

Masculinities and help-seeking

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Beyond the caveman: Rethinking masculinity in relation to men's help-seeking

Dr Hannah Farrimond

Egenis (ESRC Centre for Genomics in Society), College of Social Sciences and
International Studies, University of Exeter, St German's Road, Exeter, EX4 4PJ

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Abstract

Statistically, men make less use of health-care services than women. This has been interpreted as the result of the ‘hegemonic’ masculine code in which ‘real’ men are understood to be physically fit, uninterested in their health, and self-reliant. However, less attention has been paid to understanding how hegemonic masculinity intersects with the wider Western socio-cultural contexts of men’s help-seeking, particularly the valorisation of health as a form of social achievement. This paper presents the results of interviews with fourteen higher socio-economic status (SES) men to uncover their ‘interpretive repertoires’ in relation to health and illness, help-seeking and masculinity. Although many interviewees drew on the stereotype of the ‘Neanderthal Man’ who avoids the doctors to explain help-seeking by men *‘in general’*, they constructed their own experiences of help-seeking in terms of being responsible, problem-solving and in control. It is argued that the framing of help-seeking in terms of ‘taking action’ chimes with an increasingly pro-active ‘expert patient’ approach within Western health-care. This conceptual reconstruction of the dominant masculine code in relation to help-seeking, from ‘Neanderthal Man’ to ‘Action Man’, may lead to greater gender equality in terms of accessing health-care. However, it has the potential to exacerbate social inequalities between men from different SES groups.

Key words: Men’s health, masculinity, masculinities, help-seeking, gender difference

The aim of the study presented in this paper is to unpack and critically examine the theory that hegemonic masculinity, with its emphasis on control, self-reliance and the suppression of emotional or physical distress, is incompatible with help-seeking practices; that ‘real men don’t visit the doctor’ (Courtenay, 2000b; Lee & Owens, 2002a, 2002b). Although a body of recent work has begun to question any simplistic link between constructions of masculinity and men’s health-care practices, much of the work has been theoretical (Galdas, 2009; Schofield, 2010; Schofield, Connell, Walker, Wood, & Butland, 2000) or focused on specific illnesses related to gender roles, such as prostate or testicular cancer (Broom, 2005; Smith, Pope, & Botha, 2005). This paper adds to this literature by focusing on narratives concerning multiple symptoms and help-seeking practices experienced by a small sample of middle-class men in the UK. It uses this conceptually generative sample to explore how twenty-first century men cope with the tension between being traditionally masculine and the current emphasis on ‘being healthy’ as a social achievement.

Help-seeking is characterised here in a wider sense than just visiting a health professional or doctor. It includes how individuals become aware of, and respond to, symptoms of ill-health in terms of social norms and cultural practices (Galdas, 2009). As Zola pointed out, the ‘pathways to the doctor’ are often complex (Zola, 1973). Most individuals experience some clinical symptoms some of the time. Those that visit the doctor are not necessarily those with the most severe symptoms. People are ‘tipped over the edge’ to become a patient for numerous reasons. Many of these are not specific to the illness itself (such as pain levels) but include social, familial and work contexts, such as

not being able to function in these. Furthermore, patients use ‘lay networks’ of friends, families, colleagues or other individuals, to help them assess and respond to symptoms (Smith et al., 2005), as well as to seek help on their behalf (Zola, 1973). The question this study asks is not: ‘do men visit the doctor?’, but ‘*in what ways* do men visit the doctors (or not), for which illnesses and through which pathways?’

The notion that ‘men don’t visit the doctor’ has been framed by research indicating gender differences in both mortality and morbidity. Across the developed world, men are likely to die earlier and experience more heart attacks and mortality from cancer than women (Case & Paxson, 2005), although they suffer less chronic long-term illnesses. This has been argued to be the result of men’s health behaviour, or rather, their propensity towards unhealthy behaviour. This includes higher rates of violence, drug-use, unsafe sex, smoking and drinking coupled with less preventive action (for a comprehensive review, see Courtenay, 2000a). This unhealthy behaviour is coupled with a failure or delay in seeking medical help when ill. Men visit the doctors less often than women and use fewer health-services, even when reproductive services are accounted for, although the differences start to disappear when the health problem is serious (Stoverinck, Lagro-Janssen, & Weel, 1996). They may be less likely to seek help or treatment for psychological problems (Ussher, 1991). Men may also need encouragement to seek help from significant others such as their female partners (Norcross, Ramirez, & Palinkas, 1996).

However, the framing of these gender differences as problematic should be approached with caution. A recent report into differential gender access to the UK health-care system described the evidence base as ‘surprisingly poor’ (Wilkins, Payne,

Granville, & Branney, 2008). Furthermore, a simple head-count of who goes to the doctors and how often doesn't tell us what happens when they get there. There is evidence that although women visit the doctors more frequently, men consistently receive more aggressive, comprehensive treatment for the same disease (American Medical Association Council on Ethical and Judicial Affairs, 1991). Secondly, the bifurcation of health concerns, which portrays men as the 'forgotten victims' can end up problematizing difference for its own sake. It also ignores the medicalization of women's lives (Connell, 2000; Lee & Frayn, 2008).

