

Try to be healthy, but don't forgo your masculinity:

Deconstructing Men's Health Discourse in the media

ABSTRACT

The emergence of discourse around men's health has been evident now for at least 10 years across academic, policy and media texts. However, recent research has begun to question some of the assumptions presented concerning masculinity and men's health, particularly within popular media representations. The present paper builds on previous research by interrogating the construction of men's health presented in a recent special feature of a UK national newspaper (The Observer, November 27, 2005). The dataset was subjected to intensive scrutiny using techniques from discourse analysis and several inter-related discursive patterns were identified which drew upon essentialist notions of masculinity, unquestioned differences between men and women, and constructions of men as naïve, passive and in need of dedicated help. The implications of such representations for health promotion are discussed.

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Introduction

The emergence of discourse around Men's Health has been evident now for at least 10 years across academic, policy and media texts (see Courtenay, 2000; White, 2004). The increased attention afforded men's health can be traced to a number of interlinked factors, such as published statistics highlighting sharp sex differences in major illnesses, vociferous expressions of concern from health professionals, and media constructions of a 'crisis' in masculinity generally (see Horrocks, 1994). However, recent research has begun to question some of the assumptions presented concerning masculinity and men's health, particularly popular media representations (Gannon, Glover & Abel, 2004; Clarke, 1999; Lyons & Willott, 1999; Coyle & Sykes, 1998). A focus on media materials is important because of their power in defining and reinforcing specific meanings around health (Seale, 2002; Bury, 1997). The present paper builds on previous research by interrogating the construction of men's health presented in a recent supplement of a leading UK Sunday newspaper: The Observer (November, 2005). This feature forms part of a wider corpus of men's health

material collected from UK newspapers (Jan 2005-06) and is selected for analysis here because it contains a series of articles covering a range of relevant issues. Intensive scrutiny of this feature draws on techniques from discourse analysis (Potter & Wetherell, 1987) and aims to identify dominant representations of men's health and their implications for health promotion.

The term 'Men's Health' is now very much in vogue across academic, policy and media texts. It is typically associated with the following set of claims:

- there is now a men's health 'crisis' since men are particularly vulnerable to a range of health problems;
- men do little or nothing to protect their health;
- 'masculinity' is to blame for men's poor health;
- dedicated research, policy and service provision is required to address the problem of men's health

These interlocking claims are now discussed. Over the past ten years or so, the state of men's health has emerged as a key concern in the UK and beyond. The UK Government Department of Health has expressed concern about statistics showing men to be at risk from several major diseases because of poor diet, high alcohol consumption, smoking

etc. (Office for National Statistics, Social Trends 30, 2000; Office for National Statistics, Social Trends 34, 2004). This picture is repeated in Europe (White & Cash, 2004), Australia (White, 2002) and North America (Courtenay, 2000). For many disease-related phenomena, men are worse off than women (e.g. heart disease, mental illness, life expectancy), although there is considerable variation between men. For example, men from working class backgrounds are over-represented in figures for chronic sickness (Office for National Statistics, 2002; Baker, 2001).

The general vulnerability of men to disease is wryly conveyed by Dr Ian Banks (President, Men's Health Forum):

'If you compare all the major killers, such as heart disease and lung cancer, men easily come out best, from the undertaker's point of view'

(<http://www.menshealthforum.co.uk>, accessed 13/01/05).

In the academic literature, recent reviews on men's health (e.g. Courtenay, 2000; White, 2004) emphasise men's greater vulnerability to major health problems (physical injury, most cancers, obesity, suicide etc.). However, it is clear

that men's health research is in its infancy. As White (2004) acknowledges, traditional medical research was almost exclusively oriented towards white middle-class men, with findings generalized to women and other groups of men. Moreover, gender was not considered in any analyses, so that men qua men remained invisible. With a few exceptions, this situation has not changed significantly - there is still a dearth of health-related research in which gender is explicitly considered. While many studies do include sex as a variable, few explore how culturally dominant notions of masculinity and femininity might influence health practices. For example, a questionnaire-based study by Wardle, Haase, Steptoe, Nillapun, Jonwutiwes & Bellisle, (2004) found that women were more likely than men to report healthy eating, diet restriction and to place more importance on healthy eating - but there was little attempt to explore why this might be the case.

Another problem with research which is ostensibly concerned with men's health is the tendency to resort to stereotypical observations when gender is considered, notably that 'hegemonic masculinities' (Connell, 1995) play a negative role in men's health. Briefly, hegemonic masculinities work to oppress women and other men through a

range of ideals and practices such as competition, aggressiveness and heterosexuality. While many men will not actually attain or maintain culturally valued modes of masculinity, they nonetheless benefit through complicity with dominant ideals. Such privilege is not readily available to 'marginalised' masculinities, however, which are evidenced in groups of men who occupy relatively disadvantaged positions by virtue of categories such as class and race. In addition, 'subordinated' masculinities are those which are actively subjugated, such as the stereotypically 'effeminate' practices of gay men. So, hegemonic masculinities comprise sets of identities and practices which exist in relations of power to each other. Despite this complexity and diversity, hegemonic masculinity is often reduced to a singular construct - the stereotypical macho man for example - which is deployed in relation to the 'crisis' in masculinity and men's health. This tendency is lamented by Connell in his recent review of the concept of hegemonic masculinity (Connell & Messerschmidt, 2005).

