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The Social Barriers and Social Facilitators of Men's
Medical Help Seeking Behaviours

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Abstract

The Social Barriers and Social Facilitators of Men's Medical Help Seeking

Gender, along with men's alignment with the normative masculine identity have been identified key determinants of medical help seeking for cancer symptoms. Combined these factors influence the self construct and shape individual attitudes, values, beliefs, norms, expectations and thus behaviours regarding health and including when medical help is sought. Socially conditioned from birth and with a need to conform to social expectations, men delay medical help seeking until their pain is unbearable, or they are faced with an inability to complete routine tasks due to the severity of their illness symptoms. This pattern of men's delayed help seeking contributes to their early mortality from all the leading causes of death, including gender neutral cancers.

Lifestyle factors have been identified key determinants of cancer and thus cancer is concentrated in low socio economic areas where factors such as poor nutrition, high obesity and low exercise prevail, as does delayed medical help seeking by men. In considering how best to address men's delayed help seeking, the source and accuracy of the health information men held was investigated and was found to be to a large extent, inaccurate. A positive factor identified however was that men do discuss health issues, informally amongst themselves.

With numerous factors influencing men's medical help seeking, Bronfenbrenner's Ecological Systems Theory (1979) was identified a suitable framework on which to base this investigation into those social factors that influence men's medical help seeking. Suggestions are made as to how to use this same framework to effect population behavioural change in this regard, that if successful would see improved treatment outcomes and a reduction in the gender mortality disparity.

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Chapter 1: Introduction

This thesis discusses gender as a key determinant of medical help seeking for cancer symptoms. Gender as used in this paper is described by Barnett, Marshall, Raudenbush, & Brennen (1993) as:

Primarily the product of social and cultural processes... varying over time and across cultures. It includes but is not limited to biological, sex, differential socialization experiences [and] individually held expectations for socially defined gender-specific roles and sex role attitudes. (p.794)

It is thus recognised that gender has a strong influence over a man's personal and social identity, the two strongly intertwined, with social identity referring to how one behaves, responds to and processes social factors (Myers, 2000). It is here argued that it is these social factors that shape a man's attitude, values, beliefs, norms and behaviours regarding health matters including when they will seek medical help. First and to establish gender differences in medical help seeking behaviour, I consider identified gender differences with regard to health outcomes. As this paper studies a small group of men with cancer, I proceed to discuss cancer and its prevalence within Western societies across both genders with particular focus on New Zealand, the basis of this study. Considered at this time are the socio economic determinants of cancer, recognised in the Ottawa Charter for Health Promotion (1986) as influencing both an individual's health and medical help seeking behaviours. I then proceed to discuss the identified gender cancer mortality disparity from a social perspective, and argue that a man's sense of self and belonging within a society bear strong influence over his medical help seeking behaviour. The social theoretical framework on which I have based this thesis the Ecological Systems Theory (Bronfenbrenner, 1979) that is then fully explained with emphasis on the social aspects that too are reflected as either a barrier or facilitator of each participant's medical help seeking behaviour.

Health Outcome Gender Differences: The Mortality Disparity

“Men die, women suffer”

(Oksuzyan, Bronnum-Hansen, & Jeune, 2010, p. 213).

The World Health Organisation (WHO) (2001) reports that from conception more men than women die at every age “For all 15 leading causes of death” including suicide (Courtenay, 2001, p.1). Whilst women lead in longevity, health records reflect women access health services more frequently and suffer more chronic health conditions, incapacity and disabilities during their life course (Oksuzyan et al., 2010) suggesting that despite possible equal illness incidence, men do not access medical help. Addis & Mahalik (2003) describe this reluctance of men to seek medical help as a “phenomenon that spans across all ages, nationalities and racial and ethnic backgrounds” (p.5). To capture gender mortality statistics and too create population projections, Period Life Tables using actual mortality statistics for total population age groups are used (New Zealand Ministry of Health, 2011). On studying the Period Life Table, 2011, the life expectancy of a newborn girl in New Zealand in 2010 was 82.4 years whilst that of a boy born under identical conditions was 78.4 years. This mortality difference of 4 years reflects a continuance of a gendered mortality pattern that is common to Western nations (Courtenay, 2009). Illustrating same, **Figure 1** reflects New Zealand’s actual mortality figures for adults aged between 35-69 years, over a 57-year period ending December 2007.

**National mortality trends for all causes of death: New Zealand (Aotearoa)
population aged 35-69 years: 1950-2007**

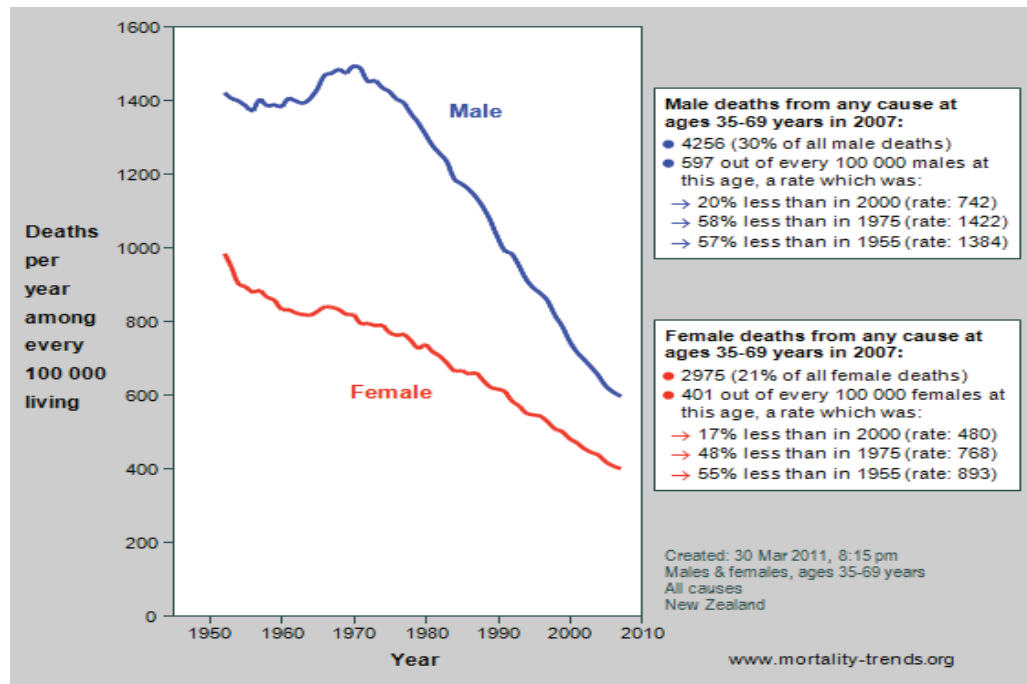


Figure 1. (New Zealand Ministry of Health, 2010)

During this period men comprised 30% of the total national deaths (New Zealand Ministry of Health, 2010) and when considered historically this pattern reflected influence of prevalent ecological, social, political, cultural and economic factors (Doyal, 2000; Noone & Stephens, 2008) also identified in Bronfenbrenner’s Ecological System’s Theory (1979).

Consistent with the “male-female health survival paradox” (Oksuzyan et al., 2010, p.213), and when selecting any year within this period, significantly fewer men accessed medical services (New Zealand Ministry of Health, 2011) despite men near doubling the standardised death rate from non-gendered diseases and near tripling similarly located women’s age standardised deaths from suicide (New Zealand Ministry of Health, 2011; New Zealand Ministry of Health, 2010). Specific to this study, gendered differences in cancer mortality

were also apparent. As such I now explain exactly what cancer is. I then provide cancer specific health statistics to highlight its national prevalence and to reflect its relevance to this study. Consideration is given to social location of cancer within society. This topic reveals some of the social barriers and facilitators that men encounter that influence their decision making when illness symptoms first present – and whether they seek medical assistance.

What is Cancer?

*Cancer is one of the main killers in Western society today...
a modern-day scourge!*

(Pinell, 1987, as cited in Bishop & Yardley, 2004, p.467).

'Cancer' comprises more than 100 distinctive diseases with the commonality of rapid and abnormal growth of certain cells that invade and destroy healthy surrounding tissue and at times spread to other parts of the body (New Zealand Ministry of Health, 2010). Whilst cell reproduction is a natural bodily process, with age, cells reproduce at a slower rate and thus hold greater risk of not 'fitting' as well with other cells, increasing the risk of cancerous abnormalities. Thus both cancer risk and incidence consistently increase with age. Supporting this, Fox & Stephens (2008) found that in Western developed nations those aged between 50 to 59 years have a 1 in 20 chance of developing cancer (excluding a simple skin cancer), a statistic that increases to a 1 in 5 chance for those aged 70 to 79 years, and a 1 in 2 chance for those aged 80 years and over. Capturing the ages when cancer is more prevalent and thus people more conscious of its incidence, all the participants in this study are aged between 50 and 79 years.

The Social Location of Cancer

When considering the causes of cancer, Cotugna, Suar, Heimendinger, & Kahle (1992) identified near 80% of national cancer cases were lifestyle related. Supporting this, Fox & Stephens (2008); and White, Thomson, Forman, & Meryn (2010) found lifestyles that reflect patterns of poor diet and/or inadequate levels of exercise positively correlated with cancer incidence. Upon raising this issue with the American population however, a mere 38% accepted the existence of a relationship between lifestyle factors and cancer (Gascoigne & Whitear, 1999), depicting relevance of both Bronfenbrenner's Ecological Systems Theory (1979) and that identified by Underwood (1992) who found populations high in obesity (and thus with high cancer incidence) mostly of low socio economic status (SES). Bronfenbrenner's Ecological Systems Theory (1979) identifies the socio-ecological impact on individuals across the socio-economic spectrum. Here and in this regard Wilkins (2007) found that individuals positioned at an individual's meso and micro systems (Bronfenbrenner, 1979) tended to pool their material and emotional resources to help facilitate one close to them access medical treatment when identified as necessary. Specific to cancer patients and as identified by Marshall et al., (2011) the impact on the nuclear family when an individual accesses cancer treatment is reflected in a fall in patient's income as well as a fall in the gross earnings of the adults within that household. Reflecting these support people as social facilitators of medical help seeking, Marshall et al. states:

Cancer is therefore a family experience and family members often have as much, or more difficulty in coping with cancer as does the person diagnosed with cancer (2011, p.171).

The WHO's Global Strategy for Health for all by the Year 2000 (1981) identified low SES as consistently characterized by unhealthy living practices. These individuals have adopted such behaviours as a means of survival. As reflected in Bronfenbrenner's Ecological Systems Theory(1979), these behaviours have been socially, politically, ecologically, and economically

shaped, developed, learnt and adjusted across generations and over time and now reflect the norms and expectations of those people (Bates, Hankisky, & Springer, 2009). Reflecting such, **Figure 1** depicts a national mortality peak in 1975 that coincides with the political instability and flux experienced in New Zealand at that time (New Zealand Government, Ministry for Culture and Heritage, 2012). This thesis here aims to identify such social factors that influence men's medical help seeking behaviours. Concentrating on the social barriers and social facilitators that men within a given community experience, the geographical boundaries in which the study was located was controlled.

Maintaining focus on cancer I now return to the gender mortality disparity and consider these figures specifically with regard to those who died from cancer.

Cancer: “Men die, women suffer” (Oksuzyan Bronnum-Hansen, & Jeune, 2010)

New Zealand national cancer mortality statistics reflects more men die at every age from gender neutral cancers, despite women having higher cancer incidence until age 53 years (after which there is incidence parity) (New Zealand Ministry of Health, 2010). **Figure 2** reflects the gendered cancer mortality pattern in New Zealand for residents aged 35-69 years over a 57 year period ending 2007.

New Zealand's (Aotearoa's) Cancer Mortality Trends: Population age: 35-69 years: 1950-2007

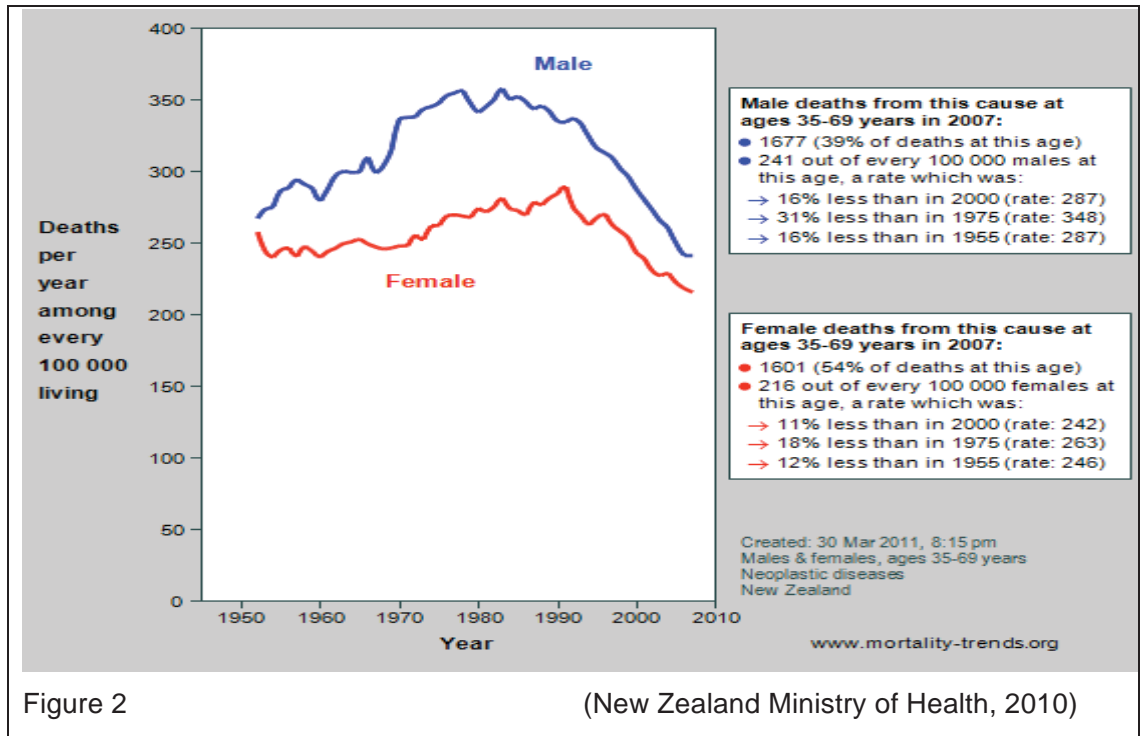


Figure 2 (New Zealand Ministry of Health, 2010)

Figure 2 displays consistent higher male cancer mortality between 1950 and 2010. As no significant reforms have been enforced to address this as and consistent with information released by the New Zealand Ministry of Health (2002), a significant gendered cancer mortality pattern remains prevalent today.

Figure 2 reflects a delayed, almost mirrored mortality pattern of women. This pattern is consistent with that identified by Bishop & Yardley (2004), who found the late diagnosis of cancer in men resulted in reduced treatment outcomes and earlier death. Further reflecting same and captured in New Zealand's national statistics, men diagnosed with lung cancer die within 5 years – this being a mortality figure 5% higher than that of women similarly diagnosed (New Zealand Ministry of Health, 2010). This figure also suggests that men might not conform to medical recommendations and this too would compromise their health outcomes. In light of that gained on the social location of cancer

such behaviour suggests strong social barriers are faced by men with regard to attending to their health, including seeking medical assistance, and possibly complying with same. Why then, do some men seek medical assistance, whilst others do not? This thesis aims to also uncover those social facilitators of such behaviours prevalent within this society. I now explore why men respond so differently to social factors than women – and what it is that makes men so resistant to seeking early medical help, when they feel ill.

The Social Influences on Behaviour

All humans have needs that can be satisfied only through social interaction with others (Kaplan, Greenfield, & Ware, 1989, p.237).

The Social Identity Theory (Tajfel, 1981, 2010) argues that our interpretation and understanding of the world and our place in it is socially constructed, dynamic and thus dependent on others. Tajfel (1981) describes interpersonal communication as fundamental in shaping and developing both individual and collective ideas, a view that is supported in this thesis. The dynamic nature of our behaviour is evidenced through time and reflected in Bronfenbrenner's Ecological Systems Theory (1979) that depicts both direct and indirect social influences on behaviours.

Lifestyle choices as discussed earlier, are not only a reflection of one's identity but are too a reflection of social and economic status, resource availability and accessibility – mostly driven by social factors, not the individual (Watson, 2000; WHO's Global Strategy of Health for all by the Year 2000, 1981). Reflecting social influence in a different way, Durkheim (1951) identified that highly cohesive neighbourhoods have high male suicides and attributed this to the social expectation for conformance and the lack of regard or recognition of individual attempts at difference that is commonly seen in men competing within group for social recognition and social status (Courtenay, 2011). Similarly Durkheim (1951) found fragmented neighbourhoods also give

little regard to their citizens and identified that again, this unmet need of men for external social validation and recognition resulted in heightened anxiety, chronic depression and suicide. Complementing this finding on the social influence the neighbourhood has on individual behaviours, Collings, Ivory, Blakely, & Atkinson (2009) found that in New Zealand the SES of the neighborhood and in particular neighborhood deprivation were key drivers of male suicide – regardless of the individual’s personal SES. This finding reflects consistency in the strong relationship between men’s perception of being socially accepted and their health and health behaviours. It also supports for Bandura’s Social Cognitive Theory (1969), that argues that individual behaviour and understanding of the world are shaped by the environment and the relationships formed and all reflected through behaviour (Myers, 2000). Further supporting this and more recently, Jetten et al., (2012) identified a positive correlation between social identity, health and health promoting behaviours. This finding suggests that individuals engage in activities that either support or compromise their health and well-being in accordance with their self construct. It also reflects the complex nature of social influence on a person’s sense of self and of ‘being’. As both social structure and social power exist within any society, to promote individual and indirectly, collective health, members within a community thus need to actively manage their collective identity and structure (Myers, 2000).

In short, it is through social interaction that people construct and reconstruct events and adjust its meaning with all the new contextual information they receive, often resulting in changed behaviours and outcomes (Bracht, 2000; Browns & Bond, 2008; Kypri, Paschall, Langley, Baxter, & Boudfeau, 2010). Considered this way, the early diagnosis of cancer is thus in our own and our community’s hands, as our understanding and practice of health and health behaviours are socially driven (Stephens, 2008). Behaviour thus reflects “A transaction between the individual and the world as they constitute and are constituted by each other” (Munhall, 1989, p.72).

Who am I?

The Social Identity Theory (Tajfel, 1981) cites group membership integral to the development of the self-construct, as it shapes social behaviour – *‘who I am when interacting with others’*. Jetten, Haslam, & Haslam (2012) support same and further describe group membership as the ground where individuals learn to interpret, understand and manage their lived experiences, as summarised by author, Virginia Woolfe, *“We are not one and simple, but complex and many”* (The Waves, 1931)

Tajfel (1981) defines the self construct as comprising two intricately interwoven identities, i) the Personal Identity and ii) the Social Identity. The Personal identity refers to those specific qualities that one holds, whilst the Social identity develops through social interaction with others. ‘Social Identity’ thus reflects a person’s alignment to the “Value and emotional significance” they attach to every group to which they belong (Tajfel, 1981, p.255). In considering the topic under study, men, first and foremost belong to that gendered group, ‘Men’. Their subsequent behaviours thus need to reflect alignment to the social attributes and values associated with being ‘a man’ and are thus driven by the need to conform to the socially determined normative masculine identity. Considered differently, for men to view themselves masculine, they need inert alignment with gendered social norms (Marshall, Larkey, Curran, Weihs, Armin, & Garcia, 2010). Supporting same, men’s social interaction with other men has been found to hold strong influence over the other’s health behaviours (Kaelin & Neugut, 2005).

As raised previously, the way a person views themselves in relation to others and the world around them shapes how they view themselves in relation to their environment (Jetten et al., 2012; Myers, 2000). Here, relevant environmental and cultural factors include the beliefs and values held within a society that shape its normative masculine identity; the health information and beliefs shared amongst those people including their access to current

information and its means of dissemination within that community. Extending our scope to include the workplace, Myers (2000) identified a positive correlation between the work environment and individual self-esteem a finding supported by Fernando (2010) who also identified that the social environment of the workplace as influencing the social and self identity. Fernando (2010) argues that people bound through the commonality of work proximity, nature, and resource accessibility, adjust their beliefs to align with that of the in-group. Elaborating on the benefits of the workplace on health and help seeking, and replicating Doyal's findings (2000; 2001), Jetten et al. (2012) found workplaces that encouraged positive employee morale saw improved staff health, increased work output, reduced absenteeism and an overall increase in observed health promoting behaviours amongst staff. The work environment can therefore serve as a facilitator of men's help seeking and does indeed shape one's self construct.

In contrast, competing with other men for social recognition and status further tends to steer men towards high risk taking behaviours (Courtenay, 2006) that include delayed help seeking (Andersen, 1995); alcohol-fuelled anti-social behaviour (Dabbs & Morris 1990); and multiple sexual partners with no use of sexual protection (Courtenay, 2003). Here and in each instance when questioned, men have described such behaviour as overt displays of virility and 'superior masculinity' (Courtenay, 2003) that should be socially bragged about to male peers. Such social influence thus serves a barrier to medical help seeking, and I believe it too reflects an inert need for social acceptance and belonging in men.

