likely than men to see the doctor, and in many cases that women tend to seek help for less serious or even 'trivial' reasons. In contrast men, because they seek help less often, are positioned as the serious or legitimate users of health care. For example, in this account Jacob has indicated that his condition is not serious enough to warrant attention because it is not bothering him, a position that is orientated towards the seldom-using man. Although this is a position he has previously rejected, this is not problematic for him because it is women that go to the doctor frequently and for trivial reasons, not men. Essentially, this means that Jacob can both identify as a legitimate user of health care, a virtuous position in this particular context, whilst maintaining a masculine identity because he suggests that he will seek help but only when it is necessary.

Finally, further evidence for this argument is presented in the following passage where Jacob provides a rhetorical account of his previous help seeking experiences to reinforce his position as a legitimate user. In this instance, Jacob draws on the medical repertoire to describe a time when he went to the doctor for some moles that he thought needed to be examined:

Jacob: It depends a bit on, on what it is that's wrong with me. Whether I react immediately. I went to the doctor for something, not that long ago, I can't remember what it was. And I got him to check out, oh yes that's right, I had a couple of little, um, they weren't exactly moles but like moles on my [body]. And one of them had started to um get a wee bit itchy (mmm) and tingly and such like. So about three or four days later I got to the doctor (oh) and got them removed (mm). I asked him about the one on my [deleted] and he looked at it and he said it doesn't need to be touched and um I got him to check my back and everywhere else when I was there at the same time (yeah). So I do sometimes (laughs).

Jacob's account of his skin condition functions in two important ways. Firstly he reinforces his position as a willing help seeker, as indicated in his last sentence. Secondly, by constructing his problem as legitimate or needing to be 'removed', Jacob constructs his own health behaviours as not feminine and not trivial in nature.

Throughout each interview many men, including Jacob, used the HBR to position women as the frequent-users of health care whilst using the medical repertoire to validate their health behaviours as legitimate. Although they rejected the seldom-user position offered by the HBR, the emphasis they placed on legitimising their health behaviours indicates the hegemony of masculine discourse and how it shapes the way each respondent identified as man. These results illustrate how, throughout these interviews, each of the respondents went to lengths to identify as a "...man, but not that kind of man" (Edley & Wetherell, 1997, p. 209). In other words they maintained a masculine identity whilst simultaneously rejecting cultural ideals that equate masculinity with stoicism and reluctance to seek help. Furthermore, many men constructed a powerful masculine identity by using the medical and natural body repertoires to construct themselves as knowledgeable of medicine and of their own bodily experiences, whilst constructing seldom-using men as ignorant and doctors as ineffectual. I suggest that this was one context specific strategy for doing hegemonic masculinity.

It is important to note that the positions these men took up, the masculine identities they negotiated, and the way these men used the three repertoires to construct their health cannot be generalised outside of this context. It is quite possible or even likely that if these men were in a different context such as a focus group, being interviewed by someone of the opposite sex, or outside of a formal discussion, they may have taken up rather than rejected the seldom-user position. In such a case the hegemonic strategies these men used would be more likely to involve displays of invulnerability and stoicism rather than through the display of medical knowledge. Nevertheless, these results illustrate two important points regarding masculine identities. Firstly, that the construction of a masculine identity is best conceived as a process of negotiation within a situated context rather than through the display of fixed traits or qualities. Secondly, that there is no single dominant or hegemonic masculinity per se but multiple ways of doing hegemonic masculinity that are again highly context dependent.



## Summary

In this section, I firstly summarise the main points I have made throughout this study. I then go on to discuss the limitations of this study. The theoretical implications and the implications this study has for men's health promotion are also discussed. Based on the findings from this study, I will finally provide a number of recommendations for future research.

This study aimed to determine whether the criticisms made against hegemonic masculinity are warranted in this particular context. Or in other words, to examine whether hegemonic masculinity is relevant to these men and whether it is a useful theory for understanding the ways men construct masculine identities.

I have identified three interpretative repertoires these men drew upon throughout the interview to both construct 'health' and to position themselves, other men, and women as health care users. These men drew on the health behaviours repertoire to position women as the frequent and trivial users of health care services whilst positioning other men as reluctant to seek help. They drew on the medical repertoire to position themselves as the legitimate-users of health care and as experts of medicine. Finally, they used the natural body repertoire to construct themselves as experts of their own bodies.