With respect to men's health, the assumption that 'masculinity is bad for your health' is clearly challenged by masculinised practices which can be viewed as health-

promoting, such as sport. Although there are risks of injury, cardiovascular activities incorporated in sport and exercise are associated with health protection and even enhanced self-esteem (Crone-Grant, Smith, & Gough 2005). However, men often talk about sport and exercise in terms of masculine attributes such as competitiveness, toughness and homosociality rather than health benefits (Messner, 1992). So, the links between masculinities and health need to be investigated further, and should consider the burgeoning literature on masculinities which has been produced within the social sciences since the 1980s (Kimmel (1987); Seidler (1989); Connell (1995); Wetherell & Edley (1995); Connell & Messerschmidt, 2005). This literature has produced complex understandings of how masculinities are socially constructed within diverse contexts.

Although there is some recognition of variability in health outcomes between men according to social categories like class, age, disability and ethnicity, the complexities pertaining to masculinities have yet to be incorporated into health policy (Robertson & Williamson, 2005), professional practice (Seymour-Smith et. al., 2002) or mass media representations (Coyle & Sykes, 1998). The media in particular have tended to reproduce stereotypes relating to

gender and health (Lyons & Willott, 1999), and given the huge ongoing interest in men's health shown by the media, and the power wielded by media in promoting images of health generally (Bunton, 1997; Seale, 2002), dedicated analyses of media materials become important.

An interesting paper by Singleton (2003) presents a critical analysis of North American self-help books on men's health. The main argument is that such texts perpetuate a neo-conservative ideology which constructs individual men as responsible for attaining good health and well-being. Further, Singleton argues that this individualist rhetoric favours middle-class men and neglects the influence of social factors such as class and race on health status. Another study by Toerien & Durrheim (2001) reports on a discourse analysis of the magazine *Men's Health* (South African edition). Their focus was not so much on men's health as on conflicting constructions of masculinity ('macho' and 'new') and on how a compromise identity position of 'real masculinity' was promoted. This analysis highlights the continued appeal of hegemonic forms of masculinity for men, and, I would add, implies a resistance to actively adopting new masculinities and new health-protective lifestyles. Similar findings come from

studies of specific conditions, such as infertility (Gannon et al., 2004) and prostate cancer (Clarke, 1999).

In the UK there have been some critical analyses of newspaper texts featuring men's health. For example, Coyle & Sykes (1998) focus on male mental health as presented within a 'guide to men's health' provided by the British broadsheet newspaper The Independent. They found that a 'crisis' in men's health was unequivocally conveyed, with men presented as 'victims' of competing forms of masculinity ('traditional' and 'new'). They also found that hegemonic forms of masculinity, although implicated in negative health practices such as risk-taking, were at the same time promoted in favour of alternative, 'feminised' modern masculinities. This simultaneous valorization and critique of hegemonic masculinities leaves 'unhealthy' masculinities unchallenged and arguably absolves men from actively protecting their health. Another discourse analytic study by Lyons & Willott (1999) also considered representations of men's health by a UK Sunday newspaper, this time the Mail on Sunday, a more 'middlebrow' publication. In contrast to The Independent feature, the explicit target of The Mail on Sunday piece was women: 'a woman's guide to men's health'. Clearly, as the authors go

on to argue, men are presented as passive and helpless when it comes to health matters, and in need of women's protection. Although they acknowledge complexity and contradictions in the way men and women are construed, they argue that predominant discourse patterns located in the texts work to uphold conventional gender relations which position women as nurturers and men as naïve infants.

Building on such work, the aim of the research reported in this paper is to further interrogate contemporary newspaper portrayals of men's health. What follows then is a discursive analysis of a special feature on Men's Health which appeared in The Observer (November 27th, 2005), a leading UK Sunday newspaper whose readership can be characterised as middle-class, professional and left-of-centre. Latest readership survey figures (Oct 2004 - Sept 2005) cite 1,297,000 Observer readers, with more than half male (700,000), and about equal numbers of younger (<44) as older (>44) readers. The Men's Health feature explicitly addresses men rather than women, and presents several articles on a wide range of health issues. Such dedicated media features offer researchers an excellent opportunity to scrutinise prevailing assumptions about men's health, and with only a brief glance at this particular feature one

is struck by the sheer richness of the material. Specifically, the main objective of the analysis is to deconstruct men's health discourse within the special feature and to argue for a more sophisticated conceptualisation of masculinity and men's health.