The Normative Masculine Identity

The normative masculine identity is socially constructed from the hegemonic masculine identity – the latter reflecting the ultimate traits identified to depict strength, power, control and thus, dominance over others. The development of

the normative masculine identity within each society proceeds in accordance with Bronfenbrenner's Ecological Systems Theory (1979), shaped by culture, values, beliefs and the attitudes held and socially reinforced by those same people, resulting in social expectations of those men. One such commonly shared social expectation is that men do not seek medical attention unless seriously ill. With no clear boundaries as to what constitutes 'serious illness', men often endure acute levels of pain prior to help seeking

I here present one of the key barriers to men seeking medical help as the social pressure for alignment with the normative masculine identity, the normative masculine identity holding expectations of men that support unhealthy behavioural practices. Alongside fear and loneliness that too have adverse effects on men seeking medical help is the social pressure placed on men for emotional stalwartness as "Boys don't cry" (Chapple & Ziebland, 2002, p.216). Such message is communicated consistently through life and encourages boys... and men to disregard physiological and psychological health cues; the extreme consequences being...suicide (New Zealand Ministry of Health, 2010). Identifying the need to address this, Myers (2000) describes emotional expression as the foundation of close interpersonal relationships with others; Courtenay (2003) supports this, and suggests that men's skill deficit here might attribute to the emotional dependence men often form on their female partner, again reflected in the high suicidality evidenced in heterosexual middle aged men when either widowed or separated - regardless of the length of their spousal relationship. Overt alignment with the normative masculine identity thus serves in such instances a barrier to men seeking medical assistance.

Social Recognition

From birth, caregivers, including parents, send different gendered messages to male and female infants and Eisler (1995) found caregivers physically hold male infants further away from their own body and nurture them

less often than they do females. This gendered behavioural response is maintained throughout life and extends to the social encouragement of boys... and men...to withstand emotional expressions of pain and distress, these being associated with weakness Chapple & Zieland (2002) and discussed under the next subheading.

The social encouragement and expectation of men to display alignment with the normative masculine identity thus encourages high risk taking behaviours. Having identified males as physiologically predisposed to same from conception (Ingemarsson, 2003; Eriksson et al., 2010) the combined effect of a physiological predisposition and social pressure to display superior masculine traits thus serves to feed men's uptake of high risk activities including dangerous sports and undertaking activities requiring physical superiority, strength and/or aggression (Courtenay, 2003; Mathers, Vos, Stevenson, & Begg, 2001). Hegemonic behavioural displays receive social recognition and approval from women, as well as other men that serves to reinforce such behaviours as desirable in men. In line with this desire of men to earn or retain such social recognition, during interviews with men hospitalized with prostate cancer Chapple & Ziebland (2002) found all the patients admitted deliberately delaying medical help seeking despite their experience of extreme pain, stating:

It is not 'macho' to seek advice about health problems...

Boys don't cry...

It is not 'masculine' to display signs of weakness"

The latter remark identifies the 'sick role' as one socially associated with weakness, supporting men's reluctance to seek medical assistance as in so doing it publically deems them 'weak' . Similar responses were received in interviews conducted by White & Johnson (2000) and Galdas (2001) reflecting men's inert need for recognition as a man who conforms with the normative masculine identity, social expectations of men – as each individual tries to establish their place within society (Tajfel, 1981; Watson, 2000).

Age is too identified a significant influence on social behaviours as despite an inert need for men to display normative masculine behaviours for which they receive social recognition and status (Doyal, 2000; 2001), diminishing physiological abilities impose a forced shift in men's behaviours. Whilst the relationship between age and behaviour is recognised, no consistent relationship pattern exists, (Doyal, 2000; 2001) and whilst some men might increase their seeking of social validation as they get older, others withdraw from the social arena same (Davidson & Meadows, 2010; Gorski, 2010; Ye et al., 2009).

Still reflecting a change of behaviour in accordance with a change of life stage, prior to fatherhood and when men have few social responsibilities the majority were found to have no regular doctor whom they would access if ill (Sloan, Claire, Gough, Brendan, Conner, & Mark, 2010). Fatherhood however, altered this and whilst some fathers increased their health promoting behaviours and help seeking to support them meet their social responsibilities (Davidson & Meadows, 2010; Robertson, 2007), others further distanced themselves from same and willfully masked illness symptoms and delayed medical help seeking as they prioritized meeting a familial social perception of strength and invincibility (Gough & Robertson, 2010; Marshall et al., 2011; Sloan et al., 2010). Fatherhood is attached to the social expectation that these men will provide and protect their family. The manner in which men meet this responsibility is reflected in the social recognition and respect earned in the community. Reflecting men's behaviour here as a social response to their change status, amongst those who increased attention to their personal health needs with this added familial social responsibility, their behaviour was consistently found to revert to that observed pre fatherhood once their children had achieved financial independence (Robertson, 2007; White et al, 2010). This behaviour reflects the high priority men place on meeting social expectations with little regard to the personal impact such behaviors might have on them. Further reflecting men's heavily weighted desire for social recognition and lack of regard for long term health consequences, the primary concern of men

hospitalised with cancer was identified as not mortality, but retention of their sexual function - sexual virility being a hegemonic and normative symbol of masculinity (Broom, 2010). Again reflecting same, when considering cancer treatment options Gascoigne & Whitear (1999) found the majority of young and middle aged men unwilling to risk loss of their sexual function, electing instead treatment options with poor health outcomes. This finding supports Oksuzyan et al's. (2010) statement raised early in this paper, "Men die, women suffer" (p.223). Quality of life and social recognition for their masculine traits appearing more important to men than longevity.

I now discuss two key emotions not accommodated for in the normative masculine identity, fear and loneliness.

Fear and Loneliness and the need for micro and mesosystem supports (Bronfenbrenner 1979)

Health beliefs are dynamic (Jetten et al., 2012) and people's attitudes, knowledge, experiences and interpretations of illness are constantly reshaped in accordance with their sense of self within a given context and in accordance with their lived experiences. Providing a contrasting view to that previously considered, Doyal (2000, 2001) suggests that men's general lack of regard to their personal health is a symptomatic response to loneliness and their lack of meaningful social connection with others. Doyal (2000, 2001) identifies meaningful relationships as requiring social and emotional investment, support and reciprocity, all traits that males have historically been socially dissuaded from developing, these traits being socially associated with femininity and weakness. Doyal (2000, 2001) argues that men's alignment with the normative masculine identity thus penalizes them as they do not discuss or publically acknowledge illness symptoms experienced for fear of social judgment. Not socially discussing health issues limits the degree of health information that men hold on pertinent issues; it compromises individual decision making on

health related matters and it denies men the opportunity to access social support people that would encourage they seek medical help when ill.

Also feeding feelings of fear is the social expectation that men display emotional control, that socially supported has resulted in men having no safe outlets where they can express feelings of loneliness or fear (Emslie, Ridge, Ziebland, & Hunt, 2006) other than a medical appointment, and without compromising their social position and status (Doyal, 2000). In this regard Courtenay (2011) identified the unspoken social expectation that men to endure a higher degree of pain and discomfort prior to help seeking as a factor that compounds any feelings of fear and anxiety that men might have with regard to their illness symptoms - as they too risk adverse social judgment for seeking medical assistance for same.

Still with regard to fear and specifically relevant to this study, de Nooijer et al., (2001) found a high degree of fear and reluctance to seek medical help in men who witnessed others die from cancer. Countering this finding, Wilkins (2007) identified that men do informally access help in this regard and found that men do turn to close family and friends (within Bronfenbrenner's micro and mesosystems, yet to be discussed) for same. Shifting the discussion to those social supports that are available to men and supporting Wilkins (2007) finding, Courtenay & Sabo (2001) identified that men with high levels of social support were more attentive to their health needs when compared to a comparison group who had low levels of social support. Additionally, they found members of the latter group three times more likely to die before those with higher levels of social support regardless of SES. In this regard and as early as 1977, Kapal, Cassel, & Gore (1977) identified a powerful relationship between the social environment and one's physiological and psychological health. Here Kapal et al. (1977) identified that regardless of personal SES, ethnic minorities living in the USA who had no developed local social network experienced the highest rates of respiratory and psychological diseases, including tuberculosis, schizophrenia

and suicide. More recently and showing consistency with these findings, Seymour, Cooke, Hough, & Martin (2010) found the hospitalization for sepsis greatest for single men regardless of their personal SES.

The key social role held by close friends and family with regard to men's health outcomes is apparent and Andersen, Cacioppo, & Roberts (1995) identified the role of these individuals here as being to validate the seriousness of illness symptoms experienced and to encourage their medical help seeking. Andersen (1995) reflects this in his Model of Total Patient Delay, (1995) where he identifies delayed medical help seeking from those with no close social supports.

The pressure that men experience to conform with what they perceive to be the social expectations of when it is appropriate for them to seek medical help leads me to a more systemic issue; that of the social conditioning from birth that infant boys are subjected to that, from that age inadvertently promote their subsequent resistance to seek medical help. Similar social messages continue to be transmitted to men throughout life and used by those high up the social hierarchy (positioned at Bronfenbrenner's macrosystem (1979)) to steer men towards high risk taking behaviours through the public promotion of hegemonic masculine traits and use of the social system positioned beneath.

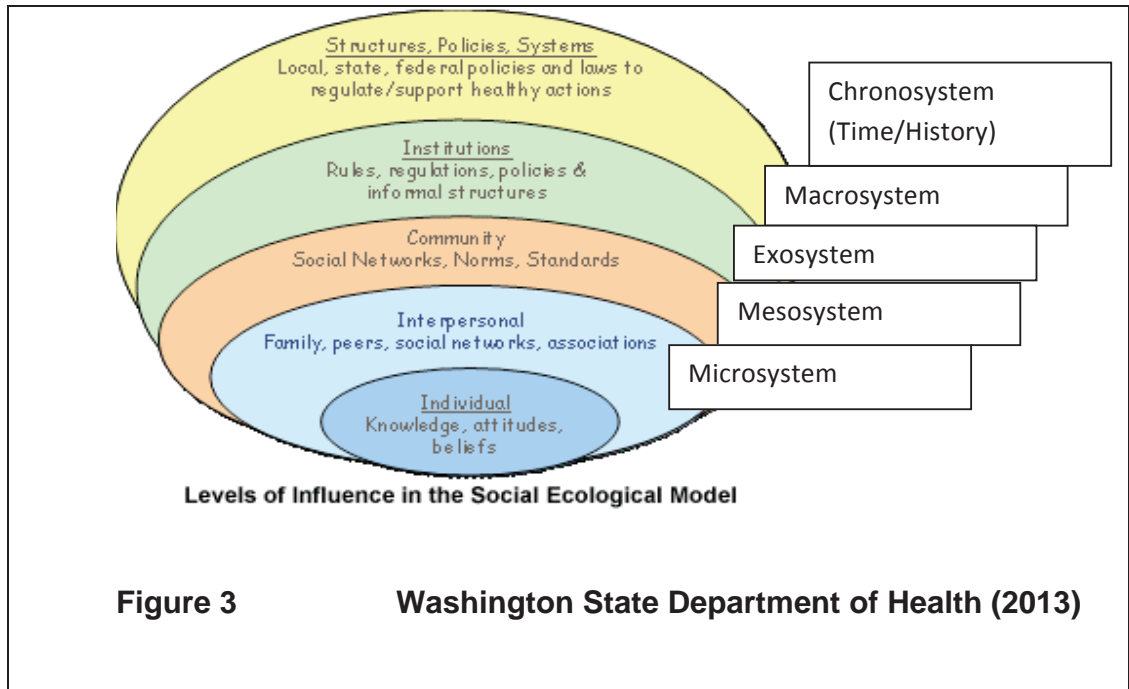
These findings reflect the strong, positive correlation between social support and the self construct, sense of self-worth, health attitudes and behaviours that include going to the doctor. They too reflect the entwined and complex nature of the social and ecological environment on men's well-being and behaviour and as captured in Bronfenbrenner's Ecological Systems Theory (1979); the social aspect of this model as considered in this thesis is now explained.

Chapter 2: Bronfenbrenner's Ecological Systems Theory (1979)

The theoretical model on which this thesis is based is Bronfenbrenner's Ecological Systems Theory (1979). This model has been selected as it fully captures the social nature of health and reflects the impact of same on an individual's personal health practices, attitude, decisions and ultimately, behaviours. Focus is thus concentrated on the social aspects of the model.

As has been demonstrated earlier, the effects of the social environment on men's behavioural response to illness symptoms is significant and health promoting behaviours including help seeking cannot be considered to the exclusion of SES. SES is reflected in social hierarchy and is thus well captured in the Ecological Systems Theory (Bronfenbrenner, 1979) which captures the hierarchical, "spatially heterogeneous, non linear [and] dynamic" social systems that influence individual decision making and behaviours (Wu, & David, 2002, p.11). To highlight the social aspect of Bronfenbrenner's Ecological Systems Model (1979) I introduce it using relational terms to illustrate health as structured by society; "That health is a matter for people embedded in social life; health related behaviour being more about that social life than about health" (Stephens, 2008, p.19). Directly derived from Bronfenbrenner's Ecological Systems Theory (1979), **Figure 3** below thus reflects how people at each hierarchical level of society play a part in shaping an individual's self construct and experience of the world whilst influencing their decision making and behaviours to reflect conformance with the prevalent traditions and norms of that society.

Social Ecological Model: Hierarchical Levels of Social Influence



In **Figure 3** the individual rests at the core of the structure depicting all the hierarchical social and ecological levels that influence and shape them to be who they are at that time. Every level of society that has a direct and/or indirect influence over one's knowledge, attitudes and beliefs – these all being derivatives from and representative of that society.

Positioned at the microsystem and bearing direct influence on the individual are those with whom an individual holds close personal relationships, namely family and friends and those who form a part of one's close social networks. Reflecting the intimacy shared with people at this social level, Myers (2000) describes the emotional expression here shared as the foundation of close interpersonal relationships with others. It is individuals at this level whom Andersen (1995) found to be most accessed by men for validation of their illness symptoms prior to help seeking. Here Galdas, Cheater, & Marshall

(2005) found the informal social exchange that takes place at this level being that from which men gain the bulk of their health related knowledge.

The mesosystem represents the community, the collectives with whom the individual has a close affiliation, who too hold have a direct influence over their attitudes, beliefs, decisions and behaviours. Also here positioned are neighbours, extended family, health and community support services and social networks. Social norms and expectations suited to that community are enforced at this level and through membership numbers, social influence is great and conformance to same expected.

The exosystem represents those institutions that are delegated tasks from those within the macrosystem. The exosystem's role being to enforce the rules and regulations that have been decided upon at an influential social and political level to reflect the values and traditions of the wider society. Such bodies include local councils, libraries, the mass media, etc , they serve as tools used by the macrosystem to receive and disseminate messages . Social influence from this level can be either direct or indirect .

The macrosystem represents those political, multinational and large corporate bodies that are responsible for political and national decisions and have economic influence that impacts the society's well being. These are the social power holders who determine resource allocation and thus shape a nation's socio economic divides (Wilkins, 2007). Those positioned at this level aim for support of their decisions across society and hold strong position in determining the traditions, culture and values of that society.

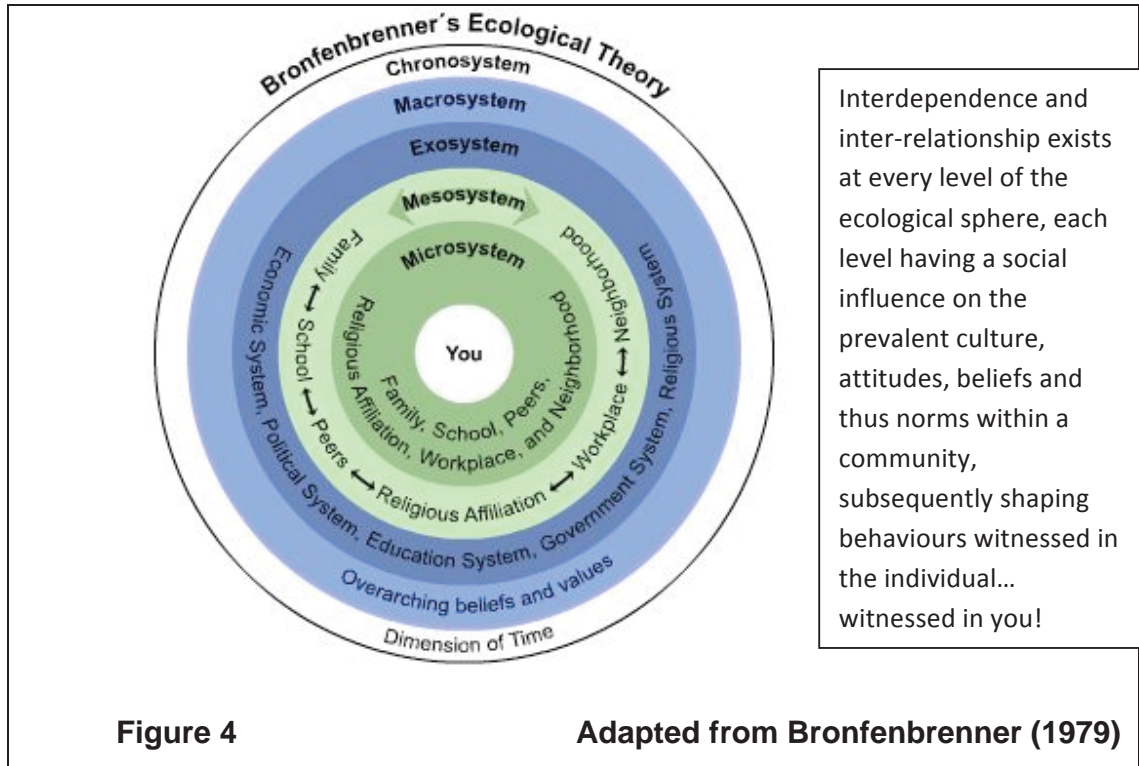
With reference to this topic under study and to reflect the entwined nature of social influence across the social hierarchy, SES and decisions made by those who implement Structures, rules, policies and systems, influence the type and quality of health information that is made available at each level below

them. It is at this level that decisions are made as to how health messages are conveyed to individuals, and it is the role of Institutions to work with their allocated resources through Community and health services to convey these messages to those close to the individual and to the individual themselves. Andersen's Model of Total Patient Delay (1995) captures the significant role that the health sector (that would span the social hierarchy) holds with regard to influencing individual medical help seeking. Supporting the need for a different approach by the health sector that encourages men to access medical services, the lack of accurate health knowledge by men, particularly amongst those of low SES was prevalent (Broom, 2010; Robertson, 2007). Here and during interviews with men hospitalized with cancer the majority reported having misinterpreted their cancer symptoms as part of the regular ageing process resulting in delayed medical help seeking (Broom, 2010). This finding appears consistent amongst men and might contribute to the gendered mortality differences discussed earlier. As such, a lack of accurate health information is likely to be a socially constructed barrier to early help seeking behaviours in men. Compounding this lack of knowledge is the fact that due to alignment with the normative masculine identity, men seek medical help only when their illness symptoms cannot be tolerated any longer due to severe pain, or their inability to complete routine living tasks (Courtenay, 2011; Gough & Robertson, 2010; Stephens, 2008), the outcome evidenced in the gender mortality differences (New Zealand Ministry of Health, 2010).

Figure 3 illustrates how no individual exists in isolation and depicts how individual behaviour is influenced by those in both our direct and indirect social environment.

Having introduced you to the working structure of Bronfenbrenner's Ecological Systems Theory (1979), I now proceed with a more detailed explanation on why this is the most suited model on which to base this thesis.

Ecological System's Theory (Bronfenbrenner, 1979)



The Ecological System's Theory (Bronfenbrenner, 1979) as illustrated in **Figure 4** reflects the interconnectedness and bi-directional 'domino effect' decisions at any level of the ecological structure have on all others. The 'domino effect' as defined by The Collins English Dictionary (1991) is "A series of similar or related events occurring as a direct and inevitable result of one initial event" (p.265). Explaining this using **Figure 4**, each individual is positioned at the core of the diagram and enveloped within their heterogeneous micro, meso, exo, macro and chrono systems that comprise the world as they know it, structured within the dimension of time and history, the chronosystem. The micro and meso systems reflect those direct social influencers on an individual. Socially transposing this model onto that depicted in **Figure 3**, the micro and mesosystems thus include those community and health service providers whose role is to deliver that directed from the macrosystem. It includes all formal and informal social settings where people come together and

interact with a common purpose. Interpersonal relationships developed with others of varying depths and intimacy thus characterize the social aspects of these ecosystems. As reflected in **Figures 3 and 4**, the macro and chrono systems represent those indirect influencers on an individual's social identity. Whilst the chronosystem represents time in relation to national and international history, the macrosystem comprises powerful national and corporate bodies that ultimately determine the social positioning of individuals within that society. They achieve this through the implementation of policies, laws, regulations and behaviours directly transmitted to individuals through the exosystem. At the macrosystem key decisions that influence the social determinants of health as reflected in WHO's Global Strategy for Health for all by the Year 2000, (1981) are effected and thus the macrosystem shapes the SES of that society and the individuals in it. As such, those at the macrosystem are responsible for spearheading the desired culture, social norms and expectations of that society, these being refined and mildly adjusted at each eco-level to ultimately and uniquely shape each person's individual self and social identity, their self construct (Tajfel, 1981).

