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'It's caveman stuff, but that is to a certain extent how guys still operate': men's accounts of masculinity and help seeking

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Abstract

It is often assumed that men are reluctant to seek medical care. However, despite growing interest in masculinity and men's health, few studies have focussed on men's experiences of consultation in relation to their constructions of masculinity. Those that have are largely based on men with diseases of the male body (testicular and prostate cancer) or those which have been stereotyped as male (coronary heart disease). This paper presents discussions and experiences of help seeking and its relation to, and implications for, the practice of masculinity amongst a diversity of men in Scotland, as articulated in focus group discussions. The discussions did indeed suggest a widespread endorsement of a 'hegemonic' view that men 'should' be reluctant to seek help, particularly amongst younger men. However, they also included instances which questioned or went against this apparent reluctance to seek help. These were themselves linked with masculinity: help seeking was more quickly embraced when it was perceived as a means to *preserve* or *restore* another, more valued, enactment of masculinity (e.g. working as a fire-fighter, or maintaining sexual performance or function). Few other studies have emphasised how men negotiate deviations from the hegemonic view of help-seeking.

Keywords: Men's health; Masculinity; Help-seeking; Scotland

Introduction

As developments in sociological theories of gender, and masculinities in particular, have focussed more attention on men's health over the last decade there is increasing interest in whether and why men are unwilling to seek medical help. One recent review of men's help-seeking suggests that: "Men are often characterized as unwilling to ask for help when they experience problems in living. Popular stereotypes portray men … avoiding seeking needed help from professionals. A large body of empirical research supports the popular belief that men are reluctant to seek help from health professionals" (Addis & Mahalik, 2003, p. 5) . Men's "apparent reluctance to consult a doctor" has been identified as "an important obstacle to improving men's health" (Banks, 2001, p. 1058). Underlying this is a concern that fewer visits to the doctor and delays in getting timely advice may decrease men's chances for early detection, treatment, and prevention of disease. Thus, men's 'underusage' of the health care system has been clearly constructed as a social problem.

Empirical data do show that men consult their general practitioners (GPs) less often than women, and gender differences in GP consultation rates are particularly marked in the reproductive years (women in the 15–24 and 25–44 age groups are twice as likely to visit a GP compared to men (ISD, 2000). The higher number of

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consultations amongst women has attracted various explanations. At least part of the excess is accounted for by consultations for contraception and pregnancy, consequent on the medicalisation of reproduction. Beyond this it is often assumed that women have a greater propensity or willingness to consult than men (especially for 'minor' symptoms), although there is little empirical evidence to support this supposition (Adamson, Ben-Shlomo, Chaturvedi, Donovan, 2003; Hunt, Ford, Harkins, & Wyke, 1999; Wyke, Hunt, & Ford, 1998). Courtenay maintains that "the interpretation that men really are ill and they are simply denying it is rarely proposed" (Courtenay & Keeling, 2000). Some have attributed men's "reluctance" to seek help with certain physical, emotional, and sexual health problems (McKee, 1998, p. 601) to a 'poorer awareness of health' (Banks, 2001), or an unwillingness to take responsibility for health (e.g. Calman, 1993). Emphasis has also been placed on the "perceived or real barriers that prevent men from accessing the health care system" (Tudiver & Talbot, 1999, p. 47), and the 'constricting role expectations' or 'psychological difficulties' men are thought to bring to the consulting room (Maharaj, 2000; Good & Dell, 1989). It has been suggested that men may be put off by "male unfriendly" surgeries with few male receptionists and practice nurses and a preponderance of material on child and women's health in waiting rooms (Banks, 2001).[1] Furthermore, men are often portrayed as reliant on female partners (or other female relatives) in health matters, and women are said to encourage awareness of health issues, to assist men in interpreting symptoms, and to play a key role in persuading men to seek help (Norcross, Ramirez, & Palinkas, 1996; Seymour-Smith, Wetherall, & Phoenix, 2002); Tudiver & Talbot, 1999; Umberson, 1992; White & Johnson, 2000). However, some of this research (e.g. Seymour-Smith et al., 2002; Tudiver & Talbot, 1999) is based on doctors' perceptions of male patients as opposed to men's own reports of their experiences.

Whilst the presentation of sex-disaggregated data (and explanations for apparent differences) is an important starting point for research on gender and health, it has the inherent danger of reifying differences between men and women, and homogeneity within gender classes. This is particularly the case where the "commonsense knowledge [is that] men and women act differently" (Connell, 1995, p. 4). The statistics showing that men (as a group) consult less frequently than women, and the infrequently challenged 'commonsense knowledge' that they consult less 'readily' than women, raises questions about what help-seeking means for men and how it is placed in relation to constructions of masculinity. Connell has argued that:

> Rather than attempting to define masculinity as an object (a natural character type, a behavioural average, a norm), we need to focus on the processes and relationships through which men and women conduct gendered lives. 'Masculinity', to the extent to which the term can be defined at all, is simultaneously a place in gender relations, the practices through which men and women engage that place in gender, and the effects of these practices in bodily experience, personality and culture (Connell, 1995, p. 71).

Such arguments have been influential in the increasing recognition of the complexities of masculinity (see, for example, Brod & Kaufman, 1994; Hearn & Morgan, 1990; Mac an Ghaill, 1996; Whitehead & Barrett, 2001). It is now commonplace to view masculinities as multiple, contested, dynamic and socially located in both time and place. As Kimmel has remarked, "masculinity must be proved, and no sooner proved that it is again questioned and must be proved again" (Kimmel, 1994, p. 122). He describes masculinity as

> … a constantly changing collection of meanings that we construct through our relationships with ourselves, with each other and with our world. Manhood is neither static nor timeless; it is historical. Manhood is not the manifestation of an inner essence; it is socially constructed. Manhood does not bubble up to consciousness from our biological makeup; it is created in culture. Manhood means different things at different times to different people. We come to know what it means to be a man in our culture by setting our definitions in opposition to a set of 'others'—racial minorities, sexual minorities, and above all, women (p. 120).

Hearn and Morgan have suggested that "many of the central concerns of men and masculinities are directly to do with bodies" and that we need to "elaborate theoretical links between constructions of the body and bodily processes in society … and constructions of gender and gender identities" (Hearn & Morgan, 1990, p. 10). Although health has emerged as a focus of interest in masculinities research (see, for example, Watson, 2000), less empirical research has been done on masculinity and help seeking. This is surprising given the emphasis in social theory on 'what bodies do' (Connell, 1995, p. 71) as the perception of symptoms and signs of illness suggests disruption to normal 'bodily processes'. Those studies of help-seeking behaviours

[1] This assumption that men will prefer to consult male doctors has not been widely researched. One small study of health and help-seeking amongst young men (Richardson & Rabiee, 2001) showed that they had a marked preference to seek help from female doctors. In this study two of the three groups of men interviewed made homophobic comments about male doctors as 'justifications' for not being able to 'trust' them.