Despite the complexity of gender differences in health outcomes, several theories have posited a relatively simple relationship between 'being a man' (or more specifically, a man as defined by 'hegemonic masculinity') and men's reluctance to be health conscious or seek help (Courtenay, 2000b; Lee & Owens, 2002a, 2002b). 'Hegemonic masculinity' is a term used to define the dominant form of masculinity acceptable within a patriarchal culture; what it means to be a 'real' man (Connell, 1995; Levant, 1996). This 'code' is a set of ideals and practices, such as being competitive, aggressive, emotionally contained, self-reliant and heterosexual. It is also linked to the social roles of men as material providers. This code frames power relations between men and women and between men and other men. Those who do not conform to hegemonic masculinity, such as those in 'marginalized' or stigmatized groups (e.g. working-class, ethnic minorities, homosexuals) are discriminated against, as are women. Being 'naturally' strong, not prone to disease or illness, unconcerned with pain or minor health problems, and self-reliant is typically masculine. Unhealthy practices, such as not going to the doctors, are seen as displays of masculinity. These have an ideological function: 'by

dismissing their health needs and taking risks, men legitimise themselves as the 'stronger' sex' (Courtenay, 2000b, p. 1397).

Some research has investigated the link between hegemonic masculinity and health by using quantitative scales to measure gender role or masculine ideology. For example, individuals who scored high on 'masculinity' using the Bem Sex Inventory reported significantly less symptoms than those who had scored low on 'masculinity', *irrespective of gender* (Annandale & Hunt, 1990). Similarly, another measure, the Conformity to Masculine Norms Inventory (CMNI) (Mahalik et al., 2003) has shown a significant negative relation between high scores on the inventory and attitudes towards psychological help-seeking. Qualitative research has also explored the relation between masculinity and health behaviour in older men (McVittie & Willock, 2006), in Latino and African American men for sexual health (Kalmuss & Austrian, 2010), for heart disease (Emslie & Hunt, 2009) and depression (Emslie, Ridge, Ziebland, & Hunt, 2006). O'Brien and colleagues found that in focus groups with Scottish men, reluctance to seek help was perceived a masculine behaviour, particularly amongst the younger men (O'Brien, Hunt, & Hart, 2005). When the men did seek help (and thus depart from the 'hegemonic script'), they did so within a prescribed set of masculine 'illnesses' and 'behaviours' such as seeking help for sexual dysfunction or to maintain work, which allowed the help-seeker to maintain their masculinity.

Although recent research into gender roles has emphasised the dynamism and fragmentation of masculinity (Connell & Messerschmidt, 2005; Segal, 1990), it is a key tenet of 'Men's Health' that masculinity is to blame for men's lack of interaction with health services (Cranshaw, 2007). However, being masculine not the only or most

important aspect of the social self in contemporary Western society. Another highly relevant social identity is that of being 'healthy'. Crawford has argued that in late modernity, health has become a pre-eminent value in its own right (Crawford, 1994). This is because 'health' has become an arena in which the social values of the Protestant work ethic of self-control, self-denial and individual responsibility can be displayed. Furthermore, this valuation of health is ideologically driven; dividing up the 'unhealthy' and thus less morally worthy, from the 'healthy' who are socially valued. 'Unhealthiness' is projected by the middle-classes onto already stigmatised groups, such as single mothers or the working-class as a way of maintaining their 'fitness to rule'. It is thus the duty of all citizens to be 'healthy', to engage in protective behaviours and manage the risks of their environment (Petersen & Lupton, 1996).

This leaves us with a tension: how does the need for men to dismiss health risks and take risks that Courtenay describes fit with the need to be a proactive healthy citizen? One explanation of how some men engage in help-seeking practices focuses on the 'pluralization' of masculinities (Connell, 2000; Galdas, 2009). Galdas cites the work by Emslie and colleagues (Emslie et al., 2006) on depression, a condition in which it is difficult to display traditional masculinities. They found that although most men drew on hegemonic ideas in relation to suppressing emotion, some men had reconstructed new identities outside this ideal, for example, portraying their creativity and sensitivity in living with depression as a positive aspect. Robertson has also found that some men drew on other aspects of identity (e.g. being gay) to legitimize healthy behaviour in relation to mental health (Robertson, 2003). Galdas's work with South Asian men shows that they do not see help-seeking in relation to heart attack symptoms as less manly or weak, but as

an appropriate social norm (Galdas, Cheater, & Marshall, 2007). Galdas concluded that in some social contexts, different identities (e.g. being gay or South Asian) may be prioritized over being masculine. However, it is far from clear that men are prioritizing alternative (i.e. non-dominant) identities when they seek help from health professionals.

A second strand of theorising about men who are seek medical intervention is provided by Lee and Frayn (Lee & Frayn, 2008). They argue that the move towards a preventive model in health represents a ‘feminisation’ of health, in which being typically ‘female’ and a passive recipient of medical intervention is valued, and being typically ‘male’, and being resilient and self-reliant, is seen as a medical ‘problem’. They illustrate this by a gendered analysis of cancer screening practices, pointing out that although the men’s health movement has sought parity with women’s screening, current research suggests such screening to produce anxiety and increase medicalization. Lee and Frayn certainly make the case for over-medicalization in the case of screening. However, it does not follow from this that all help seeking is unnecessary or inappropriate for men. Nor is it clear why they characterise help-seeking as a passive ‘feminine’ act (about ceding control to another). Newer notions of the patient in preventive medicine characterise them as ‘active’ or as an ‘expert’ who takes charge of their illness and becomes equal to the health professionals treating them.