Those at the macrosystem have superior social power over others in the Ecological structure and the interdependence of money, power and social factors on health behaviors is also captured in Bronfenbrenner's Theory (1979). One example of such is how power and dominance are used by those at this level to influence individual beliefs and promote national interests. One such example is the use of the mass media to appeal to citizens' social and moral ethics to perform tasks not necessarily desirable and often dangerous and/or physically and psychologically grueling such as army enlistment during times of war (Bates, Hankivsky, & Springer, 2009). Here, social expectations imposed on men, coupled with each individual's need for social acceptance at their microsystem level and beyond (Galdas et al., 2007) is seen as obtainable only through social conformance and thus men are drawn into such services, where they compromise their health and longevity in return for social power, status,

recognition and most importantly, acceptance (Courtenay, 2009; Galdas et al., 2007).

Fully captured in Bronfenbrenner's Theory (1979) is how any significant activity at any eco-level always has an effect on the other eco-levels. At the core of the ecological structure is the individual whose social environment including their cultural and ecological beliefs, norms and understanding are directly shaped from conception (Ingemarsson, 2003) by one's parents and caregivers, then subsequently post birth by all other direct and indirect social interactions. Social norms are thus directly and indirectly reinforced through daily living activities that include social interaction with others (Stephens, 2008) all influenced by factors that at some level hold position at the macrosystem (Bronfenbrenner, 1979). Reflecting the value of social norms on behaviours as discussed by Courtney (2006), men's alignment with the normative masculine traits of independence and strength (Lyons & Chamberlain, 2006) can serve as a social facilitator of medical help seeking behaviour as men have been identified as accessing medical help when their ill health symptoms adversely affect their performance of daily activities (Brown & Bond, 2008; Galdas, Cheater, & Marshall, 2007). It is those positioned within the micro and mesosystems, namely, community and health supports and service providers, family and friends who here have the opportunity to influence the individual's health beliefs and subsequent behaviours.

Briefly returning your attention to Tajfel's Social Identity Theory (1981) that identifies one's social identity as shaped by their environment, a sense of self is thus deemed impossible without this social component that defines one's sense of belonging within the world. It is within this social structure that men establish, exert and thus communicate their social power, status and positioning - both with women and against other men, all of which in turn affect their own, and others' physical and psychological health and behaviours, including medical help seeking.

Supporting the relevance of a Social Ecological Systems approach in identifying the social barriers and facilitators of men's medical help seeking behaviours, I now draw attention to the WHO's global strategy to improve health for all by the year 2000 (1981) and its recognition of social structure as highly relevant to health outcomes.

WHO's Global Strategy for Health for All by the Year 2000, (1981) and the subsequent Ottawa Charter for Health Promotion (1986) are fit within the Ecological Systems Theory (Bronfenbrenner, 1979) as they draw on social, financial and ecological factors and how these influence an individual's and society's health and health behaviours. Here, both documents identify SES a key determinant of health and health behaviours and aim to reduce the health disparities witnessed across the socio economic divides.

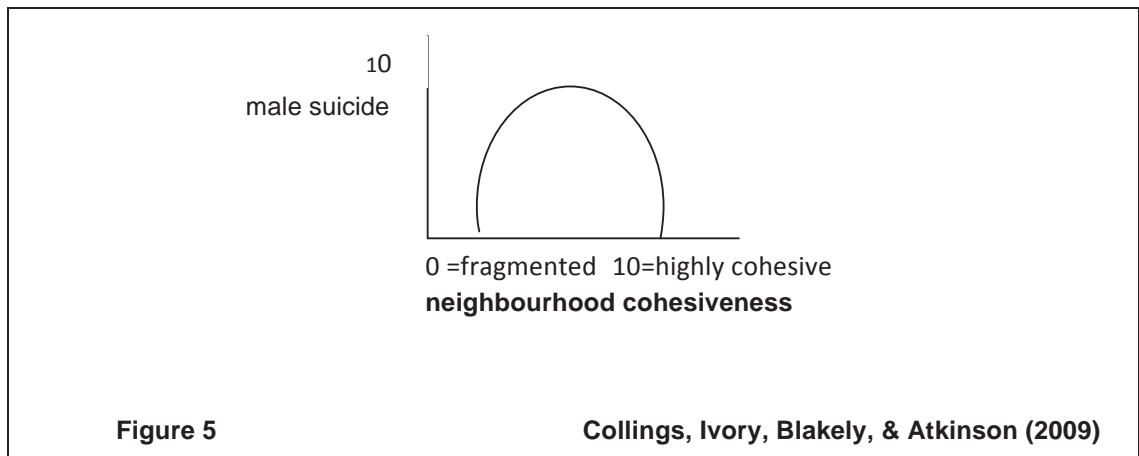
The positive correlation between health, behaviour and individual SES were also identified by Dabbs & Mottis (1990) and Galdas et al. (2005) and both studies found that not only are men's health behaviours influenced by their personal SES but individual alignment with the normative masculine identity and factors related to social power status were also found to influence same. This, along with the social and empirical data on which WHO's Global Strategy for Health for all by the Year 2000 (1981) was based thus conflict with Collings, Ivory, Blakely, & Atkinson's (2009) findings on the social influence of one's residential neighbourhood. This alternative view on the social influences on individual behaviours by those at the meso and Microsystems is now discussed.

Durkheim's Theory (1951)

Collings et al., (2009) identified Durkheim's Theory (1951) relevant and identified a positive correlation between the SES of one's residential neighborhood, individual health and proactive health behaviours –regardless of individual SES. Durkheim's Theory (1951) as cited by Collings et al., (2009) further identified an inverse 'U'-shaped relationship pattern when measuring

the cohesiveness of one's residential neighborhood and male suicidality, a relationship pattern that is depicted at **Figure 5**.

Durkheim's Theory (1951): An Alternative View of the Social Influence on Behaviour at the Meso and Microsystems (Bronfenbrenner, 1979)



Interpreting **Figure 5** above, Collings et al., (2009) identified Durkheim's Theory (1951) as reflective of individual behaviour that is in direct response to the cohesiveness experienced in their residential neighbourhood. Here, Collings et al., (2009) identified that those polarized neighbourhoods that were socially either highly fragmented or highly cohesive both held low levels of male suicide. Whilst Bronfenbrenner's Theory (1979) reflects the latter, as the neighbourhood falls within the meso and micro systems where close relationships exist and where people hold strong influence over each other's beliefs, attitudes, values, social understanding and thus behaviours, highly fragmented neighbourhoods should on reflect the opposite, and see high male suicides. This is further deduced when applying The Social Identity Theory (Tajfel, 1981) earlier discussed. Here, a strong positive correlation is identified between well being and social acceptance. In a fragmented neighbourhood with the risk of social isolation, men are likely to be trapped by the socially constructed behavioural norm that requires they display emotional sterility that is informally interpreted a masculine 'strength' (Chapple & Ziebland, 2002).

Regardless of the view supported above, social influence at the meso and micro systems is in both cases identified as influencing one's experience of health and ultimately health behaviours.

Socio Economic Status (SES)

Money and disposable income are key determinants of health and health behaviours - the relevance of this captured in the identification of the social determinants of health that include poverty, social exclusion, unemployment and poor housing. These and other social factors form the basis of the influential WHO's Global Strategy for Health for All by the Year 2000 (1981), and the subsequent Ottawa Charter for Health Promotion (1986) (Stephens, 2008).

On studying the different health outcomes in one community, New Zealand Ministry of Health (2010) identified that men positioned in the middle to high socio economic groups enjoy greater longevity and better health than those less financially secure. This suggests that decisions made at a macro level (Bronfenbrenner, 1979) inadequately cater for the needs of those of lower SES. Such evidence of same apparent when considering the limited social and structural health resources available to those resident in low SES areas (Wilkins, 2007). National social power thus rests with the elite positioned at the macrosystem and distanced from the lived experiences of those less fortunate (Bronfenbrenner, 1979) and the high rates of violence and anti-social behaviours prevalent in low SES areas (Wilkins, 2007), is in part attributable to these men having limited other means to display normative masculine traits and to reinforce their position within a community (WHO's Global Strategy for Health for all by the Year 2000, 1981).

As discussed earlier, health and health decisions are reflected through lifestyle – the latter determined by SES; SES reflects resource accessibility and social power that, combined with lifestyle choices, shape attitudes, values, decisions and behaviours. As such Wilkins (2007) describes the true cost of

health as determined by both social and financial status. This is better demonstrated when considering how proactive health behaviours often carry costs eg) going to the gym requires additional disposable income. This renders the ability of a person of low SES to adapt their lifestyle in a sustainable way to promote healthy living is often unattainable (Wilkins, 2007). As far back as 1969, Mitchell's Social Network Theory identified this and Mitchell (1969) declared behaviour, including help seeking as influenced by the socio-structural characteristics of the environment (Marshall et al., 2011) – this being captured in Bronfenbrenner's Ecological Systems Theory (1979) and as supported in this thesis.

Bronfenbrenner's Ecological Systems Theory (1979) fully captures the influence of social power and disposable income on lifestyle, as social and financial status including the area in which one resides and works, all influence how health messages are communicated, how they are accessed, and how they are understood by different communities. SES too influences the attitudes and behaviours of those positioned at the meso and exosystems who use knowledge of one's financial status to determine and as relevant to this thesis, the type of medical interventions offered during help seeking. Here, individual SES is thus also likely to influence the time delay preceding treatment and as imposed by the health system; the quality of health care received; and the cost of illness to those positioned at the individual's meso and micro systems who too experience financial decline (with varying impact dependant on SES) when caring for a chronically ill family member undergoing medical treatment (Marshall et al., 2011).

The influence of SES on health is thus seen at all hierarchical levels, with those of lower SES experiencing earlier mortality and illness than wealthier counterparts (Marshall et al., 2011; New Zealand Ministry of Health, 2011, WHO's Global Strategy for Health for all by the Year 2000, 1981; Wilkins, 2007). Supporting this, Marshall et al. (2011) identified that the more disadvantaged a social group, the more limited their access to health services

relative to their needs. Furthermore, patients accessing these services reported feelings of judgment from the treating doctor (Jetten et al., 2012) this being an identified barrier to their future medical help seeking and an issue raised by Hirini (2004). Specifically exploring the process individuals of low SES undertake prior to help seeking, Hirini (2004) identified that they needed to plan for the costs incurred at the doctor's visit, as well as the costs of any prescription medication and transport to and from the doctor. People of low SES mostly work in the labour industry, many on a casual basis, where they are paid per hour. Their working day comprises 8 or more hours of arduous tasks that take both a physical and mental toll. An appointment with the doctor thus costs the individual dearly as they need to take time off work. If fortunate enough to be able to access a service outside of their working hours, child minding costs might be incurred, and additional environmental safety risks could be encountered as low SES areas often have high crime (Hirini, 2004; Wilkins, 2007). Considering all of the above here discussed, SES thus has strong influence over men's medical help seeking behaviours.

Culture

Culture drives behaviour and thus shapes those behaviours practiced by every individual across the social hierarchy. It reflects people's values, and how they receive, interpret and act upon received information. Being value based, culture is thus too represented in the norms and social expectations of those socially bound together.

Reflecting significance of culture and tradition when considering health and health behaviours, Hirini (2004) identified that community health interventions and messages were only successful in shifting health behaviours when conveyed in a manner consistent with the core cultural beliefs and values of that community. Marshall et al. (2011) challenge this, and argue that the more times a single message is received in different forms and across different environments thus targeting a wide audience of varying cultural, educational

and literacy levels - the more likely individuals are to receive, retain and internalize such message as they adjust their behaviours to match that promoted from the cues received, and are able to discuss the message with others who might too have received it. Such social behaviour has the potential to thus serve as a facilitator of men's help seeking, the reverse too being true should adverse health messages be received (Marshall et al. (2011).

Still promoting relevance of culture on health behaviours, Hirini (2004) identified a doctor: patient cultural match as a key facilitator of future help seeking in men. Andersen (1995) supports same and identified individuals more likely to access those health services where they felt accepted and where respect was shown to their culture. This suggests that a barrier to medical help seeking in bi-cultural New Zealand as the Western oriented approach to health and the use and dissemination of information resources that often do not match the prevalent literacy, comprehension level or culture of many individuals, including Maori.

The Doctor-Patient Relationship

Continuing the discussion raised earlier by Hirini (2004) of the doctor-patient relationship influencing men's medical help seeking, Eriksson (2010) identified 70% of men reported not having seen a doctor in 5 years or more. On exploring the most effective means for doctors to engage with male patients, Wilkins (2007) found the doctor-patient relationship heavily influenced by the manner in which the doctors enquired about issues beyond the patient's immediate presenting issue. This finding reflects men's positive response towards interest being shown in their general well being, an approach that could be used to facilitate future help seeking behaviour. Here, Kapal et al (1977) identified that patients whose doctors had assisted them forge community links did not delay seeking medical assistance when ill.

Reflecting men's general uncomfortableness when seeing a doctor, Marshall et al. (2011) found that a short wait period prior to being seen served

to facilitate future help seeking behaviours in men, with the reverse also true. Marshall et al. (2011) further found the standard appointment length, and how patients are treated when they exceed such time also significantly influence that individual's subsequent help seeking.

Reflecting the influence of money and social status on health outcomes, the WHO Global Strategy for Health for all by the Year 2000 (1981) notes the majority of health clinicians are raised in homes of middle to high SES, whilst the majority of society being served have lower SES, and with globalization could too be of different cultural backgrounds, culture shaping an individual's experience of illness. To illustrate some of the problems this might present, in New Zealand and across the Commonwealth, migrants and refugees comprise 27% of each nation's lowest SES (Wilkins, 2007). When questioned, individuals from these communities identified communication difficulties and the fear of judgment from health professionals as key barriers to them seeking medical assistance when ill (O'Brien, Stein, Zierler, Shapiro, O'Sullivan, & Woolard, 1997); similar findings were reached by Tassell, Herbert, Evans, & Young (2012) in their cultural study on how to engage Maori in the health system.

Reflecting reluctance of those of low SES and minority groups to seek medical help, Marshall et al. (2011) found 25% of these individuals accessed the public hospital emergency department as their primary health provider. Here, both Williams (2010) and Underwood (1992) found financial constraints, language barriers and perceived disrespect from health staff were the primary reasons for delayed help seeking.

Supporting the need for a social and unified approach to communicate to men the importance that they proactively seek medical assistance I now discuss the issue of help seeking behaviour.

Chapter 3: Help seeking

Kaniasty & Norris (2000) found help seeking behaviour to be positively correlated with the amount of social support that one has. Recognising the influence of a socio-cultural, ecological and political hierarchy they cite these, “as well as imagined barriers” adversely impact individual help seeking.

Smith, Pope & Botha (2005) studied patients’ help seeking experiences for several different types of cancer and found “strong similarities in patients with different Cancer types” (p.283). Here, they identified 2 key help seeking determinants i) the ability to correctly identify the symptoms as cancer, and ii) fear of a diagnosis. They further identified that pain served as the catalyst for medical help seeking, and that men, whilst they appeared to dismiss their symptoms, did in fact monitor same and Smith et al., (2005) found the visual appearance of symptoms directly influenced medical help seeking as it validated their need to seek help.

The media and health insurance providers were identified as an important information source for men, however, Matteredne & Sieverding, (2008) also raised concern of the “saturation effect” (p.16) from overusing the mass media. Over use of the mass media served to desensitize men to the message, resulting in their disregard of same (Matteredne & Sieverding, 2008).

Independence and quality of life are markers of successful ageing and Smith et al. (2005) found that maintaining these were key facilitators of help seeking. Here, and in this regard, Smith, Tran, & Thompson, 2008, p.188) found the social groups to which men belong as having significant influence over their behaviours.

Naturally, poor health awareness is a barrier to help seeking, and it is here that the health and community sectors play a key role as discussed below.

The Health Care System

Telles & Pollack (1981) describe the health sectors' role as to provide formal "legitimation" of illness (p 247). This resonates true for men who describe talking to a doctor as baring their masculinity, illness symptoms, pain and weakness for judgment (Jetten et al., 2012). This finding is supported by Andersen (1995) who found men's perceived need for medical help differed from the results of a medical Needs Assessment - the latter identifying the patient's health condition more severe than interpreted by the individual. In this regard Gascoigne & Whitear (1999) found it not uncommon for men attending a medical appointment for one issue to be diagnosed with another much more serious health concern. These studies reflect delayed help seeking in men and support that on which this study was established, that men do not in the first instance seek medical assistance when ill.

In addition to seeking help from primary health providers, people's health needs have too been studied using activity and/or mobility limitation assessment tools relevant to the illness symptoms experienced (Hirini, 2004). A 'gap analysis' is then drawn to identify any variance between a person's perceived need for help and their medically determined health needs. Findings from these instruments show that retention of their functional abilities a key motivator for men's help seeking (White et al, 2010; Fox & Stephens, 2008). In querying the extent of this variance, the Australian government Identified significantly more Australian men than women are medically misdiagnosed. In an attempt to address this, spearheaded from the macrosystem and working through the national health network consumers were invited to participate in the development of a framework to guide doctors better engage with, correctly diagnose and appropriately treat men who access their service (North East Valley Division of General Practice, 2001). Positive national health outcomes were achieved following roll-out of this framework by the Australian Commonwealth Department of Health and Aged Care, leading to the development of an Australian National Men's Health Policy (2010) that would

guide medical practitioners appropriately engage with, diagnosis and treat their male patients. For sustainability and continued practitioner support of this policy educational resources targeting men and providing accurate information on important men's health issues were developed and nationally distributed (Australian Institute of Health and Welfare, 2011) Giving recognition to Hirini's (2004) recommendations, the information disseminated through the population provided consistent, linguistically and culturally adapted messages that would appeal to different communities within Australia's diverse population. Two years on and to reinforce these same health promotion messages, in 2011 Australia held a National Men's Health Forum & Conference targeting indigenous men's health issues. Indigenous men represent an important section of the total population and at this conference the information covered elaborated on (and did not altered) those health messages previously distributed at the of the initial policy roll-out (Australian Institute of Health and Welfare, 2011). Upon reflecting on the success of this Australian response to a significant national health it fast becomes apparent that Bronfenbrenner's Ecological Systems Theory (1979) was the basis of this multifaceted approach. Here, support from the macrosystem was gained, essential to for the success of any program that targets a large and diverse audience. Working through the exosystem, the mass media, national policy and regulatory bodies all worked together to educate health professionals and the public on best practice to achieve correct medical diagnosis. Public awareness campaigns were launched as was the wide dissemination of culturally appropriate resources that conveyed these same consistent messages took place through various community service providers. The long-term result of this initiative has been that all Australian health services now have to work within the National Men's Health Policy framework (Australian Institute of Health and Welfare, 2011).

This example demonstrates how a successful community, socio-ecological approach towards health has succeeded in changing health behaviours across a large body of people. Considered within Bronfenbrenner's

Ecological Systems framework (1979) it is clear that those people positioned at the micro and mesosystems (including neighbours, (Collings et al., 2009) provided a platform that enabled the exchange of health messages consistent with that being publically promoted. Constant reinforcement of a consistent message received through various media, with time, effects behavioural change (Sloan, Gough, & Conner, 2010).

Having here discussed the issue of men being misdiagnosed by health professionals, and a successful intervention that has been applied to address same, I extend this discussion to explore men's personal perception of their need for medical help when they experience illness symptoms.

Perception of Need

Amongst Maori, Hirini (2004) identified 'need characteristics' as the sole determinant of health care uptake. Whilst accepting this as a possibility, Tassell et al., (2012) and Andersen (1995) encourage we view individuals as unique and shy away from heterogeneous assumptions made of any group. Consistent with this view, Telles & Pollack (1981, p.76) summarise an individual's perceived need for help as:

Less a matter either of the ability to perform, or of medical state, than of how one feels.