Method

The feature on Men's Health under scrutiny here contains 12 discrete units, 3 of which are small inserts covering 'the numbers' i.e. statistics about Men's Health which we can merge as one category (unit 4 below), thus making 10 discrete units (totalling 8,300 words approx.), as follows:

1. 'Men's Health Special: WARNING: being male can seriously damage your health' (lead article by 'Dr Ian Banks, Men's Health expert', 1387 words)
2. 'Doctors' Notes' (quotes from a brief survey of medics, 283 words)
3. 'The Problem doctors: Be afraid, be very afraid' (journalist piece about men's reluctance to visit their GP, 1247 words)
4. 'The numbers' (select statistics on Men's Health: 4a, 4b, 4c)
5. 'Men and doctors: The three types' (brief sketch outlining 3 male stances on health and doctors, 226 words)

6. 'The Big dangers: Eight problems, eight solutions' (major health risks for men are summarized along with advice on minimizing these risks, 1446 words)
7. 'Prostate Cancer: My husband's silent killer' (focus on wife's account of her husband's 'silent killer', 1316 words)
8. 'Prostate cancer: the facts' (some information about prevalence, symptoms and treatment, 267 words)
9. 'Living very dangerously, men's sexual game of risk' (journalist piece on the problem of men and sexual health, 1123 words)
10. 'Sex disease: the facts' (five major diseases are covered in terms of prevalence, cause, symptoms and treatment, 448 words).

The approach to analysis was both inductive and informed by techniques from discourse analysis. My agenda was to critically examine how men's health discourse was constructed in the texts, to identify the main assumptions about men, masculinity and health. Specifically, my starting point was a stance that 'men's health discourse' presented narrow definitions of masculinity which ultimately would undermine health promotion efforts targeting men. Although this general position informed my data analysis, I attempted to remain open-minded to unanticipated themes and constantly sought to check my emerging analysis against counter

examples ('negative case analysis'). So, I included everything in my initial analytic sweep rather than focus specifically on material which confirmed my expectations. This meant detailed, systematic, line-by-line coding to begin with, a 'bottom-up' mode of analysis grounded in the data - akin to grounded theory analysis (Glaser & Strauss, 1967). During this process I identified emerging clusters of themes and constantly checked links between these. I also identified relevant discursive strategies used within the data, so there was a dual focus on content (what is being presented?) and process (how is it being presented?).

Discourse analysis is increasingly being used to study health-related phenomena (see Willig, 2004) and is particularly relevant for the study of media texts (see Day et al., 2004). The umbrella term discourse analysis belies a number of methods (Wetherell et al., 2001) and I am using an eclectic approach which focuses both on discursive practices (how discourse is used to perform specific functions within a text) and discursive resources (how texts are informed by wider cultural norms) (see Wetherell, 1998). So, I am interested both in identifying broad discourses of masculinity and health presented within the texts and in the ways in which such discourses are promoted (and resisted)

and bring off specific effects. For example, the discourse 'masculinity is bad for your health' can be analysed with respect to the purported content of masculinity (e.g. tough, risk-taking) and the ways in which 'unhealthy masculinity' is reinforced (e.g. by constructing *all* men as 'naturally' disinterested in their health).

Analysis

Merely eyeballing the above headlines presented in the special feature tells us a lot. Beginning with the lead article, which obviously sets the tone for the whole feature, the message that men are at risk is emphatically conveyed (the 'Warning!' formulation drawing upon the traditional caution about cigarette smoking and lung cancer). Similar strategies are used by the media to convey risk in other health contexts, for example women and drinking (see Day et al., 2004). The term 'male' is used which suggests that every man is similarly at risk by virtue of their biological sex status - there is no scope for individual variation. The author of this piece is presented as an 'expert', a device which is conventionally used to authorise an account, in this case lending credibility to the thesis portraying the perilous state of men's health. Glancing down the list of articles one is also struck by the language of facts and

statistics: 'the numbers'; 'eight problems, eight solutions'; 'sex disease: the facts' etc. Such discourse rests on constructions of masculinity as problem-focussed, wherein men are regarded as rational information-processors, and on medical terminology (cause, symptom, cure). Further, the insider account of prostate cancer (unit 7) is provided by a woman rather than a man, as if men are disallowed from depicting their own vulnerabilities (although clearly men's health has an impact on women's health, and women should make a contribution in debates about men's health). Finally, the theme of men as risk takers (and sexual adventurers playing a 'game') is presented in unit 9. These and other themes around Men's Health are presented below, where we highlight the discursive strategies used to construct a crisis in Men's Health and demonstrate the complex and contradictory ways in which the term is deployed.

Men's Health Crisis: all men equally implicated

In this section the construction of a 'men's health crisis' in the feature is interrogated to demonstrate that all men are incorporated and, implicitly, hegemonic masculinity is to blame for the poor state of men's health. The problem here is that the very term 'Men's Health' is a crude signifier which incorporates all men and erases differences

between men, whether in terms of social identities (by class, race, sexual orientation etc.) or lifestyle. Sometimes within the special feature variation is acknowledged, for example with respect to social class and health outcomes such as mortality (Unit 1), or age (e.g. young men's sexual risk-taking, Unit 9), but other dimensions of difference are barely mentioned, such as ethnicity (Unit 1), or not mentioned at all, such as sexual orientation. Interestingly, Seymour-Smith et al. (2002)'s study of health professionals' talk about men's health found that a heterosexual male patient was assumed. The little attention paid to diversity within the Observer special feature works to construct all men as the same and equally implicated in the 'crisis' in men's health (see also Coyle & Sykes, 1998).