A final strand of thinking about masculinity and the valuation of health comes from research into media representations of men’s health. Cranshaw conducted a critical discourse analysis of the popular UK men’s magazine ‘Men’s Health’. He argues that such magazines have strategies to reconcile paradoxical dominant hegemonic (‘heroic’) notions of masculinity with caring for one’s health by emphasizing the entrepreneurial

nature of the individual in creating the healthy (and aesthetically pleasing) body. This is, he argues, in line with Rose's notion of the body as a site for self-improvement (Rose, 1996) and the neo-liberal social valuation of self-reliance. That magazines which have a direct commercial interest in promoting 'men's health' have these strategies is not surprising; their consumption rests on normalising and reconciling the two concepts. However, other studies have shown that the mainstream print media still favours hegemonic conceptions of men and women in relation to health, with women portrayed as the carers of infantile men who have to be persuaded to visit the doctors (Lyons & Willott, 1999). Furthermore, it is not clear where conceptualising newer healthy masculinities in terms of epitomising self-reliance leaves help-seeking behaviour, which by its nature involves turning actively outwards to seek care.

This study therefore sets out to investigate the socially situated health practices of help-seeking amongst a sample of UK men, particularly focusing on their 'interpretative repertoires' (or sets of everyday discourses) (Wetherell & Potter, 1988) concerning masculine and healthy identities. The sample of middle-class professional men was deliberately selected to explore the tensions between theories which suggest hegemonic masculine codes are associated with avoiding help-seeking and theories of the valuation of being healthy. Both are theories of social dominance where it might be expected that the middle-classes (as the dominant social group) would most obviously evidence these ideals and the practices associated with them.

Method

Episodic interviews

This study utilised a specific type of qualitative in-depth interview known as the ‘episodic interview’ (Flick, 1997, 2000). In essence, the episodic interview invites individuals to tell a series of personal stories or experiences from their lives. These are specific to the topic under consideration; in this instance, participants were asked to recount real-life episodes connected with health, illness and care-seeking. The episodic interview is designed to elicit both episodic (linked to concrete circumstances) and semantic knowledge (abstract and decontextualised). In doing so, it aims to overcome some of the inherent difficulties associated with the narrative and semi-structured formats. As Holloway and Jefferson have argued, semi-structured interviews, with their structure of quick questions and answers and language of abstract questions tend to elicit intellectualizations or generalized statements (i.e. semantic knowledge), rather than concrete events, practices and actions (Holloway & Jefferson, 1997). On the other hand, narrative interviews which hold to the uniqueness of the biography of the participants can run into difficulties with thematic comparison across subjects. They can also be very long. The episodic interview acknowledges the innate narrative aspect of human experience, however, its more structured nature also allows for the exploration of pre-theorised ideas.

Flick produced a nine phase interview format to guide researchers for using episodic interviews. The key difference with a typical semi-structured interview is the inclusion of a direct question to tell the interviewer about stories, experiences, instances or ‘times when that happened’ after every question. This principle of eliciting stories is explained to the interviewee at the start of the interview so that they know what to expect (Phase 1).

So, the interviewer may ask *'How is your work affected by health/illness?'* followed by *'Can you give me some typical examples or instances to illustrate that?'* The aim is to continually and systematically keep the interview grounded in happenings and events rather than speculation or abstract reasoning. The interview questions are produced according to a guide that comprehensively covers the topic of interest, focusing on key moments rather than in a chronological biographical format. The phases and the questions used in this study are shown in Table 1. As can be seen, Phases 1 to 4 focus on eliciting narrative 'episodes'. Semantic knowledge, or argumentation, was the focus of Phase 5 which asked for more abstract opinions. No questions were asked explicitly concerning gender/masculinity and health until this 'argumentation' phase. No direct questions were asked about 'Neanderthal Men' or 'cavemen'; the use of these terms was very much the vocabulary of the participants and not the researcher.

Phases of episodic interview

Phase One: Introducing the episodic interview principle

Phase Two: Concept of topic/Biography

Subjective definition

First experience

Most significant experience

Experience of healthiness

(Repeat with topic of ‘illness’)

Phase Three: Meaning in everyday life

Concrete health practices

Illness prevention

Domains of everyday life: Household

Domains of everyday life: Work

Domains of everyday life: Social

Phase Four: Central focus on the topic

Reaction to minor/explicable symptoms

Reaction to major/mysterious symptoms

Care-seeking from non-professionals

Avoidance

Expectation

Information

Care-seeking from professionals

First experience

Most significant

Delay

Avoidance

Phase 5: General opinions or attitudes towards topic

Perceptions of gender difference

Phase 6,7,8 and 9

Questions used in this study on the topic of health and illness

‘I’ll ask you lots of times, can you tell me about a situation, story or experience related to health and illness. Are you ok with what you are being asked to do?’