Feelings – at the heart of an individual's self construct are too drivers of behaviour (Oksuzyan et al. 2010). Here, Courtenay (2003) found men to mostly hold negative feelings towards health promoting activities, suggesting that it is this attitude that is a barrier men's medical help seeking. Sandman, Simantov, & An (2000) replicated this finding and further identified 25% of men desist from engaging in any health promoting behaviour even when ill, and only do so when their illness symptoms become unbearable and/or adversely impact upon their ability to perform their regular activities. Reflecting individual awareness of the need that their illness symptoms did warrant medical attention, these same

men were consistently found to recommend others (of both genders) with identical illness symptoms seek help (Robertson & Williams, 2010). Such action reflects a willful intent by this group of men to not access medical treatment despite their aware of the appropriateness for same (Chapple & Ziebland, 2002; White & Johnson, 2000). Reflecting fear of a cancer diagnosis, De Nooijer et al. (2001) found that when men detect a known cancer symptom, at a cognitive level they recognize the need to seek medical help. Men's subsequent delayed help seeking suggests fear of a formal diagnosis that they perceive could socially place a man in a less socially powerful position (Fox & Stephens, 2008). When illness symptoms persist worsen and become more visible, men still seek social validation of their illness symptoms prior to actually help seeking (Galdas et al. 2007) – again, this being interesting behaviour as these men advised others much earlier during similar illness to seek medical assistance.

Chapter 4: The Present Study

I have here discussed the gender mortality disparity that reflects very different gendered health outcomes despite gender neutrality in most illnesses, including many cancers. This study considers social factors to be the key drivers behind men not seeking medical assistance when ill and thus compromising their health outcomes.

The self construct is shaped by physiological , ecological and social factors to reflect how one views themselves in relation to others and their perceived place in the world – both driven by the need for social acceptance achieved through conformance to social norms, expectations and behaviours, SES driven and reflected in individual lifestyle choices.

Through focusing on the social aspects of Bronfenbrenner's Ecological Theory, (1979) it is possible to concentrate on those direct and indirect influences on each participant in their decision making process to seek medical help. Health behaviours including each participant's perception of illness and the importance for them to gain social approval through external validation of their illness symptoms and prior to help seeking is studied. This information will reflect if individual alignment with the normative masculine identity and the need for social acceptance and power has in fact served as a barrier to these participants' help seeking behaviour.

An attempt was made to control for SES disparities in the participant group - to improve the quality of the comparative process between participants

The doctor –patient relationship, both pre and post cancer diagnosis are specifically studied for this reason, including who specifically the participants access as their social supports. The doctor-patient relationship post cancer diagnosis is studied in relation to treatment compliance and to identify any

shifts in participants' attitudes towards medical help seeking. As such, this study's aim is to identify the direct and indirect social factors across the socio ecological structure which influence these men's medical help seeking behaviours.

Chapter 5: Method

This section describes the procedures, analytic technique and measures used in this study.

a) Procedure

The initial interview data for this research was gathered by a Doctoral Candidate who was conducting research on men's experiences of cancer support. The study was supported by the Cancer Society who is also interested in men's help seeking behaviours and their pathway to diagnosis. Participants were recruited for the study using staff based in the Regional District Health Boards and various Primary Health Organisations. These staff used a basic survey tool to capture the biographical data of those patients who had indicated interest in participating in the study. These patients were provided with information about the study and the estimated requirements of their personal time and availability. Individual semi-structured interviews about both professional help seeking and experiences post-diagnosis were conducted with 40 men who resided in the Horowhenua/Otaki and Whanganui/South Taranaki regions of New Zealand. The interviews were recorded and transcribed by the interviewer.

Using age and ethnic identity as suitable selection criteria for this study, 10 of the 40 interview transcripts were selected for this study on men's medical help-seeking behaviours. To reflect New Zealand's biculturalism the selected participant group comprised 5 Maori and 5 Pakeha. 9 of these interviews were conducted in the participant's home and one interview took place at the Cancer Society's office in a town easily accessible to both participant and interviewer. 9 of the interviews were conducted with only the participant in the room. Upon the participant's request, 1 interview was conducted in the presence of a voluntary caregiver. To support the study's validity, no questions were directed at this caregiver, neither did they respond to any of the questions asked of the

participant. Each interview extended between 1-2 hours, the interview length largely driven by the participant's physical and psychological capabilities at that time.

Historically, the Horowhenua, Otaki, Wanganui and South Taranaki region has predominantly consisted of people of low SES and this region was identified as suitable for this study due to its poor cancer survival statistics and limited resident access to psychosocial services (New Zealand Ministry of Health, 2010). In this regard, Statistics NZ (2013) cite the average annual household income from all regular sources for the year ending June 2012 as NZ\$81,067. All the participants' household income fell way below this amount reflecting collectively annual their household income is lower than 50% of the households in New Zealand.

b) Participants

The sample comprised 10 men aged between 50 and 74 years at the time of their cancer diagnosis. Standard participant information gathered during the interview is reflected in **Table 1**. Each participant is here identified by a pseudonym.

Participant Information

Pseudonym	Age Now	Age diag.	Health provider	Adults in accom.	Highest level of education	Work environ.	Cancer info	Diagnosis process/other info
Arthur	69	64	Public	+adult female	Before 16yo	Outdoor	Prostate-curable	Regular medicals. Acute symptoms
Bert	74	72	Public +pvt	+adult female	After 16yo	Indoor	Prostate-curable	Regular medicals. Nil symptoms
Bazza	77	74	Public + pvt	+adult female	After 16yo	Indoor	Prostate – remission	Medicals. Nil symptoms.
Colin	59	57	Pvt.	Lives alone	After 16yo	Outdoor	Breast - curable	Early help seeking. symptoms
Hank	67	57	Public	+adult female	Before 16yo	Outdoor	Prostate - palliative	Delayed help seeking. Acute symptoms
Beau	66	64	Public	Lives alone	After 16yo	Outdoor	Prostate- curable	Medicals+Delayed help seeking
Moko	72	69	Public	Lives alone	Before 16yo	Outdoor	Prostate - remission	Delayed help seeking. Acute symptoms
Monty	76	74	Public	Lives alone	Before 16yo	Outdoor	Prostate- control	Regular medicals. Nil symptoms
Ricky	53	50	Public	Lives alone	Before 16yo	Outdoor	Prostate-monitoring	Early help seeking. Acute symptoms
Powie	57	55	Public	+adult female	After 16yo	Outdoor	Bowel-curable	Delayed help seeking. Acute symptoms

Table 1 Standard participant information gathered for a study on the social barriers and social facilitators of men’s medical help seeking behaviours

To introduce each participant to the study, I now provide personalised information on each one whilst using pseudonyms to protect their identity.

1. Arthur

Arthur identifies as Pakeha. He is married and lives with his wife. They have no children or family in New Zealand. His illness and treatment lead to his early retirement.

Diagnosed with Prostate Cancer 5 years ago at 64 years' of age. Prior to his cancer diagnosis Arthur attended medical check-ups with his GP every 6 months, his last check was 4 months prior to being diagnosed at which time his test results were all returned clear. The moment Arthur identified a cancer symptom he sought medical assistance resulting in an early cancer diagnosis with curable treatment outcomes.

Arthur had an adverse reaction to administered medication whilst in hospital that resulted in him being violently ill. He was placed on a long wait list for treatment resulting in multiple infections and to wearing a catheter for several months. Arthur identified the wearing of a catheter most humiliating and recounted having observed similar with his father, prior to his father's death from cancer. Arthur's adverse experiences in dealing with the health system might adversely influence his future perception of need.

Arthur identified having a strong social support network that included very close friends and his former workmates. He stated, "If you've got somebody, if you got friends around you that are, are good like that, that, that sort of boosts your morale".

2. Bert

Bert identifies as Pakeha. He is married and lives with his wife. Bert has adult children who provide strong family support. Bert is currently retired.

Bert was diagnosed with Prostate Cancer 2 years ago at 72 years of

age. Prior to his cancer diagnosis, Bert attended check up appointments with his GP every 6 months, a behaviour highly encouraged by his GP who Bert described as “just an extremely good doctor and he was very hot on the prostate cancer diagnosis”. Bert’s cancer was detected during a routine medical check with his GP. As with Arthur, Bert too received an early cancer diagnosis and his treatment outcome incurable. Bert accessed alternative cancer treatment as well as the mainstream treatment provided by the public system.

3. Bazza

Bazza identifies as Pakeha, he is married and lives with his wife. They have adult children who live independently and they have strong family support. Bazza is currently retired.

Bazza was diagnosed with Prostate Cancer 3 years ago at 74 years of age. Prior to his cancer diagnosis, Bazza was aware of his extensive sun skin damage that resulted in him undergoing a medical procedure a few years prior, as such, Bazza attends annual skin cancer check-ups however does not attend any regular medical checks with a GP. Bazza identified no cancer symptoms prior to going to the doctor and had gone to the doctor for an unrelated reason. It was the doctor who suggested a comprehensive health check and subsequently Bazza was diagnosed with a serious coronary condition and cancer. Bazza’s s cancer is currently under control.

4. Colin

Colin identifies as Pakeha, divorced and a solo parent. Colin was diagnosed with Breast Cancer 2 years ago, at 57 years of age. Colin sought immediate medical assistance when he first noticed possible cancer symptoms. Due to his early diagnosis, Colin’s cancer is believed to be curable. Whilst not undergoing regular medical checks with his GP, Colin did seek prompt medical help when he identified any changes on his skin.

Colin gained his cancer knowledge through formal and informal lessons delivered in the workplace. Colin has a family history of cancer. He described his social supports as “ My sister and brother in law...And some of my close, my good crew, close friends in [town of residence]...And some of the guys at work, yeah”.

5. Hank

Hank identifies as Pakeha, married with adult children and grandchildren. None of their children live with them however they visit regularly and provide strong family support.

Hank was diagnosed with Prostate cancer 10 years ago then aged 57 years. Hank is now in palliative care. Prior to his cancer diagnosis, Hank delayed medical help seeking until he experienced acute illness symptoms that compromised his quality of life, he states, “I was just a little bit concerned. But for a little while I did nothing about it because I thought 'Oh, it will get better', 'I can handle it', you know, 'I will overcome anything”.

Prior to diagnosis Hank identified not being interested in gaining information on cancer, stating “I wasn’t aware of it because it didn’t think it affected me at the time, but I did know what symptoms probably to look out for...and I didn't look out very well”. Hank eventually sought validation of his illness symptoms from his wife whom he describes as his greatest support.

6. Beau

Beau identifies as Maori, separated and living alone. He has a close relationship with his sister in law – who connected Beau to the Cancer Council Coordinator – who proved to be strong support for Beau. Living and working within an old age community, Beau describes the setting “a village” and reported a close and supportive relationship with these community members. Beau has continued to work through his cancer treatment.

Beau was diagnosed with Prostate Cancer 2 years ago when aged 64 years. Prior to his cancer diagnosis, Beau stated, “I did not believe the urinary flow thing” electing instead to believe that there is no cure for cancer and it will always end in death. Beau was diagnosed with cancer as he sought medical assistance for a different health issue. At this time the doctor had Beau’s PSA tested however failed to explain to Beau both the purpose of the test, and what the elevated result later returned actually meant. Beau therefore did not act on this information for 18 months until by chance it was explained to him by a family member . Despite this delay prior to treatment, Beau’s cancer prognosis is curable.

7. Moko

Moko identifies as Maori. He is divorced and has a close relationship with his sister and adult nephew – and has daily contact with them. Moko has no children of his own and is now retired.

Moko was diagnosed with Prostate Cancer 3 years ago at 64 years’ of age. Prior to his cancer diagnosis Moko reported having no knowledge of cancer beyond believing that “it kills”. Moko experienced urinary and erectile difficulties for over a decade prior to diagnosis and did not consider these cancer symptoms and a cause for concern. Moko sought medical help as he was feeling very ill, and from that appointment was diagnosed with diabetes and cancer. Moko’s cancer is currently in remission.

Moko has been involved in establishing a men’s support group at the hospital aimed to provide support for men with cancer. He also reported having returned to the church and gaining much social support from the congregation.

8. Monty

Monty identifies as Maori, and lives alone. He is now retired.

Monty was diagnosed with Prostate Cancer 2 years ago at 74 years’ of age. Prior to his cancer diagnosis Monty had nursed his wife with cancer. Two

of his brothers had prostate cancer. With this history, Monty held a good awareness of various cancer symptoms and routinely underwent medical checks with his GP, stating, “I was quite happy having the, the, the blood tests”. Monty reported holding the belief that if caught early, cancer was curable. Despite this sound approach Monty had for cancer detection, the cancer he was diagnosed with was very aggressive, and he experienced no symptoms. Monty returned an elevated PSA reading taken during a routine medical check-up and within two weeks his cancer was inoperable.

Monty receives strong family support from his children who repeatedly invite him to live with them, an offer Monty repeatedly declines, stating “I ain’t ready for that yet”. Monty maintains daily contact with his family and his sister has agreed to be his full time caregiver when his health deteriorates. Post diagnosis Monty states, “I just still do what I normally did before... When you’re my age...you only hang around for your kids’ sake”.

9. Ricky

Ricky identifies as Maori and diagnosed at 50 years old, is the youngest participant in this study. He is now retired.

Ricky was diagnosed with Prostate Cancer 3 years ago. At the time of diagnosis the cancer had spread to his bladder requiring radical prostatectomy and bladder surgery and he now has to wear a permanent stoma bag. His cancer is under close medical supervision.

Prior to his cancer diagnosis Ricky advised that he associated cancer with death – as his father died from cancer. Ricky identified having limited knowledge of cancer symptoms, and the first and only symptom he experienced was blood in his urine (no pain) and he immediately sought medical help, stating, “that just freaked me right out!”. The GP misdiagnosed Ricky and a few days later Ricky presented at the hospital with the same issue and was there correctly diagnosed.

A lack of understanding about prostate cancer lead to Ricky end his relationship as he did not want to harm his partner, and as post treatment he cannot perform sexually, sex being a key part of Ricky's identity. Now single, Ricky lives with a dependent child. He has support from the Cancer Control Coordinator as well as strong family support comprising siblings, children and grandchildren, all living independently and who maintain regular contact with him.

10. Powie

Powie identifies as Maori and is single and retired. Powie's bowel cancer was identified whilst he was undergoing emergency bowel surgery for gangrene. Prior to this, he had sought medical assistance several times from his doctor with regard to bowel problems and was misdiagnosed – resulting in the spread of his cancer to his lymph nodes. Powie twice stated that whilst aware of the symptoms of bowel cancer, "I didn't think it was cancer". Powie eventually presented at the hospital in acute pain where he was diagnosed with cancer. His cancer is now in the curable stage following extensive surgery and treatment and he has a permanent stoma bag.

Powie has a strong social support network including the neighbours, family and friends. Powie failed to adhere to medical recommendations and post hospital discharge his health deteriorated until a voluntary caregiver alerted by the neighbours and known to Powie through his social network, offered to move in and provide him with full time support at no cost.

At the time of the interview, all participants had undergone some form of cancer treatment reflecting their engagement with the medical profession. The sample comprised only those who had completed the most demanding phase of their cancer treatment e.g.) surgery and/or aversive chemotherapy that was completed at least 6 months prior to their interview. The sample also included individuals who were chronically ill with cancer and men in palliative cancer treatment. Excluded from the sample were men diagnosed with cognitive

deficits; men with an active serious psychiatric illness; and those diagnosed with cancer who were yet to undergo aggressive forms of treatment.

c) Analysis

As suggested by Braun & Clarke (2006), the entire data set was initially read prior to coding. The aim of this process being to facilitate the formation of ideas, the coding of themes and the identification of possible patterns within the data set.

The Constant Comparative Method of Analysis

Comparing and contrasting data is the core intellectual analysis procedure of the Constant Comparative Method (Boeije, 2002). On using a thematic analytical approach in this thesis and as suggested by Braun & Clarke (2006), data from each interview was coded against predetermined demographic factors reflected in **Table 1**. The aim of this process was to support the study's reliability, its validity, and to enable suitable within and between interview comparisons.

To control for generational differences, only men over 50 years at the time of diagnosis were identified suitable for this study and thus this study focused on the behaviours of mature men. Age is relevant when considering socio cultural factors such as attitude and behaviours that too are shaped by the influence of history and time.

To control for possible cultural difference and to capture the bicultural nature of New Zealand's population, the selected participants comprised equal numbers of men who self identified as Pakeha (New Zealand Caucasian) and Maori. Whilst not a selection criteria, all the participants communicated effectively in English. To enhance the flow of dialogue and information gathered during the interview process (Boeije, 2002) the interviews were semi structured and individual participant responses initially coded, compared and contrasted within itself and then against each other. This process was repeated with each

emergent sub-theme until no new information was identified for either analysis or coding (Boeije, 2002; Braun & Clarke, 2006). Sub themes were then categorized as social barriers or social facilitators of men's medical help seeking.

Coding has a fundamental role in the Constant Comparison Method of Analysis as it enables emergent themes and sub-codes within each data item (interview) to be compared with the rest of the information gathered at each interview. The themes and sub-codes identified in each data item are then compared and contrasted individually with each of the other data items that comprise the data set, otherwise known as the sample group.

For this thesis, themes and sub-themes within each data item were coded, and within each data item, code comparison and contrast was performed. Contradictory information within each data item was also noted. Once this process was complete and still within each data item, similar codes were then combined as sub-themes and these sub themes compared and contrasted against each other seeking to:

- a) clarify that each sub-theme was in fact identifying a different social factor relevant to this study; and
- b) identify how each sub-theme related socially to the other and to the overall topic of enquiry.

The emergent findings were then categorized as either i) a social barrier or ii) a social facilitator of men's medical help seeking behaviours.

Once each data item was correctly coded and the social barriers and facilitators that influenced each participant's behaviour identified, the codes within each data item were compared and contrasted against those in each of the other data items that comprised the data set. Similarly coded data between the individual data items were then grouped, compared and contrasted.

Contradictory information between the coded data items was noted and sub-themes identified also coded.

Once this process was complete similar codes across the data set were combined as sub-themes and these sub themes compared and contrasted against each other again seeking to clarify that each sub-theme reflected either a social barrier or social facilitator of men's medical help seeking behaviours.

Below I detail the steps undertaken when the Constant Comparison Method was applied within each data item, after which I explain the process applied between data items.

e) Comparison within each interview:

Coding:

Initially data within each interview transcript (data item) was coded in accordance with the two codes on which this study is focused, being: a) the social barriers and b) the social facilitators of men's medical help seeking behaviour. Once data extracts were identified and grouped under either code, to gain a thorough understanding of the contents of each data item, the similarly grouped data extracts were compared ie) comparison of all the social barriers to men's medical help seeking within each interview were compared; the process was then repeated for the social facilitators of men's medical help seeking.

Compare and contrast data extracts

All data extracts were sub-coded at their surface meaning; no hidden meanings beyond that specifically stated by participants was sought or hypothesized about. Metaphors, their assumed meanings and their use by both the interviewer and participants were analysed at face value and patterns looked for. Each time a code repeated itself within a data item, similarly coded

data extracts were compared to it, and conflicting data extracts contrasted to it – this process providing insight into alternative ideas and themes less easily identified. The comparison of similarly coded data extracts within each data item facilitated the analysis of consistency of how each code was considered; it identified if new information was being presented and if so, raised additional questions that often resulted in a sub-code being identified.

Sub-codes:

Sub-codes resulted during the process where similarities and differences in similarly coded data extracts were categorised. Coded data extracts were arranged into sub-codes where each sub-code identified a different social factor that influenced men's medical help seeking behaviour. This process enabled the tightening of each sub-code's boundaries as new information identified was given a different sub-code for separate consideration; through this process, patterns linking the sub codes could be identified. The comparison process was complete when no new information was gained, no further questions raised, and all existing questions were answered.

Each sub code was then analysed within each data item and in relation to the two key codes, i) whether it served as a social barrier or ii) whether it served as a social facilitator of men's medical help seeking behaviour. Some data extracts were associated with more than one sub-code; Braun & Clarke (2006) here advised that any information attached to a sub-code is always relevant to the study. Supportive and conflicting data extracts were then paired to and compared with their associated code. Here focus was in on the context in which the participant provided that information ie) their social attitude and perspectives on medical help seeking in relation to and representative of their responses.

By comparing and contrasting similarly coded data extracts within each data item, consistency was achieved as each sub-code was considered in the same way.

A summary description of each sub code was then written, including its relevance to the social barriers or social facilitators of men's medical help seeking behaviours – the primary codes being investigated in this study. These sub-codes were then categorised as reflecting either 'a social barrier' or 'a social facilitator' of men's medical help seeking.

The sub codes used in this study and discussed separately below were:

- i) The nature of work undertaken employed (factor directly reflecting SES)
- ii) The normative masculine identity
- iii) Individual health promoting knowledge and behaviours prior to receiving a cancer diagnosis.
- iv) Gendered, self and social identity
- v) Knowledge on cancer specific information including its risk factors
- vi) Their source of health information
- vii) Knowledge on their own specific cancer prior to diagnosis
- viii) The person to whom the participant turned to for social support/external validation of illness symptoms prior to their medical help seeking
- ix) The doctor-patient relationship
- x) Initial health service provider accessed (factor reflecting SES)
- xi) Persons involved in treatment decision making
- x) Type of support provided by family, whanau and friends

f) Comparison between interviews

The comparison and contrasting of each coded data extract between each similarly coded data item across the data set was then undertaken (Boeije, 2002), and as suggested by Braun & Clarke (2006), key questions were raised of each sub code, namely:

- i) What does this mean in the context of the social barriers and social

facilitators of men's medical help seeking behaviours?