This study highlighted the influence that social context can have on the way men can identify as health care users. It took into consideration, for example, the likelihood that the invitation to participate, their own knowledge of men's health issues, and my own utterances throughout the interview created a unique context that was likely interpreted as a critical analysis of their past health behaviours. Combined with the moral pressure on all people to 'be healthy', it was not surprising that each respondent identified as a regular or virtuous user of health care services.

Firstly, I have argued that identifying as a regular user of health care was dilemmatic for many men, as this is a position they had constructed for women. They solved this dilemma by positioning women as the frequent and trivial users of health care whilst positioning themselves as legitimate-users. By doing this, these men were able to

identify as regular and virtuous users of health care whilst still maintaining a masculine identity. Secondly I have argued that in positioning themselves as experts of their bodies and of medical issues a number of men were performing a context specific form of hegemonic masculinity that effectively reconstructed health or 'being healthy' as masculine behaviour. From this position the respondents constructed seldom-using men as ignorant of medicine and reliant on their wives for help whilst also challenging the status of doctors' as medical experts. In other words, these men constructed a powerful masculine identity for themselves, in relation to other men and in relation to doctors.

These results firstly suggest that although able to reject the seldom-user position and the associated negative health behaviours, many respondents were influenced by the hegemonic nature of dominant masculinity to construct their health behaviours as 'not feminine'. As a concept, hegemonic masculinity has been recently criticised as being insufficient to understand the intricate ways men construct masculine identities. Nevertheless, this study has provided a fine-grained analysis of how hegemonic masculinity can influence the way men can identify as both masculine and as health care users. In doing so, I have shown how these men drew on constructions of hegemonic masculinity to construct a masculine identity that exists in direct opposition to a feminine identity.

These results also suggest that there are multiple strategies for doing hegemonic masculinity. Hegemonic masculinity has also been criticised due to the vagueness surrounding the term hegemonic masculinity itself. These critics have argued that although Connell (1995) infers there is only one hegemonic masculinity, there are actually many ways of doing hegemonic masculinity dependent on the social context of the situation. The results from the current study have shown how the respondents rejected what has been considered to be culturally appropriate and dominant masculine way of doing health, whilst constructing a powerful masculine identity in relation to men that do not seek help. Thus, I have argued that these results support these criticisms of hegemonic masculinity by suggesting that there are multiple ways of doing hegemonic masculinity dependent on the social context.

### *Limitations*

One limitation for this study was the small number of respondents. With more respondents and more discourse to analyse I could have been more confident that I was hypothesising *from* the discourse rather than imposing my own thoughts and ideas *on* the discourse. Potter and Wetherell (1987) argue that it is insufficient for an analyst to state, which statements are variable and which are consistent. Thus, they argue that in order for a discourse analysis to have ‘validity’ the respondents themselves must be shown to orientate themselves towards the variations and consistencies in the discourse. In this particular study I predicted that although men may reject the seldom-user position they would face a problem in identifying as a regular health care user because this was a position they had constructed for women. Indeed many men did face this dilemma and solved it by drawing on the medical repertoires to construct their health behaviours as legitimate as opposed to trivial or ‘feminine’. Therefore, because I have illustrated how these men orientated themselves towards the variations and consistencies, I am confident that, regardless of the small sample size, the results are ‘valid’ in concordance with Potter and Wetherell’s recommendations.

A further limitation of this study concerns my inexperience as an interviewer. There were a number of times throughout the interview that I interrupted the respondent or attempted to put ‘words in their mouth’. This was most evident during times of silence, which I found to be uncomfortable but are, in fact, natural to any conversation. In retrospect, the respondents’ accounts would have been more ‘in-depth’ or ‘rich’ if I had waited for them to continue our conversation rather than interjecting myself.

A final limitation concerns the nature of the interview questions and is also related to my lack of experience. Upon reflection, a number of questions that I asked throughout the interview were prescriptive in nature. For example, questions such as “would you go to the doctor in this situation” can only give rise to a limited type of response. In future I would ask questions that were more open ended and flexible to allow the respondent more freedom in their responses. Thus, rather than asking questions that required a yes or no answer I would ask questions such as “What do

you think are the issues here?” to gain a less prescribed and therefore, a better understanding of their health care constructions.