The participant is then asked *‘Can you tell me about a typical example or story or time when this happened to illustrate that?’* after every question

‘When I say the word ‘health’, what do you think of?(Can you tell me about a typical example...)’

‘When you look back, when did you first think about health?’ (Can you...)

‘When has health been of most importance in your life up til now?’

‘There are times when we feel healthier than at other times. Can you tell me about a time when you felt really healthy?’

‘Could you tell me about yesterday, what did you do to do with health?’

‘What did you do to stop yourself getting ill?’

‘Who in your household or family looks after health/illness?’

‘How is your work affected by health/illness?’

‘If you think about your social life, what role does your health play in these situations?’

‘Sometimes we get symptoms such as a sore throat. What do you do if this happens?’

‘Sometimes people get other symptoms which are less obviously explainable, such as a lump. What do you do?’

‘If you were going to talk about a health problem to someone who wasn’t a doctor, who would you talk to?’

‘Do you ever avoid telling close friend/family about a health problem?’

‘What do you expect from your partner when you are ill?’

‘Where do you get most of your information about health/illness?’

‘When you think of going to the doctors, what do you think of?’

‘When was the first time you went to the doctors?’

‘When was the most important time you went to the doctors?’

‘Have you ever delayed/hesitated about seeking medical help?’

‘Have you ever avoided going altogether?’

‘Do you think men and women perceive health differently? Why?’

‘Do you think that in general men and women react to being ill differently? Why?’

‘Sometimes it might be said that men avoid going to the doctors or reporting their illnesses? Do you think this happens and why?’

Noting of small talk after interview, demographic information, feedback on method and analysis of interviews

Table 1: Nine phases of the ‘episodic interview’

Participants

Fourteen men aged 20-60 were invited to participate through circular emails placed initially within workplaces (e.g. architectural practice, IT consultancy), with participants asked to suggest other potential interviewees. Those that were interviewed were therefore part of a relatively similar 'social milieu' (Bauer & Gaskell, 1999) of professional men, although they varied by age (mean age 41, s.d. =14.08), sexuality (one described themselves as gay, the others as heterosexual), ethnicity (one described themselves as Anglo-Indian, the others as White British) and marital status (seven were married, two having been previously divorced, three were in partnerships but not married and four were single). In terms of their socio-economic status, they were predominantly engaged in professional or white collar jobs (e.g. engineer, lawyer, artist). Two were semi-retired from their professions and one owned his own design business. Eight of the men currently had access private health-care, or had had access in the past, including six out of the seven men over 40. Typically it was provided by their employers as part of a benefits package. Pseudonyms are used throughout.

Procedure and analysis

Participants were given an information sheet and consent form in accordance with the ethical requirements of the LSE Ethics Committee. Participants were interviewed in their own homes or in their workplaces by the author. The interviews followed the episodic interview design and took approximately one and a half hours each. They were tape-recorded and later transcribed. A manual thematic analysis was conducted (Flick, 1997). This consisted of a preliminary reading of the transcripts from which a coding frame was

developed. This included broad pre-theorised categories (e.g. marital status and health) as well as new themes that emerged from the material. The transcripts were then re-coded using the coding frame by the author.

Results

i. Social contexts and life challenges

In contrast to some groups of men in which interpretative repertoires of health have been studied (e.g. Campbell, 1997), this group of men did not have poverty-stricken or dangerous lives. Nevertheless, they had distinct 'life challenges' in relation to health. Most feared lifestyle illnesses or diseases of longevity such as heart disease and cancer rather than infectious illness in relation to themselves, although two told of the deaths of their children from meningitis and hepatitis as paradigmatic examples of how *'everything can change in an instant'* (William, government advisor, aged 60). Nevertheless, they emphasised that 'being healthy' and being in control of one's health, is an important life goal in its own right, in line with Crawford's thesis. Many detailed quite extensive health maintenance regimes which took time and money (e.g. going to the gym), primarily to *'keep fit'* and *'look good'*. Additionally, some of the older members of the sample emphasised necessity of keeping healthy to avoid becoming ill in the context of aging.

This sense of high self-agency in relation to health was supported by their working conditions. All the men in this study currently held or had held professional occupations, which allowed them to negotiate episodes of illness perhaps more easily than if they had occupied a non-professional role. As several pointed out, they were paid by annual salary so there was no financial penalty for not going to work, even if there

was a moral desire to evidence fitness to work, to *'just get on with it'* (Shaun, IT consultant, aged 24). Furthermore, as Harvey, a junior architect in a large firm in Central London explained, it was relatively easy to accommodate his regular hangovers within office work:

I do 'nothing' tasks, like finding files or talking to my colleagues if I feel too bad to do close drawing work. No-one really notices. (Harvey, architect, aged 26)

The perception of a high sense of personal control over health was also based on relative financial security. All but one of the men who were over forty, for example, had private health care, and several participants reported going for Well-Man or company health-checks as part of their work benefits. This sense of control was coupled, however, with 'responsibilities'. These men were, as whole, achievement-oriented, taking pride in describing their work and active social networks, and, for the men over forty in the sample, their strong desire to continue this achievement into older age. Nevertheless, these 'goals' could also be seen as demands, given that they rarely mentioned dependence on others to provide them. The emphasis was firmly on 'good health' as a foundation for a 'good life'.