- ii) What are the underlying assumptions being made?
- iii) What does this suggest?
- iv) What lead each participant to behave as they did?
- v) Why does society interpret it this way?
- vi) What is the summary explanation?

I now proceed to discuss the results found from this investigation on the social barriers and the social facilitators of these participant's medical help seeking behaviours.

Chapter 6: Results

Overview

The aim of this investigation is to identify how social factors serve as either a barrier or facilitate men's medical help seeking. In presenting my findings this section has been organized as follows:

1. **Observed help seeking behaviours**
2. **The Normative Masculine Identity**
3. **Where men gain their health knowledge**
4. **Gender roles and its influence on help seeking**
5. **Doctor- Patient Relationship**
6. **Family & Friends (Micro & Meso Systems)**

1. **Observed help seeking behaviours**

In opening this section I discuss the help seeking behaviours displayed by the individual participants.

Five of the participants, for various reasons delayed medical help seeking. Three participants promptly sought medical attention when they first identified their symptoms, whilst two regularly attended medical checks-ups and this was how their cancer was diagnosed. Four participants noticed their ill health symptoms long before they sought help – electing not to act on them until their discomfort reached an unbearable level. As such, participants' behaviours are spread between early help seeking on symptom identification; proactive, preventive health practices; and delayed help seeking. To highlight this division of participants across these three groups, I provide brief

explanations as to how these participants came to be diagnosed with cancer.

Hank, Moko, Bazza and Powie are the four participants who willfully delayed seeking medical assistance. In explaining the reasons for their delayed medical help seeking, Hank described himself as “Just a little bit concerned” when his symptoms first presented, namely “trouble urinating;... urgency when I did and ...that I was getting quite swollen in my groin”. He admitted,

For a little while I did nothing about it because I thought 'Oh, it will get better', 'can handle it', you know, 'I will overcome anything.'

True to this belief, Hank continued to hide his symptoms from everyone and only disclosed same to his wife when his urgency to reach the toilet reached the stage where on a few occasions he failed to make it and soiled himself.

Moko on the other hand, first experienced erectile problems 10-15 years prior (whilst in his 50s) and elected to ignore it. He acknowledges that he had been feeling progressively unwell and it was only when he could no longer bear these symptoms that he sought medical help. On why he had delayed help seeking, Moko explains that it simply did not cross his mind to go to the doctor, “I didn’t think of anything about that at all”. To indicate how unwell Moko was when he did go to the doctor, from this appointment he was diagnosed with both diabetes and prostate cancer, and was prediagnosed with hypertension.

Whilst Bazza was aware that difficulty passing urine was a symptom of prostate cancer, he elected to interpret this difficulty as ‘the norm’, stating, “I’d always, always been traditionally very slow in passing urine. Always”.

In all three cases above, each participant attempted to justify their delayed help seeking behaviour, such response indicating awareness that they are at fault and their behaviour goes against the social expectations with regard to medical help seeking.

The final participant in this group and who willfully delayed help seeking is Powie, who had been to his General Practitioner (GP) for treatment of his illness symptoms, and the intervention provided the GP was not working. Powie advised his GP of same. Soon after and in acute pain, he is rushed to hospital by a neighbour and is operated on within two hours. The nature of Powie's illness symptoms with regard to his GP's interpretation and (mis)treatment of same, contrasted to the acute pain Powie must have been in to warrant near immediate surgery when presenting at the hospital suggesting delayed help seeking and thus he has been grouped along with those others who deliberately delayed help seeking.

In considering the next group of participants, three promptly sought medical help on first noticing their illness symptoms. Two participants, Arthur and Ricky described themselves as panicking when each noticed large amounts of blood in their urine, whilst Colin, the third participant, monitored a swelling under his arms for a week prior to help seeking. During this week whilst he monitored his symptoms, Colin consulted male peers about his symptoms seeking external validation of his concerns. He stated:

I thought, 'I'll give it a week, and if it's still there in a week, I'll go to the doctor.' So I went the next week - it was still there. And I, I thought it, kind of in my mind, I thought, 'Shit! Is it getting a little bit bigger? I'd better go.'

The final group of participants, Monty, Bert and Beau were diagnosed with cancer following routine medical check-ups. Both Monty and Bert attended specific six- monthly appointments for full medical checks, whilst Beau was at the doctor monitoring a different health condition.

With his prostate cancer caught in its early stages, Bert proudly states:

I was proactive with that. I always had my PSA blood test. And I always had my digital test. And ah, it was through that that it was picked up.

Beau however, complying with his doctor's recommendations, attended regular appointments to monitor his blood pressure during which his doctor fails to inform him that he too was having a regular PSA blood test. This lack of communication by the GP is directly responsible for Beau's inaction when later told that his PSA result was elevated – as he had no knowledge of what this meant, "She may as well have been talking about my big toe" (Beau).

Reflects recognition of community GPs as the primary health service providers for non urgent medical matters, with the exception of one participant who had acute symptoms and went directly to the hospital, all the participants consulted a GP in the first instance.

With regard seeking external validation of their illness symptoms prior to help seeking, only two of the participants (Colin and Hank) conducted same. In Hank's case, despite possibly experiencing extreme pain from the swelling in his groin (as an initial symptom), he waited until his illness symptoms interfered with the completion of his routine activities, and due to the nature of his symptoms (being unable to hold his urine until he reached the toilet), knew that he could not continue hiding it from others. Colin on the other hand, held sound knowledge of his symptoms yet still sought external validation from peers reflecting alignment with the normative masculine identity and not wishing to be seen to be consulting the GP when it is not warranted. Below I discuss the normative masculine identity.

2. The Normative Masculine Identity

All the men placed value in maintaining personal alignment with the normative masculine identity, their responses reflected the importance to them that their social image reflects emotional and physical strength, endurance and independence.

Even in his description of the preceding events leading to his symptom presentation, Ricky uses rugby comparisons to self assess the pain he felt,

drawing on past sports injuries and tackles as his measure – and reflecting strong alignment with national normative masculine identity.

Well we were playing league or rugby, it didn't feel like any of those hits, and when you get tackled sometimes and in those games it does really actually hurt. I didn't think I was that much to worry. I got a little bit winded but. Nah, I got up. And I couldn't feel it was that bad... It didn't feel as hard as getting hit by somebody tackled

Ricky was also one of the two participants who spoke of his “fight” of cancer in a gendered manner, reflected in his choice of words. Here both participants described their ‘war with cancer’ and spoke of their attitude of persistence to “conquer;” “kill” and “beat” it, whilst also articulating how their current success at this had reinforced their masculine identity:

It just makes me feel, feel more of a man, I think, because, because I've had what other people haven't. And I've, I've conquered....I've done it...And I've beaten it...When it comes out of that [remission], I'll deal with it... as it comes” (Ricky)

The ability to provide fast, effective solutions to problems is a prized normative masculine trait. Individuals high in this trait hold much social power. The desire for men to display this (a trait that complements that of ‘being in control’) facilitates help seeking amongst these participants evidenced when post diagnosis, six of them used positive self talk to help them confront and deal with their cancer. Here, these participants applied self talk to gain control over their feelings of anxiety and fear as none of them disclosed their emotional turmoil to anyone. Arthur now describes his approach used:

'Try and buck your ideas up'... Try and get over it... 'Don't be such a baby!' ...'Don't be such a fool.'

Reflecting how alignment with the normative masculine identity served to his detriment, Hank initially denied acting on his cancer symptoms as he believed he would 'beat' it and admits that even post diagnosis, he maintained this attitude and belief in his 'invincibility', despite intellectually knowing otherwise:

I probably would have noticed [symptoms] some time earlier, that I was, my urine, my bladder was changing habit... thought 'I'll overcome it, I'll handle it and you know, with the treatment they give you now, 'I'll, I'll' be fine (Hank)

Whilst his alignment with the normative masculine identity was the direct reason and thus a barrier to Hank's medical help seeking, it too served to benefit him as he applied this attitude to his daily life, reflecting strength and 'invincibility' – normative masculine traits that have seen him double his medically projected years of life. Hank's normative masculine attitude has been to 'fight and be the victor' – decisiveness and determination reflecting socially valued, masculine traits. "I won't let it beat me" (Hank).

Reflecting value for the normative masculine trait of independence, all the participants with children identified caution not to 'burden' their children with their health needs during their cancer treatment.

My grown up daughter. She was here staying, looking after me. Until [voluntary caregiver] turned up and offered to and it sort of took a lot of pressure off my family also. Cos they weren't you know, didn't really have to worry about me...And it's better them [children], it's far better off to be at work, you know what I mean? And looking after their family, instead of [me] (Powie).

None of the participant's adult children indicated caring for their father as 'burdensome' or problematic, and in every instance their children, unsolicited and once aware of their father's risk of cancer increased the amount of time

they spent with them. Ricky recognised this of his children and encourages others on a similar journey with cancer to embrace it.

Emotive traits stand polarised to normative masculine traits and Colin and Moko both independently mobilized their support network echoing the importance of having “somebody close to talk to” (Ricky) to manage their mental health – a pitfall that Ricky is well aware of as he fell into depression. Here Moko describes the “big enemy is isolation”. Seeking support however stands in conflict with the normative masculine trait of strength and independence. **Thus strong alignment with the normative masculine identity can be a barrier to help seeking** – with the final result being suicide (New Zealand Ministry of Health, 2010). Reflecting this risk, three of the participants described their symptoms of depression since diagnosis, and two reported suicidal ideation during this period.

Reflecting a need to publically display emotional strength and control - whilst awaiting his test results prior to diagnosis, Bert experienced high levels of anxiety but would not access any supports or tell anyone of his potential cancer diagnosis, lest he did not have cancer. Bert fears that disclosing feelings of anxiety and then not being diagnosed with cancer would publically expose him as ‘weak’. Similar behaviour was seen in Ricky who despite experiencing suicidal ideation whilst awaiting diagnosis, would not access any support services then for the same reasons as Bert.

Bazza too values independence and strength and deliberately withholds telling family and friends of his diagnosis “I’m not telling nobody”. He does however accept his wife doing same and was grateful for the community support that had been shown to them. This behaviour reflects both a gendered position and alignment with the normative masculine identity.

That one’s identity is reflected in personal image is evidenced as two participants, Arthur and Ricky, described feeling robbed of their masculinity at having to wear a catheter. This reflects the importance of the physical

appearance in meeting normative social expectations of what a man should look like.

The thought of having to have a bag on the whole time, was for me, was not 'disgusting', to me, being a male, was, well it was more 'degrading' (Ricky).

The 'degradation' Ricky feels indicates that had he been fully aware and understanding of the end result post surgery, he is likely to have not proceeded with the removal of his bladder. Arthur holds similar sentiments and recalls his last image of his father as weak and frail, with a catheter inserted before he died. **The known consequences of help seeking that would alter a man's physical appearance away from the socially accepted norm is likely therefore to be a barrier to help seeking.**

Avoidance: a normative masculine response

Moko normalizes his delayed help seeking as "being a typical male, didn't want to know". This pattern of avoidance is evidenced in eight of the participants and indirectly reflects alignment with the normative masculine identity as each of these men avoided those issues that conflicted with the social expectations of men. Thus, by completely avoiding an issue, men cannot be measured against those associated normative traits. **This avoidance taken by men thus serves as a barrier to help seeking.** Eg) by deliberately avoiding receiving cancer information, participants can hide their emotions associated with the death of a loved one, as well as their own fears of death from cancer. As stated by Moko:

What I knew about cancer, then, is that my, my dad had it and he passed away though it. And that's all I know, and all I know is the big, big 'C' word, and I was scared.

Beau too associates cancer with a death sentence – a learnt response from his experience of many family members dying from it. “That it kills you. That you’re dead. There is no cure.” Again, avoiding receiving information on cancer thus enables Beau to not live in fear of it.

Whilst avoidance might be viewed an immature way to respond to such issue and information gathering and empowerment through knowledge, it is a normative masculine response as it protects participants from exposing their vulnerabilities polarized to the normative masculine identity, ie) fear

He [GP] came to me, and I’m shaking, and he, and he said to me, um, 'What are you shaking for?...And then he, then he turned to me sister-in-law, and said'Yeah, he’s, he’s got cancer of the prostate.' ... And I just sort of the world’s collapsed around ... Cancer is finish. That’s it.

(Beau).

Three other participants (Bert, Moko and Arthur) recalled similar experiences of fear regarding their diagnosis and prognosis, yet none considered help seeking as it would conflict with normative masculine expectations.

Whilst not articulating being afraid of being socially viewed ‘weak’ and less than ‘invincible’, Hank’s blatant disregard of his cancer symptoms that he acknowledged knowing were indicative of prostate cancer, coupled with his strong alignment with the gendered and normative masculine identities, indicates his inaction as driven by fear. Fear of the confirmation of cancer.

In total, seven participants discussed an emotional struggle through their journey from awaiting a cancer diagnosis, to date. These emotions are captured at **Table 2:**

Emotional Responses to Diagnosis and Treatment

<u>Emotions experienced pre/at diagnosis</u>	<u>n=10</u>
Fear	4
Shock	2
Loss of control	1
Acceptance	3
<u>Emotions experienced post diagnosis/during treatment</u>	
Depression	3
Suicidal ideation	2

Table 2: Emotions identified by participants through their diagnosis and treatment processes

Table 2 reflects seven participants experienced emotions that conflict with normative masculine traits and who would have benefited from social support. **The experience of strong adverse emotions without suitable social support to normalize same is isolating and a barrier to medical help seeking.**

All seven participants stated difficulty in managing their above noted emotions as expressed by Bazza: “No I didn’t feel I had control of the situation at all”.

Avoidance behaviour delays formal and thus social recognition of men in the ‘sick role’, the sick role representing weakness, vulnerability, lost independence, a need for physical and emotional support.

The need to hide a lack of knowledge or understanding serves as a barrier to medical help seeking. .Avoidance also prevents exposure of what the individual perceives to be personal weakness ie) limited reading skills; a lack of understanding of the terminology used by GPs; limited financial resources to pursue alternative options if available, etc reflecting a pattern of avoidance by this group. Only one participant sought a second medical opinion of his diagnosis and treatment options. Eight of the participants passively accepted the treatment recommendations with minimal questions. At the time of the interview, four of the participants were still unclear as to the aim of their treatment ie) palliative or curable.

Avoidance:Sex

When considering Ricky's situation, with his cancer diagnosis, much stands in conflict with his masculine worldviews. Ricky's life experience has taught him that cancer results in death – and believing he would have no control over such – he made the concerted effort not to increase his knowledge on this subject. Ricky's alignment with the normative masculine identity has also been evidenced in the high risk jobs he has held through life. Sexual virility is a heavily weighted normative masculine trait that highly influences a man's self construct and now confronted with having lost his natural sexual ability, Ricky's sense of self and belonging in this world is destabilized – evidenced as he questioned his mortality and future.

'Shit, am I going to die?' ... My head was blown... My head seemed no sex She's [life is] all over. It goes boom. It just blew my head.... Then I started to stress on. What is happening. What what am I going to do. .. I contemplated doing it, like suicide (Ricky).

Avoiding confronting his sexual issues, as again, he does not know how to reconcile this with his masculine identity, Ricky terminates his relationship, stating:

Once, once sex was not in the mixture...well, as a male, I thought well, 'That's it. She's [life's] all over.' Because, I, you can't get an erection... I'm unhappy with me.

Avoidance: Information

Four participants cited how avoiding considering any issue on the topic of cancer, helped them publically conform to normative masculine behaviours and social expectations. Reflecting same, post diagnosis Bazza stated, "I didn't really want to know about it, but I needed to deal with it". Bazza's recognition for the need for action reflects his alignment with the normative masculine trait of decision making and control.

Interestingly, Monty's brother recently died from prostate cancer and a few years earlier, Monty's wife died from bowel cancer. Yet, and again reflecting avoidance, Monty maintained belief of the non aggressive nature of cancer.

3. Where Men Gain Their Health Knowledge

Poor general health awareness is a known barrier to help seeking, and this finding applies to two participants in this group.

Men's Behaviours: individual awareness of specific cancer symptoms facilitated prompt medical help seeking in one participant. One participant presented with illness symptoms to his GP and was misdiagnosed. Two participants sought medical help with the rapid onset of acute symptoms (much blood in their urine); one presented at the GP for a general health check believing he was well and with no symptoms identified; three participants were identified as having an elevated PSA level during a routine health check and two elected to ignore their ill health symptoms until they were no longer bearable. In investigating where men gain their health knowledge, one participant who ignored his symptoms (Hank) advised that he had two uncles

who had prostate cancer, and that he had also:

“Done a bit of reading [newspaper and articles] about it... I did know what symptoms probably to look out for and I didn't look out very well.. I probably would have noticed some time earlier, that I was, my urine, my bladder was changing habit... I have only myself to blame”

With half this participant group not exceeding school beyond 16 years of age the major source of health information received by participants was reported to be visual cues transmitted through the mass media, and from informal discussions with men – mostly initiated by those who had experienced cancer. One participant, due to the nature of his work had received formal cancer awareness workplace training. Only two participants (Bert and Colin) had access to a computer and whilst Bert and his family subsequently conducted extensive online research on alternative treatment options, Colin reported not using his computer for non-work reasons.

When questioned on his knowledge on cancer, Bert blurts out a statement assuming everyone holds the same knowledge he does, a common error made during informal conversations.

The normal lay things, like, most - as far as prostate's concerned - most people die with it, rather than of it.

Bert too twice mentions believing that all cancer (other than skin cancer) is hereditary and does not consider lifestyle or age a cancer risk factor. None of the participants identified age as a known risk factor. All the participants identified smoking and the sun as cancer risks – and attributed their knowledge to mass media coverage on same. Two participants also identified drinking large amounts of alcohol a cancer risk factor.

When querying the specific symptom awareness participants held - of the different cancers, five participants could identify skin cancer symptoms; one was aware of lung cancer symptoms; five described knowing the symptoms of prostate cancer and one participant knew the symptoms of bowel cancer –

interestingly, it was this latter participant who was later diagnosed with bowel cancer (a secondary diagnosis at that time). Two participants also identified knowing to have any lumps checked by a doctor.

Table 3 shows where the participants reported gaining information on cancer prior to their initial symptoms or diagnosis.

Where information was learnt	# who learnt it this way <i>n=10</i>
Talking to Doctor	4
Talking to other men	10
Talking to others with cancer	3
Talking to peers	3
Witnessing death of a loved one	5
Cigarette Packs	1
Magazine/ articles/pamphlets	2
TV/Radio	4
Newspaper	5
Formal training	1

Table 3 Where cancer information was learnt

Table 3 captures participants' responses on their cancer knowledge and their information sources. All the participants identified gaining information from other men. Skin cancer awareness campaigns on TV and the radio were the most recalled named by all the participants and three participants cited the logo "Slip, Slop, Slap". Other messages received included the graphic pictures

on cigarette packs; and the prostate cancer commercials on TV and in the newspaper.

The 'don't go around in the sun... was freely available through the public, through the media. As in the... as in it comes through the lounge [on the TV and radio] (Beau)

Moko immediately recalled a TV commercial using two well known local celebrities, and reported having mentally referred to this commercial to gain a better understanding of his own situation and ability to 'beat it'. Moko states:

I've only got prostate cancer. Look at Paul Holmes. Look at Buck Shelford. They've, they've come through it. And I'm going to come through it. So this is what I told myself. [I heard about them] on the, on the TV, but it was when I had it too. It was about the same time. Because it was a lot of, um things about Prostate cancer then... All I thought about was those Paul and Buck. And all I did not know - whether they'd had the treatment or not. But see it in the, on the TV and in the paper. That they were doing quite well, and they, they've done it....so I just, just said yeah, I'll do it.

Further reflecting how the mass media influences all within an individual's socio ecological structure, Bazza explains how from the information received from a commercial, his daughter arranged for him to have alternative therapy to support his cancer treatment:

My daughter happened to see a TV programme about this guy who had intensive vitamin C treatment for swine flu. He was on death's door and So she said, 'Oh I think you should do that.' And she made the booking for me.

Eight participants reported learning 'facts' about cancer through social interaction and informal discussions with other men, the only exceptions being Powie and Moko who both stated making concerted efforts to avoid discussions on cancer. All these participants advised that these discussions (pre their own

diagnosis) were never initiated by them, but by the other who had experienced cancer. Post diagnosis, Beau however actively sought out men he knew had cancer, to gain information and support from them. Beau explained how he approached other men for support and information on cancer:

They, they were the elder statespersons, and they still are really. I let them speak...I went to them. And I says, 'I got a problem.' I never said I knew what they were going through. I said, 'Oh, mate, can you help me? I'm having trouble with this condition I've got.' 'What condition's that, Beau?' When I, then I opened up. And they came straight back (Beau).

Informal discussions and exchange of information between men is thus a facilitator of men's help seeking behaviours.

