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## **“Men give in to chips and beer too easily”: how working class men make sense of gender differences in health**

### **Abstract**

This article, based on qualitative research with working class men, explores men’s perceptions and experiences regarding gender differences in health. The article demonstrates how men put forward a range of behavioural/cultural, materialist/structural and psychosocial factors, which were believed to impact differently on men’s health compared to women. A common theme underpinning their explanations was the ways in which men and women were located within two distinct gender categories. These characterisations were used to explain why health-damaging beliefs and behaviours were more prevalent among men and also why men were better suited for certain kinds of jobs, albeit with potential costs to their health. Men also believed that women were protected from the damaging physical and emotional impact of manual employment because of their primary role within the home and because they were less emotionally robust, which required men to shield women from the stresses they experienced. However, men’s emotional withdrawal can also be viewed as another example of how men use whatever resources are available to achieve and maintain dominance over women. Finally, the article demonstrates how a gender and class-based approach can capture the impact of men’s health-related practices alongside the broader cultural and structural influences on men’s health.

## **Introduction**

In the UK, interest in men's health has emerged in the light of compelling epidemiological data; men die younger than women, experience higher rates of injury and illness, and take more risks with their health (ONS 2006).

Attempts to explain patterns of male health often make reference to men's greater propensity to adopt health damaging behaviours, such as smoking, drinking and violence, and can be categorised into two types of response.

One has typically sort to chastise men for their poor health; the notion being that, unlike women, men simply abdicate personal responsibility for health (DH 1993). The other has concentrated on dominant expressions of masculinity to explain patterns of male health (Broom and Tovey 2009; Gough 2006). In essence, the norms of masculinity, defined in opposition to femininity, which encourage emotional and physical strength and reject weakness or vulnerability, may cause men to define certain 'risky' behaviours as essentially masculine attributes (Courtenay 2011). However, despite the gender paradox in health, where men die earlier than women despite having more socioeconomic resources, two areas remain under-researched. First, studies have tended to concentrate on men's health-related behaviours to explain patterns of male health, which neglect the broader social and economic context of men's lives (Lohan 2007). Second, relatively few studies are grounded in the everyday experience of men themselves (Robertson 2007) and little is known about how men make sense of gendered patterns of health.

In attempting to rectify these deficiencies, this study builds upon research from within the field of men's health, which has sought to incorporate concepts from the broader study of men and masculinities (Coles 2009). One significant outcome of this body of inquiry has been the conceptualisation of 'masculinities' as plural, influenced by socio-cultural factors and dependent on other aspects of identity and wider social structures (Paechter 2003). Central to this shift has been Connell's (1995) concept of 'hegemonic masculinity', premised on a hierarchical range of masculinities and associated practices, which has become the 'culturally idealised' or dominant pattern of masculinity. Many men therefore align themselves with its characteristics such as stoicism, resilience and the denial of weakness and seek to emulate hegemonic forms that are equated with being successful, capable and in control (Connell and Messerschmidt 2005). The strength of Connell's conceptual framework lies in its ability to facilitate an understanding of masculinities as fluid but also hierarchical with certain configurations of masculine practice gaining dominance at the expense of other configurations that become subordinated to and/or marginalised from hegemonic forms. Thus, working class men, for example, who are denied the social power and resources necessary for constructing hegemonic masculinity, may seek to employ other strategies for constructing gender identities that validate them as men, albeit within subordinated and/or marginalised positions. The shift to a more variable range of 'masculinities' has been used to add understanding in terms of variations in health experiences between men and women as well as between different groups of men (e.g Noone and Stephens 2008). However, critics have argued that while the 'men and masculinities' approach provides a more theoretical

understanding of men's health, research in this field has run into a 'masculinities road-block' (Lohan 2007: 494), preoccupied with masculine identity and its influence on men's health behaviours divorced from the broader political economy of men's lives. The need remains therefore to link theories of masculinity and health to broader theories regarding social class and health, which highlight the social and economic context of men lives, in order to develop more complex understandings regarding patterns of male health.

### **Study design**

The analysis presented in this article arose from a research study which explored the ways in which two groups of working class men, living in two contrasting socio-economic areas, made sense of their gender and class position and its impact on health. Other articles emanating from this study have focused on men's views regarding their material and social circumstances (Author a) and their constructions of masculine identities (Author b). This article has a different focus of analysis in that it examines how this group of working class men made sense of the differences in health between men and women. Working class wards were chosen as the sites of investigation on the premise that this is where the socioeconomic circumstances known to compromise health are at their most profound (Scambler 2012). A comparative approach was adopted in order to capture the impact of broader structural factors whose distribution differs in line with social position and which have established health effects. The design of the study, therefore, permits the examination of views that prevail *within* as well

as *across* the two areas. The study design was influenced by commentators who highlight the need for more qualitative research to better consider the contextual and experiential linkages between the realities of men's lives and their health (Robertson 2007).