Interpretive repertoires I: Men vs Women

The differences between men and women in relation to health were often framed in generalised and essentialist terms, as the result of biological differences. Women's bodies were perceived as more complicated; or as one man put it *'there's more there to go wrong'* (Brian, telecoms engineer, aged 56). As found previously by Bendelow's work on pain and gender (Bendelow, 2000), women's experiences of menstruation and

childbirth were argued to give them a tolerance of pain and ill-health. This was linked to a more stoical attitude towards ill-health than ‘men in general’, who were argued to exaggerate their suffering in a stereotypical way. For example, Dave, an office worker in the City, recalled how the men in his shared house at university had reacted to common illnesses in a ‘*typically male way*’:

Well, I am obviously male, so illness to me is massive hypochondria because men do not take pain very well, especially not being ill. We [the men in the house] had coughs and colds and it was always a lot worse when we had it...the general consensus of opinion is women seem to have a much bigger pain threshold than men due to, you know, menstruation and stuff (Dave, office worker, aged 27)

‘Women in general’ were also perceived to be more oriented around health at several levels, from being concerned with diet and eating healthily, to noticing the health of others. Again, this was often framed in terms of essential biological difference, for example, one former higher education teacher (Paul, aged 59) cited an evolutionary argument he had read in the book ‘Why Men Don’t Iron’ that women’s brains were programmed for social interaction, which meant they were predisposed to pay more attention to other people’s physical well-being.

Interpretive repertoire II: Neanderthal Man vs Action Man

Another stereotype to emerge about men and illness was that ‘men in general’ do not go to the doctor. This was linked by several participants to the image of the ‘*Neanderthal Man*’ or as ‘*a hangover from cave-men times*’. This caricature is the

embodiment of the traditional male 'code' or ideology discussed in the introduction, where men are characterised as independent, strong, self-reliant, emotionally restrained, and additionally, heterosexual (Connell, 1995). Within this discourse, being ill and seeking help is associated with being 'weak' and with other excluded or subordinate masculinities, such as being feminine or homosexual:

There are people I know, like my brother who is Neanderthal Man personified and would refuse to go to the doctor, you know, EVER! Because he is healthy, and that's it. He seems to have some sort of strange thing where if you go to the doctor, you have 'lost the battle' and you are some sort of poof and you are wet. 'Nothing that a good night's sleep won't sort out, my son!'. Etcetera. (Tom , lawyer, aged 32)

The interpretive repertoire of 'men don't go the doctor' mainly emerged at the end of the interview during the argumentation phase designed to elicit more abstract opinions, in this instance, on the differences between the genders. Despite these generalized assertions, however, the earlier part of the interviews elicited numerous real-life narratives in which the interviewees went to the doctors for a variety of complaints. The men in this study had visited doctors' surgeries, health-clinics or walk-in surgeries for eczema, heart problems, lumps in their stomach, testicular lumps, anal discomfort, hearing disorders and numerous other symptoms. Several also had sought help from alternative practitioners such as chiropractors or acupuncturists for back problems or tennis elbow, or had bought alternative preparations such as arnica for swelling.

Many also reported episodes of persistence in help-seeking in the face of indifference by the doctor or an unsatisfactory encounter. Stephan, a 54 year old business

owner lived part-time in the West Country as well as in London. He emphasised how, as a self-employed individual who does much travelling, he had to be fit to run his company. He argued that as a result, he was pro-active in response to illness symptoms and persistent if not happy with the original diagnosis given by the doctor:

I went to the doctors fairly quickly about that...I'm not sure when, I may have got the pain again. But I dealt with it reasonably quickly and was reassured it wasn't cancer. The doctor didn't take it terribly seriously. But when I came down here, it got worse. I went to the doctor several times. I really did treat it seriously. But he just said 'oh, you've got haemorrhoids, everybody's got haemorrhoids'. I said 'No!' It must be worse than normal because there was constant pain. It was only when I got them to put this stethoscope or spectroscope in that they found it and I thought then 'how stupid, you could have done this months ago. (Stephan, business owner, aged 54)

Stephan also reported being a 'prime mover' in the end decision on whether and when to give him a hernia operation.

This propensity to be relatively proactive in seeking help in certain contexts was framed as 'taking action'. The episodes told by the men in the sample conformed to formulaic narrative structure, with little emotional detail beyond 'I was worried, so I then...' Indeed, the phrase 'so, I decided I had better do something about it' became somewhat of a mantra repeated for each illness episode. Talking about his reaction to a suspicious lump, Gary, a 24 year old sports scientist, clearly articulated the negotiation between old (Neanderthal) and new (Action) masculine identities in his decision-making process about whether to seek help:

I remember a couple of years ago when I found a lump under my left arm and, bloody hell, I was worried about it! I thought 'hang on, lumps aren't supposed to happen'. I mean, part of you, especially being a bloke wants not to be a hypochondriac and just go through it. I suppose it is some kind of bizarre masculine hangover from cavemen, I think. But half of you tells you that 'hang on a minute, quick diagnosis solves the problem'. If there is something there, get it sorted.