### *Theoretical Implications*

Regardless of afore mentioned limitations, the results from this study have theoretical implications for the study of health care utilisation and gendered identities. Many of the themes and arguments I have raised throughout this study are by no means unique to these seven men. Robertson (2003) also identified aspects of morality that influenced the way men could identify as health care users. He argues that contemporary health carries a moral connotation of the good citizen whereby individuals should identify as regular health care users. Robertson identified a dilemma for his respondents between a belief that real men do not care about health and a moral pressure that individuals should care. Similar results were found in the current study as I have argued that, due to the social context of the interview, all of the respondents were compelled to identify as good and regular health care users or as Crawford (1994) would suggest, as responsible and moral people. Warren, Andy, and Jacob in particular, took these moral connotations of health further to position themselves as lay experts of men's health care, whilst positioning other men as ignorant of health concerns. From here they spoke of the current issues with men's health and the need to 'fix the problem' or 'educate' other men.

Robertson (2003) also found that many men needed to legitimise the times that they did seek medical attention as warranted and valid. For example, many men cited significant life changes such as marriage and fatherhood and family history of ill health to provide a rationale for their positive help seeking behaviours. Also, when it came to specific illnesses, he discovered that many of the men would readily discuss their help seeking behaviour yet claimed preventative health was a waste of the doctor's time. He argues that these men legitimised their behaviour because they needed a way of saving face or maintaining their masculine identity however, he fails to explain why this may be the case. Similar results were found in the current study, but I have argued that because gendered identities are constructed in opposition, these men were compelled to legitimise their health behaviour in order to appear 'not feminine'. Although Robertson does not explicitly make this same

argument he does, however, argue that his respondents constructed health as a woman's concern not men's.

Moral aspects to health care were also evident in the discourses of lower-class men in an analysis of media representations and men's constructions of health and illness (Hodgetts & Chamberlain, 2002). For example, these authors found that many of their respondents endorsed media messages such as men's need to seek help more regularly, to undergo more healthy lifestyles, and to be aware of unhealthy masculine attitudes. However, unlike the current study, Hodgetts and Chamberlain found that although their respondents did endorse these media messages, they resisted them at the same time by introducing additional and externalised rationales for not seeking help. For example, they raised issues such as their low socio-economic status and the resulting lack of respect from doctors to externalise or shift the responsibility for illness away from the individual to encompass broader social constraints. Yet, in the current study a number of respondents either constructed their help seeking delays as a consequence of 'machoism' or drew on the medical and natural body repertoires to provide a medical rationale for not seeking help. Although there are differences in the results of these two studies, all the respondents' accounts of help seeking delays indicate that culturally idealised or hegemonic forms of masculinity had a major influence on the way they could construct their health. Yet, these discrepancies also suggest that there are more factors that influence a decision to seek help than masculine identities and attitudes alone.

The elaborate and sometimes contradictory ways respondents constructed their health behaviours suggests that the decision to go to the doctor is a multifaceted and complex one. Although previous research has indicated that men often delay seeking help out of a fear of appearing vulnerable, results from the current study have shown how respondents *endorsed* and detailed their own positive help seeking behaviours. Thus, the suggestion that men delay seeking help simply because they do not want to appear weak fails to take into account how social context can influence the way men construct their health. In some contexts men will perhaps refrain from identifying as regular health care users but in other contexts the opposite may be true. For example, O'Brien et al. (2005) found that although many respondents did endorse men's reluctance to seek medical attention certain groups of men highlighted the

importance of help seeking in order to *preserve* more important aspects of masculinity. Similar conclusions may also apply to the men in the current study in regard to their highly masculine roles as farmers. Just as O'Brien et al. related the fire-fighters' willingness to discuss their healthy behaviours to their occupation, it is possible that the respondents' dependence on their health to continue farming was one reason why they endorsed the importance of men's health and their own positive help seeking behaviours. In other words the potential damage to their identities caused by admitting their positive health behaviours may have been small compared to the inability to work due to an unhealthy body. This point becomes especially pertinent when considering that many of the respondents were facing the end of their farming careers. Thus in order to continue on in this, often physical, occupation for as long as possible, staying healthy becomes even more important as Howard suggests:

- Jack: Um for you yourself, do you think anything's changed from when you were in your twenties and thirties to now? As far as your health goes, like the way you sort of see your health.
- Howard: Has it deteriorated or?
- Jack: No, like the way you=
- Howard: =Oh how I view my health?
- Jack: Yeah.
- Howard: Um yeah, probably that I consider now (mmm) whereas I didn't consider it in the past. If I was sick, I was sick and I was always "How long is it going to take to get right" and it was always going to get right (yep) yeah, perhaps yeah, yeah um. More aware of your self (yeah).