Colin cited having learnt about skin cancer risks from informally talking to colleagues following mass media health promotion adverts and from him observing a proactive response from the public:

People going, having moles cut out, where you never heard ten years ago, fifteen never heard of anyone going having their moles cut out. And my friends on the farm, and people, different people are saying now, 'Crikey Dick', you know. You know, it makes you a bit more, a bit more aware of covering up (Colin)

Whilst not a male to male discussion but too reflecting the influence of socialisation on knowledge, attitudes, beliefs and behaviours, Beau learnt the significance of a PSA test during casual conversation with his sister-in-law, he stated:

She gets her knowledge through her condition and, what she's going through. Chemo. And stuff

That men rely on other men for their knowledge is reinforced as Arthur stated long before his own diagnosis, he recalled having had detailed discussions on the cancer treatment that two of his friends were at that time

undergoing. Since his own diagnosis, Arthur had additional conversations with them:

I've known other friends from the [club] that have had prostate problems, namely a couple of presidents and they said that it's, 'Radiation is a piece of cake.' You know, 'You'll be right. You'll get through it.' And I know now that they're still in remission

Arthur explains that all the information received from other men is not positive, and some information can actually serve as a barrier to help seeking:

And then you had somebody else give you the negative attitude...of, 'You'll have this' and 'You'll get this.' You know, and, 'Ooh, I wouldn't go through it.' (Arthur).

Like Arthur, Bazza too learnt much about cancer from friends who had had it. He recalls..

I suppose from talking with other men, around the traps, I suppose. I've a couple of a couple of people, well a couple of people I play tennis with have had prostate cancer. And ah, they, they've been quite open about it all. Different, different types, from the sort of cancer that I had, but...They've been treated in different ways than I've been treated. But yeah, they were quite ah, yeah, quite open about it (Bazza)

Until their own diagnosis, death of someone close from cancer was no indicator of individual cancer awareness and in response a few participants had completely avoided the topic, (Powie, Beau, Moko), whilst others, elected to learn from it (Colin) and gain more information by which to guide their life decisions, including their cancer awareness and subsequent decision making and behaviours.

Here, Colin advised of how he chose to learn more about cancer from his friend dying from it at a young age.

Also reflecting upon a similar discussion with a friend who had since died from cancer, Bert expressed fear at the prospect of cancer ever reaching his bone as he recalled how “horrible” his friend’s death from it had been.

Identifying the importance of social supports and the role of friends, Bert speaks of a friend with cancer who, with no family and no assets, returned from holiday and “died fairly quickly”. Bert recalls the joys in his life, and his renewed will to “beat” cancer, “Hell. I don’t want to leave it [life]”.

Knowledge of others’ misfortune helps individuals value what they have, serving as a facilitator of help seeking. All the participants identified interaction with family and friends most important to them.

Participants independently discussed how information on cancer received informally from friends and family was two-fold, some facilitating help seeking behaviours, whilst other information did not – due to the nature of its outcome.

Social interaction with other men is thus a powerful way to transmit information to men, however, the impact of same is purely dependant on the individuals involved and the outcomes they have witnessed. **Positive outcomes will serve to facilitate help seeking, whilst the negative outcomes, will serve as a barrier to help seeking in both those accounting and receiving those messages.**

4. Gender and its influence on help seeking

Gendered roles serve to as a barrier to men's help seeking behaviours. Considered from a gendered position, the health of the family is the woman's role, and men seek care-giving, nurturing and health related support from the woman in the home.

Reflecting gendered positioning in those participants in stable relationships, all four, soon after diagnosis expressed a need to tend to financial and practical matters should they die. The male's role being to protect and provide for the family.

Similarly, Bert describes himself as:

A good Kiwi... I love rugby, tennis, boxing and all sorts of things. So I'm a man's man, but I look after myself and do the tests

The word 'but' as used by Bert, indicates that this is not a 'regular' Kiwi man's behaviour – to attend to his health needs. Bert continues to speak of how he proactively adheres to medical recommendations and consumes water prior to radiation therapy to avoid physical burns that this treatment may cause. He then immediately then states it is his wife who prepares his flask of water, and proceeds to tell the wife of another patient who is there for radiation therapy to do the same for her husband. Thus whilst Bert in one breath speaks of his proactive attention to his health – he immediately then reveals that he and his wife strongly adhere to gender roles in their home (his disclosure also revealing that he does not recognise this). It is thus a false sense of 'health independence' that Bert holds.

Again reflecting gendered positioning in the home, Bazza does not tell anyone of his cancer diagnosis, yet accepts support from family and friends, advised of his cancer by his wife, her behaviour here also reflecting her gendered position. Bazza's wife also accompanies Bazza to every appointment - again in fulfilling her gendered role expectation.

Bazza and his wife have been married for over fifty years. As reflected in both Bert and Bazza's examples, gendered positioning in a relationship does not work in isolation, both parties need to fulfill certain roles and the expectations of the other. Both Bazza and Bert's wives thus maintain and reinforce their gendered position through their own behaviours.

Bazza undergoes intensive vitamin 'C' treatment recommended by his daughter. He states, "I went along with it. I wouldn't have gone there [of my own volition]" this statement indicating he would not seek or be receptive to such information but willingly complies as his daughter recommended it – and she shares the gendered position with her mother, both as care-givers in the home .

Four of the participants rely on a female in the home to provide them timeously with their correct medication. Similarly, Ricky who does not have a resident female to fill this role, stops taking his medication as he describes the combinations he has had to take, "confusing".

Reflecting a similar attitude to Ricky, Powie, his son, and Powie's male friend (the two latter both travelled from abroad to support Powie's recovery post surgery) fail to attend adequately to his medical needs that are much like Ricky's, resulting in Powie losing a significant amount of weight and compromising his recovery. This changes and his health significantly improves once a female caregiver moves in. Women do not have a special gift that prevents them from getting "confused" with complicated medical regimes. Adherence to such requires commitment, and these men's inability to meet this requirement reflects their gendered positions and a lack of commitment to attend to such tasks.

Powie's change of attitude and treatment compliance once he has a female caregiver further reflects his gendered position - as his caregiver tells him of her expectation that he take some responsibility for his health.

I had pills to take four times a day, and if you didn't take them... but she woke up at exactly 2am; 4am; 6am. She just leave them on my table there

Powie woke up, and took the tablets – without prompting by his caregiver.

This gendered discussion and these examples draw to mind Oksuzyan et al's. (2010) statement: "Men die, women suffer" – is this perhaps one reason why? Do men die as they lack commitment to undertake what they perceive to be a woman's role in the home?

Returning to sex, two of the participants associated 'being a man', with being able to sexually perform. One of the men (Ricky) deals with this by "killing" his relationship, despite reassurances from his partner that it was alright. Ricky later describes this, him terminating his relationship as the most "stressful" part of his whole cancer experience. Yet he will not consider doing it any other way, reflecting what a fundamental role Ricky's sexual ability has on his gendered and self identity.

Hank also receives reassurances from his wife that his sexual inability is OK, and it does not detract from his masculinity nor their relationship. Hank soon regains confidence in his gender and self identity and states:

My wife was so supportive and understanding that I didn't feel inadequate because she made me feel not inadequate

The complimentary role that Hank's wife plays in reassuring him of his masculinity and social position reflects her complementary role in this 'gendered dance'. This has not been achieved in Ricky's relationship as Ricky holds a **much stronger gendered identity that serves as a barrier to his well being, and to his help seeking.**

Reflecting mental inclusion of their wife in their coping and treatment processes, and reflecting their strong complementary gendered positioning, three of the four participants in a stable relationship interchangeably shift

between the first and third person when recounting their experience with cancer. eg) “I said, well OK. We’ll we’ll do it [radiation therapy]” (Bazza). Reflecting they did not walk the journey alone, and each partner had a role in to fulfill.

In contrast, Moko demonstrates how men can take self responsibility for their health, as without a woman to attend to his needs, he mobilizes a lot of support services, family, friends and neighbours to assist him. He then states,

“It [cancer] makes me feel more of a man, because I’ve had what other people haven’t. And I’ve I’ve conquered. I’ve done it”

Powie holds a similar sentiment to that of Moko, saying “I haven’t lost any mana. Yeah, we’re actually gaining it”

Not being immersed in a gendered identity serves to facilitate these men’s help seeking, and they proactively take responsibility for their health, recovery and well being.

5. Doctor-Patient Relationship

The doctor-patient relationship was found to be a key influence on men’s help seeking and treatment compliance. Amongst this group, all identified the local GP as their primary health provider. Five of the participants disclosed having medical conditions that required monitoring prior to their cancer diagnosis, it is unclear as to how many participants had a regular GP who played a role in their help seeking or whether this function was met by local medical health centers.

Prior to receiving a cancer diagnosis, nine of the participants sought help for their symptoms from a GP in the first instance. The remaining participant (Arthur) presented directly at the hospital due to the acute nature of his symptoms (hemorrhaging whilst he urinated). The GP’s gender did not once

come up as an issue for consideration by any of the participants. All the participants reported preferring a direct, yet compassionate approach by the health professions with whom they were dealing. The participants all stated they preferred an informal, casual approach by GPs.

Nine of the participants held a passive role in their treatment decision making. The remaining participant (Bert) was the only participant to request a second opinion regarding his diagnosis and treatment options.

The passiveness witnessed in the nine participants is attributed to their lack of understanding of much that they were being informed of by the medical staff. This is evidenced as Moko does not know the full extent of his cancer or the aims of his treatment (ie) curable or palliative? Additionally and reflecting this passiveness as consistent behaviour seen in the doctor-patient relationship, upon initially help seeking the GP Moko consulted conducted a thorough medical examination in relation to his symptoms, yet Moko was unaware of what he was being tested for, or why. This is evidenced as the first Moko learns that he has been tested for cancer is from the urologist; this is however despite the GP having attempted to conduct a digital exam with Moko and failed to reach his prostate before referring him on. Moko is informed of his diagnosis by the radiation oncologist – with whom he has only had minimal contact. A more suitable and safe way to inform patients of their diagnosis would be through their GP and for it not to be delivered by the last specialist to see him.

Moko expressed the impact of his diagnosis delivered as above:

I was very brassed off when I heard it. And I, I was het up about it. I was frightened, scared. To be honest, I wanted to drive off the bridge.

To encourage help seeking in men, doctors and specialists need to ensure that patients are aware of the procedures they are undergoing and why, and that they have support people with them when diagnosis of serious illnesses are delivered. Failing which and as disclosed by four of the

participants, fear and escape through suicide presents as an option.

The manner in which men are informed of their diagnosis might therefore contribute to the high male suicidality across all ages (New Zealand Ministry of Health, 2010), whilst also detracting other men from future medical help seeking.

Reflecting an inadequate doctor-patient relationship, Moko speaks of being too “lazy” to do things he most enjoys – this lack of exercise further compromises his diabetes management and mood fluctuation. If managing his total well being, a good doctor-patient relationship would reflect GP involvement and assessments conducted into Moko’s lethargy, providing continuity of care. **Such treatment could facilitate Moko’s earlier help seeking in the future.**

A good doctor-patient relationship is definitely a facilitator of medical help seeking, the reverse being true too, and on the latter I now elaborate.

Ricky initially sought help from the GP when he urinated blood. Without thoroughly checking him, the GP advised “you have nothing to worry about”. Ricky left, despite not being satisfied with this response, evidenced in his words:

And I thought , 'Well, maybe you should have told me to come back tomorrow and we'll do a follow-up or something.

During the interview Ricky mentioned six times how “freaked out” he was at the sight of excessive blood in his urine. Ricky’s experience of horror at the symptom, and the GPs response indicate a clear lack of rapport between them, and when Ricky next hemorrhaged, he did not consider returning to that GP:

I, I went straight - instead of going to Dr [GP] - I went straight up to the hospital, to [city]. Because I only for the fact that... because he didn't offer me a come back call the next day

Ricky’s response reflects how a poor doctor-patient relationship serves as a barrier to future medical help seeking.

Powie experienced similar with the GP he consulted who misdiagnosed him. After repeated visits Powie then asks his GP for a referral, and advises the GP:

I think I must have cancer. I've got something that's worse than what you're saying it is, Doc.

Reflecting a different approach, Powie's GP does not dismiss his concerns, but tries to assist with a referral to a specialist. With Powie declining this due to his pain experienced, the GP then advises Powie on how to go about receiving prompt attention when he goes to the hospital. Despite this GP having misdiagnosed Powie, a positive doctor-patient relationship was experienced as the GP took Powie seriously and tried to assist him. Powie's recognition of this is evidenced as Powie returned to the GP post his surgery,

Went back and seen him and said you're all right doc, I mean everyone makes a blue

Despite it being culturally inappropriate, Ricky proceeds with an invasive biopsy procedure purely because he feels comfortable with the treating specialists who casually interact with him. Ricky states:

They straightaway put you at ease...they come to you with a friendship sort of thing... they weren't doing the pointing the figure at me and but they made me feel comfortable

Patient trust is here gained from a "no-blame" approach being adopted by health staff, regardless of the patient's presenting symptoms. The meaning of a 'no blame' approach and importance of same was cited by four participants. Here Moko stated **valuing not being 'judged' but treated for his illness symptoms. Such is the basis of a good doctor-patient relationship that will encourage future help seeking.**

Powie raised the issue of the specialists joking with him – one who too was described as dressing very casually - and wearing socks and sandals. This behaviour by the specialist was well received by Powie – a good doctor-patient

relationship also lessens the fear experienced when individuals are hospitalised

Ricky described his two treating specialists “friends”. Their approach to support Ricky understand the complicated procedures he was to undergo was to explain it to him in stages over a series of visits and using diagrams that he could relate to. Such approach fosters a positive doctor-patient relationship with the resultant benefits as previously discussed. This example highlights how the terminology used by health staff in their interaction with patients, as well as their interpersonal manner needs to be pitched to the patient’s level of understanding.. As formal validators of illness, GPs and specialists hold the powerful social role of shaping the norms, values beliefs and expectations of their patients with regard to health and help seeking.

Colin too recalls a positive interaction with his surgeon that resulted in him fully committing to a treatment plan despite being aware that he would struggle to financially meet the ‘gap’:

And the day he diagnosed me, he [surgeon] said, ‘I, I’ve only known you for three or four weeks, but I know that you’re going to be one of the ones that will get up and fight it. I feel that with your attitude, and with what I’ve seen in two or three weeks, that you’ll be as good as gold

Colin proceeded with treatment, and developed a good doctor-patient relationship. The GP demonstrated flexibility in his hours, to help Colin minimise his time from work when he needed to attend medical appointments. He also provided Colin with emotional support during their appointments.

GP appointment flexibility too is a facilitator of help seeking behaviours.

Only four of the participants reported a clear understanding of their cancer and treatment including the treatment aim. Three of these four participants had a tertiary level of education whilst the other participant (Monty) had nursed his wife with cancer for nine years and was thus well familiar with the terminology used. That the other six participants were all unclear to some

degree of their cancer and/or treatment reflects a failing of the GPs/Specialists involved in their care and reflects the patient, as a person, has been lost in the medical process.

Reflecting the influence medical staff have on patient's treatment compliance, Ricky recalled:

I do remember asking a nurse - just randomly - what, what one pill was for, and all she says was, 'It makes you... it's to make you feel better.' Then I thought. 'Oh my gosh!' Sort of made up my mind that I wasn't going to take anything more by that stage.

One participant (Arthur) was misdiagnosed by the hospital and erroneously discharged. Upon his GPs insistence he was readmitted . He was placed on a waitlist for surgery in six months. He had several infections and after four months following a series of catheters he had to use (that he described as “disgusting” him). He pleads his case to a visiting specialist and has his surgery brought forward to four and a half months, after which he suffers countless health complication not experienced previously. Arthur's case reflects appalling medical management and a blatant disregard for what he values as important (not wearing a catheter). Unlike the others participants, Arthur was unable to name any of the health professionals with whom he interacted and could cite as having developed a positive rapport with. This, coupled with the adverse effects of his surgery, suggests that Arthur's experience and to those whom he tells of it, is likely to be a barrier to medical help seeking.

Two participants subsequently experienced medical complications following surgery (Ricky had a twisted bowel; and Arthur an adverse reaction to medicine he was administered and he had infections). Bert had staff ready to prepare him for a biopsy that had already been conducted, then delivered inconclusive MRI scan results as conclusive – that needed to be reversed. The errors made by health professionals when interaction with men at their most

vulnerable is a barrier to help seeking.

In this regard Bert here describes the emotional roller coaster experienced from having to deal with the health system the most difficult part to bear:

the worst thing I've had with all of this - and I put it in my diary in the form of a graph - is the ups and downs. You know. And the the first thing is, you, you learn... the discovery of cancer, and that you've got it, and that's horrible. Then the acceptance stage you sort of go through. The bone scan was a huge high, after what I'd seen. And, and it came back negative...

Monty's negative experience too reflects a lack of regard for patients' emotions. Monty was lead to believe that his cancer was operable, and waiting for the urologist to come in and explain the surgery, the urologist bluntly advises him that in fact his cancer is inoperable.

Oh, there was never any likelihood of an operation. It's too far advanced. There's no way we can operate, that is out of the question. Sooner or later it will catch up with you and kill you so go away and have a good time

Monty is then prescribed incorrect medication by the registrar resulting in his complete loss of faith in the health system, this being a barrier to help seeking. He states,

There's the registrar joker in a Specialist Department. You got to that stage of your medical career [registrar], you should know what the rules are.

Again and as with Ricky, Monty is dealing with two specialists (an urologist and a registrar) regarding one issue with an unsatisfactory outcome.

The positive effects of good doctor-patient relationship are described by Bert who cited holding his GP in high regard and thus adhered to all his

treatment recommendations, including regular medical check, despite Bert's his personal belief that cancer was genetic and he was 'invincible'.

Table 4 reflects the social barriers and facilitators that the participants have identified as influencing their medical help seeking and treatment compliance as directly related to the their interactions with health staff :

Health Staff Interactions: Social Barriers and Social Facilitators of Medical Help Seeking

Facilitators of medical help seeking directly related to interactions with health staff	n = 10	Barriers of medical help seeking directly related to interactions with health staff	n = 10
Previous positive experience dealing with health professionals regarding chronic health issues	2	Previous negative experience dealing with health professionals or knowledge gained from others to this effect	2
Specialist serving as an advocate for the best treatment options to be discussed with the patient	1	Misinformation by health staff	4
Efficiency within the health system and sharing of patient results with relevant departments	3	Terminology used that is not understood by the patient	6
Relaxed, interpersonal communication style with patients	7	Lack of specific details on what procedures involve (prior to the patient agreeing to same)	3
Ability to empathise with patients	4		
Provision of all relevant information in a manner clearly understood by patients	5		
Flexibility in appointment setting to assist patient's attendance	4		
Regular staff who are able to provide personalized support as required	4		

Table 4: Social barriers and facilitators directly related to interactions with health staff

6. Close Family and Friends

Family and friends positioned in each participant's micro and mesosystems have been found to be the strongest facilitators for the participants' help seeking behaviours. These include friends, wives, the immediate and extended family, the Marae, church, work, sports and social clubs, neighbours, Cancer Society, Cancer Society's Men's Group, Maori Cancer Coordinator, and others with cancer. All the participants identified their family as most important in their lives, and the reason for them to 'fight' cancer and live and continue to be a part of the lives of the younger generations in their family, including nephews and nieces, grandchildren and great grandchildren.

I want to see them. I want to see that ten year old that I carried get to varsity. Do the things she wants. Like piano, she wants. Ballet, she wants ...'I'm going to get on with life as best as I can, and use the support around me. (Beau).

On identifying his symptoms, Colin recalls his first thought::

My daughters. I thought, well , 'You've got to do something here straight away.'

Ricky too, identifies thoughts of his children as what stopped him killing himself upon diagnosis.

My kids. All the years that I had gained with my kids up to that stage – and we were tight as – seeing that disappear and not knowing that its gone.

Arthur's wife is the first person who comes to his mind at diagnosis:

Well, you know, as I've, as I've said, you know, you've got to try and, try and be strong for your partner. You've got to think positive.

Most of Monty's immediate family is resident in Australia and on hearing his diagnosis they all flew down to be with him. Monty values the significant role of his family and has daily contact with them.

All of the married participants described their wife as "100% supporting" (Hank). Only Arthur did not have a support person with him at the time of diagnosis as his wife was very ill and he was hospitalised.

Bert here describes his wife's support as invaluable, comprising "hugs and concern and diet".

Beau had his sister in law (a cancer patient herself) as a support person, and it is through her that he heard the doctor's diagnosis – reflecting the powerful role of trust and honesty she held.

You get told [the diagnosis]. And, and, your support person, just looks at you, and just looks at you and just nods. She, she nodded. And I knew. She understood, what I was going through right at that time... and she took over. Yeah that was good for me.

All the participants cited valuing personal interest shown in their health by their family and close friends, through specific questions and in the things they did, like chopping the wood or helping paint the roof and clean the house (Monty). Most importantly, all the participants identified it was simply their physical presence, as stated by Powie,

"To just come around and just have a yack, you know this, this, it's a good medicine".