The claim about the 'crisis' in Men's Health is announced by the bold 'Warning' headline which initiates the lead article and the whole special issue (unit 1). The crisis is further established using extreme case formulations (see Pomerantz, 1986) - 'Male health is under the microscope as never before' (emphasis added) - highlighting the contemporary urgency of the 'problem' (see also Lyons & Willott, 1999). Note also the scientific metaphor used, as if male (sic) health is an object that can be readily isolated, observed

and measured, a discrete entity that allows no contamination by variation or subjective experience.

The 'objective' status of the purported crisis in Men's Health is reinforced with reference to a raft of statistics presented within each feature:

'Many more men than women drink too much - 27 per cent of men (5.6 million people) drink more than the recommended maximum of 21 units a week; 7 per cent drink more than 50 units a week; and 40 per cent drink more than the recommended four units a day (compared with 23 per cent of women)' (Unit 6);

and in the separate lists of statistics, e.g. Unit 4a:

81 The average life expectancy for men in Kensington and Chelsea

76 The average life expectancy for men in the UK

33 per cent of young men use illegal drugs

28 per cent of men smoke

45 the average life expectancy for men in 1901

66 per cent of overweight men admit they could not be bothered to go on a diet even if it improved their sex lives.

Statistics, much like quotes from 'experts', are used to lend authority to a claim, since numbers and 'facts' are generally seen to stand outside personal opinion or bias (see Potter et al., 1991). As the whole feature is liberally peppered with statistics, the cumulative impression is one of a *real* medical predicament for men. The sense of crisis

is further reinforced by the constant insinuation that *all* men are affected. The inclusion of all men is signalled most obviously by the deployment of the key term 'Men's Health'. The impression of homogeneity is further maintained through the unqualified use of the terms 'men' and 'male', as in:

'...and all the other challenges that life throws at the male brain' (Unit 1)

'Men don't like to go near the doctor' (Unit 2)

'There is an ideal doctor's appointment in the minds of men (Unit 3)

'...messages that recognise male views and attitudes' (Unit 9)

The unequivocal message proffered by such statements is that all men are the same, that there is an essential masculinity which impacts (negatively) on health-related issues.

Difference between men is also obscured through the use of emphasis and generalisation, such as:

'In general men hate asking for anyone's help' (unit 2)

'The average male... generally chooses to stay away from the surgery altogether' (unit 3)

'...attitudes which so many men display towards their health' (Unit 9).

While ostensibly allowing for exceptions, phrases like 'in general', 'the average male', 'so many men' work to standardise the category of men, especially when exceptions to the rule are conspicuous by their absence (Potter, 1996). Even if exceptions were to be presented, it is likely that

such 'deviant cases' would be trivialised and as such would work to reinforce the hegemonic position (see Seymour-Smith et al., 2002).

Not only are all men implicated in the men's health 'crisis', but masculinity is construed narrowly as unhealthy and enduring, offering little hope of change. Men are presented as intransigent, difficult to persuade on health matters, and ultimately disinterested in looking after their bodies. A number of extracts used above conspire to fix (unhealthy) masculinity as global and stable. Here are some other examples:

'The problem is not GP-culture, it is male culture' (Unit 3)

'Men just don't like to go near the doctor, especially if they are asymptomatic. I'm no different, and I'm a man'.
(Unit 2)

'There is a culture of men just putting up with stuff. They somehow worry that they are wasting people's time.' (Unit 3)

'Brutal playground conditioning, probably reflecting millennia of evolution, has taught us that frailty must be punished with merciless teasing. In macho culture vulnerability may be cultivated only as a tool for the seduction of women. It should be hidden from the sight of other men' (Unit 3)

'...young men and their tendency towards reckless sexual conduct' (Unit 9)

'we should accept that their [young men] sex lives are often chaotic and that they often make decisions under the influence of alcohol and drugs' (Unit 9)

So, men are relatively unhealthy and unminded to change, a 'tendency' inherent within 'male culture' and fashioned by 'conditioning' and 'evolution' which we should 'accept'. In Seymour-Smith et al.'s (2002) study, it was found that health professionals interviewed used formulations like 'we know what men are like' to suggest the inevitability of 'unhealthy' men.

The alleged male concern about 'not wasting people's time' is interesting in that worry for others is usually associated with women. Perhaps this concern relates to a fear of being feminised as a malingerer or hypochondriac, since it is everyday and routine healthcare that is traditionally the realm of women (see Lyons & Willott, 1999).

Even male doctors are implicated in the construction of men as reluctant to seek help - a particularly powerful example which reinforces the plight of ordinary, untutored men:

'Dr T, a local GP, also male, also in his thirties, and also, by his own admission, a bit rubbish at seeking help when he needs it' (Unit 3)

And even when men are aware of certain symptoms and conditions through case examples at home or in social networks, they still refuse to seek help early. Unit 7, for

example, presents a poignant story of a man who died from prostate cancer told through the eyes of his wife:

'Despite the fact that two of Mike's friends had suffered with prostate problems he had never discussed the disease with his doctor' (Unit 7)

Such discourse serves to stabilize masculinity as essentially detrimental to health. In contrast, women and femininity are presented as health-conscious and healthy in the feature, and men are invited, sometimes explicitly, to follow the good example set by the opposite sex.

Why can't men be more like women?