### *Implications for Men's Health Promotion*

Although any type of generalisation is problematic at this level the implications of these findings for men's health promotion are still significant. The complex nature of these men's accounts suggests, for instance, that any single health promotion exercise may be too simplistic to appeal to all groups of men. For instance health promotion that aims to appeal to men through the use of mechanical metaphors of the body such as 'getting a tune up', 'maintenance', or having an 'oil change' assumes that all men construct their body in this way, when this may not necessarily



be the case. For one of the respondents in particular this way of constructing the body was problematic as although he used mechanical metaphors he argued that, unlike a machine, some medical problems are very difficult to diagnose and treat and that there is 'no warranty' on work that doctors do:

Jack: So just to bring up a word that you just mentioned, um, like the mechanic (yeah), when you take your car to a mechanic you expect it to get fixed (yeah), so you don't see the doctor patient relationship quite the same way?

Howard: No, I've often thought that, that you know, there's no warranty on here [unknown] when its your mechanic you expect it to be fixed "you said you were going to do this part of it" (yeah) [unknown] but you also know that the mechanic is going to find a reason "Ok we've done this, but really, this is the problem that we didn't see. But yeah um, the doctor, mmm, no, it's a bit different, I don't know why that is.

In regard to health promotion and the 'crisis of men's health' I argue that promotional initiatives, which consistently generalise and contrast masculine identities *against* positive help seeking behaviours, are not only misguided but may also be compounding men's health problems. In concordance with this argument, Robertson (2003, p. 113) states that stereotyping men effectively "...stifles our ability as health professionals to maximise the opportunity afforded by such events." (Health work with men). However, Robertson stops short of providing an adequate explanation of exactly why stereotyping is detrimental to men's health. I contend that the different ways men construct their health behaviours in relation to both women and other groups of men suggests that to place all men together in a homogenous group of 'non-help seekers' would be inappropriate. Because masculine and feminine identities are constructed in opposition, one can begin to understand how constant generalisations about masculinity may lead men to assume that negative health behaviours are actually *appropriate* for the 'real man' and are indeed necessary behaviours to avoid being labelled 'a girl.' For example, I suggest that exposing men to promotional initiatives that portray males as unconcerned with health whilst portraying women as a quasi health experts could actually make it more difficult for men to seek help because this further reinforces 'being healthy' as feminine behaviour. Robertson argues that although the stereotyping of men as

uninterested in health is counter productive to men's health in general, health care professionals need to understand that men need their health concerns to be explained. In this sense he suggests that health professionals must therefore help men 'legitimately' look after their health. Although it is difficult to visualise what Robertson's suggestions may look like in practice, the results from the current study certainly suggest that the 'legitimising' of health is a topic that warrants further research.

### *Future Research*

This study has highlighted the importance of social context by illustrating how situational or contextual factors can influence the relationship between seeking medical help and constructing a masculine identity. By understanding the intricate ways that social context can influence the formation of gendered identities one is in a position to argue that men and women do not belong to mutually exclusive and homogenous groups. Therefore, although it is impractical and counter-productive to study *every* social context an individual may experience; a myriad of different social contexts, based on factors such as socio-economic status, age, ethnicity, and situational differences, await further research and understanding.

This study has also discussed how masculine identities can be constructed and maintained in opposition to feminine identities. Future research could further enlighten the theory that gendered identities are constructed in relation to 'the other' (Hall, 1996) by studying *women's* constructions of health care utilisation. If gendered identities are indeed constructed in opposition, women should construct feminine identities in a similar fashion to men. For example, if men were compelled by hegemonic masculinity to construct their health behaviours as 'not feminine' one would expect women to be compelled by hegemonic *femininity* to construct their health accounts as 'not-masculine'. If this is indeed the case, women's accounts should highlight a willingness to seek help and to be involved in preventative medicine and screening for disease. One would then be in a position to examine the relationships between masculine and feminine identities or how contextual factors such as time, place, ethnicity, and age can influence the extent to which *both* sexes endorse hegemonic principles of their respective genders.

## Conclusions

This study is a 'fine grained' analysis of the discursive resources seven rural, older men used to make sense of 'health' and going to the doctor. In concordance with previous research, I have identified the gendered nature of health and shown how gendered identities are constructed in opposition. In illustrating the ways these men were compelled to construct their positive health behaviours as 'not feminine', I have also provided support for hegemonic masculinity as a theory for understanding the construction of gendered identities.

Previous research and the findings from the current study provide the basis for an understanding of gendered identities that goes beyond traditional gender roles to include the influence of social context on the way one can identify as masculine or feminine. In regard to health promotion, the results from this study suggest that the impetus for improving men's health must be based on an understanding that there is variation not only between men and women but also between different groups of men. Although this research does not solve the 'crisis of men's health' it further strengthens the importance of social context to this area and psychological research in general.