The research took place within two working class wards – one relatively deprived and one less deprived – in a large post-industrial city located in the West Midlands, UK. Analysis of official statistics was used to categorise wards as either 'deprived' or 'less deprived' according to: levels of employment in social classes IIIM, IV and V; levels of unemployment; housing tenure; and levels of overcrowding (Rose 2005). Two wards were subsequently selected for investigation: Hibbs (deprived) and St Mary's (less deprived). Although geographically adjacent, these areas differ in the profile of residents in terms of poverty, deprivation and unemployment. The 'less deprived' ward has traditionally housed the city's relatively well-paid and 'well-protected' skilled manual working class though industrial decline has seen substantial numbers experience unemployment, job insecurity and a relative decline in living standards. In comparison, the 'deprived' area is an area of economic and social disadvantage with high rates of unemployment, high proportions of unskilled and semi-skilled manual workers.

The data used in this article draws upon in-depth semi structured interviews conducted with twenty-two men (eleven from each of the study areas). The choice of in-depth interviews reflects a shortage of men's voices in the field of health as well as philosophical assumptions; ontological and epistemological,

about individuals and the contextual conditions that shape and embed their perspectives and experiences around health (Popay and Groves 2000). Men were recruited through a number of 'key' contacts working in community and public settings and via informal social networks. These contacts included a community development worker, an advice worker and a community education worker all of whom had dealings with men via their work in a range of community sites, including an employment development project, a community advice centre and a local college. They were approached by the researcher who introduced them to the study and provided them with information sheets and leaflets which they could then pass on to individual men. I also spent time within different recruitment settings, approaching and speaking to men about the study. Every effort was made to reflect the demographic makeup of the areas and to include men who were less frequent users of these services as well as those better known within these settings.

The men who took part in this study ranged in age between 21 and 62, average age 40. All interviewees described themselves as white and heterosexual. Most men lived with a wife/partner and had dependent children living with them. All eleven men in the 'less deprived' area owned their own homes, while all of the men in the 'deprived' area lived in rented accommodation. Nine of the men in the 'less deprived' were in employment and most were in skilled and semi-skilled occupations. Only four of the men living in the 'deprived' area were employed and all were in unskilled occupations (see Figure 1).

**Figure 1: Participants in each ward**

	<b>Hibbs Ward (deprived)</b>	<b>St Mary's Ward (less deprived)</b>
<b>Age (years)</b>	21, 27, 28, 32, 32, 33, 39, 40, 40, 50, 52	25, 26, 34, 39, 41, 43, 46, 53, 53, 57, 62
<b>Living Arrangements</b>	Living with wife/partner n=8 Divorced/living alone n=1 Living with parents n=1 Lone parent n=1	Living with wife/partner n=10 Divorced/living alone n=1
<b>Dependent Children</b>	Zero n=4 One n=3 Two n=1 Three n=1 Four n=2	Zero n=5 One n=2 Two n=2 Three n=2
<b>Accommodation</b>	Rented n=11	Owner occupier n=11
<b>Employment Status</b>	Employed n=4 Unemployed n=7	Employed n= 9 Unemployed n=3
<b>Employment Type</b>	Unskilled (e.g. labourer) n=4	Skilled (e.g. toolmaker) n=3 Semi-skilled (e.g. glass-cutter) n=5 Unskilled (e.g. labourer) n=1

The men were each interviewed on two separate occasions as a means of building relationships and potentially allowing access to more in-depth perceptions and experiences than might have been available through a one-off interview (cf. Cornwell 1984). The second interview took place approximately three to five weeks after the first, which allowed time for



reflection and identification of issues requiring clarification or elaboration. The parts of the interview which informed this article include the portion where men responded to a direct question about gender differences in health as well as other points in the interview when men discussed their own experiences in relation to gender and health.