Expressing similar sentiments, Arthur states:

If you've got somebody, if you got friends around you that are, are good like that, that sort of boosts your morale a wee bit

Moko described his nephew as most supportive “coming around and rings me up and asks me if I’m alright. Very specific. Wants to know” . This nephew is the person to whom Moko turns during his medical emergencies, knowing “he’d come straight up”.

Ricky had suicidal ideation at the time of his diagnosis. He only spoke of his cancer to his children and sister, and described himself as “isolating”. His children in response, increased their visits to him. Ricky states:

They told me They love me! They stuck around. And I had them more times too. And the thing is that, they were turning up here every weekend, and every time that they did have free, they were here...I love it when my kids visit.

Ricky states his cancer experience showed him how much he values his family:

That I'm worth being around... And because my kids tell me they love me and I'm not shy to say it back... all my kids know that I'm there for them 100%... if they weren't as strong to me as what they are, I think I probably would have pulled the plug a little while ago.

Ricky also notes how his relationship with his grandchildren had deepened since his cancer diagnosis:

We've always been tight, but since this has happened, my grandkids love being here, and I don't know who or how they see it, but ah, when they turn up it feels like this is our last day. And we use it up!..They've warmed to me, I'm, I'm just warming back to them. (claps hands together) But it just seemed to have gotten stronger since this [cancer] happened.

Ricky is now learning the Maori language so that he speak in his

language on the Marae, where he will be able to share his values and learnings of the importance of family - and through speaking in Maori, reciprocate and make his family proud.

The need to 'protect' their family members' well being was too expressed by all the participants. Ricky deliberately does not tell his mother that he has cancer until after his surgery and he is on the road to recovery, as he knows worry will consume her.

She took it pretty hard - she took it harder than me. She couldn't stop... she's probably still crying now... But I was so glad that I did keep it till after it was done, rather than any time before. I know she would have been there too.

Whilst Bazza, Colin and Hank all admit to withholding telling their children all that they are experiencing for the same reasons.

Arthur receives his diagnosis whilst hospitalized, and his wife is very ill at home. He worried about how to tell her of his diagnosis:

I didn't know how to face the wife with it... how she was going to react... we've been married over thirty years. I rung my best friend's wife - told her... and I said 'Well, if I break it to her when you're there, will you..'

Monty recognised the helplessness felt by his family, and appreciated their concern and desire to help, as they asked him:

Do you want anything?... They just felt like they had to do something I suppose.

Reflecting the value Monty has for his family, when told he is in remission he 'treats himself' to two weeks spent with his grandson and great grandchildren. This involves him flying to Australia, forcing him to face his flying phobia.

Also keen to protect his children from watching him die as his cancer

progresses, Monty declines offers from his children to live with them, and instead accepts one from his sister who will relocate from Australia and move in and care for him at such time.

Keen to maintain a mutually strong relationship, Beau values his family enough to tell them the type of support he needed from them, and what he didn't want. This honesty served to bring their relationship closer, as captured by Beau:

At the start of it, yeah sure I welcomed that [rubs on the back to show support]...But something kept telling me, 'You're not going to lose this'.

Beau starts interpreting comfort as expressed through rubs on the back as sympathy, and unhelpful, and tells his family to stop this – which they do without question. Beau tells them:

Just treat me normally... it's not sympathy I want ... It's just my family and whanau... talking to me as if I'm going to be around for too long.

The importance of humour, and being able to laugh in life was raised by eight of the participants. Humour was cited by Powie as important whilst he was in hospital, and received by the specialists, by Beau who recounted how his friends use black humour with him, and by the other participants too, all consistently also spoke of deriving such pleasures from the youth in their family. (The lack of input by Arthur and Bert does not mean their disagreement of same, merely it was not raised during their interview). Returning to the importance of laughter, Beau talks of how his friends' black humour helps maintain his spirits, stating:

That black humour helped me as well because I could only laugh. And I found that great ... and I took all of that and put a positive spin on it.

Two participants (Moko and Beau) cited appreciation for the active involvement of a family member in their treatment process and in dealing with the health services. Moko had his nephew, and Beau, his sister-in-law, these supports asked those questions that Moko and Beau hadn't thought to ask.

Beau speaks of the help provided by his sister in law:

From the diagnosis to... to what step we're going to take with you.

Yeah. This is this is where she did help and, a lot, yeah.

Other unsolicited forms of support provided by close family and friends included cleaning the house (Monty; Moko; Ricky; Powie), cooking meals (Powie; Colin; Monty; Beau), providing fresh produce (Powie); driving the participant to and from treatment (all at various times), financial assistance (Bert), assistance with the completion of every-day tasks (Hank), and ensuring medicines are taken correctly (Hank; Powie; Arthur; Bazza).

With regard to the latter, Powie recognizes how after his hospital discharge and despite support from his children his health deteriorated due to his non compliance with his medicine regime and inability to adequately care for himself. His live-in caregiver remedied this. As recounted by Powie:

Well I was down to something, 60 something kilos. Thanks to her, and looking after me, giving me the right medication. And. Because, I wasn't listening before to people, but now, she's just you don't listen to me, well I'm leaving. So. so get your act together. So take your pills and eat the food that I've left here for you".

Hank too, speaks very appreciatively of the support his wife has provided him:

My wife was 100% supporting, and that was another thing that I thought, well, our life is shortened together so we must do as much as we can together while I had time, and ahhh, [wife's name] has been my number one support. She figures out all my medication, looks after me. Having arthritis, I can't reach my feet, so you know, if anybody's got to pull my socks on or off...

Nine of the participants, unsolicited, advised how invaluable the verbal support they received from other men was, particularly soon after their diagnosis when they felt most vulnerable.

Moko gained strength from the show of non verbal support he received from his whanau from his hometown and on the Marae who, on learning of his diagnosis regularly travelled to the hospital to see him; he states:

Marae and the old people: Aunty, and Uncle, and all them would come up... all the old people come up... I might have about 20 around my bed. They'd have a prayer and then have a bit of a sing-song. Well I's say, it's good to be wanted!

Moko's final words appropriately close this section as they capture how support from those close to us, physically(neighbours), emotionally(family) and spiritually(Marae; church) reinforce our self construct and sense of self worth – reflecting a sense of belonging in this world – that combined, serves to facilitate help seeking, as we want to live to be a part of those we love's lives.

Chapter 7: Discussion

The Ecological Systems Theory (Bronfenbrenner, 1979) captures the social nature of health and in line with this study reflects the impact that society has on an individual's decision to seek medical assistance. It reflects health as "A matter for people embedded in social life; health related behaviour being more about that social life than about health" (Stephens, 2008, p.19). Mapping the results obtained in this thesis onto the theoretical framework on which it is based, I systematically discuss the results and how the hierarchical levels of Bronfenbrenner's Ecological Systems Theory (1979) have influenced them.

Using this approach, the non linear, active social systems (Wu & David, 2002) that combine to influence individual medical help seeking behaviours are considered.

1. Observed help seeking behaviours

Results relating to Hank will be those most focused on under this section and considered closely against theory.

Hank delayed help seeking and deliberately disregarded his illness symptoms that he suspected to be cancer until such time as they interfered with him completing his routine tasks. Until then, Hank elected to believe that these symptoms would "get better" without intervention. Courtenay, (2009, 2011) found that men delay help seeking until such time as their pain experienced becomes intolerable, or until their symptoms heavily impact upon their ability to perform routine tasks. Hank's behaviour fully reflects this.

Whilst Hank did not articulate considering going to the doctor when he first experienced what we now know to have been cancer symptoms, his behaviour in keeping them hidden reflects his awareness that he was not conforming to the social expectation that he investigate them. Hank later admits "I have only myself to blame" explaining that he was aware of his symptoms

possibly being related to cancer, yet maintained his attitude of 'invincibility', "It will never happen to me" reflecting his fear of being socially judged less than invincible... weak (Doyal, 2000,2001).

Hank's behaviour to hide his symptoms from others further reflects his awareness that those people emotionally close to him (in his microsystem) would have strong influence over his decision to seek medical assistance. By continuing to hide his symptoms that were steadily worsening, including the swelling of his genitals that physically represent masculinity, Hank's behaviour displays alignment with gendered social norms of masking any problem related to his 'manhood,) and also align with the normative masculine identity, as a 'real' man is invincible – and can conquer anything, having qualities of strength, endurance, independence, emotional control and decisiveness (Chapple & Ziebland, 2006). It is only when Hank realizes that he cannot control the urgency with which he has to urinate and risks social exposure of this 'weakness' that he discloses his symptoms to his wife.

The reason Hank has approached his wife is because he identifies her as the strongest influence in his microsystem who helps him make suitable decisions to best support his well being; he therefore has a strong level of trust in her in this regard. The interpersonal relationship shared between Hank and his wife plays a great role in his attitude, beliefs and behaviours – and thus she too has shaped his self belief of 'invincibility'. Hank and his wife's union and home is one environment where they have jointly created a world comprising common and/or complimentary traditions, attitudes, values, beliefs, roles, norms and expectations through which they experience the world (Jetten et al., 2012). Every group that Hank belongs to ie) every meaningful relationship he has comprising two or more people, will similarly comprise those traditions, attitudes, beliefs, roles, norms, values and expectations shared by those parties and with which, for social acceptance (Tajfel, 1981) Hank will conform, with the cumulative effect of all these human interactions shaping his self construct and thus behaviours.

The role Hank's wife plays is apparent as Hank approaches her and discloses his symptoms. Hank's gendered position indicates that his wife holds a gendered complementary role to his own, and within their relationship this means that as the female of the home, it is her role (and Hank's gendered expectation) that she fulfils the role of caregiver and nurturer – where issues related to health and well being of the family fall within her domain (Doyal, 2001). Unaware of Hank's former attitude towards his health, it cannot be determined in this study if age, and Hank's diminishing physical abilities (not being able to put on/remove his socks due to arthritis) has shifted his need for external validation of his illness symptoms prior to help seeking towards prolonging same, as identified by Doyal (2000, 2001).

In her gendered position within Hank's microsystem, Hank holds the expectation that his wife will assess his symptoms and provide external validation for help seeking, making it a shared decision and removing his personal responsibility for same – and she responds accordingly.

Reflective of the Social Identity Theory (Tajfel, 1981), Hank's attitude of invincibility forms part of his self construct. It reflects how he interprets the world and his place in it, and in Hank's case his attitude of invincibility reflects strong alignment with both the gendered and the normative masculine identities, shaped by every social environment of which he forms a part (Bronfenbrenner, 1979); this includes those people in Hank's micro system eg) his immediate family and close friends, who play a large role in shaping his attitude of 'invincibility', as do those within his meso system. This view is supported by Marshall et al., (2011) who argue that it is through social interaction that we construct and reconstruct events and adjust the meanings we attribute to life issues with each bit of new contextual information we receive, and in so doing shift and continually shape and reshape our beliefs and attitudes that in turn drive our behaviour.

From the information here available on Hank, it is my understanding that those in his meso system would include extended family members with whom

he has infrequent contact, eg) nieces and nephews; those institutions and services that Hank deals with on a regular basis, eg) his local sports club/RSL; his bankers, etc. People at this level are directly influenced by messages communicated through the mass media, eg) newspapers, radio or TV, as well as others in their own ecological social structure and it is these people, along with those in his micro system (close/immediate family and friends) with whom Hank would discuss issues relevant and meaningful to him, where he would form opinions that influence how he views the world and his role in it – therefore shaping his behaviours.

Newspaper organizations, TV and radio stations fall within the exosystem as it is their social role to communicate topical issues that reflect the values, traditions, norms and expectations and what is happening in the wider society – and in so doing, influence those receiving such messages. The exosystem comprises those bodies who enforce policies and procedures driven from a national level and specific to smaller communities eg) the local council; and government agencies who provide services within a community, to name a couple. Hank receives messages directly from the exosystem, eg) through watching TV; reading the newspaper; receiving a welfare payment, or indirectly through interactions with others positioned in his meso or microsystem on such issues – either way, influencing his outlook on the matter being considered and causing him to reflect and possibly reshape his own attitude on a particular issue due to this new contextual information he now has.

The macrosystem represents national government and large influential institutions who make the decisions that influence the nation eg) political, economic, social and health policies. As explained earlier, every individual across the ecological systems hierarchy is influenced either directly or indirectly by decisions made at the macro level.

2. The Normative Masculine Identity

Results relating to Ricky will be those most focused on under this section and considered closely against theory.

Ricky strongly aligns with the normative masculine identity and admits that the effects of his surgery, (having to wear a stoma bag) on his image, his inability to partake in the sports he enjoyed, coupled with his inability to sexually get an erection combine to heavily impact upon his self identity and thus self construct.

The development of the normative masculine identity within any society proceeds in accordance with Bronfenbrenner's Ecological System's Theory. Hierarchically it is based on tradition and culture that reflects the values, beliefs and attitudes of a community that determines how men should 'look' and 'behave'. Such behaviours men engage in reflecting domination, power, control and strength receive social recognition and approval (from women as well as from other men) and socially it is constructed within that environment that those traits are reflective of 'masculinity'; socially interpreted as valuable traits for a man to hold and against which men are contrasted to women, and within group, compared amongst themselves and judged.

The language Ricky uses when discussing his experience of cancer highlights his alignment with the normative masculine identity. Ricky speaks of 'beating' cancer, of 'conquering' it, singlehandedly. He speaks of a battle where only he was involved, fighting the arch enemy 'cancer' whilst conjuring images of his aggression, determination and veracity to win. All of these traits being normative masculine traits, traits valued and recognised by Ricky as held by him. Now, with a stoma bag and unable to get an erection, Ricky struggles redefining his position in the world as he adjusts to a new image of which he is unfamiliar, and one that calls for him to identify and draw on different strengths in himself. With his physical image now deteriorating due to an inability to play

rugby and other contact sports, Ricky is also isolated from his social network that comprises those men with the commonality of playing sport. With playing sport nationally accepted as a normative masculine behaviour, Ricky seeks to reestablish his self construct – and his place in society – where he will feel comfortable - as a New Zealand man.

Normative masculine traits are recognised and given value through the mass media, through formal and informal discussions and activities that those at the meso and micro systems engage in, including at work; socially; politically – in both a formal and informal environment – influenced by that taking place at the exo and macro systems, that too serves to reinforce those traits that are valued in New Zealand men. Macro system influence has been used to show consolidation with other men, to further reflect shared values eg) Historically, New Zealand has used men's sporting activities to bring countries together and to emphasis national values eg) New Zealand and Australia's national boycott of playing sports against South Africa - in protest of South Africa's political position reflecting apartheid.

As he adjusts his self construct, the acts and words of love and kindness from his children and grandchildren, positioned at his microsystem reveal to Ricky their unconditional love for him and unwavering expectations of him as their father and grandfather. Not having been in a position where he needed to consider this, and not accustomed to sharing emotive expressions – in line with the manner in which normative masculine behaviours within Ricky's social environment have been expressed until then, Ricky regains self confidence in his personal, familial and social role as father, and grandfather. These roles and social role expectations do not stand in isolation but too form an aspect of the normative masculine identity – as part of being a man, is to raise a happy, healthy family.

Alignment of the social expectations imposed on men and of an individual's acceptance at their microsystem is with regard to those positions they occupy is essential for the development of the self construct (Myers, 2000).

This learning then brings out in Ricky the decision making trait – more commonly recognised as a normative masculine trait amongst those of medium and high SES, where decisiveness, level-headedness, equity of judgment, and assuredness are socially interpreted as normative masculine traits (alongside those traits reflecting physical dominance, strength, endurance and independence). Learning the fluidity and dynamic nature of social norms, and as they are reflected and experienced in response and in according to one's environment, Ricky makes the decision and coaches himself beyond procrastination.

The two aspects of the normative masculine identity as reflected in different communities have here been demonstrated, where the physical traits that reflect physical dominance are more commonly seen in areas of low SES – where national resource allocation and decision making (of the macro and exosystems) limits these people's abilities to excel and align with the more business oriented aspects of it (Wilkins, 2007). Here, national priorities and resource allocation too ensure that such divide remains, as a nation needs men strong in both socially recognised sets of traits. SES thus determines what the normative masculine identity looks like in different communities. The two aspects of the normative masculine identity complementing the other. The normative masculine identity is expressed within communities and manifests as per the resources available in accordance with the community's SES (Collings et al., 2009). It is there shaped and behaviours supported by those positioned at the macrosystem, and too reinforced from below, by those within the micro and meso systems. Accordingly, a nation raises men with bold attitudes, values, beliefs and norms that are shaped to meet national physical, political, economic, and social needs (Bates et al., 2009).

Social norms are thus directly and indirectly reinforced through daily living activities at every level of society, this includes direct and indirect social interaction with others (Stephens, 2008), influenced by factors that at some level hold position within the macrosystem (Bronfenbrenner, 1979).

3. Where Men Gain their Health Knowledge

Results relating to Bert will be those most focused on under this section and considered closely against theory. Noted is that Bert is one of the two participants in this thesis who had access to a computer. Bert however reported not conducting online research into cancer prior to his diagnosis and only used the computer, with the support of his children, when seeking alternative treatment options. As such, it is Bert's knowledge gained prior to his diagnosis that is of interest and will here be focused on.

Bert identified gaining the bulk of his information and specifically that on skin and prostate cancer from his GP, whom he described as "an extremely good doctor and he was very hot on the prostate cancer".

Holding his GP in high regard, Bert complied with his GPs recommendations, and has for years attended 6 monthly PSA and digital tests. This is despite Bert being "quietly confident" that he would never get cancer as "it was not in his family". Bert's maintenance of this practice reflects the strong influence a positive doctor-patient relationship can hold on health related behaviours, as despite this doctor relocating to another town, Bert continued to have these tests at the same intervals.

Bert also identified gaining information on cancer from talking to a friend who had cancer (and who later died from it). In the results captured, a differentiation has been made from those who merely witnessed the death of someone from cancer and through observation gained information, and those who actually engaged in discussion with those with cancer with the aim of learning something about the illness. Bert and his friend have been identified as falling into the latter category – where they actually discussed his cancer, however, the core information that Hank appears to have retained from these discussions is what he has based his 'known cancer facts' on – the incorrect belief that cancer is only hereditary. Had Bert not had a GP who promoted prostate testing, based on the knowledge that his 'family does not have cancer',

Bert would never have undergone regular PSA and digital tests, and possibly remain undiagnosed today.

The need for accurate information on cancer to be more effectively disseminated across communities and particularly amongst the low SES who have limited access to same in comparison to those of higher SES is recognised and well documented (WHO's Global Strategy for Health for All by the Year 2000, 1981) – yet the gap between the health knowledge held between the low SES and those of higher SES remains, with more individuals of low SES continuing to die young for this reason – being incorrect information on which they based their help seeking decisions (Wilkins, 2007).

Considering the participants' collective results on where they gained information on cancer, the entire group identified talking to other men as a means through which they had gained 'something' about cancer, even if it was unsolicited. This finding reinforces that "All humans have needs that can be satisfied only through social interaction with others" (Kaplan et al., 1989, p.237), and it is through such social interaction that the self construct and behaviours are thus shaped (Jetten et al., 2012).

Further highlighting the power of informal social interaction on behaviour, with it here identified that men talk informally to other men about health issues; this finding presents an opportunity where men's behaviours could be greatly altered through their sharing and spreading of accurate health information. All that is required here is commitment towards achieving this from the socially elite, positioned at the macrosystem – the powerful decision makers of what resources are allocated where.

Information dissemination of health, or any other information across a society requires the support of those positioned at the macrosystem – where resource allocation and national health priorities are identified and conveyed through the exosystem for apportionment to those at the mesosystem where it is hoped the messages will be received by all individuals. The health system

thus plays a key role in identifying the suitability of the messages conveyed, the medium used that will create topical discussions, and that the messages aim to reach a population not merely 'pockets' of a population. Without consistency of approach across a society, counter messages risk being received and the effect of such campaign reduced.

The low SES are identified as most disadvantaged with regard to accurate health information (Broom,2010, Robertson, 2007) and incidentally too, this demographic sports the highest cancer incidence (New Zealand Ministry of Health, 2010). One reason for this lack of accurate information is limited technological access to same, or interest to access same electronically by individuals – due to their lower educational levels reached, lack of disposable income, and/or lack of comprehension of the full ramifications of same. Every point here relates to SES and systemic decisions at the macro and exo systems that filter through the social ecological hierarchy to impact upon individual beliefs, attitudes, and behaviours. Supporting this view, Marshall et al., (2011) found the more disadvantaged a social group, the more limited their access to health information and services relative to their need, further reflecting a lack of prioritisation by those elite at the macrosystem to invest adequate human and financial resources in the low SES communities (positioned at the bottom of the social power hierarchy).

One possible reason for this lack of prioritisation to correctly inform the low SES with accurate health information is that as such emphasis would remove privileges that those of higher social status enjoy as an increasing amount of resources are continually directed at modern, technologically advanced and expensive health solutions that stand to benefit the socially privileged, perhaps even place the country as a leader in health solutions, all the while this being at the expense of the lives of the poor.