I would suggest, therefore, that the men in this study often characterized illness in terms of problem-solving. The construction of symptoms as something to 'sort out' is functional in the social context of this milieu which places a high value on self-efficacy, agency and taking responsibility.

Interpretive repertoire III: 'Mine' vs 'Our' Responsibility

There was also a complex set of negotiations concerning help-seeking practices in relation to the participants' immediate social networks and wider society. These negotiations involved drawing on multiple 'fluid' notions of masculinity according to context. For example, Hardeep was a civil engineer (aged 29) who worked in an organizational role on construction projects. He described how he would draw on traditional masculine norms of care-seeking within what he perceived as stereotypically 'macho' work environments, but drew on a different social norm of being relatively open about health issues within his own social milieu:

I don't really think it is due to general stereotypes of men not talking about their health with each other, because I don't really mind about it, but if I was going out

with a bunch of blokes who are brickies at work, I wouldn't really start talking about testicular cancer, but other people who are, perhaps... more enlightened about things...I hesitate to say more educated, because that's stereotyping...but maybe a bit more enlightened, a bit more enthused about it, then yeah, I wouldn't really have too much of a problem (Hardeep, civil engineer, aged 29)

This negotiation between identities was often subtle. Pete, an architect in his late-twenties detailed how he would talk about his illnesses to several of his close male friends of his 'ilk' in London, 'the type of people I associate with', but not with old friends from home whom he had grown up around. Some of the younger men in the study didn't live with their partners, which led them to have wide networks of communication about illness, but nevertheless to perceive help-seeking as their own responsibility. For example, Pete mentioned telling his (then) girlfriend who was a doctor about a lump under his arm and was asked if he would have told her had she not been a doctor:

I might have told her anyway, yeah. You know. But I might have just told her in passing really, as it is my health, my problem and I will sort it out (Pete, architect, aged 28)

The primary motivation for initiating discussions about illness within these social networks appeared to be finding the cause for symptoms than for gaining sympathy. Certain types of illnesses were also more popular topics than others. Sports injuries, or injuries sustained when drunk were talked of as a matter of pride amongst friends. Hardeep, for example, had injured his leg when playing football, and had told all the construction workers about the tackle, one of whom subsequently took him to hospital. In contrast with this openness, however, he also revealed he had had a testicular lump for

three years, yet had told no-one except his male best friend just two months previously. In line with other research (O'Brien et al., 2005), it is arguable that taboos relating to masculine identity and help-seeking may be shifting in certain social milieu from general reluctance to seek help, to norms and taboos against care-seeking for specific illnesses which are seen as 'unmanly' or threatening to masculine identity, such as having problems with the testicles.

A similar normative taboo concerning seeking help emerged from the reports of the two men who had mental health problems (depression) in the sample. Both had eventually sought help for their symptoms and had ongoing contact with mental health services and their regular GP practice. However, both reported that they had delayed telling anyone about their depressive symptoms early on, and that their help-seeking was very restricted to what one participant, Ben, an actor/stand-up comic in his early twenties called his '*inner circle*' of '*people who knew*'. He had transmitted information about his depressive symptoms slowly, from telling his mother, to involving a close friend, then visiting the doctor through their encouragement. However, he recounted no scenarios of open storytelling about his mental health experiences, as Hardeep had, for example, in relation to physical injuries in sport. Although both men with depression had to some extent reconstructed their identities to show their illness as positive (e.g. in Ben's case as related to his creative potential), their help-seeking when new episodes of depression occurred was often still delayed and limited. This reflects both the wide stigmatisation of mental illness in general, and the specific transgression of normative masculinity which is 'able to cope' (Emslie et al., 2006).

For others in the sample, such as older men who were married for long periods, their health-related identities had been formed as part of a couple and, as a consequence, there was less emphasis on individual responsibility for health. For example, several men in their fifties reported that they didn't mention any illnesses to people other than their wives, or, on occasion, their grown-up children and expressed incredulity that they should do so. This response to informal help-seeking amongst social networks may reflect more traditional male identities which surrounded some older participants as they grew up in the 50's and 60's, although, as Sam, a 55 year old artist who had been married for over thirty years suggested, this may be as much about ingrained norms as any belief that illness is a sign of weakness:

[If I am ill] I tell Sandra my wife I am not well and what I am going to do about it. But I suppose generally, I can't think of any good reason why anyone would be interested! There are friends and relatives I have who delight in telling people and I have always wondered why...it's a mystery. My dad had this thing where if you talked to anyone, it was a sign of weakness. I suspect I have picked up on that one...he always thought that to tell anyone anything about yourself that was an honest reflection of anything you were struggling with would given them one over on you. I don't feel like that. I just wonder why they would be interested.