All of the interviews were audio recorded and fully transcribed. Following transcription, a 'thematic' review of the data was carried out manually which allowed the researcher to systematically and thoroughly compare and contrast men's accounts, build up categories, test emergent theory and attach 'meaning' to the data (Russell Bernard and Ryan 2009). Excerpts were labelled with key themes, which were then coded. The coding scheme was generated both by the empirical data and by the researcher drawing upon predetermined research questions, particularly at the outset of the process of analysis. Coding and analysis was undertaken throughout the period of data collection so that findings of early fieldwork informed the focus of later data collection. This process of 'analytic induction' aimed to reflect the complexity of these men's accounts and provide a framework to help make sense of that complexity along with the broader social context in which they are located (Frankland and Bloor 1999). This analysis of the data identified a typology of three broad responses to gender differences in health which emerged from the men's accounts. In presenting these findings, confidentiality has been protected by using pseudonyms and changing place names which could otherwise identify participants.

## **Findings**

Across their accounts, men put forward a range of factors which they suggested could account for differences in men and women's health. In line with traditional research within the field of inequalities in health (Bartley 2004), these factors can be grouped under three broad headings:

behavioural/cultural, materialist/structural and psychosocial.

Behavioural/cultural factors relate to differing acceptable attitudes to health-related behaviours between men and women. Materialist/structural factors relate to conditions and exposures within the workplace, which these men believed impacted differentially on the health of men. Psychosocial factors relate to the adverse psychological impact of employment and unemployment, which were perceived to affect men differently to women. Whilst these different 'types' of factors are presented as discrete categories, it is important to note that men would often oscillate from one type of factor to another, suggesting that each provided its share of explanation. Nobody, however, disputed the suggestion that men experience poorer health than women.

### **Behavioural/cultural factors**

Regardless of their socio-economic position, men's initial responses regarding gender differences in health often concentrated on perceived gender differences in attitude towards health and health-related behaviours, such as smoking, drinking and poor diet:

Men give in to chips and beer too easily [laughs]. ...They know they shouldn't be drinking to excess. ...For most women it is a totally different lifestyle. I think women have got more self control.

(Devlin 34, deprived area)

There was also some sense that men were aware of the need to change, which implicitly included the notion that men should think more like women:

Men don't look after themselves. ...Fatty food, the beer and the fags. ...It's not good for you. ...Women have a different perspective. ...But I think that attitude is changing. I think men can see that it's not good for you.

(Patrick 37, less deprived area)

Men often framed distinctions between men and women in terms of biological and evolutionary differences. Thus, women's maternal instincts were perceived as underlying women's natural orientation towards the maintenance of their own health and the health of others (cf. Farrimond 2011). In contrast, men's 'risky' behaviours were defined as outward expressions of being male, which resulted in a consistent set of potentially health damaging traits or characteristics (Gough 2006):

It's in our makeup. There is a part of us needs that rush, whether it's driving a car faster, whether it's chasing somebody else down the street to kick his head in. ...It's that buzz ... we need that. ...It does

something inside our brain that probably stimulates testosterone that stimulates our reproductive capabilities.

(Harry 50, deprived area)

In these terms, men's lack of 'self-control' was viewed as part of their biological predisposition towards aggression and competitiveness, which leads to men's predominately destructive behaviour as well as their more resigned attitudes towards health. These types of responses were often combined with wider cultural forces that propel men towards patterns of behaviour which threaten their health:

Men tend to be more fatalistic. Live more for today. ...Women look upon themselves more as carers. ...They tend to have less peer group pressure to be one of the boys. To go out every night ... and drink a gallon of beer [laughs].

(Owen 52, deprived area)

As with other research (e.g. O'Brien et al 2005), health-related behaviours were one of the means by which these men articulated and demonstrated aspects of hegemonic working class masculinity, which earned them status amongst other men (see Author b). However, although men endorsed hegemonic ideals that valorised unhealthy behaviours, they recognised that women made more sensible decisions about their health and implicitly blamed male behaviour for the poorer state of men's health. As said, there were also indications that culturally held notions of working class masculinity were

undergoing change and that men were increasingly aware of the need to prioritise their health. Men appeared particularly sensitive to the fact they smoked, which was presented as a coping strategy rather than as a sign of masculine toughness:

I do feel a total idiot sometimes that I smoke ... I never wanted to see myself as a "smoker". I wanted to be healthier than that. ...But ... the benefits appear to outweigh the negatives at the moment.

(Chris 28, deprived area)

As is apparent in this extract, men also sought to contextualise the risks associated with smoking by reference to their wider social conditions in which this behaviour was embedded:

I know about cigarettes. ...People say there're bad, well they probably are. I'm at the stage of my life, it's sad but they're doing me more good than bad. ...They help me relax. ...I don't see them as a threat. Not with everything else that goes on around here.