Sex difference discourse is used throughout the feature and asserts that: men are the same (as are all women), men are different from women, and, tellingly, that women are better at caring for their bodies. In other words, the female pole of the sex binary is promoted as healthy whereas the male pole is relegated as unhealthy. There were a few exceptions to this trend wherein gender was dismissed as an irrelevance, but this was confined to two select quotes from doctors within one Unit only (2).

The statistics cited frequently draw comparisons between men and women and reinforce sex differences in health-related outcomes e.g.

- 3 the number of times men are more likely to commit suicide than women (unit 4b)
- 5 The average number of years by which women outlive men (unit 4c).

As one might expect, only statistics which reinforce the comparatively worse position of men are reported - statistics showing no difference or areas where men have better averages than women (see Connell, 2000) are omitted. Arguably, these comparisons not only describe sex differences in health-related problems, but imply a gender-based explanation i.e. men are more susceptible to major diseases because of *the way they are* (see also Seymour-Smith et al., 2002). This gendered account of men's health is presented more explicitly throughout the units:

'Why don't we all just accept that in general men hate asking for anyone's help (about anything - have you ever watched a couple trying to navigate round an unfamiliar town/city in their car?). Whereas women are often genuinely interested to have a variety of options and also seem in general more comfortable to put themselves in someone else's hands' (Unit 2)

This quotation from a doctor polled by the newspaper constructs sharp sex differences in help-seeking, implying a general feature of masculinity which extends beyond the health domain. According to the literature, help-seeking for

men connotes vulnerability and dependence, attributes disavowed within conventional masculinities which configure the male body as tough and impregnable (see Connell, 1995; Courtenay, 2000). Conversely, women's purported propensity to seek help is construed as positive open-mindedness rather than weak dependence. Autonomy, usually a privileged (masculinised) position, is thus marked as negative and unhealthy here, whereas the (feminised) concept of interdependence is valorized. Similarly, when men actually visit a doctor's surgery, their way of talking about their health is critiqued:

'[a] man had been suffering chest pains and he decided to use the analogy of a dodgy car part to explain it. Men are generally mechanistic about health when they are sitting in front of a doctor, while women take a more holistic approach' (Unit 1)

Although the statement is qualified ('generally'), an essential truth about men is nonetheless conveyed - 'men are generally mechanistic' - not men can be or some men are, thus suggesting that a mechanistic attitude is something inherent in (all) men. Men's alleged use of metaphors which construct their bodies as machines is considered an impoverished form of discourse, a view which reproduces the traditional notion that men are inarticulate about personal issues such as emotions and bodies, preferring action (or, in health contexts, inaction) rather than words. By contrast,

the 'holistic approach' which women are said to adopt is clearly favoured.

In addition, women were sometimes presented as prompting unwilling male partners towards healthcare services:

'Men don't generally like to go near the doctor, and when they do, it is usually because the lady in their life has nagged them silly.' (Unit 2)

The caricature of the nagging wife (and the hen-pecked husband) is reproduced here, a scenario where women are dominant within domestic and health spaces and men are subordinate (again, heterosexual men are assumed). Arguably, it is an unflattering portrait of both sexes, but in the context of men's health it portrays women as proactive and men as passive. Such discourse reinforces health as a feminised arena, and here is much evidence of women playing a central role in men's health across various contexts (see Oakley, 1994; Norcross et al., 1996). Or perhaps it is more accurate to suggest that *illness* is reinforced as a feminised arena while health (e.g. not needing to see a doctor) is implicitly construed as masculine? Regardless, the health supporting role of women is not disputed within the feature. For example, regarding past initiatives which targeted women to reach men, the criticism from the doctor-

author (Unit 1) refers to the number of men without partners and their resultant inability to benefit from their support. There is no alternative suggestion that men's' health promotion should target men directly.

Sex difference discourse is also used in relation to specific health problems, such as sexually transmitted infections (STIs):

'Men generally know less about sex than women, are less likely to visit any form of sexual advice service and get more of some STIs, such as gonorrhoea and genital warts. Their actions are too often based on their attitudes which so many men display towards their health generally: denial that they have a problem; delay in seeking help; a propensity to engage in risky behaviour; aversion to being tested; reluctance to discuss their problem.' (Unit 9)

Here, as well as reinforcing the standard message that men are reluctant to seek help, men are presented as less aware of bodily functions, in this case concerning sex. Men's' greater susceptibility to certain STIs is directly linked to their poor knowledge; indeed, men even suffer from 'denial'. But another feature of masculinity is implicated: 'risk-taking' - one of the attitudes that 'so many men' display. Risk-taking is conventionally associated with men and masculinity (White, 2002) and in a health context is judged irrational and dangerous. This is an inversion of the normative association between femininity and irrationality

(Ussher, 1991) - it seems that in the feminised domain of health, women are the rational actors whereas men are critiqued as illogical. This inversion is also interesting because women are positioned as at once rational (making sensible decisions about health) and embodied (being in touch with their bodies). Historically, mind and body are normally marked as diametrically opposing, gendered domains. In addition, women are construed as strong in the context of health while men are weak - another inversion of traditional gender positions:

'...man-flu, the under-recognised medical phenomenon where men are incapacitated for days by the same mundane virus that women endure with a degree of stoicism which leaves many men, frankly, baffled. One in three men takes time off work when he has a cold. For women the number is one in five' (Unit 3).