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Hello everybody

As some of you may know, I am about to go into the final year of a master of science in health psychology, which involves conducting a yearlong research project. I recently received some funding from Massey University to do some research over the summer holidays, so I thought this a good opportunity to do a small pilot study for my masters thesis next year and involve some people in the valley at the same time.

As part of my course, I have been looking at the rather unfortunate health status of men in our society and this is particularly the case for rural men. One of the issues that comes up often is the fact that, for a number of reasons, men tend to delay going to their doctor (or do not go at all) when they have a medical problem. Therefore, when we do finally drag ourselves along the condition, be it injury or illness, may gotten serious and in some cases, potentially life threatening. Consequently, treatment is more complicated, recovery takes longer and the cost to the public health system is higher.

Obviously there are many reasons why we choose not go to the doctor: Its too far away, hard to get an appointment or the cost etc, but I am most interested in how the men of the valley view the use of general practitioner services. Unfortunately what I think doesn't matter, so I need the opinions of the men in the valley. Because this is only a small study, I would narrow potential participants down to men over 50 years of age and am hoping to get around 10 participants. But if the study goes well, it would be expanded further for next year

I must stress that I am not interested in personal health details. Peoples haemorrhoids, although painful, restrictive, and pretty irritating are not the focus of this study! However what I am interested in is participants' opinions: There are no right or wrong answers here, there is no deception or psychoanalysing but a chance to get a good understanding of what rural men do actually think. Participation is completely voluntary and all information given will remain anonymous. This means that although parts of the interview may be quoted in the final project, there will be know way of identifying whom the participant actually was.

I understand that a health related issues have come up in the valley before and a committee was formed to address these issues. Those people involved are welcome to contact me with their comments or suggestions for this research.

At this early stage I welcome feedback from the whole community with regard to

1. Objections and comments
2. Any questions regarding the study
3. Interest in being a participant

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Dear Ida Valley Citizen

As you may have read in last week's school newsletter, I am proposing a research project for mid January 2005. In this project I am interested in the thoughts and opinions of Ida Valley men over 50, with respect to visiting their general practitioner. I would therefore like to extend an invitation to those men over 50 years of age to participate in this study.

### *What is the study about?*

The purpose of this study is to gain an understanding of rural men's thoughts and opinions in regard to visiting their General Practitioner. This study asks questions such as: What factors would prevent one from seeking medical help? Why would one go to the doctor in certain circumstances but not in others? Surprisingly little is known at present about the answers to some of these questions and I would like to discuss these issues with the men of the Ida Valley.

### *What will participants do?*

I am asking men over the age of 50 to initially watch a segment from a Jack Nicholson movie that raises some of these issues and then to comment on how it may relate to their own experiences of going to the doctor. The interview itself will take place in your home, or a location of your choice, and will take approximately one hour.

### *What will happen to the interview information?*

What people say in the interviews will be audio-taped and their own transcribed version will be initially returned to them, so they may withdraw or add comments, as they desire. The information gained from the interviews will then be used to answer the immediate questions. At this stage I must emphasize that this study is not concerned with personal medical details, that the results will be anonymous, and that peoples names or personal details will not be used. Every participant will receive a summary of these results at the end of the study (which is in 2005) and a report will be sent to the valley health committee. The final results of the study will be submitted for publication in a professional journal.

### *Am I eligible to take part?*

I will be very interested to hear from men who are 50 years of age or older. Participation in the study is entirely voluntary. If you do choose to take part in our study, please know that you have the right to withdraw at any time. As a token of appreciation, participants will receive a voucher for a free video hire. **If you are interested in participating, please complete the enclosed reply form and post it back to me in the freepost envelope.**

### *Summary of your rights*

If you choose to participate in the study you have the right to:

- Receive information about the results at the conclusion of the study.
- Contact the researchers at any time during the study
- Participate in the study with confidence that your personal details are completely confidential
- Decline to take part or withdraw from the study at any time.
- Withdraw any piece of information that you have volunteered.

If you have any questions about this study please feel free to contact me at work (06 3505799 ext. 2049) or at home (06 3594565) Alternatively, I can be contacted by email: [jacknoone@slingshot.co.nz](mailto:jacknoone@slingshot.co.nz)

Happy New Year everybody and I hope to catch up with you in January

Jack Noone.

## Reply Form

I have read the information sheet about the proposed study and I am interested in participating.