(Bob 39, deprived area)

In making these connections, men demonstrate the complex interplay between social constructions of working class masculinity, men's location within the social structure and patterns of health-related behaviour. In other words, they provide a link between agency and structure in the context of men's everyday lives and demonstrate how their negative health behaviours

can be viewed as a form of agency to help men meet the challenges of their social conditions (cf. Williams 2003). For example, the accounts of men living in the deprived area, who experienced the greatest depth of financial hardship, tended to focus on the ways in which behaviour provided an 'escape', albeit temporarily, from their situations; "I think a lot of men find oblivion in drink" (Harry 50, deprived area). In contrast, men in the less deprived area tended to define such behaviours in terms of 'reward' or a means of compensating working class men for the generally monotonous, unfulfilling and often harsh nature of their working environments:

Men feel justified working in a foundry all week if they can go to the pub at the end of the week and get pissed. It gives you something to look forward to. ...The amount of blokes that I have worked with who say they only live for the weekend.

(Tom 41, less deprived area)

These two aspects of their lives; i.e. manual occupations and men's tendency to use avoidant coping strategies, such as smoking and alcohol, were often used by men to distinguish themselves from women. The ways in which men dealt with emotional distress, for example, was perceived to be in opposition to how women cope in similar circumstances:

Women are more amenable to building up those sorts of close relationships ... where they do discuss emotions. ...You keep it in.

...And it comes out in different ways. ...By you getting pissed all the time or smoking [marijuana] every night.

(Chris 28, deprived area)

In addition, men often compared the more physical and dangerous types of occupational roles undertaken by men with the less hazardous types of work associated with women, such as housework and childrearing. Not only did this have implications for men's health it also heightened men's desire to seek forms of gratification outside of work:

Men tend to have physically more demanding jobs. Because of that they tend to want to enjoy themselves more. Drinking more. Smoking more.

(Jim 32, deprived area)

In summary, men were generally perceived to behave less healthily than women. Attempting to explain why men act in particular ways, men often presented men/masculinity and women/femininity in binary or oppositional terms (Courtenay 2011), with the naturally assertive and irrepressible male compared with the caring and restrained female. Alongside this type of viewpoint, men also felt that aspects of hegemonic working class masculine identity constrained men's ability to make better health-related choices, which was also linked to men's relatively subordinate location in the class structure.

### **Materialist/structural factors**

These men also focused on the ways in which they believed men and women are differentially exposed to material conditions considered damaging to health (Lohan 2007). In making these types of connections, men focused on the more tangible and obviously direct hazards associated with working class male employment:

Men's work is heavier, harder and longer physically. A man, if he's working in a physical job, can possibly do forty years of hard physical work. ...They're going to generally wear their bodies out over that period of time.

(Lee 34, less deprived area)

These was also some sense that men's exposure to workplace hazards were likely to diminish as 'traditional' working class occupations became increasingly defunct:

The reason men die earlier is that their life until recently has been far more dangerous than women's. You've only got to go back thirty years to the coalminers and the steelworkers. They were killed off in their fifties by the nature of their work. Now that's all gone, I think we'll see a change.

(Bert 53, less deprived area)



However, whilst the conditions associated with working class employment were often used to help explain men's lower life expectancy, occupational status and income were also central to their identities as working class men. Without exception, these men's relationships with their families were first and foremost portrayed in financial terms, which also entrenched the idea that men's occupations are primary:

You are the provider ... the gatherer. The wife tends to the family. ...I see that as my role. ...Women like to see a man to be a man. To provide the money ... so they have a better life.

(Patrick 37, less deprived area)

The potential for working class employment to cause health problems was also used as evidence of men's self-sacrificial willingness to fulfil this aspect of their gender role. Indeed, men's readiness to suffer pain and discomfort was one of the ways by which men verified that they had the masculine attributes required for much working class employment:

If a guy comes into the trade he expects to get knocked and hurt and burnt because to have learnt to be a mechanic he's already got burnt ... he's already been knocked and bruised and cut. ...If he said to me; "I hurt my hands" [laughs] ... he shouldn't be here.