Despite men's continued dominance of the public sphere, men are portrayed as pathetic, self-pitying hypochondriacs who shirk work-related duties while women are robust and responsible (see also Lyons & Willott, 1999)

The implication of sex difference discourse in the context of men's health is that men need to change and, more specifically, should model themselves on women:

'What matters more is somehow getting across to men that they no longer need to behave like cavemen for them to be heroes - they can guzzle less, work less hard, drink less beer and fight less. And if they behaved more like women, they would start to live longer' (Unit 2)

Here, a bottom line argument (Potter, 1996) is used to alert men to the seriousness of their health-compromising lifestyles: if they do not change their habits and become like women, they will literally die earlier. A three-part-list (Jefferson, 1990) is used to emphasise men's unhealthy activities - excessive drinking, fighting and working - reinforcing hegemonic masculinities predicated on public consumption, violence and breadwinning. It is interesting that class and age dimensions of 'fighting' are left unexplored here - it is young working class males whose health suffers through aggressive episodes (see White, 1997) - again reinforcing the homogeneity of men.

So, there is a clear exhortation that men model themselves on their female counterparts. This is in contrast to the strategy of targeting women to care for men's health, as critiqued by Lyons & Willott (1999). However, given the ubiquitous construction of masculinity as unhealthy and (biologically) fixed, the prospects for changing men do not appear promising. How can men change if they are set in their (masculine, unhealthy) ways? The 'solution', it would seem, is for healthcare services to evolve in order to reach men, leaving men's masculinity relatively intact. For example, why persist in the fruitless task of encouraging

men to seek help when services can be brought to them in places where they are comfortable? The following section examines the main strands of male-centred healthcare presented in the feature and discusses the implications for masculinity and men's health.

Male-centred healthcare: maintaining masculinity

Despite the general assumption that men are disinterested in health-related issues, the feature (especially the lead article) also contends in places that men actually do care about their health. Specifically, it is suggested that men will divulge information about their bodies, but not in conventional healthcare contexts such as doctor's surgeries, which are regarded by men as feminised. For example, a recent poll conducted by the Men's Health Forum for the Department of Health is invoked, with quotations such as:

'The system and the environment feel like they have been set up for women... it feels like you are sitting in a ladies' hairdressers' (Unit 3)

While this claim is disputed in some instances, the dominant message across all the units is that healthcare is a feminised domain which deters men from presenting at GP surgeries and clinics. Consequently, the lead article advocates turning the spotlight on to the quality of

services for men, rather than on encouraging men themselves to change:

'Perhaps we spend too long chastising men over their attitude towards health rather than wagging the finger at the delivery of services, education, workplace practices and society's expectations' (Unit 1)

Here again, men are presented as uniformly embodying a particular (negative) stance towards health, implicitly one that is difficult if not impossible to change. Responsibility for improving men's health is therefore situated with poor services and broader cultural constraints on men which promote restrictive and unhealthy masculinities. With the focus on changing services, several recent 'male-friendly' initiatives are cited. For example, it is reported that 'men traditionally make more use of anonymous health advice such as telephone advice lines (men do not like 'help lines') (Unit 1). Hence, masculinity remains unaffected, since men are independently taking control of their problem by seeking out relevant information rather than, say, meaningfully disclosing problems to relevant others - an issue for many men since admitting to problems is coded as weakness within conventional masculinities (see Broom, 2005). Although such anonymous services are endorsed in the article, exclusive use of websites and phone lines is not advocated in this piece however, since a live consultation with a

health professional may reveal associated problems. Other methods are proposed, methods which are explicitly designed to appeal to men.

One such method is the 'well man clinic'. A Scottish example is cited in the article as a success story, managing to attract a good number of working class men for consultation and treatment. The effectiveness of such initiatives is presented as evidence that men (even 'hard' working class men) do care about their health and will consult health professionals in homosocial environments where they feel comfortable. Again, hegemonic masculinities may not be threatened by participation in an environment which mimics a male-dominated social club.

The third initiative which is valorized in the article concerns a series of publications aimed at demystifying men's health issues and offering advice for men in the style of a car maintenance manual. This approach consciously draws on men's 'mechanistic approach to health', a claim that is presented as fact, and the effectiveness of the manuals is warranted by citing sales figures ('over 120,000 copies'), awards ('from the Plain English Campaign in 2004') and their powerful impact on the author ('Haynes HGV Man, "the

practical guide to healthy living and weight loss" [the author lost three stone while compiling it]'). Men's 'mechanistic' approach is underlined in the planned 'Brain Manual' on men and mental health where 'coping with work, relationships, sex and all other challenges life throws at the male brain will be dealt with as if the man were a computer'.

So, mental health is reduced to the brain (not the mind), which is the same for all men ('male brain'), and used to process information (not emotions) like a computer. This is ironic because one reason why some men suffer mental health problems is an overly rational, problem-focused approach to emotional difficulties (see Coyle & Sykes, 1998). The narrow, essentialised definitions of masculinity signaled by the format of these manuals means that men are not encouraged to change their identities. Again, this is somewhat ironic given that masculinity has been implicated in poor health for men and that the main goal of these initiatives is to make men healthy. A final approach to improving men's health cited is the idea of introducing health advice sessions 'in schools, colleges, workplaces and other places where men congregate' (Unit 9).