1. *Interviews will take place from January 10<sup>th</sup> to January 23<sup>rd</sup>; do you have regular times that would suit you for interviews?*

I am only available at certain times of the day. These are:

.....

2. *What is your current age?*      \_\_\_\_ years

3. Would you like to receive a summary of the results of this research at the completion of the study?      ☐ Yes      ☐ No

*Please provide us with your contact details so that we can contact you about an interview time:*

Name.....

Address .....

Phone Number .....

Signed.....

Thank you for your interest. If you have any questions about this form please phone 06 3505799 ext. 2049 (work) or 06 3594565 (home)

Remember to use the **free post** envelope to return this form. You *don't* need to use a stamp.



**Massey University**  
COLLEGE OF HUMANITIES AND SOCIAL SCIENCES

SCHOOL OF PSYCHOLOGY  
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[www.massey.ac.nz](http://www.massey.ac.nz)

May 23<sup>rd</sup> 2005

Dear

As promised, I am sending you a copy of our interview transcript for you to remove or add comments as you desire. Please note that you are not obliged to review this. Most people make no changes to their transcripts and if this is the case for you there is no need to return the transcript.

Nevertheless, if you do decide to read through our interview, please do not be alarmed by the seemingly ungrammatical way we often speak. Everybody does this, myself included, it is simply the way people communicate and this is not part of the analysis. There have been instances in the past where people have painstakingly corrected their grammar throughout the interview. I can't stress enough that there is no need to do this!

Thank you for your ongoing participation. Once we have the checked transcripts I will begin the analysis and hope to send you a summary of the results by the end of this year.

Hope the winter treats you well

Regards

Jack Noone  
Freepost 86  
School of Psychology  
Massey University  
Private Bag 11 222  
Palmerston North.



1. Participants were initially asked a number of question regarding aspects of the movie segments

What was happening to Harry at the beach house?

How did he respond to the chest pains?

Was this a reasonable response?

Was it a sensible response?

Why do you think the he acted in this way?

What do you think stopped him from asking the woman to drive him to the hospital?

Would you stop and go to the doctor if you experienced chest pains like that?

Why or why not?

2. Participants were then presented with a number of scenarios and asked a number of questions as follows.

**“Pat is a 50 year old that has been experiencing stomach pains for 5 days.”**

Should Pat go to see a doctor? Why/why not?

Would he tell anybody? Who would he be most likely to talk to?

What if Pat were a woman? Would it be any different? Why?

What if Pat heard that other men had been experiencing the same problems, would that influence Pat’s decision to seek help? Why?

Why would Pat delay going to see the doctor?

**“Doug sees blood in his urine.”**

Repeat questions

3. Regarding the former resident of the valley that had recently died of pneumonia:

Can you describe to me the circumstances leading up to his death?

Why do you think he did not go to the doctor earlier?

4. Regarding the respondents healthcare utilization

Can you think of a time when you didn’t go to the doctor for a medical problem when you knew that you really should have?

Can you explain these circumstances to me?

Do you have faith in your doctor’s ability to cure your problem?



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### Participant consent form.

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

I understand that I have the right to withdraw from the study at any time and to decline to answer any particular questions.

I agree to provide information to the researchers on the understanding that my name will not be connected with any information from interviews or discussions. The information will be used only for this research and publications arising from this research project.

I agree to the interview/discussion being audio taped. I understand that I have the right to ask for the audio tape to be turned off at any time during the interview.

I understand that the interview will be transcribed and returned to me so that I may add or remove comments at my discretion.

I agree to participate in this study under the conditions set out in the information sheet.

**Signed:** .....

**Name:** .....

**Date:** .....

1. Square brackets indicate that some transcript has been deliberately omitted. Material within square brackets provides clarification, e.g.:

A: I think [the deceased man] should have gone to the doctor.

2. Round brackets either indicate agreement from the other party, pauses to the nearest second, or laughter from the speaker, e.g.:

A: So I do go to the doctor (mmm, yeah) but only (3) when I need to (laughs).

3. One or more colons indicates an extension of the preceding vowel sound, e.g.:

A: We::::ll I don't always go to the doctor.

4. An equals sign at the end of a speaker's utterance and at the start at the next utterance indicates the absence of a discernable gap, e.g.:

A: I guess by this stage you can=

B: =Yeah I know what you are about.

5. ... indicates that words within a sentence or turn of talk have been omitted.
6. .... Indicates that an entire sentence or turn of talk has been omitted.
7. All names have been changed to protect the respondents' identities.