(Bert 53, less deprived area)

This extract also indicates how working class occupations could involve men participating in working practices designed to elicit deference from other men, which further imperilled their health. Many of these men described practices that were premised upon action and strength and incorporated competition with other men, who were often demeaned as 'wimps' or 'sissies'; i.e. subordinated within an informal hierarchy of working class masculinities. These practices also distinguished men from women, who were viewed as more rational and not likely to endanger themselves whilst seeking to exert dominance over others:

Some blokes have got to carry heavier things than others. If you carry one, they carry two. If you carry two, they carry three. ...You might ask someone to give you a hand to carry an item ... and they'll carry it off by themselves. ...So you go back next time and try to do one yourself ... and you end up hurting yourself [laughs]. ...Women don't do that. ...Women are more sensible [laughs]

(Lee 34, less deprived area)

While such behaviour was considered particularly relevant to men, there was also evidence that men's working environments could put them at risk regardless of their individual behaviour. One man described how a lack of adequate safety equipment combined with reckless working practices could heighten men's exposure to known carcinogenic substances, despite their own attempts to protect themselves from potential threats:

You would come across a boiler that was covered in blue asbestos. ...I've seen lads ... this macho bit, pick up the boiler with stuff flying everywhere. ...I tried not to get involved because I know how dangerous it is. But you know you are on the same site and its blowing about.

(Ron 40, deprived area)

Thus, alongside men's risk-taking as a means of attaining masculine status, it was also clear that the often precarious nature of working class employment could constrain men in terms of their ability to avoid hazards, because to do so heightened the chance that they would be viewed as dispensable by employers. Many described how they felt they had "little choice" but to take risks associated with their employment, despite being "frightened" by certain working practices. As such, their accounts illustrate men's decision-making processes regarding their working environments, which often highlighted the tradeoffs men made in terms of their health and which they perceived as less applicable to women; "There are certain things that men do that perhaps women would avoid. ...I think there are different pressures on men" (Marcus 32 deprived area). One man used the term "survival" to portray the intensity men felt in relation to their role as provider, which in the context of limited employment opportunities could drive men to accept jobs or adopt risk-taking attitudes they might otherwise refuse or repudiate:

You reach a stage where survival becomes the optimum regardless of how you do it. ... If you want to survive, you have to use whatever

strengths you've got. ...Even though it's dangerous or it's against your principles.

(Tom 41, less deprived area)

In summary, although working class employment was acknowledged as likely to involve dangers, which primarily damaged men's as opposed to women's health, men's willingness to sustain such assaults was often viewed as a marker of their credentials as working class men. The inherent risks associated with their employment were often compounded by the ways in which working class men established and maintained valued masculine reputations within the workplace and also by the potential lack of employment opportunities. These could act as 'conditioning' influences on men's actions and their ability to protect themselves when faced with harmful working environments. Thus, here again, their accounts provide illustration of the need to contextualise men's potentially health-damaging behaviour; i.e. agency, within the context of wider social and cultural structures (cf. Williams 2003).

### **Psychosocial factors**

These men also focused on the negative psychological impact associated with the social expectations placed upon working class men. For example, the fundamental premise that working class men maintain employment was believed to generate higher levels of stress compared to women's primary position as carers:

There is less pressure on women to work. ...We always said that I took the role as provider and she raised the family and looked after the house. ... Women have a much more maternal instinct. Being there for the kids ... they've got more of a bond so possibly they are less stressed in that sense.

(John 53, less deprived area)

In addition to its hazardous and physically demanding nature, working class employment was also associated with a range of stresses which were perceived to damage men's bodies. One man used the experience of his father to illustrate how the loss of autonomy and control associated with manufacturing processes could damage health:

The work my dad did caused him problems all his life. ...It was stress ... from repetitive work. ...I couldn't do it. ...I would get stressed out ... probably have a heart attack. ...Stress is the biggest killer of all.

(Barrie 46, less deprived area)

Men reported a range of what they perceived to be stress-related symptoms including migraine and indigestion, which they linked to their working environments:

I've had this problem where I feel sick all the time. ...Being on holiday ... no pressures. ...It totally disappears. ...So there is a definite link. I

start back to work. The stress involved with that ... comes back straight away.

(Julian 26, less deprived area)

However, it was also clear that many believed the stresses associated with unemployment had a greater intensity and were potentially more harmful to men. Unsurprisingly, this view was most evident among those men, such as John, who had been made redundant and who made a clear distinction regarding the impact on his well-being:

When you've got a job you have a positive attitude. ...The more you are under pressure the happier you are. When you haven't got a job you lose all confidence. ...You get a bit down and a bit fed up.

(John 53, less deprived area).