4. Gender Roles and its Influence on Help Seeking

Who we are is socially and culturally shaped and rests at that core of all

we think and do. Social and cultural influences on gender thus too contribute to shape our self construct and thus behaviour. In a bid for acceptance we conform to gendered roles, norms and expectations as we do to normative masculine and feminine norms (Barnett et al, 1993). Physiologically determined, gender roles thus closely align with the normative masculine and feminine identities.

Being a social, cultural construct that is physiologically driven, gendered roles and behaviours are thus supported and encouraged across the social hierarchical sphere. Here, women are encouraged to occupy less risky work positions, and supported at every social level should they wish to remain in the role as homemaker. In both instances, women's contributions remain less valued than men's reflecting support from the macrosystem of men's gendered position being to provide for the family, and the role expectation of women - as homemakers, nurturer's and care-givers – not equal to men and not performing the same role. This gendered expectation is too reflected in mortality rates, as more men die at every age from gender neutral illnesses including suicide, than women (New Zealand Ministry of Health, 2010). Such findings further reflect women social position inclined towards nurturance. Here Oksuzyan et al., (2010) identified that more women suffer chronic illness than men – men merely die sooner due to late diagnosis and thus compromised treatment outcomes (Bishop & Yardley, 2004).

Gendered behaviour has further been identified by Davidson & Meadows (2010) to shift in accordance to the life stage an individual occupies. They found that fatherhood adjusted men's health promoting and help seeking behaviours to align with what these men socially identified as 'expected and responsible behaviours of fathers' -- to look after themselves, and in so doing be able to provide and protect their family. Once their children were independent, Davidson & Meadows (2010) witnessed a return to the behavioural pattern seen in these same men prior to fatherhood, this finding reflecting how gendered roles and social expectations effect change in men's behaviour, further

highlighting the human inclination towards social conformance, through which acceptance is gained (Tajfel, 1981).

Gendered positioning was most apparent in those participants in stable heterogeneous relationships, and all four, soon after diagnosis expressed a need to tend to financial and practical matters should they die. The interesting aspect of this is not the tasks at hand, but the timing - that reflects a gendered approach to the issue – again, for men to ensure the financial security of the family.

The complimentary female gendered role is to assume the role as nurturer and caregiver in the family – to meet the family’s ‘softer’ needs that include ensuring their health and well being. As the opening line of this thesis states, gender is here viewed a key determinant of medical help seeking for cancer. To tease this out in accordance with the results from this investigation, I now focus on Bazza’s gendered responses that reflect those attitudes, beliefs, values norms and role expectations that have shaped his help seeking behaviours.

Bazza attended a doctor’s appointment to undergo a full medical check prior to him cashing-in a life insurance policy. His focus was on obtaining money to continue providing for his family – in line with gendered and normative masculine role expectations. At this appointment and in subsequent follow-ups, Bazza received a primary diagnosis of a serious cardiac problem requiring urgent surgery and a secondary diagnosis of prostate cancer, already past the operable stage. Whilst Bazza indicated having gained cancer information from talking to men “around the traps” and also indicated being aware of prostate cancer symptoms prior to his diagnosis, he failed to act upon the urinary difficulties that he experienced “years” prior – again reflecting a gendered position – health matters needing to be spear head and lead by the female in the household. That Bazza consults and includes his wife in all his health decisions is reflected in his interchangeable use of “we” and “I” when discussing his health and treatment – a pattern also identified in the communication style of

the other married participants.

Bazza does not tell anyone of his cancer diagnosis, yet accepts support from family and friends. This seemingly contradictory position again reflects gendered roles held by Bazza and his wife and socially accommodated by those at their micro and mesosystems, and reflective of the non-linear multi-directional social influence people have on others and as reflected in Bronfenbrenner's Ecological Systems Theory (1979). Bazza's gendered positioning is further reflected in a statement he makes that reflects his wife's support of him as serving to meet her need to fulfill her gendered role expectations – he doesn't need anyone's support.

Interestingly, despite Bazza not even telling his daughter of his cancer diagnosis, he goes along with alternative Vitamin 'C' therapy that she arranged for him. Bazza's willingness to undergo this alternative therapy reflects his own concern about his health – something his gendered position would never let him admit, (and thus his overt protestation about how he would never consider alternative therapy of his own volition – yet covertly, he does not hesitate to accept and try this option). Reflecting his strong alignment with gendered roles, Bazza declines to consider alternative therapy suggested by his son –health is the woman's domain. Bazza promptly communicates to his son that his son's behaviour is conflict with gendered norms - and thus Bazza would not consider his suggestion.

The example above highlights how the gendered position serves as a barrier to men's help seeking as it disempowers men from taking control over their health, and ultimately, their life. It is evidenced across the hierarchy of the social ecological sphere as individuals holding different gendered positions in accordance with the norms, attitudes and values promoted at their micro and mesosystems, earn different rates in accordance with the gendered expectations of which gender would best fill such role – such difference endorsed at the exosystem, and through the inaction at the macrosystem is there too supported (Norcross, Ramirez, & Palinkas, 1996).

5. Doctor-Patient Relationship

In the next two sections I refrain from acute analysis of feedback from a single participant and consider the collective information gained against theory.

Bronfenbrenner's Ecological Systems Theory (1979) highlights the influence of social power. Social power difference was most apparent from the participants' interactions with staff in the health sector – resource allocation for these services directed from the macro system. Resource allocation includes the quality of GPs and specialists; the facilities available and the ability to meet the demand in the area – marked in this region with wait lists up to six months. Marshall et al., (2011) found short wait lists served to facilitate future help seeking in men, the reverse being true too. Additionally, short waitlists would stand to support patients' mental health, (and possibly reduce the gendered suicide disparity (New Zealand Ministry of Health, 2010)) - as seven participants cited feelings of emotional distress, fear and depression immediately before and/or soon after diagnosis – with none accessing any form of social support to alleviate same.

Nine participants held a passive role in their treatment decision making – agreeing to that recommended by the health staff without even a second opinion reflecting social power difference between the participants and the GP/Specialists with whom they are dealing. Supporting this belief is the fact that the only participant to challenge the GP when dissatisfied with the suggested intervention – this participant being tertiary educated – holding different social power to the other participants. Passive behaviour instead governs the doctor-patient relationship across this participant group – reflective of social subordination. Interestingly, this autonomous reign given to the GPs and Specialists by participants is despite inadequate treatment being provided by the health service and as reflected in the following figures: three participants were initially misdiagnosed; two experienced additional health problems attributable to medical error; three displayed and articulated symptoms of depression including suicidal ideation, yet were not assessed in this regard; one

participant was subjected to fourteen catheters that exacerbated the infections he experienced whilst on the waitlist for surgery with no initiated consideration by the hospital to bring his surgery forward. Two participants were unaware that their GP was having them tested for prostate cancer (that, whilst a positive proactive behaviour by these GPs, does raise the question of informed consent – and whether this was obtained from the participants). One participant was discharged from the hospital post intervention with long term chronic health issues, directly related to the inadequate health treatment provided whilst hospitalised; one participant was prescribed incorrect medication; one participant was informed that his cancer was curable, and whilst waiting for the specialist to advise of treatment options, was instead told, “It will eventually kill you. So go out there and enjoy yourself”. Another participant was delivered inconclusive MRI results with a dire prognosis, only to be advised days later that those results were wrong. Confirming the point here raised, O’Brien et al., (1997) found little regard given by GPs to individuals of low SES, despite cancer being recognised as lifestyle and age driven, and health services could easily provide male patients with accurate information to support small lifestyle changes that could reap great social benefits within a community – particularly as men discuss health issues informally with other men.

With the exception of the experiences of two participants, a display of superior social power has further been communicated to participants through medical explanations not aimed for their comprehension - apparent from participants citing no control over either their cancer or treatment options. Further reflecting this lack of explanation/ineffective communication from GPs and Specialists with these patients, the majority of participants did not have a clear understanding of the stage of their cancer or their treatment objectives (ie) palliative or curable – information that should be deemed essential information for a patient and those at their meso and micro systems.

Applying Bronfenbrenner’s Ecological Systems Theory (1979) to this study, the key social barriers to these men seeking help is the lack of

investment from a macro level into the health of this community – evidenced through the high number of medical errors made by the GPs within this very small sample alone. This, combined with the limited accurate, accessible and understandable health information that is disseminated to men through the meso and exo systems ie) community services including sporting facilities; the long hospital waitlists for cancer treatment; and the lack of investment in health professional training to support workers communicate more effectively with residents of this area do not support early medical help seeking within this community.

6. Close Family & Friends

The word 'family', as used in this thesis, is not defined by blood, but by those internal emotional close connections two or more people have formed based on mutual respect, honesty and trust. The social platform on which these individuals interact represents one where the parties all feel safe to 'be themselves' without the fear of social judgment. Based on this operational definition, Bronfenbrenner (1979) identifies the role of the family and friends represented as the micro system, as crucial to an individual's existence – as these individuals hold roles essential in the development of the self construct, a view supported by (Tajfel, 1981). Reflecting this one participant explains the powerful role of those in their micro system, stating:

They would offer their time, and I found that helpful and I was always grateful to be amongst their company (Beau).

Reflecting a strong connection between social support and behaviour, Kaniasty & Norris (2000) found help seeking behaviour positively correlated to the amount of meaningful social support held (ie) from within an individual's microsystem.

Recognising the influence of the normative masculine identity on behaviour, Andersen (1995) identified men hold a need for external validation of their illness symptoms prior to help seeking – the role of validator met by those within the microsystem who would not pass social judgment on the individual. This view is supported by Norcross et al., (1996). Within this participant group however, only 3 participants sought external validation of their symptoms and only two 'needed it' prior to help seeking – the third participant having already decided that he would seek medical assistance had his symptoms not reduced after a week of 'watchful waiting'. This participant was able to reach such decision due to his accurate knowledge on cancer symptoms.

The two participants who did seek this external validation were both married each over thirty years their behaviour thus reflecting a possible gendered position too. This said, Jetten et al., (2012) found men recommended others seek medical assistance when presenting with similar symptoms to that

displayed in themselves despite them not necessarily seeking medical help for same. This suggests that the process of validation of illness symptoms is only undertaken when the individual knows that medical help seeking is warranted and as a first step to formal help seeking.

The microsystem provides a level of support that encourages individual growth and development as it is the social level at which individuals informally interact and shape their understandings of the world and their place in it. Messages from the macrosystem are filtered through the social hierarchy using a complex array of means to be directly accessed by individuals as well as indirectly accessed through interactions with others positioned at the micro and mesosystems who would have received such message. Messages conveyed to individuals through the micro and mesosystems use language that is understood by the individual thus reduce the risk of misinformation. The micro and meso systems thus draw together the social hierarchy to support accurate communication across the social, ecological structure. As reflected in the results of this group, Galdas et al., (2005) found informal social exchange between men at the micro and mesosystems is where men reported gaining the bulk of their health related knowledge – such information being used to guide help seeking decisions and subsequent behaviours, and therefore accuracy of same is essential.

Reflecting the social impact of cancer on those at the micro system, Marshall et al., (2011) identified a household's disposable income reduces when caring for someone with cancer. Awareness of this was identified in the participant group as participants desisted from being cared for by their family preferring instead, they go out to work, to care for and provide for their own micro family (Powie). Such behavior reflects a mutual level of support and respect held between the individual and their family – with neither wishing to compromise the well being of the other. In this regard, Powie states “Your family's the main thing”, minimizing his own role in same, in favour of permitting

the younger generation additional 'mother's time', if this was at all being compromised through his daughter spending increased time with him.

With the normative masculine identity dissuading men from emotional expression, men's social isolation is evidenced in high suicide rates across all ages (New Zealand Ministry of Health, 2010), suicide too often seen when a man loses his partner after the age of 40 years, regardless of how long he might have had this partner (New Zealand Ministry of Health, 2010). Interestingly, this finding is not supported amongst this group, with the majority of participants not in a relationship and, save one, this was not raised as an issue of concern for the others as participants cite strong family support (children, grandchildren, great-grandchildren, nephews and nieces) to fill this role, whilst two participants further mobilized an active support network to support their physical and psychological needs, in recognising that "The big enemy is isolation" (Moko). Knowing this, means willfully utilising those at the micro and meso systems to prevent it. "Use your family for support and don't just hide about it – be open" (Hank).

Those at the micro system thus hold an essential social role in maintaining the health and well being of an individual and in this study have emerged as key influencers on the participants' behaviour as they represent relationships meaningful to the individual. As cited by one participant:

They're there to help me, and I'm here to help them, by giving them proper answers, I just want to be straight out (Moko).

From this study it is identified that medical help seeking behaviours are most positively influenced when individuals have an intergenerational blend of supports positioned at their microsystem – comprising peers – with life experience and knowledge; adult children – who hold current and accurate health related information, and youth – who energise the soul and give the older generation a new lease to life "Me grandchildren are better than medicine" (Powie).

Chapter 8: Limitations of this Study

Limitations of this study identified during this thesis were:

Due to New Zealand's bi-cultural position, the small sample size prevented investigation into attitudes, values and behaviours that might be culturally driven and would warrant different interventions to shift individual behaviours.

The short duration of the study prevents investigation into participant behavioural shifts over time in response to changes in life factors that have impacted upon them. Such changes are suggested from the changed attitudes witnessed in participants through their journey with cancer and their reestablishment, where applicable of their self construct.

The influence of age on behaviours and attitudinal and behavioural shifts is important. Due to age being controlled for, it could not be established if the findings are also age and life stage related.

In the developed world today, the younger generation has easy access to technological information, regardless of SES. With the knowledge of cancer a key determinant of help seeking behaviours – youth now having access to this knowledge and its impact on help seeking behaviour needs investigation.

Homosexual and transgendered individuals have been excluded from this study, both groups requiring a specific similar study into their driving social influences with regard to their help seeking behaviours.

The influence of sexual function over treatment decision making in younger, sexually active men requires study. Gascoigne & Whitear (1999) found young and middle aged men not prepared to forfeit their sexual function for longevity. Sexual function did not pose a factor of concern for eight participants in this thesis and further study into same in relation to age is required, as is using a larger sample to ascertain if sexual performance or the risk of losing same does influence men's help seeking attitudes and behaviours.

To determine if culture holds influence on help seeking behaviours, particularly amongst Maori accessing the medical model, further study is required with a Maori participant group ideally conducted by a Maori investigator. A Maori investigator would thus also identify subtle cultural differences that cumulatively could hold significant influence on Maori help seeking behaviours

People of low SES as reflected in this sample, have limited options but to access a Western health practitioner, regardless of cultural differences (Lyons & Chamberlain, 2006). This influences the individual's experience of help seeking as evidenced when one participant wished to stop the digital examination process stating "Maori, we, we are very much tapu about our bodies. I want to change my mind sort of a thing". The help seeking and treatment processes in such instance risks being disempowering and can undermine an individual's sense of self worth and serve as a barrier to future help seeking.

Chapter 9: Conclusion

The Ecological Systems Theory (Bronfenbrenner) 1979 has here enabled study of men's medical help seeking behaviour within a socially constructed, hierarchical non linear framework as exists in society today. Here, all power and influence is held by the socially elite, positioned at the macro system and in control of resource allocation and of those decisions that can result in national and international behavioural responses - all of which have health ramifications on individuals – the extent of which being determined through individual and neighbourhood SES. Health, and thus too medical help seeking behaviours cannot be considered to the exclusion of a community's access to resources – where quality and quantity too are decided upon at the macro system. Individual disposable income is also relevant when it comes to help seeking, good health and treatment always bearing additional costs that too need to be met ie) non prescribed medicines to counter side effects. .

Struggling with meeting the basic SES driven factors that serve as a barrier to individual help seeking, those at the macro system allocate resources to develop, or refine new medical interventions, using high levels of advanced equipment, with highly trained specialist staff, treatments only afforded to the elite – whilst denying basic health resources to the poor who have no alternative but to rely on other systems within the social hierarchy for support. Thus the influence of those positioned at one's micro and meso systems has here been given attention – as it is ultimately through people - and with people that individuals and groups achieve success – health or otherwise.

The main findings of this thesis are:

From the results obtained and considering the supporting information accessed in the preparation of this thesis, key findings on the social barriers and social facilitators of men's medical help seeking behaviours are:

Information is power, and access to accurate cancer and health promoting information can shape the attitudes and behaviours of men away from the belief that cancer automatically results in death, and thus facilitating their medical help seeking.

Men gain a large proportion of their health information from informal discussions with other men and attention needs to be focused on disseminating accurate health information across societies – to ensure that correct information is held at the powerful micro and meso systems – where such information will informally be shared and reinforced.

Two participants pre diagnosis made concerted efforts to avoid receiving any information on cancer as they had witnessed deaths of loved ones from it. From their personal experiences with cancer, these two men have shifted their views to now view cancer and their experience endured as developing their 'mana'; a conquest they have won, and from which they, and the other participants wish to spread accurate information to other men, and to provide other men with support to 'beat' cancer too – an attitude shift witnessed across the participant group. Men are thus keen to share their experiences and learnings with others and this is a resource that is not being utilized to promote early help seeking behaviours in men.

For effective behavioural change and timeous help seeking in men, commitment is required from the macro system to allocate adequate resources to enable accurate health information dissemination across society, and encourage sustainable healthy lifestyle change.

The doctor-patient relationship can be a key facilitator of early help seeking and training of health staff is required to support interpersonal skill development to positively engage with those of different SES, different cultures, and/or backgrounds. Such system is being rolled-out in Australia, and can be used by New Zealand, to learn and develop similar, suited to our people.

The exo system could invest in graphic messages conveyed through the mass media – that require consistency, frequency and for effectiveness need to be disseminated across a broad area, targeting no specific group but using appropriate, culturally sensitive material suitable to all within that society. This enables consistency in the message to those receiving it at the micro and mesosystem where informal interactions can further disseminate same to those who have not been exposed to it

An informal and casual interpersonal approach from health staff is a social facilitator of medical help seeking – as it personalizes an otherwise invasive and/or scary experience.

A strong sense of community within the micro and mesosystem levels can serve to facilitate early help seeking through providing the social environment where men can informally meet, talk and support each other whilst partaking in physical activities to improve their general well being. As in New Zealand, involvement in sports at any level, eg) player, spectator, coach, etc. is a large part of the normative masculine identity.

Whilst the normative masculine identity is a key driver of behaviour, with the correct resource investment and approach, it can be shaped to encourage

men's help seeking behaviours – this being evidenced in the shifts made by most of the participants in this study, as they gained new information, and for survival, had to adapt their self construct – these changes made easier through support from the micro and mesosystem.

A barrier to help seeking behaviour and consistent to the findings of this thesis, is a strong gendered identity that serves to disempower men as they do not gain the key information required to help them identify cancer symptoms, and only draw attention to same seeking validity of their symptoms when they have long progressed. Future research needs to consider how to deconstruct gendered positioning with regard to individual health care and thus promote early medical help seeking in men.

As a Western bi-cultural nation, New Zealand needs to step back and look at the qualities of alternative health approaches towards achieving improved national health outcomes, as opposed to holding the individual responsible for same. Health and good health practices including early help seeking is a social matter, lifestyle dependant and requiring a social approach – from every level of Bronfenbrenner's Ecological Systems hierarchy (1979). Such approach could shape new behaviours as support would be received at every social level. Here, new norms would be developed with health focused social expectations.

The macro and exo system need to ensure that GPs and Specialists are competent and providing a high standard of care. Medical errors serve as a barrier to future medical help seeking

Despite men's outward appearance of strength, they are extremely vulnerable when faced with emotive issues and emotional expression has never been an encouraged normative masculine trait. At the time of diagnosis GPs need to be mindful of how the diagnosis is delivered. Ideally it should be encouraged that men have a support person with them at that time to support their mental health well being.

Men should be fully informed of the outcomes of their surgery including any physical changes from such, as the self construct is entwined with the body image and psychological support might be necessary to support men make the necessary adjustments.

Men fear appearing 'weak' and will often avoid signs of illness in a bid to not have to deal with the social impact and social judgment of same. Education and support is essential to encourage men to seek early medical assistance, from which the health outcomes are good, often curable.

As humans, we all gain support from each other, and the knowledge of others' misfortune helps individuals value what they have, serving as a facilitator of help seeking. This practice is seen and practiced across societies in the form of support groups – and men should be encouraged to access same – as support groups also remove those feelings of isolation that feed depression

The social power difference experienced between doctors and patients can hamper future help seeking by men, through feelings of being 'judged'. Men are very conscious of social power status, in line with the normative

masculine identity, and GPs need to be mindful not to communicate negative messages to patients through undue formalities. Men consistently reported good doctor-patient relationships here GPs adopted a casual approach, using their first names, dressing casually and even joking with the patients. GPs must therefore remember that they need to engage with the person first and foremost, not with their illness.

GP flexibility with regard to appointment locations and times was cited an important medical help seeking determinant – as this served to reduce added stress in men, as impact on their work and thus income can then be minimised, without compromising their treatment outcomes or compromising their decision seek medical assistance.

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