Despite some identification with a traditional masculine ethos, many of the older men were pro-active help-seekers. They reported that their consciousness about health had increased greatly in the last decade. One retired higher education teacher, currently aged 60, for example, reported the age of 50 as a 'benchmark' for his health consciousness, primarily triggered by a cholesterol test (above 10) which he was told was

'very high'. To counter this, and his sense of 'getting older' he started engaging in daily health maintenance regimes, in particular, walking an hour a day, monitoring his blood pressure at home and taking statins. Many other men in this study reported having health problems, from cholesterol to a serious heart condition, picked up through preventive screening. These accounts suggest that there is no longer a clear dividing line between health maintenance, illness prevention and pro-active help-seeking from health professionals for this social milieu of middle-class, middle-aged men. As a consequence, it has become more normative for these men to encounter health-care professionals and to seek their help.

The descriptions of help-seeking in this social milieu also supported the notion that female partners have an active role in monitoring men's health and encouraged them to visit the doctor, in line with previous theorising (Norcross et al., 1996). Beyond this, however, the support was often described as reciprocal. Bernard, an auditor aged 55, reported how he and his wife Martha (who had recently taken early-retirement from teaching) decided to get a 'once-over' in middle-age by booking themselves a BUPA Well-Man and Well-Woman check. It was very much presented as a joint enterprise:

Since this BUPA thing, we went home and emptied our larder and our fridge and threw away all the crisps and everything and started again

A similar repertoire emerged over their shared decision-making over symptoms and seeking help, with both of them monitoring and encouraging the other to seek help:

A while ago I thought I was going to the toilet too often. I read something and thought it might be my age. I told Martha (his wife) about it and basically it is because we drink too much and I have to get up in the night...Martha is not

always as prompt as she should be, you know, popping to the docs, so we tend to take it in turns to persuade each other to go!

For these well-established married couples, health appeared to constitute a 'joint project' within their households. Encouraging each other to seek help in response to symptoms reflected a broader proactive mind-set concerning health.

Discussion

The 'interpretive repertoires' of thought and behaviour of the men in this sample made sense within their 'life challenge' to be individuals who are in control, achievement-oriented and responsible, in both their professional lives and at home. Consistent with Crawford's thesis, health was an arena in which these values could be displayed. Masculine and healthy identities were negotiated within the social contexts in which the men found themselves in, line with Zola's research. Masculine identities were negotiated according to who was present (e.g. work colleagues, friends of a similar 'ilk'), the type of illness (e.g. characteristically 'male' such as testicular lumps) and the identity demands of the situation (e.g. avoiding work, promoting a couple or 'joint' identity around health, or displaying sports injuries). A common repertoire emerged which drew boundaries between the hegemonic masculine stereotype of the doctor-phobic 'Neanderthal Man', which was associated with older generations and the working class, and newer help-seeking practices engaged which oriented around 'taking action'. By identifying themselves as the type of men to 'take action' in relation to symptoms, the men in this study identified themselves as healthy members of society. Given the strong ideological premise of hegemonic masculinity, that it affords power, this is perhaps

surprising. You might expect to see the most proto-typical displays of hegemonic masculinity amongst a middle-class group, such as the sample deliberately selected here. This leads me to agree with Gough that ‘we need to trouble the facile equation between hegemonic masculinity and ill health’ (Gough, 2006, p. 2486).

The question is, though, how should it be troubled? One inherent problem with the theorisation of hegemonic masculinity in men’s health is that it has become associated with a set of fixed values (e.g. self-reliance, aggression, dislike of homosexuality) and practices (avoiding health professionals, risk-taking) which are often reified in measurement scales which do not allow for the historical and cultural flexibility that Connell originally envisaged (Connell & Messerschmidt, 2005). Hence, help-seeking practices, which by definition require men to turn outwards, seem to flout the notion of self-reliance. Viewed with greater flexibility, it can be argued that Neanderthal Man and Action Man are not polar opposites as symbolic representations of help-seeking, but different facets of an evolving (and perhaps dominant) masculinity which emphasizes responsibility, self-agency and being in control. The men in this study were not prioritizing alternative identities, as Galdas (Galdas, 2009) suggested might account for some types of help-seeking, but reformulating dominant ones.

This is not surprising given the powerful valorization of health within Western cultures. ‘Being healthy’ (and in control) has become a mechanism for demonstrating ‘fitness’ to rule (Crawford, 1994). Top politicians are not ashamed to be seen on their treadmills and their medical records are under scrutiny. Taking action to solve health problems is being reformed as a masculine act. The importance of health as a social value is also evidenced in this sample by the men in their fifties, many of whom described

reciprocal patterns of help-seeking with their partners as part of the life project of 'being healthy'.

Furthermore, health-care systems are not static entities. New forms of health-care are emerging which may increase men's contact with health professionals. As discussed in the introduction, the primary one of these is the move to a 'preventive' rather than 'reactive' model (Radley, 1994). The reactive model depends heavily on the patient initiating the visit in response to the symptom, whereas the 'preventive' model focuses on assessing the risks and symptoms in a proactive way, through 'silent' non-symptomatic indicators (e.g. blood pressure or cholesterol) or through screening (e.g. for aortic aneurism). This preventive approach, reinforced by economic incentives for surgeries in the UK, is having the effect of bringing previously unavailable populations of middle-aged and older men into GP surgeries in much greater numbers, as reflected by the experiences of several men in this study who had had both private and NHS screening. However, in treatment pathways that depend heavily on patient initiation, such as for chest pain (White & Johnson, 2000) or cancer symptoms, there remain concerns that the tendency of men to delay seeking symptoms may persist in delivering gender inequalities. It must also be remembered that 'access to interventions is not self-evidently a good thing' (Dixon Woods et al., 2005, p270). Indeed, as Lee and Frayn point out, a risk-based preventive model of health-care for men provokes the same concerns about the medicalisation of everyday life which have beset women's health.