Employment and the ability to handle its pressures appeared confirmatory and signalled their hegemonic status as working class men, which was subsequently diminished when men lost their jobs. Their narratives provided vivid illustrations of how unemployment initiated changes in how they believed they were perceived by others, which damaged their self-identity; "It's really demoralising. ...You have no status. ...You're an easy target" (Chris 28, deprived area). Moreover, the process of finding work included the likelihood of them being declined by prospective employers, which they viewed as more damaging than the strains connected with employment:

I don't mind putting myself under pressure, but it's a different sort of pressure working twelve hours a day than looking for work. ...I'm convinced that most of the health problems I get are induced by the pressure and stress of looking for work. ...Because you are only going to get rejected by everybody.

(Harry 50, deprived area)

As such, men distinguished between work-related stresses which they could endure and potentially master and those associated with unemployment over which they had no control. In this context, a number of men used the term 'breakdown' to illustrate the emotional impact that joblessness had on their health. However, all sought to (re)construct acceptable masculine identities through hegemonic representations of the controlled, stoic working class man:

There is an awful lot stress goes with [unemployment]. ...Mulling things over and over, you become mentally exhausted. ...I came close to a breakdown. ...It was only for a tiny moment. ...I had a good moan. I said to myself; "You silly bugger. You'll just have to buck yourself up".

(Ron 40, deprived area)

Crucially, men perceived that women were protected from such psychological assaults on their health primarily because women were not defined in terms of paid-work or subject to the same expectations regarding their participation in full-time employment. In addition, men believed that they shielded women from many of the stressful events associated with work. Arthur, for example,

had not informed his wife when facing the threat of redundancy; “I wouldn’t give her the details. That would cause her anxiety. That’s the one thing I wouldn’t want to do” (Arthur 62, less deprived area). Time and again, men reported how they shouldered the burden of work-related stress, which included the anxieties associated with seeking employment:

I won’t share it because I think to myself I am the only one that can do anything about it. So there is no point her being worried about it as well. There is no point two of us worrying about it. ...And I know she can’t handle too much herself.

(Harry 50, deprived area)

Also evident here is the ways in which men drew upon culturally dominant constructions of masculinity and femininity to validate their decisions, which constructed men as stronger, both physically and emotionally, than most women (cf. Courtenay 2011). Thus, whilst stress was recognised as one of the mediating mechanisms between the workplace and health problems, their sense of vulnerability tended to be framed within a wider acceptance of hegemonic masculine norms, which they also used to distinguish themselves from women:

I get a bit weepy now and again. But if you’ve been doing something for thirty years and it looks like you’re going to lose it I suppose it’s only natural. ...I don’t like putting my troubles on to [wife] because she’s a



worrier by nature. ...I usually tend to keep things to myself. ...Men, being a man you're supposed to sort things out for yourself

(Barrie 46, less deprived area)

As we have seen, men often contrasted their coping strategies with the ways they believed women dealt with stress. Tom, for example, described how the stresses related to being out of work triggered coping enactments, such as heavy drinking, which he also framed as a strategy to protect his wife from having to contend with the emotional consequences of his unemployment; "I didn't want to add to things ... let her know how bad I was feeling. ...I used to go on the piss now and again rather than talk about it at home" (Tom 41, less deprived area). However, although their typical means of coping was usually in the company of other men outside of the home, it was the nature of the surroundings that proved supportive not the outpouring of emotion. Therefore, whilst men described a desire for homosocial contacts (cf. Kiesling 2005), which provided opportunities for emotional support, they tended to maintain certain boundaries and an emotional distance from other men:

It's not a case of sitting down and spilling your guts out. ...It's more mixing in that sort of environment with people in the same sort of situation ... it's therapeutic in a lot of ways.

(Tom 41, less deprived area)

In contrast, women were viewed as "more open", which was defined as protective, whereas men's tendency to 'bottle up' their emotions was linked to

potential health problems. For example, men's repression of emotion was perceived to be one reason why men were more likely than women to experience heart attacks. This 'difference' was particularly apparent in their understanding that men do not generally ask for help or access healthcare regarding anxiety or other depressive symptoms (cf. Emslie et al 2006). Thus, whereas it was deemed "acceptable" for a woman to speak to their GP regarding emotional distress this was not the case for men; "I don't want them to know stuff like that. ...I sort of feel embarrassed about it" (Chris 28, deprived area). Generally, their reluctance to 'open up' reflected concerns regarding emotional frailty, which they perceived in relation both to other men and women; "I'm sure some women would judge a man as being weak if he talked about his problems" (Lee 34, less deprived area). Noticeably, the one man who did admit to transgressing this hegemonic ideal defined himself in negative terms, unable to hide his emotions and therefore live up to certain cultural expectations:

She knows when things aren't right. I can't it bottle it up. I think she would know. I can't put a brave face on it. ...I am a moaner. If work is not going well, or the money is not right. I will tell her straight away.