Workplace initiatives are emphasized especially in the lead article:

'several workplace initiatives run by the Men's Health Forum with Royal Mail [Europe's biggest employer of men] and BT on issues ranging from cancer to obesity suggest that, while at work, men are most able and willing to discuss their health'.

Again, traditional masculinities are upheld: men are positioned in the public domain where they can achieve work-related goals free from the distractions of home. As well, the onus here is not on individual men to be proactive but on services to develop to attend to men's needs without any threat or cost to their masculinities. The idea of 'servicing' men reinforces the 'feminine' construction of health care and perpetuates conventional gender assumptions (women as nurturing, men as body-ignorant). The implicit message is that men are incapable of change or even that they are passive victims of forces beyond their control:

'Brutal playground conditioning, probably reflecting millennia of evolution, has taught us that frailty must be punished with merciless teasing' (Unit 3)

Similarly, men are presented as potential unsuspecting victims of enthusiastic health professionals:

'The only thing about GP surgeries that is men-unfriendly is that men don't like going to see doctors. Period. I knew one GP who used to go to the local pub to do impromptu men's health sessions [by pouncing on men at the bar]'. (Unit 2)

Further, men are infantilized as deluded, in denial, and weak:

'The Sporting Psycho: He could've played for England. Honest. But one tackle in a Sunday League game ended his professional career before it began... His back give shim a bit of gyp, but nothing a Neurofen can't handle. He doesn't need to go to the doctor. He's not sick, is he? (Unit 5)

'willful surrender to the slightest sniffle, requiring bed rest and childish self-indulgence, is the psychological tool that men use for toughing out every genuinely worrying gut ache and groin pain they feel the rest of the time' (unit 3).

The construction of men as immature fantasists who refuse medical assistance but complain of minor ailments reinforces the notion that masculinity is passive when it comes to health matters (see also Seymour-Smith et al., 2002; Lyons & Willott, 1999).

In sum, men are presented as unhealthy due to masculine vices, such as a reluctance to talk about personal issues, a sense of invulnerability, an ability to endure pain, and risk-taking. These vices go largely unchallenged within the special feature, however, with the 'solution' to the 'crisis' in men's health located within the development of dedicated services which can target men more effectively.

Discussion

The findings reported here, based on an intensive analysis of one set of media articles build on and extend previous analyses of media representations of men's health (Lyons & Willott, 1999; Coyle & Sykes, 1998). Men's health discourse presented within this special feature, as also identified by prior research, tends to rely on taken for granted stereotypes about masculinity which construct all men as essentially and always disinterested in caring for their health. This is even true for male doctors and men who have witnessed others suffering similar complaints. As well, the texts tend to erase social difference, particularly with regard to race and sexuality (class and age are covered, albeit briefly).

Further, men's stable masculinity, which positions them as invulnerable, emotionally repressed and detached from health concerns, means that they are incapable of transforming themselves into help-seeking healthy individuals. Instead, the onus is placed on services to adapt in order to reach men, thereby rendering conventional masculinities unchallenged. Conversely, women are presented as actively health-promoting and instrumental in caring for men, reinforcing women's traditional position as caring for

dependents (see Oakley, 1994), but also constructing women as strong and rational within the health domain, attributes normally associated with men and masculinity. Within the sex difference discourse conventional positions are inverted to some extent - women are empowered as proactive and mature, while men are subordinated as naïve victims.

With the above analysis we witness something of a shift away from directly enlisting women to look after men's health (see Lyons & Willott, 1999) towards directing services to accommodate and leave undiminished men's essential 'masculinity'. The problem with this scenario is that variation between men is neglected, as are the complexities and contradictions which pertain to masculine identities (see Connell, 1995; Wetherell & Edley, 1997). While one cannot deny the potency of statistics highlighting men's relatively poor health status along a number of key dimensions, we need to investigate differences between groups of men (e.g. by social class, race, age, sexual orientation etc.) and between individual men (in terms of biography, lifestyle choices etc.) to highlight diversity as well as commonality. It is encouraging that social class is recognized as a key factor in men's health status within the feature, but much more needs to be done to unpack the

meanings and practices which men present in health-related contexts. For example, two men sharing demographic features could conceivably display divergent orientations to health in general and specific health issues. A psychosocial approach is needed to account for the mutual shaping of individual and social factors in producing 'unhealthy' - and indeed healthy - men. We need to explore how masculinity is constructed in relation to various health issues by men from similar and different backgrounds (see White, 2002). We need to trouble the facile equation between hegemonic masculinity and ill-health and ask in what ways forms of masculinity can be marshaled as health-promoting so that strategies can be devised which appeal to more men.