However, where I depart from Lee and Frayn's analysis is the notion that help-seeking and being a patient is necessarily or always a passive (and therefore stereotypically 'female') act. The health-care system has also seen the recent emergence

of the 'expert patient' who is characterized by their active role in managing their health. This goes beyond the individualistic recreation of the body as part of a self-reliant, entrepreneurial role identified by Cranshaw (Cranshaw, 2007). It means being a compliant yet active patient who responds to medically initiated health promotion and intervention. Furthermore, within the renegotiated status leveling between health professional and patient, the patient has an opportunity to become 'expert' in his own disease; subscribing to relevant magazines, searching the Internet for research or social support, and taking a more active decision-making role with regard to treatment, which can include challenging medical expertise (Broom, 2005). Several of the men in this study were 'eMales' in Broom's sense or challenged their doctors on occasions. However, being an 'Action Man' in relation to help-seeking may be a role only afforded to those middle class men with the time, money and social status to 'take control' of their health. Men from lower socio-economic groups, with poorer self-efficacy, health literacy and less money may easily become disadvantaged.

In this sample, the tension between older masculine identities which encouraged avoiding help-seeking and newer forms of masculine identity of 'taking action' and being 'in control' was relatively unproblematic. In general, these middle-class men were able to negotiate between the identities depending on social context and make one more salient than the other when appropriate. Concrete instances of help-seeking were framed as masculine action-oriented behaviour, consonant with social values such as being in control and taking responsibility, thus to a large degree benefitting their social identities. Exceptions to this (such as the instances of delayed or limited help-seeking for testicular

cancer and depression) may reflect a newer illness-specific reluctance where masculinity is particularly threatened or not as easily reformulated.

So, what are the implications for help-seeking of the tension between the traditional masculinity of Neanderthal man and newer notions of health activism? Using the notion of men 'taking action' may have considerable mileage in health promotion as an image which promotes help-seeking as a masculine act. There are already examples of this; the American Diabetes Association's Modern Man's Health Campaign deliberately contrasts the old style of avoidance with the 'era of the modern man' who 'have a strong grasp of their disease and related conditions, they actively engage their health care providers and proactively manage their health' (American Diabetes Association, downloaded 21st April 2009). They offer an aspirational proactive masculine image to encourage men to be screened for Type 2 diabetes. A second approach might be to acknowledge the tension openly in health promotion discourses and activities, in line with Joffe's point that health promotion is most authentic (and therefore effective) when it reflects the lay thinking of patients (Joffe, 2002). Finally, not all men are in the position of experiencing a tension between older masculine notions of avoiding help-seeking and newer ones. Those who are marginalized, poorer or working/living in more traditionally masculine spheres may find the kind of fluid identity negotiation around health as evidenced in this sample much more of a challenge.

This study has several limitations. Talking about health with researchers constitutes a performance of health in its own right. For example, focus groups necessarily require men to perform masculinity and health in front of their peers which may lead to a gap between what men say they do in front of other men and what they

actually do in practice (O'Brien et al., 2005). This may be less the case within interviews, particularly episodic ones which ask for 'argumentation' (or general abstract opinions) separately from men's experiences, allowing the two to stand in relation to each other. Several men also specifically mentioned that they found it easier to talk to a woman about health. One critique the Men's Health movement has made of the NHS is that doctors' surgeries and clinics are 'male unfriendly' as they have predominantly female receptionists or nurses (Banks, 2001). However, this study suggests it is at least an open question whether numerically increasing men in front-line staff would encourage men to go to the doctor.

This work was intended to be conceptually generative (Crouch & McKenzie, 2006). It utilized a small and predominantly middle-class sample. Many of the older men in particular had experience of private-health care as part of a benefits package in their workplace. Only 11.5% of the total population of the UK has private health-care (Klein, 2005). The experience of these men regarding private health-care experiences is therefore not typical across the general UK population. As Segal has noted, class differences in health outcomes are often more pronounced than gender ones (Segal, 1990). Further comparative qualitative work with men from different social milieu and socio-economic groups would be highly informative.

In conclusion, any trip to a GP's surgery at 9am in the morning tells you that the stereotype that men don't visit the doctors is untrue. This paper has suggested that we should pay attention to the ways in which some middle-class professional men are reconstructing their masculine codes to incorporate help-seeking as 'taking action'. This moves the argument beyond the notion that men who are concerned with health or seek

help from health professionals are necessarily prioritizing alternative identities or becoming 'feminized'. For some men, in particular social milieu and in certain social situations, taking action in relation to health, prioritizing living well and living long, and treating doctors as equal decision-makers, may become a social norm. In doing so, they are proving themselves literally and metaphorically 'fit to rule'.

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