(Richard 43, less deprived area)

More commonly, men reportedly guarded against revealing their feelings in order to protect those around them from the often stressful nature of their structural positions. Matt, for example, who experienced long-term unemployment and severe economic hardship, played out the "strong man"

image in front of his wife and children although he recognised this came at a cost in terms of his emotional well-being:

One of us has to be the stable side. ...One person has to be the calming influence. ...My wife tends to be a lot more open. ...Bottling it up isn't the ideal way of doing it. What it's doing is making me personally feel worse. I feel a constant low. But I'm trying to calm my wife and family down ... so they don't feel worse.

(Matt 33, deprived area)

This pattern of masculine practice, referred to as 'protest masculinity' by Connell and Messerschmidt (2005), may also have enabled these men to sustain power within their relationships. In other words, men such as Owen, who was also lacking in economic resources, may have used emotional withdrawal as a strategy to allow them to maintain their status as the dominant partner:

My wife would say that I give the impression that I don't care. But when I am under stress that is my way of coping with it. I literally switch off. It may not be right for the other person but it's the only way. ...Somebody has to keep control. ...I have to cope, no matter what, because if I go down, the boat goes down. Everybody goes down.

(Owen 52, deprived area)

In summary, the stress associated with employment and unemployment was primarily viewed as 'male-orientated', which had direct and indirect effects on men's health. Moreover, men felt they had to hide the negative feelings they experienced because women were perceived to have greater sensitivity to stress and were more likely to be wounded by the work-related concerns faced by men, which had consequences for men's well-being. However, their construction of men and women as different and men's tendency to withhold emotion may also have enabled lower status men to maintain an advantage over the women in their lives. As Schrock and Schwalbe (2009) note, men achieve status as the dominant partner in different ways, which in the case of those men who lacked the economic means to exercise power, could be signified by their capacity to exert control over their own emotions.

### **Discussion and conclusions**

There has been much public and policy discussion regarding the persistent gender paradox in health, whereby men have a lower life expectancy despite having more socio-economic resources than women (Courtenay 2011). However, little research has explored men's own views regarding gender differences in health. This study has attempted to make a specific contribution to this field through its exploration of how working class men make sense of why men in general have shorter lives than women. Unlike men in other studies (e.g. O'Brien et al 2005), these men did not consider the enactment of working class masculinity to be health-enhancing. Their narratives demonstrate the ways in which gender differences in health were perceived and experienced as the outcome of factors associated with working class

employment, individual behaviour and psychosocial environment, which were believed to impact differently on men compared to women.

Although men put forward a range of factors to account for gender differences in health, a common theme underpinning their explanations was the ways in which men sought to distinguish themselves from women, which have negative implications for men's health. These men made their distinctions based upon the 'things done' by men, which were framed in opposition to those done by women and located men and women within two distinct sex and gender categories (Connell and Messerschmidt 2005). Thus, one respect in which men and women were deemed to be different was in relation to their biological and evolutionary characteristics. These characterisations, exemplified by aggression and courage, were driven by powerful male hormones such as testosterone, which 'hardwired' certain attributes into men's brains and bodies (Buchbinder 2013). Women, in contrast, were programmed for social interaction and predisposed to pay more attention to the well-being of others. Additionally, male and female characteristics were perceived to be socially and culturally encouraged, which provided some indication that certain manifestations of masculine identity were amenable to change (Farrimond 2011). Whatever their individual standpoint, men tended to use such characterisations to explain why potentially health-damaging beliefs and behaviours were far more prevalent among men than women. Thus, while men were not entirely blameless, they felt men should not be held entirely responsible for their poorer health. Moreover, the same attributes which underpinned men's health-related behaviour were perceived to serve

the interests of women, for example, in terms of facilitating men's role as protectors/providers, notwithstanding the fact they also helped to preserve men's privileged position vis-à-vis women (Schrock and Schwalbe 2009).