The analysis also cautions against relying on traditional assumptions about masculinity in order to deliver effective services (Robertson, 2005; Scott-Samuel, 2006). While the initiatives discussed can and do produce effective outcomes for men's health, we should extend the repertoire of health promotion methods in order to reach men who do not align themselves with the masculinities advertised by car manual formats or who do not favour all-male meeting places. A caveat here is that opportunity and flexibility in reconstructing masculinity along more 'healthy' lines might

be a privilege afforded to relatively affluent middle-class men rather than men who inhabit environments brutalized by poverty, unemployment or racism (see Collins et al., 2000). In other words, some men have access to resources which enable 'healthy' reinvention of identities and practices while remaining complicit with hegemonic ideals.

More generally, the analysis also suggests the continued appeal, but also the flexibility, of hegemonic masculinities. Although we have seen that a space for male vulnerability has been opened up within mediated men's health discourse, we have also witnessed the prevalence, and indeed celebration, of health-defeating masculinised practices such as sexual risk-taking, stoicism and alcohol consumption. Perhaps because stereotypical aspects of masculinity such as machismo are now culturally recognized as outmoded and faintly ridiculous, a straightforward adherence to hegemonic masculinities is decried and some identification with 'new' masculinities forged (see Wetherell & Edley, 1997). But this articulation of apparently nonhegemonic masculinities can work, paradoxically, to reinstate hegemonic ideals. For example, other analyses have shown how men can now occupy positions within discourses of victimhood, but that such discursive work often functions as a 'backlash' to the

perceived excesses of feminism and women's power in general (e.g. Gough & Peace, 2001). In light of such work, Connell & Messerschmidt (2005) now underline the ambiguous quality of hegemonic masculinities and the dynamic deployment of masculinities in practice. The point is that when vulnerability is recognised, as it is in the media text examined, it is recognised in only a limited way, framed and sanitised within a wider acceptance of hegemonic masculinity, and presented as a problem for services while absolving men themselves from changing.

In terms of future research, it would be useful to extend the analysis to other newspapers and printed media. Indeed, relevant newspaper materials on Men's Health have been collected (Jan 2005-06) by the author and an initial scan of this data reinforces the analysis presented above. It would be especially useful to contrast representations of men's health found in different publications. The Observer newspaper, which provided the special issue on men's health analysed here, is part of the group which publishes the Guardian, a national daily with a largely professional left-leaning readership which is somewhat caricatured by the term 'guardian reader'. Arguably, gender politics receive more attention in these publications, and it is possible that

other UK broadsheets such as The Daily/Sunday Telegraph, generally perceived as more politically conservative, will uphold traditional gender relations in a much more strident fashion. Another point of comparison is between broadsheet and 'tabloid' newspaper representations. The notoriously shorthand and often blunt style of tabloid reporting suggests a less sophisticated approach to gendered issues such as men's health, although we must not presume substantial differences in content (see Day et al., 2004).

The wider role of the media in reporting health issues also bears discussion. In recent times, a clear consciousness-raising function has been ascribed to the media, as consumers turn to newspapers, magazines, television and the internet for information about health and illness (see Lyons & Willott, 1999). Hence the campaigning tone of the special issue on men's health, designed to provide solutions to the 'crisis' of men's health. While promoting awareness of health issues for their readers is a laudable service, there is a tendency towards simplification and distortion of expert knowledge on health (see Clarke, 1991). In a personal communication from one of the expert contributors to the special issue on Men's Health analysed for this paper, the heavy hand of the editor was greatly lamented. Problems of

sensationalism and reductionism aside, the editing process is clearly selective and arguably informed by, in this case, stereotypical understandings of gender which persist in contemporary society (see also Day et al., 2004), and specifically the now widespread notion of a 'crisis' with men and boys (e.g. Horrocks, 1994). In her analysis of media representations of prostate cancer, Clarke (1991) encountered themes about male sexual performance, competition, brotherhood and machismo which, she argues, may alienate ill men who do not identify with stereotypes of masculinity. She proceeds to argue that the mass media, along with other dominant institutions such as medicine, law and religion, reify hegemonic masculinities, perpetuate the subordination of women, and, ultimately, undermine (media) efforts at men's health promotion. Seale (2002), however, questions the media's purported maintenance of patriarchal gender relations in the context of health and illness. His media analysis of cancer reports found that women were often positioned more favourably than men as experts in the management of emotions. The analysis reported here suggests both the continued preoccupation with hegemonic, health-defeating masculinities and the positioning of women as knowledgeable experts in the arena of health and illness. At first glance, this gender difference discourse accords power

and status to women, but risks the reading that women are linked to illness complaints and men to health, since men supposedly do not use health services unless in serious pain. Overall then, the media can be seen to both reflect and reinforce hegemonic masculinities and 'crisis' discourse in reporting men's health. The extent of media influence on men's health promotion remains to be seen, however, and for this reason it is important to instigate reception studies in order to examine how media messages about men's health are taken up, modified and resisted by readers themselves.

In sum, men's health discourse, especially in popular media, needs to expand to accommodate a complex array of masculinities and acknowledge potentially meaningful differences between and within groups of men. Statistics which reinforce sex differences, and those which report differences between social groups e.g. by class, need to be treated with caution and contextualized with evidence from qualitative research on masculinities and men's health. We must not assume stable, uniform unhealthy masculinities, or ubiquitous sex differences, as men's health is a convoluted domain which the casual deployment of 'men's health' discourse glosses over.

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