These men also connected gender differences in health with men and women's primary gender roles, as breadwinners and carers respectively. Here again, elements naturally present in men had the effect of legitimating gendered subordination/segregation by upholding the perception that men were better suited for certain kinds of occupational roles, especially those that involve danger, physical prowess and a willingness to suffer pain and injury (Buchbinder 2013). Working class industrial labour also provided men with opportunities to enact masculine toughness that signified their worth as the strongest and most fearless, which bestowed status within their occupational worlds. Thus, not only was men's employment one of the domains through which they could distinguish themselves from women, it also provided the potential for men to win respect and gain advantages over other men, albeit at costs to their health. Nonetheless, such behaviour can be seen as a form of agency, whereby men, less equipped in terms of skills and social location, could attempt to gain status through 'hierarchies of masculinity' rather than 'hierarchies of social class' (Lohan 2007: 500). At the same time, dangerous practices were often undertaken 'unwillingly', by men under pressure to keep their jobs. Therefore, these practices were also rooted in the structural reality of men's occupational insecurities, not simply in their gender, which constrained their agency (their ability to change/improve their position) and adds to our understanding regarding why such negative practices may persist

amongst certain groups of men. Thus, perhaps unsurprisingly, when thinking about gender differences in health, men highlighted the ways in which stereotypically male occupations could underwrite the production and reproduction of men's poorer health. Furthermore, in demonstrating how economic crisis can reduce the power of working class men to withstand exposure to the conditions that compromise health, these men provided an illustration of the ways in which class position can be seen to translate into the structural determinants of health inequalities (cf. Scambler 2012).

The attitudes and expectations regarding men's role as breadwinners also led men to perceive that they had more stressful lives than women, which could contribute to gender differences in health. This viewpoint was premised on the notion that male employment was paramount, defined as a primary signifier of men's position as 'good' husbands/fathers, which generated a range of pressures for men particularly as they felt their employment status was closely scrutinised. Against this backdrop, men's employment and unemployment could result in certain 'compensatory' behaviours as a means of helping men cope both with the psychosocial assaults of the workplace and/or the insult of not being the breadwinner (Courtenay 2011). Moreover, men believed women were protected from the emotional impact of such conditions because of their primary role in the home and because they were characterised as less emotionally robust and therefore in need of protection. Phrases like "she can't handle too much" and "she's a worrier by nature" denoted a powerful message regarding women's apparent emotional fragility and informed men's collective rationale for not voicing their worries and concerns, which was also

perceived to impact on men's health. This repudiation of their own emotional needs could be viewed as men attempting to (re)construct a valued hegemonic masculine identity and sense of purpose often under difficult social and economic conditions (Coles 2009). Alternatively, it can also be viewed as an example of how men, who lack the economic means to elicit deference from their partners, can employ other kinds of resources available to them to achieve dominance and control (Schrock and Schwalbe 2009). However, regardless of the view taken regarding men's motivations, in making these connections their accounts illustrate the ways in which they perceived how psychosocial pathways to poorer health may be gendered.

As with all research, this study has certain limitations. The number of men recruited was relatively small and all self-reported as white and heterosexual. Therefore, the degree to which the findings are generalisable to other groups of men remains an open empirical question. In addition, these interviews were also encounters between men. Like in other such encounters, masculine identities were constructed and conveyed through what was said in the interview process. Therefore, we should exercise caution when interpreting men's representations of how they say they behave, which may differ from how men actually behave (Buchbinder 2013). However, the author adopted several measures to ensure rigour and establish confidence in the findings (cf. Mays and Pope 1995). The researcher was immersed in the research field, using extensive notes to capture their thoughts and observations of interactions with study participants during and after interviews. Repeat interviews helped establish rapport and trust and enabled the researcher to



build continuing, fruitful relationships with respondents. The researcher continued to collect data until the point at which conceptual insights ceased to be generated. The data was also analysed in a thorough and exact fashion. Thus, along with ongoing theoretical contemplation, the researcher sought every opportunity to enhance the validity of this fine-grained, in-depth enquiry and to build confidence in the quality of the data. Therefore, although this was a relatively small scale investigation, the level of engagement of the men concerned and the rigor of the research process suggests that the findings are trustworthy. Additionally, it is also reassuring that the findings of this study resonate with previous investigations within the field of men, masculinities and health.

In summary, this article has demonstrated how gender differences in health-related behaviours, primary social roles and the associated stresses, were perceived to shape men's health in more harmful ways compared to women. It has also shown how men consistently sought to distinguish themselves from women, who they collectively defined as fragile and in need of protection, which offered men lacking in economic resources the means by which they could elicit deference within the home. As such, their accounts provide evidence of how men may engage in damaging practices in order to achieve and stabilise their dominance over women, as well as other groups of men. This article, therefore, contributes to the evidence that the construction and enactment of hegemonic masculine identities may come at a considerable cost to men's health in terms of emotional and physical damage. It also shows the value of shifting the focus of investigation beyond masculinity to include

the field of political economy, as this provides access to the potential pathways and mechanisms mediating the broader structural influences on men's health.

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